Greater Johnstown School District
Kindergarten Registration Package
2022-2023

This application package includes all forms necessary for registration into the Kindergarten program. Each form must be filled out in its entirety. Please ensure that you have signed all applicable areas of the packet.

All forms must be brought to the Knox Building, 400 South Perry Street. Open Enrollment will run February 14th-18th between the hours of 8:00 am and 3:00 pm. Please do not submit applications prior to that date.

Please check off each form as you complete it:

- Registration/Residency Form
- Racial/Ethnic Identification Form
- School Entrance Health History
- Home Language Questionnaire

You must also provide the following when submitting the application:

- Copy of Original Legal Birth Certificate with Seal
  (A copy will be made when you bring in the application)
- Immunization Records from your pediatrician
- TWO Proofs of Residency (for example)
  * Drivers License (with current address)
  * Pay Stub
  * Utility bill or other bill
  * Copy of Deed
  * Lease Agreement
  * Change of Address From (stamped by the Post Office)

If you have any questions regarding the registration process, please call 518-762-4611 ext 3120
REGISTRATION FORM
GREATER JOHNSTOWN SCHOOL DISTRICT
400 South Perry Street, Johnstown, NY 12095

Student’s Full Legal Name: __________________________________________________________________________________
(First)    (Middle)   (Last)

Sex: _______ Male   ______ Female   Grade: _______   Date of Birth _________________________

Street Address (Actual Residence not PO Box): ____________________________________________________________

Street number and Name
_________________________________________________________________________, New York        Zip Code: __________________________

City/Village

Mailing Address (PO Box Acceptable): __________________________________________________________________

Parent/Guardian: ______________________________________________________

Name

Home Telephone: ______________________________________________________

Cell Number: ______________________________________________________

Work Number: ______________________________________________________

E-mail address: ______________________________________________________

Custody: Child’s legal custodian is __________________________   Relationship: _________________

Child lives with: __________________________________________   Relationship: _________________

Is there a custody issue? __________________________

*If custodial rights have been altered, then proof must be in writing. See below for acceptable proof.

Order of Protection* __  (*If an order of protection exists, it must be submitted to building principal at time of student enrollment)

Parent/Guardian Information

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Home Address</th>
<th>Work Place and Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother (include maiden name)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Guardian</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is this a foster placement: _____ Yes _____ No

If yes, name of county ____________________________________________

If yes, copy of DSS 2999 Form required

☐ Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement __________________________________________________________________________ (living arrangements). If box is checked, please complete STAC-202 form. The answer you give will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don’t have the documents normally needed, such as proof of residency, school records, immunization records or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.
Brother(s) and Sister(s) Information

<table>
<thead>
<tr>
<th>Name (First and Last)</th>
<th>Sex</th>
<th>Birth Date</th>
<th>Living at Home</th>
<th>Present Grade</th>
<th>School Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What Mode of Communication does/do the Parent(s) prefer:
[ ] Written Notice  [ ] Phone Calls  [ ] Email  [ ] Person to Person

______________________________________________  Date: ________________________
Signature of Parent, Guardian or Student (for unaccompanied homeless youth)

Business Office Signature  Date

PROOF OF VERIFICATION OF AGE PROVIDED:
[ ] Birth Certificate
[ ] Baptismal Certificate
[ ] Other (see list below): ______________________

EVIDENCE OF CUSTODY PROVIDED:
[ ] Judicial Custody Papers
[ ] Guardianship papers
[ ] Signed affidavits

PROOF OF RESIDENCY PROVIDED:
[ ] Copy of Deed
[ ] Copy of Purchase Contract, with Letter from Attorney (including date/time of closing)
[ ] Lease Agreement or Statement from Landlord, Owner or Tenant from whom you lease or live with
[ ] Third party statement establishing the physical presence of the parent(s)/guardian(s) in the school district
[ ] Other (see list below): ______________________

Other proofs of Age:
Passport;
Official driver’s license;
State or other government issued identification;
School photo identification with date of birth;
Consulate identification card;
Hospital or health records;
Military dependent identification card;
Documents issued by federal, state or local agencies;
Court orders or other court-issued documents;
Native American tribal documents’

Other proofs of Residency:
Pay Stub;
Income tax form;
Utility or other bills;
Membership documents based upon residency (e.g. library cards)
Voter registration document(s)
Official driver’s license, learner’s permit or non driver ID
State or other government issued ID
Documents issued by federal, state or local agencies
Racial/Ethnic Identification – please answer both of the following questions.

1. Is the student Hispanic, Latino or of Spanish origin? Hispanic, Latino or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.
   Yes _____    No _____

2. Select one or more races from the following five racial groups: (Check all groups that apply to your child.)

   - American Indian or Alaska Native – a person having origins in any of the original peoples of North America
   - Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent
   - Native Hawaiian or other Pacific islander – a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands
   - Black – a person having origins in any of the black racial groups of Africa
   - White – a person having origins in any of the original peoples of Europe, North Africa or the Middle East

3. What language does/do the parent(s) prefer to speak?
   - English
   - Other: ________________________________  (Please specify)

______________________________  Relationship  ______________
Signature of person filling out form  Date
EMERGENCY CONTACT INFORMATION AUTHORIZATION

In order to adequately care for your child when he/she is in school, we need to have up-to-date information about your child’s care, as well as a current health and medical history. Please complete this form and return it to the school immediately.

<table>
<thead>
<tr>
<th>Student’s Name ____________________________</th>
<th>First</th>
<th>M.I.</th>
<th>Grade</th>
<th>Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student lives with: ___ Parents ___ Mother ___ Father ___ Guardian</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Father/Guardian

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Home Phone</th>
<th>Work Phone</th>
</tr>
</thead>
</table>

Mother/Guardian

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Home Phone</th>
<th>Work Phone</th>
</tr>
</thead>
</table>

Children will be released to parent/guardians and only those others listed below. This includes releases for any purpose, at any time, including at dismissal. Be sure to list all individuals that you may delegate for this responsibility and include all information. If there are any changes during the year, please contact the main office of your child’s school to report them.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Relationship</td>
<td>Address</td>
<td>Phone</td>
</tr>
</tbody>
</table>

Please complete back of form
Revised 2/14
Dear Parents/Guardians:

Please complete this questionnaire to the best of your ability and return it to the Health Office of your child’s school. This information is for the school medical record kept for each child and is of great help to the school nurse and doctor in understanding and helping to safeguard your child’s health. Thank you very much.

SCHOOL __________________________ Grade ______________

CHILD’S NAME ___________________________ Nickname __________

Birthdate ___________ Place of Birth _______________ Sex _____

Father’s Name _______________ Place of Employment _______________

Phone _____________________________

Mother’s Name _______________ Place of Employment _______________

Phone _____________________________

Home Address ___________________________ Phone ______________

Name of Doctor ___________________________ Address _____________

Name of Dentist ___________________________ Address _____________

Other Children in Family: Birthdates:

________________________________________

________________________________________

________________________________________

1. Is your child currently being treated for an illness or ongoing condition? _____
If yes, please describe ____________________________________________

________________________________________

________________________________________

2. Is your child currently taking any medication? _____
If yes, what medication? ____________________________________________
Why? ____________________________________________

3. Do you consider your child’s health to be: Good _____ Fair _____ Poor _____
4. Can your child participate in all school activities? _______________________

5. Does your child have any allergies (Foods, animals, medicines, bee stings, dust, pollen, other) _______________________

If he/she is allergic to bee stings, what actions do you want school personnel to take? _______________________

6. Please check if your child has had any problems with:
   - Asthma ( ) Persistent cough or wheeze ( )
   - Eczema ( ) Tiring Easily ( )
   - Frequent headaches ( ) Stomach aches or vomiting ( )
   - Dizziness or fainting spells ( ) Bowel movements ( )
   - Convulsions and/or Epilepsy ( ) Hernia ( )
   - More than 3-4 colds per year ( ) Kidney/urinary problems ( )
   - Tonsils or adenoids ( ) Painful joints ( )
   - Strep throat ( ) Feet or walking ( )
   - Frequent nosebleeds ( ) Bedwetting ( )
   - Anemia ( ) Frequent temper tantrums ( )
   - Heart problems ( ) Rapid changes of mood ( )
   - Diabetes ( ) Eating problems ( )

If so, is the condition under the care or observation of a doctor? _________
If YES, a statement from your physician is required.

7. Has your child had any:
   - Serious injuries ______ Describe _________________________
   - Serious illnesses ______ Describe _________________________
   - Accidents ______ Describe _________________________
   - Operations ______ Describe _________________________

8. Has your child had any of the following diseases?
   - Measles _____ Chicken Pox _____ Rheumatic Fever _____
   - German Measles _____ Mumps _____ Pneumonia _____ Scarlet Fever _____

9. When did your child last have a complete physical examination? ___________

10. Does your child have any eye problems? (difficulty seeing, crosses eyes, frequently reddened or watery eyes)
    _________________________

11. Does your child wear glasses? _________________________

12. Does your child have any ear or hearing problems? (frequent earaches, draining from ears, difficulty hearing)
    _________________________

13. Does your child wear a hearing aid? _________________________

14. Has your child worn braces or corrective shoes? ____ Are they still being worn?
    _________________________

15. Does your child have any speech problems (stuttering, difficult to understand, delayed speech development)
    _________________________
16. Is a language other than English spoken at home? ______________________

17. Will your child require any special health care in school? ______________________
   If yes, please describe: ______________________________________________________

18. Do you have any concerns about your child’s general health, behavior, or emotional well-being of which the school should be aware? ______________________________________________________

19. Was this a normal, full-term pregnancy? ______________________________


21. How did your child develop compared to other children the same age?
   Faster _____ Slower _____ About the same _____

22. Please check if your child had any of the following experiences which might influence his social or physical development:
   Frequent changes in residence ( )
   Death in family ( )
   Fires ( )
   Accidents/Injuries ( )
   Other ( )

23. Please check if you expect that your child may have any of the following problems when he/she begins school:
   Leaving home for the first time ( )
   Getting along with a new adult ( )
   Dressing, eating, toileting by himself ( )
   Getting along with other children ( )

24. Family History: Please check any that apply to your immediate family and explain the persons relationship to your child (mother, father, sister, aunt, grandmother, etc.)

   Physical disability (describe) ________________________________________________
   Epilepsy ________________________________________________________________
   Diabetes _________________________________________________________________
   Intellectual and Developmental Disabilities ______________________________________
   Depression ________________________________________________________________
   Vision Problems ___________________________________________________________
   Hearing Problems __________________________________________________________
   Thyroid Problems __________________________________________________________
   Scoliosis/back problems ____________________________________________________
   Convulsions _______________________________________________________________
   Heart Problems _____________________________________________________________
   Other ________________________________________________________________

25. Are there other concerns regarding your child that you feel the school should be aware of: ________________________________________________________________

Parent/Guardian Signature ____________________________ Date ___________
Convulsions __________________________________________________
Heart Problems ______________________________________________
Other _______________________________________________________

25. Are there other concerns regarding your child that you feel the school should be aware of: ____________________________________________

Parent/Guardian Signature ____________________________ Date __________
Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Home Language Questionnaire (HLQ)

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student’s home or residence?
   - English
   - Other
   specify

2. What was the first language your child learned?
   - English
   - Other
   specify

3. What is the Home Language of each parent/guardian?
   - Mother
   specify
   - Father
   specify
   - Guardian(s)
   specify

4. What language(s) does your child understand?
   - English
   - Other
   specify

5. What language(s) does your child speak?
   - English
   - Other
   specify
   - Does not speak

6. What language(s) does your child read?
   - English
   - Other
   specify
   - Does not read

7. What language(s) does your child write?
   - English
   - Other
   specify
   - Does not write

Please write clearly when completing this section.

STUDENT NAME:

First    Middle    Last

DATE OF BIRTH:

Month    Day    Year

GENDER:

- Male
- Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name    First Name    Relation to Student

HOME LANGUAGE CODE

This section to be completed by district in which student is registered:

SCHOOL DISTRICT INFORMATION:

Student ID Number in NYS Student Information System:

District Name (Number) & School

Address
Home Language Questionnaire (HLQ)—Page Two

**Educational History**

8. Indicate the total number of years that your child has been enrolled in school _____________

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

   Yes*  No  Not sure

   □  □  □  ‘If yes, please explain:

   How severe do you think these difficulties are?  □ Minor  □ Somewhat severe  □ Very severe

10a. Has your child ever been referred for a special education evaluation in the past?  □ No  □ Yes*  *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?

   □ No  □ Yes – Type of services received:

   Age at which services received (Please check all that apply):
   □ Birth to 3 years (Early Intervention)  □ 3 to 5 years (Special Education)  □ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?  □ No  □ Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

   ______________________________________________________________________________

12. In what language(s) would you like to receive information from the school? _____________

   Signature of Parent or of Person in Parental Relation

   Month:   Day:   Year:  Date

   Relationship to student:  □ Mother  □ Father  □ Other: _______________________________

---

**OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ**

NAME: ___________________________  POSITION: ___________________________

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

---

**NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW**

NAME: ___________________________  POSITION: ___________________________

ORAL INTERVIEW NECESSARY:  □ No  □ Yes

**DATE OF INDIVIDUAL INTERVIEW:**

MO  DAY  YR.

OUTCOME OF INDIVIDUAL INTERVIEW:

□ ADMINISTER NYSITELL  □ ENGLISH PROFICIENT

□ REFER TO LANGUAGE PROFICIENCY TEAM

**DATE OF NYSITELL ADMINISTRATION:**

MO  DAY  YR.

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

---

2  ENGLISH
Dear Parents and Guardians:

The School District very much appreciates the valuable service volunteers provide as classroom helpers, field trip chaperones, PTSA members, and in offering assistance with extra-curricular activities.

Greater Johnstown School District Policy No. 3150 states that all volunteers shall be subject to screening procedures, which may include, but are not limited to, reference checks, a criminal history check and request of information regarding previous criminal convictions, and investigation to determine whether a volunteer has a history of child abuse.

In an effort to protect the safety and security of children and school staff, it is required that volunteers complete a School Volunteer Application containing a consent to a criminal background check regarding convictions for child abuse or endangerment, sex or drug related offenses, or crimes of violence. While a prior criminal history will not automatically prohibit an individual from performing as a volunteer, any individual who refuses to consent to a criminal background check may be ineligible to be a volunteer in the Greater Johnstown School District.

A Volunteer Application form is attached and additional copies are available at each school. Applicants with children in more than one building need only submit paperwork at one site. Volunteers who are approved will be added to a District-Wide registry for the school year. District employees who volunteer will not have to go through an additional background check if they have already undergone background clearances.

It is hoped that everyone will understand that for the safety of our students and staff, these requirements are essential.

Thank you.
SCHOOL VOLUNTEER APPLICATION

NOTICE: PURSUANT TO DISTRICT POLICY, ALL VOLUNTEERS SHALL BE SUBJECT TO SCREENING PROCEDURES WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, 1) REFERENCE CHECKS, 2) A CRIMINAL HISTORY CHECK AND REQUEST OF INFORMATION REGARDING PREVIOUS CRIMINAL CONVICTIONS, AND 3) INVESTIGATION TO DETERMINE WHETHER A VOLUNTEER HAS A HISTORY OF CHILD ABUSE.

Volunteer Name:  
(First)    (Middle)    (Last)

Maiden/Alias/Other Names:  

Your Date of Birth:  
Month/Day/Year

Address:  
(Street)      (City)    (State)  (Zip)

If at current address less than five years, list previous residence(s):  

Telephone:  

Are you currently an employee of the Greater Johnstown School District?   No          Yes     Position/Building  
(Employees who have already received background clearances do not have to go through an additional background check)

Are you a (circle one) parent/guardian/family member of a student in the Greater Johnstown School District?             Yes            No

Child(ren) Name(s)    Grade/Teacher   School

Please respond to the following questions truthfully. Disclosure of a prior criminal history will not automatically prohibit volunteer status:

1.     Have you ever been convicted of child abuse or endangerment?   Yes    No
2.     Are you required to register as a sex offender?   Yes    No
3.     Have you ever been convicted of a felony?   Yes    No

MY SIGNATURE BELOW INDICATES THAT I CONSENT TO A CRIMINAL BACKGROUND CHECK FOR CONVICTIONS OF CHILD ABUSE OR ENDANGERMENT, SEX AND DRUG OFFENSES, AND CRIMES OF VIOLENCE; THAT I WILL ABIDE BY ALL APPLICABLE SCHOOL RULES AND BOARD OF EDUCATION POLICIES AND REGULATIONS; AND THAT THE INFORMATION PROVIDED BY ME IS TRUE, COMPLETE AND CORRECT.

Application Date:  
(Signature of Volunteer Applicant)

FOR SCHOOL USE ONLY:

APPROVED      DISAPPROVED      DATE:      SIGNATURE OF PRINCIPAL:  
