



District Administration Office

1 Sir Bills Circle, Suite 101 • Johnstown, New York 12095 • Phone: 518-762-4611 • Fax: 518-762-6379

ALICIA D. KOSTER
Superintendent of Schools

SCOTT M. HALE
Assistant Superintendent

STUDENT REGISTRATION

Telephone: 518-762-4611 Ext 3121

Fax: 518-762-5654

STUDENT REGISTRATION CHECKLIST

Please turn in the the following documentation to complete the registration process

Student Name: _____ Date: _____

_____ Registration Packet

_____ Proof of Primary Residency - **must provide proof as follows in addition to current Driver's Licence or Government Issued ID.**

**Please note that the District reserves the right to request further documentation reflecting residency within the GJSD school boundaries as requested by the Superintendent or their Designee*

- Current Drivers License or other official Government Issued ID, and
 - Copy of Deed and current Mortgage Statement (*current within 30 days*) for Primary Residence OR
 - Lease/Rental Agreement and Lease Payment Receipt (*within 30 days*) for Primary Residence, and
- Latest Federal Tax Return (*Front Page*) with Financial Information Redacted for Primary Residence

_____ Transportation Form, if applicable

_____ Most Recent Custody Papers, if applicable

Brother(s) and Sister(s) Information

Name (First and Last)	Sex	Birth Date	Living at Home	Present Grade	School Attending

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)

Central Registration 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:

Proof of Primary Residency - must provide proof as follows in addition to a current Driver's License or Government Issued ID.

**Please note that the District reserves the right to request further documentation reflecting residency within the GJSD school boundaries as requested by the Superintendent or their Designee.*

- Current Drivers License or other official Government Issued ID and,
- Copy of Deed and current Mortgage Statement (current within 30 days for Primary Residence)
OR
- Lease/Rental Agreement and Lease Payment Receipt (within 30 days) for Primary Residence, and
- Latest Federal Tax Return (Front Page) with Financial Information Redacted for Primary Residence

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:

- (may be requested)
- 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

GREATER JOHNSTOWN SCHOOL DISTRICT
1 Sir Bills Circle, Suite 101
(To be completed after student is enrolled)

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)

Signature of person filling out form

Relationship

Date



District Administration Office

1 Sir Bills Circle, Suite 101 • Johnstown, New York 12095 • Phone: 518-762-4611 • Fax: 518-762-6379

ALICIA D. KOSTER
Superintendent of Schools

SCOTT M. HALE
Assistant Superintendent

HOUSING QUESTIONNAIRE

Name of LEA: Johnstown School District

Name of School: _____

Name of Student: _____
Last First Middle

Gender: Male Date of Birth: _____ / _____ / _____ Grade: _____ ID#: _____
 Female *Month Day Year* *(preschool-12)* *(optional)*
 Other/Prefer not to answer

Address: _____ Phone: _____

The answer you give below 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.

Where is the student currently living? (Please check one box.)

- In permanent housing
- In a shelter
- With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): _____

Print name of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Date

Greater Johnstown School District
Johnstown, NY 12095
Health Record Update

Student Name _____ Grade _____

__ Check here (and provide details) if the 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 similar situation, or if the student is temporarily housed in a shelter awaiting permanent foster care placement. _____

CHILD FIND-The Greater Johnstown School District has an obligation to evaluate, with parental consent, and offer to students determined to be disabled who reside in the District, a free and appropriate public education. If you believe your child has a disability that requires specialized instruction or special accommodations to benefit and/or access our programs and services, please contact your child's building principal or the Director of Pupil Personnel Services at 518-736-1708 to discuss the process to initiate a referral to the Committee on Special Education or the §504 Team. If you suspect your child has a disability which adversely affects his/her educational performance and which may require special education and you are enrolling your child in a nonpublic school and are seeking supports for your child while he/she attends school there, you may initiate a referral by writing to the CSE in the school district where the nonpublic school is located.

Has your student been diagnosed with a high lead level? (Elementary Level)	YES	NO
Does your child have or recently been diagnosed with asthma?	YES	NO
Does your child have any significant allergies (peanut, bee sting, latex, etc)?	YES	NO
Does your child have a seizure disorder as diagnosed by a physician?	YES	NO
Does your child have diabetes?	YES	NO
Does your child wear glasses or contacts?	YES	NO
Does your child wear a hearing aid or suffer from a hearing problem?	YES	NO
Has your child sustained any significant injury, surgical procedure, or recent hospitalizations?	YES	NO
Does your child take any medication on a regular basis?	YES	NO

If you have answered YES to any of the above questions, please explain the specific conditions, the specific type of allergy, any activity restrictions, any special care required, the name and dosage of any prescribed medications. Additionally, please submit any relevant medical documentation (e.g., treatment plans, physician orders, diagnosis information, etc) to the Health Office.

Please list and explain any other health concerns you have for your child.

I hereby give the Health Office permission to share this information with the school staff for the safety of my child and to communicate with my child's physician office.

Parent/Guardian Signature

Date

In an emergency, when reasonable attempts to reach those people I have identified on the Emergency Contact Information Form have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or, in the event the designated preferred physician or dentist is not available, by another physician or dentist, and the transfer of my child to ANY hospital readily accessible.

Parent/Guardian Signature

Date

Refusal To Consent

I do not give my permission for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to _____

Parent/Guardian Signature

Date

Greater Johnstown School District

Administration Center

1 Sir Bills Circle, Johnstown, NY 12095

Phone: 518-762-4611

Fax: 518-762-6027

School Entrance Health History

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 (Primary) _____ 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 and submit appropriate documentation from the doctor to the Health Office. _____

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, 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	()
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, crossed 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? _____
20. At what age did your child walk? _____ Talk? _____ Toilet train? _____
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 person's 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 any other concerns regarding your child that you feel the school should be aware of: _____

Parent/Guardian Signature _____ Date _____



Lisette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

*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.*

Please write clearly when completing this section.		
STUDENT NAME:		

First	Middle	Last
_____	_____	_____
DATE OF BIRTH:		GENDER:
Month	Day	Year
_____	_____	_____
PARENT/PERSON IN PARENTAL RELATION INFO:		

_____	_____	_____
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	_____	<input type="checkbox"/> Father
		<i>specify</i>	<i>specify</i>
	<input type="checkbox"/> Guardian(s)	_____	_____
			<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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? _____

Month: Day: Year:

Signature of Parent or of Person in Parental Relation *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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO. DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	



STUDENT TRANSPORTATION REQUEST FORM

GJSD Transportation Office: 518.762.4611 X 3147 Phone

2026-2027 Academic School Year

(Please Print and Complete Form OR Make a Copy of the Form, complete and email to transportation@johnstownschoools.org)

One of our most important District responsibilities, in partnership with Brown/STA and its families, is to ensure the safe transportation of our students to and from school on a daily basis.

This form should only be used if you qualify for transportation based on the policy listed below. When requesting transportation for your Student(s), please complete the following information in its entirety. One Request Form per student is required.

Students are eligible for **Home to School** transportation based on the following:

- **Grades K-4** *All students are eligible to receive transportation*
- **Grades 5-8** *All students in grades 5-7 are eligible to receive transportation. Grade 8 students must live 1.5 miles or more from the school they attend, as determined by the District standard of measure.*
- **Grades 9-12** *Student must live 2.5 miles or more from the school they attend, as determined by the District standard of measure.*

Parent/Guardian Filing Request: _____

Student's Name (Last, First, Middle): _____

Parent/Guardian Name(s): _____

Home Address (Primary): _____

Telephone Contact: _____ Alternate: _____

A.M. Pick Up Location: _____

P.M. Drop Off Location: _____

Start Date of Service: _____

The following **Adults** are authorized to accept my student from the bus:

I hereby give my consent for transportation to be arranged as per the information provided herein.

Signature of Parent/Guardian: _____ Date: _____

Signature of School Official: _____ Date: _____

Transportation Request Forms are to be completed and returned to the Building Principal. **Transportation requests may take up to one to two weeks to process before service will begin.**