



Newburgh Enlarged City School District  
Office of Registration  
124 Grand Street  
Newburgh, NY 12550  
(845) 568-6530 Fax: (845) 568-6519  
[www.newburghschools.org](http://www.newburghschools.org)

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**Documents Needed to Register a Non-Sibling Student for the  
Newburgh Enlarged City School District**

1. Birth certificate
2. Immunizations/shot record
3. Proof of residency, one of the following:
  - Utility bill (gas, oil, electric, telephone, or cable)
  - Rental agreement / lease agreement / rent receipt
  - Mortgage statement
4. Picture I.D. of the parent/guardian

# NEWBURGH ENLARGED CITY SCHOOL DISTRICT

## Student Registration Form

### SCHOOL USE ONLY

School: \_\_\_\_\_ Other: \_\_\_\_\_

**New Student**       Custody Papers       McKinney-Vento      Student ID #: \_\_\_\_\_  
 Guardianship Papers       Foster Child  
 Restraining Order       Migrant Student      Date Registered: \_\_\_\_\_  
 **Returning Student**       Other \_\_\_\_\_       Special Permission      Date Enrolled: \_\_\_\_\_  
 No Release of Information       Title III Eligible  
 Health Inventory      Grade \_\_\_\_\_      Date of Entry into 9<sup>th</sup> Grade: \_\_\_\_\_  
 Physical Examination

### STUDENT INFORMATION

Information included here will not be shared with any 3<sup>rd</sup> party without the expressed consent of the parent, legal guardian or student over 18.

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birth Place: City / State / Country \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Residence Address:**

**Mailing Address (if different):**

Street \_\_\_\_\_

Street \_\_\_\_\_

City / State / Zip \_\_\_\_\_

City / State / Zip \_\_\_\_\_

**Ethnicity:**

- A = Asian
- B = Black or African American
- H = Hispanic or Latino
- I = American Indian or Alaska Native
- P = Native Hawaiian / Other Pacific Islander
- W = White

Country of Origin: \_\_\_\_\_

Date of Entry into U.S.: \_\_\_\_\_

Number of Years in U.S. Schools: \_\_\_\_\_

Primary Language Spoken at Home: \_\_\_\_\_

**Living With:**

- Both Parents
- Mother Only
- Father Only
- Mother/Stepfather\*
- Father/Stepmother\*
- Guardian
- Foster Parents
- Self (proof of emancipated status required)
- Group home or other court placed residence (proof of court placement required)

\*Please indicate stepparent name: \_\_\_\_\_

Name of Group Home: \_\_\_\_\_

Other (explain): \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

\_\_\_\_\_  
Father's Full Name

\_\_\_\_\_  
Mother's Full Name

\_\_\_\_\_  
Father's Address (if different from student)

\_\_\_\_\_  
Mother's Address (if different from student)

\_\_\_\_\_  
Father's Home Phone (if different from student)

\_\_\_\_\_  
Mother's Home Phone (if different from student)

\_\_\_\_\_  
Father's Work Phone

\_\_\_\_\_  
Father's Cell Phone

\_\_\_\_\_  
Mother's Work Phone

\_\_\_\_\_  
Mother's Cell Phone

\_\_\_\_\_  
Legal Guardian's Name

\_\_\_\_\_  
Guardian's Home Phone

\_\_\_\_\_  
Guardian's Work Phone

\_\_\_\_\_  
Guardian's Cell Phone

Student Name \_\_\_\_\_ Student ID \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student Entered from (School Name)	
School Address (Street) (City) (State) (Zip)	
Current Grade	Last Grade Completed

If your child is reentering the district, what is the last school your child attended? \_\_\_\_\_

STUDENT EDUCATIONAL BACKGROUND		
Previous School Name	Previous School Address	Grades Attended

PLEASE ANSWER THE FOLLOWING IF IT APPLIES: STUDENT'S SPECIAL PROGRAMS	
Has your child been retained (repeated a grade)?	<input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, what grade? _____
Check if student:	<input type="checkbox"/> Was enrolled in Gifted Program <input type="checkbox"/> Has an IEP <input type="checkbox"/> Currently in Bilingual Program <input type="checkbox"/> Currently in ESL Program
	<input type="checkbox"/> Other (explain): _____ # of years in Bilingual _____      # of years in ESL _____
Has your child ever received:	<input type="checkbox"/> Counseling <input type="checkbox"/> Remedial Math <input type="checkbox"/> Remedial Reading <input type="checkbox"/> Academic Intervention Services (AIS)
	<input type="checkbox"/> Speech <input type="checkbox"/> Special Services (explain): _____
Comments: _____	

Emergency Contact 1 (Last) (First)		Relationship to Student
Address (House #, Street, Apt. #) (City) (State) (Zip Code)		
Home Telephone #	Work Telephone #	Cell Telephone #
Emergency Contact 2 (Last) (First) *Other than Parent		Relationship to Student
Address (House #, Street, Apt. #) (City) (State) (Zip Code)		
Home Telephone #	Work Telephone #	Cell Telephone #

Name of Brother / Sister	Gender (Circle One)	DOB (MM-DD-YYYY)	Grade	School
	M F			
	M F			
	M F			
	M F			
	M F			

*I verify that the above information is correct.*

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_  
Registration verified by \_\_\_\_\_

Student Name \_\_\_\_\_ Student ID \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Newburgh Enlarged City School District  
2009- 2010 Kindergarten School Options**

After carefully reviewing the various program options available for your student, select **THREE** different schools that you believe best meet the needs of your child.

Indicate your three preferences in order by placing a “1” on the line next to your **FIRST** preference, a “2” on the line next to your **SECOND** preference, and a “3” on the line next to your **THIRD** preference.

\_\_\_ **GAMS Magnet School (K-6)** - Micro Community Magnet at Gidney Ave. (03)

\_\_\_ **West Street Dual-Language School (K-4)** –Dual Language at West St. (04)

\_\_\_ **Horizons-on-the-Hudson Magnet School (K-6)** - Gifted and Talented Program (06)

\_\_\_ **Balmville Communications and Media Center (K-6)** - Communications Enhanced through Multi-Media Equipment (09)

\_\_\_ **Fostertown ETC Magnet School (K-6)** - Creative and Performing Arts (10)

\_\_\_ **Gardnertown Fundamental Magnet School (K-6)** - Fundamental Program (11)

\_\_\_ **New Windsor School (K-6)** - Humanities through Literature (12)

\_\_\_ **Vails Gate High Tech Magnet School (K-6)** - Technology Program with Science and Math Emphasis (14)

\_\_\_ **Meadow Hill Global Explorations Magnet School (K-8)** - Foreign Language & International Studies (15)

\_\_\_ **Temple Hill Academy (K-8)** - Cultural, Academic & Physical Development (16)

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Parent/Guardian:

I have read the directions and reviewed the program options, and I submit this application for my child to attend a Newburgh Enlarged City School District Magnet School for September, 2009.

I have indicated **THREE** preferences as required, and understand that every effort will be made to honor my preferences. I understand that I am making a one-year commitment to the school that my child will attend.

The information for my child provided on this form is correct.

Parent/Guardian Name \_\_\_\_\_ (please print)

Parent/Guardian Signature \_\_\_\_\_ (Date) \_\_\_/\_\_\_/\_\_\_

Student Name \_\_\_\_\_ Student ID \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Modified Health Inventory

Does the child have any physical or emotional concerns, allergies or health conditions that we should be aware of?

Yes  No

\*If yes, please explain:

Does your child presently take any medication?

Yes  No

\*If yes, please list the names and dosage:

Does your child have any vision, hearing or speech problems?

Yes  No

\*If yes, please explain:

Does your child have any disability that has required special education services?

Yes  No

\*If yes, please explain:

Are there any special situations or concerns in your family which might affect the behavior or learning needs of your child?

Yes  No

\*If yes, please explain:

#### School Use Only

#### Immunizations

Immunizations complete/copy attached \_\_\_\_\_

Immunizations incomplete/student lacking \_\_\_\_\_ OPV/IPV \_\_\_\_\_ MMR \_\_\_\_\_ DPT/DTap  
\_\_\_\_\_ Tdap \_\_\_\_\_ HBV \_\_\_\_\_ HIB \_\_\_\_\_ Varicella

#### Physical Examinations

Please check one of the following:

\_\_\_\_\_ I will have my child's physical examination done by his/her private medical care giver. I will return the completed physical examination form to the school health office no later than 30 days following the start of school or I will present the health office with the physician's name and a verifiable appointment date.

\_\_\_\_\_ I elect to have my child's physical examination done in school and by signing below I give my permission for the school physician and/or the nurse practitioner to complete this examination. I understand that this examination will be scheduled starting on November 1<sup>st</sup> and I will receive notification of the date at least two weeks prior to the scheduled physical examination.

\_\_\_\_\_ I will be present for my child's physical examination.

\_\_\_\_\_ I will not be present for my child's physical examination.

*I verify that the above information is correct.*

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Newburgh Enlarged City School District

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

## HEALTH APPRAISAL FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

### IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached  
 No immunizations given today  
 Immunizations given since last Health Appraisal: \_\_\_\_\_

Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
 PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
 Elevated Lead:  Yes  No  Not done Date: \_\_\_\_\_  
 Dental Referral  Yes  No  Not done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Specify current diseases:  Asthma  Diabetes:  Type 1  Type 2  Hyperlipidemia  Hypertension

Other: \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_

Seasonal  Medication: \_\_\_\_\_

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse \_\_\_\_\_ Urine \_\_\_\_\_ Date of Exam: \_\_\_\_\_

*Referral*

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
<input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup>	Vision - Near Point	R	L	
<input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis:  Negative  Positive: \_\_\_\_\_

Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

### MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed  Yes  No Student may self carry and self administer medication  Yes  No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

\_\_\_ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.  
 \_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: \_\_\_\_\_  None

Known or suspected disability: \_\_\_\_\_  Please monitor

Restrictions: \_\_\_\_\_  Please monitor

Protective equipment required:  Athletic Cup  Sport goggles/impact resistant eyewear  Other: \_\_\_\_\_

(Stamp below)

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Provider's Name/Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. Rev. 10/3/07*

**Sports Participants complete reverse side**

# Newburgh Enlarged City School District

## Dental Health Certificate

**Parent/Guardian:** New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

### Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle \_\_\_\_\_

Birth Date:    /    / <small>Month Day Year</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
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School: _____	Grade: _____
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Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?    Yes    No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Distrito Escolar Extendido de la Ciudad de Newburgh

### Certificado de Salud Dental

**Padre/Guardián:** La ley del Estado de Nueva York (Capítulo 281) permite que las escuelas requieran un examen dental en los siguientes grados: al ingresar a la escuela, en K, 2º, 4º, 7º, y 10º grados. Su hijo/hija puede tener un chequeo dental durante el presente año escolar para determinar si está en condiciones de asistir a la escuela. Por favor complete la Sección 1 y entregue este formulario a su dentista para un examen. Si a su hijo/hija se le hizo un examen dental antes de comenzar la escuela, pídale a su dentista que complete la Sección 2. Devuelva el formulario completo al director médico o enfermera de la escuela tan pronto como le sea posible.

### Sección 1. Padre/Madre/Guardián, por favor complete esta sección (Por Escrito)

Nombre del Niño/la Niña: Apellido Primero Segundo \_\_\_\_\_

Fecha de Nacimiento:    /    / <small>Mes Día Año</small>	Sexo: <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino	Es ésta la primera visita al dentista de su hijo/hija? <input type="checkbox"/> Sí <input type="checkbox"/> No
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Escuela: _____	Grado: _____
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Ha notado algún problema en la boca que interfiere con la capacidad de su hijo/hija de masticar, hablar, o enfocarse en las actividades escolares?    Sí    No

Entiendo que al firmar este formulario doy mi autorización para que el niño/la niña nombrado arriba reciba un examen básico de salud oral. Entiendo que este examen es solamente un medio limitado de evaluación para determinar la salud dental del estudiante, y yo tendría que obtener los servicios de un dentista para que mi hijo/hija pueda recibir un examen dental completo con Rayos X si fuera necesario para mantener buena salud oral.

También entiendo que el recibir este examen preliminar de salud oral no establece una relación nueva, progresiva, o continua entre doctor y paciente. Es más, no asignaré al dentista o a quienes lleven a cabo el examen responsabilidad por consecuencias o resultados si yo decido NO seguir las recomendaciones enumeradas abajo.

Firma del Padre/Madre/Guardián \_\_\_\_\_ Fecha \_\_\_\_\_

**SEE REVERSE SIDE OF FORM**

**Section 2. To be completed by the Dentist**

**I. The Dental Health condition of \_\_\_\_\_ on \_\_\_\_\_**  
**(date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:**

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
- No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp)

Dentist's Signature

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**Please See Reverse Side of Form**

**Optional Sections - If you agree to release this information to your child's school, please initial here. \_\_\_\_\_**

**II. Oral Health Status (check all that apply).**

- Yes  No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes  No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes  No **Dental Sealants Present**

Other problems

(Specify): \_\_\_\_\_

**III. Treatment Needs (check all that apply)**

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.



# Home Language Questionnaire (HLQ)

## TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT \_\_\_\_\_ *Please print or type clearly*

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

STUDENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_  
Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

STUDENT IDENTIFICATION NUMBER \_\_\_\_\_

COUNTRY OF BIRTH / ANCESTRY \_\_\_\_\_

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S. \_\_\_\_\_

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION \_\_\_\_\_

DETERMINATION:  Possible LEP  
 English Proficient

*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 English. Your assistance in answering these questions is greatly appreciated.*

*Thank You*

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence?  English  Other \_\_\_\_\_ *specify*
- What language(s) are spoken most of the time to the student, in the home or residence?  English  Other \_\_\_\_\_ *specify*
- What language(s) does the student understand?  English  Other \_\_\_\_\_ *specify*
- What language(s) does the student speak?  English  Other \_\_\_\_\_ *specify*
- What language(s) does the student read?  English  Other \_\_\_\_\_  Does Not Read *specify*
- What language(s) does the student write?  English  Other \_\_\_\_\_  Does Not Write *specify*
- In your opinion, how well does the student understand, speak, read and write English?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
<b>Understands English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Speaks English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reads English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Writes English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
*Signature of Parent/Guardian/Other*

\_\_\_\_\_  
*Date*

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

## Confidential Housing Questionnaire

**COMPLETE THIS FORM ONLY IF (1) IT REFLECTS YOUR CHILD'S CURRENT LIVING SITUATION; OR (2) YOUR LIVING SITUATION IF YOU ARE A YOUTH NOT LIVING WITH A PARENT OF LEGAL GUARDIAN.**

(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)

**Check one box if you are living:**

in a shelter

in a hotel / motel due to lack of alternative, adequate housing

at a train or bus station, in a car, or at a campsite

awaiting *permanent* foster care placement

with relatives or others due to loss of housing, economic hardship, or similar reason

Is this living arrangement with relatives or others **temporary** or **permanent** ? (please circle one)

other - please describe \_\_\_\_\_

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**PARENT/GUARDIAN NAME:** \_\_\_\_\_  
(Please Print)

**STUDENT NAME:** \_\_\_\_\_  
(Please Print)

**CONTACT PHONE NUMBER: Home** \_\_\_\_\_ **Cell** \_\_\_\_\_