



Newburgh Enlarged City School District
Office of Registration
124 Grand Street
Newburgh, NY 12550
(845) 563-KIDS (5437) Fax: (845) 568-6519
www.newburghschools.org

Documents Needed to Register a Pre-Kindergarten Student for the Newburgh Enlarged City School District

1. Birth certificate.
2. Immunizations/shot record.
3. Copy of last Physical Exam and Proof of Lead Screening.
4. Proof of residency, one of the following:
 - Utility bill (gas, oil, electric, telephone, or cable)
 - Rental agreement / lease agreement / rent receipt
 - Mortgage statement
5. Government issued Picture I.D. of the parent/guardian.
6. Students **must** be toilet-trained!

NEWBURGH ENLARGED CITY SCHOOL DISTRICT

Student Registration Form (rev. 3/2010)

ID # _____

Registration Date _____

SCHOOL USE ONLY

School: _____ Other: _____

Grade: _____

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> New Student | <input type="checkbox"/> Custody Papers | <input type="checkbox"/> McKinney-Vento | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Special Permission |
| <input type="checkbox"/> Returning Student | <input type="checkbox"/> Guardianship Papers | <input type="checkbox"/> Foster Child | <input type="checkbox"/> No Release of Information | <input type="checkbox"/> Title III Eligible |
| | <input type="checkbox"/> Restraining Order | <input type="checkbox"/> Migrant Student | <input type="checkbox"/> Health Inventory | <input type="checkbox"/> Physical Examination |

Date Enrolled: _____

Date of Entry into 9th Grade: _____

STUDENT INFORMATION

*Form must be completed in INK. Information included here will not be shared with any 3rd party without the expressed consent of the parent, legal guardian or student over 18.

Student's Last Name _____ First Name _____ Middle Name _____ Nickname _____ Gender _____

Date of Birth _____ Birth Place: _____ City / State / Country _____ Date of Entry into US _____ Date Entered US Schools _____

Primary Language Spoken at Home: _____
Parent(s)/Guardian _____ Student _____

Residence Address

Street (include apartment number and/or floor) _____

- City of Newburgh Zip Code _____
 Town of Newburgh
 Town of New Windsor

Telephone (include area code)

_(_____) _____
Home
_(_____) _____
Cell
_(_____) _____
Whose cell phone?

Mailing Address (if different than residence)

Street / PO Box _____
City / State / Zip _____

Email Address

Parent/Guardian _____ Other _____

Living With:

- | | | |
|--|--|--|
| <input type="checkbox"/> Both Parents | <input type="checkbox"/> Mother/Stepparent *Please indicate stepparent name: _____ | <input type="checkbox"/> Guardian *Relationship to child: _____ |
| <input type="checkbox"/> Mother Only | <input type="checkbox"/> Father/Stepparent *Please indicate stepparent name: _____ | |
| <input type="checkbox"/> Father Only | <input type="checkbox"/> Foster Parent *Please indicate foster parent name(s): _____ | <input type="checkbox"/> Self (proof of emancipated status required) |
| <input type="checkbox"/> Joint Custody *Please provide alternate residence address and telephone: _____ | | |
| <input type="checkbox"/> Group home or other court placed residence (proof of court placement required) Name of Group Home: _____ | | |
| <input type="checkbox"/> Other (explain): _____ | | |

Parent/Guardian Initial _____

Student Racial and Ethnic Identification:

ANSWER BOTH QUESTIONS 1 AND 2. PLEASE READ THE QUESTIONS BEFORE RESPONDING.

1. Is the student Hispanic, Latino, or of Spanish origin? (Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.)

PLACE AN "X" ON THE LINE THAT BEST DESCRIBES YOUR CHILD.

_____ YES, Hispanic _____ NO, not Hispanic

2. What is the student's race?

Select ONE OR MORE races from the following five racial groups.

Place an "X" ON ALL LINES THAT DESCRIBE YOUR CHILD. You must mark at least one line.

_____ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

_____ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **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 OR AFRICAN AMERICAN:** 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.

PARENT/GUARDIAN INFORMATION

PARENT 1 (Relationship: _____)

PARENT 2 (Relationship: _____)

LEGAL GUARDIAN

Name: Last, First, Middle

Name: Last, First, Middle

Name: Last, First, Middle

Address (if different from student)

Address (if different from student)

Address (if different from student)

Home Phone (if different from student)

Home Phone (if different from student)

Home Phone (if different from student)

(____) _____ (____) _____
Work Phone Cell Phone

(____) _____ (____) _____
Work Phone Cell Phone

(____) _____ (____) _____
Work Phone Cell Phone

Parent/Guardian Initial _____

ID # _____

STUDENT EDUCATIONAL BACKGROUND

(Provide information on all schools student attended.)

Current Grade _____ Last Grade Completed _____ If your child is reentering the district, what is the last school attended? _____

Last School Attended	Last School Address	Grades Attended
Previous School Name	Previous School Address	Grades Attended

Is the child a newcomer with two or more years of interrupted education in another country? *(required for NYSED reporting purposes)*

Yes _____ No _____

Has the child attended school in the US, gone to another country for a period of time, then returned to the US again? *(required for NYSED reporting purposes)*

Yes _____ No _____

STUDENT'S SPECIAL PROGRAMS

Has your child ever been retained (repeated a grade)? Yes No If yes, what grade(s)? _____

Check if student: Was enrolled in Gifted Program Has an IEP Currently in Bilingual Program Currently in ESL Program
 Has a 504 Plan Formerly in Bilingual Program Formerly in ESL Program
of years in Bilingual _____ # of years in ESL _____

Other (explain): _____

Has your child ever received:

Counseling Remedial Math Remedial Reading Academic Intervention Services (AIS) Speech

Special Services (explain): _____

Comments: _____

Parent/Guardian Initial _____

ID # _____

EMERGENCY CONTACT INFORMATION (persons other than parents) *Please list in the order you wish to be contacted.*

	Contact Name (First and Last)	Relationship to Student	Address	Daytime Telephone (include area code)	Cell Phone (include area code)
1 st					
2 nd					

SIBLING INFORMATION

Full Name of Brother / Sister	Gender	DOB (mm/dd/yyyy)	Grade	Current School
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

I verify that the above information is correct.

Parent / Guardian Signature _____ Date _____

Registration verified by _____

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	*If yes, please explain:
Does your child presently take any medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	*If yes, please list the names and dosage:
Does your child have any vision, hearing or speech problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	*If yes, please explain:
Does your child have any disability that has required special education services?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 1st 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 _____

Relationship to Student _____

Date _____

**NEWBURGH ENLARGED CITY SCHOOL DISTRICT
Pre-K School Options
2010-2011**

Child's Name _____

School Code

DOB _____

ID# _____

Parent/Guardian's Name _____

Address _____

Home Phone # _____

Daytime Phone # _____

Mother's/Guardian's Cell Phone _____

Father's/Guardian's Cell Phone _____

Please note, to be eligible for Pre-K, students must be born by December 1, 2006. All Students MUST be toilet trained prior to September entrance.

After carefully reviewing the various program options available for your student, select **TWO** different sessions that you believe best meets the needs of your child. Indicate your 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.

Sessions

Pre-K Center at Washington Street ___ AM ___ PM

Limited seats are available at the following schools and transportation is not included*:

Sessions

Head Start of Eastern Orange County ___ AM ___ PM
My child currently attends Newburgh Day Nursery. ___ YES ___ NO

Windsor Academy ___ AM ___ PM
My child currently attends Windsor Academy. ___ YES ___ NO

Newburgh Day Nursery ___ AM ___ PM
My child currently attends Newburgh Day Nursery. ___ YES ___ NO



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 Pre-K program for September, 2010. It is my understanding that regular attendance plays a crucial part in my child's success in the Pre-K program.

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

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

Parent/Guardian Signature _____ (Date) ____/____/____

**NEWBURGH ENLARGED CITY SCHOOL DISTRICT
Pre-K Transportation Information
2010-2011**

Student Name _____ Student ID _____ Date of Birth _____

Transportation will be provided only to students who attend the Pre-K Center at Washington Street. Transportation requests not made at the time of registration, will delay bus service at the start of school.

My Child will be:

Picked up at Home: Yes: _____ No: _____

Dropped off at Home: Yes: _____ No: _____

Picked up at the Alternative Stop: Yes: _____ No: _____

Address _____

Contact person _____

Phone number _____

Dropped off at the Alternative Stop: Yes: _____ No: _____

Address _____

Contact person _____

Phone number _____

You will be notified of the Bus Route by the District Transportation Department after August 21. Changes will not be made after August 15 until September 15.

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 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L	
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th 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
--	---	--

School: _____	Grade: _____
---------------	--------------

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
--	---	--

Escuela: _____	Grado: _____
----------------	--------------

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

--	--

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>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<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 _____

PARENT/GUARDIAN NAME: _____
(Please Print)

STUDENT NAME: _____
(Please Print)

CONTACT PHONE NUMBER: Home _____ **Cell** _____