Middleburgh Central School District
291 Main Street
Middleburgh, New York 12122

Schoharie County Child Development Council, Inc.
114 Lark Street
Cobleskill, New York 12043

Greetings New UPK3 Family!

We are so happy that your child will be in the UPK3 Classroom at Middleburgh Central School. This classroom is not only special since it is the place of our youngest students, but also a unique community collaboration.

In our state, many schools work with a Community Based Organization (CBO) to offer Pre-Kindergarten services. Most often these are programs that specialize in early childhood education. At Middleburgh Central School the CBO, is Schoharie County Child Development Council. As the operator of Head Start and Early Head Start, SCCDC has a long history of providing early childhood education in Schoharie County. In fact, Schoharie County has the distinction of being one of the original locations for Project Head Start.

With these types of collaborations, families often have many questions. Here we will address the most common.

- Some children in the classroom may also be enrolled in Head Start, a federally funded income-based program. SCCDC welcomes all families to complete an application for Head Start regardless of their income. On occasion, children that do not meet the income guidelines for Head Start may be accepted into Head Start.
- As SCCDC is the organization providing the educational experience, the policies and procedures that govern all SCCDC's programs are applied to the classroom. All families in the classroom will be considered as part of the SCCDC family and are invited to join in SCCDC events, including Head Start Parent Committee.
- The staff in the classroom are employees of Schoharie County Child Development Council. They meet the state requirements for Pre-Kindergarten teachers. The classroom has an assigned Family Advocate. This individual will work with the families of all children in the classroom to complete SCCDC's registration paperwork, remind families of upcoming health and dental appointments, and provide resources.
- The classroom uses the Creative Curriculum for Preschoolers and the Teaching Strategies Gold assessment system to develop individual and classroom learning goals and track progress. The teacher will share this information with you at regularly scheduled meetings. Families enrolled in Head Start will have at least two of their Parent Teacher Conferences happen in the home of the child. Families that are not enrolled in Head Start can choose to also have some of their visits at home as well. Children and families are most often more comfortable in their home, and this provides the opportunity for families to build a stronger relationship with their teachers.

The SCCDC website can provide you with more information at: www.sccdcny.org. If you are interested in applying for Head Start, you can contact Rebecca at (518) 419-3875 or rebeccaj@sccdcny.org.

We look forward to starting the exciting journey into education with your family!

Sincerely,

Middleburgh Central School District and Schoharie Child Development Council, Inc.

Middleburgh Central School District

Record Release for Student Records

Do you authorize Middleburgh Central School District to share the following information with Schoharie Head Start Program for the UPK3 Program:

- ☐ Registration Page
- ☐ Birth Certificate
- ☐ Proof of Immunization/Physical Paperwork
- ☐ Custody Paperwork if applicable
- ☐ Child Development and Medical History
- ☐ Proof of Residency

I hereby authorize the following information to be sent to HeadStart for the student indicated below.

Student's Name (First, Middle, Last)	Gender	Date of Birth	Grade Level:

- ☐ I do NOT authorize Middleburgh Central School District to share information with Schoharie HeadStart

If you have any questions or concerns, please contact:

Laurie McGeary, Registrar
Email: Laurie.McGeary@mcsdny.org
Phone: (518)827-3600 Ext. 2601
Fax: (518)827-5181

Parent/Guardian Signature:_____ **Date:**_____

MIDDLEBURGH CENTRAL SCHOOL DISTRICT

Registration Packet Includes:

- **Registration Form**
- **Educational History**
- **Child Development & Medical History**
- **NYS Health Examination Form**
- **Dental Health Certificate**
- **Proof of Residency/Housing**
- **Home Language Questionnaire**

In order to complete registration (*this includes UPK programs)* the following documents must be provided:

- ☐ **Parent/Legal Guardian Photo ID**
  - ☐ Valid State Issued ID or Valid Passport
- ☐ **Proof of Residency**
  - ☐ **Must provide <u>TWO</u> acceptable forms of proof:**
    - ☐ Utility bill, official payroll document or letter from a federal, state or local government agency, current property tax bill, copy of signed lease agreement
- ☐ **Birth Certificate**
  - ☐ Original (we will make a copy) or Certified Copy or Valid Passport
- ☐ **Proof of Immunization**
  - ☐ Must be signed or stamped by a state licensed health care provider
- ☐ **Custody Papers (if Applicable)**
- ☐ **Special Circumstances (Residency Questionnaire)**
  - ☐ If applicable, detailing legal guardianship situations, temporary living situations, custody agreements, name changes

Middleburgh Central School District

Registration Form

Please Choose the appropriate program according to date of birth*:

❒3 Year Old UPK (3 by 12/1)**AM/PM** ❒4 Year Old UPK (4 by 12/1)**AM/PM**

❒Kindergarten (5 by 12/1) ❒*My child will be attending AM Head start

❒Grade____

Students Name:_____ Middle Initial____ Last Name:_____

Gender:_____ Date of Birth:_____ Primary Language:_____

Is Hispanic (Optional) ❒Yes ❒No

Race (Optional): ❒ White ❒Black or African American ❒Asian ❒American Indian or Alaskan Native

❒ Native Hawaiian/Other Pacific Islander

Mailing Address: _____

Physical Address:_____

Student's Home Phone: _____ Student's Cell Phone: _____

Parent/Guardian Information:

Student resides with:❒Parents ❒Mother ❒Father ❒Foster Parents (*please see attached form DSS-299)* ❒Other

Are there Legal Arrangements: ❒No ❒Yes *If yes, please provide court documents*

❒ Joint Custody ❒Sole Custody ❒Temporary Custody ❒Visitation

Primary Parent/Guardian Name:_____Relationship to Child_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Work Place: _____ Work Phone:_____

Choose All that Apply to above person:

❒ Receives Mail ❒Can Pick Up ❒Custody Alert ❒Allow Parent Portal Access ❒ Restricted

Parent/Guardian Name:_____Relationship to Child_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Work Place: _____ Work Phone:_____

Choose All that Apply to above person:

❒ Receives Mail ❒Can Pick Up ❒Custody Alert ❒Allow Parent Portal Access ❒ Restricted

List all Siblings that live in household	Gender	Birthdate	Grade	School

Parent/Guardian Signature: _____ Date:_____

Relationship to Student:_____

*Please note preferences for am or pm does not guarantee placement. Final placement will be determined by district and you will be informed by mail of your child's placement.

Middleburgh Central School District

Educational History

Student Name:_____

Has the student previously attended School in the Middleburgh Central School District?

❒ Yes ❒No If Yes, which school _____

Does the student have an IEP (Individual Education Plan)?

❒Yes ❒No

Does the student have a 504 Plan?

❒Yes ❒No

Has the student participated in any of the following programs? *Check all that apply*

❒Academic Intervention Service ❒Reading Services

❒Math Services ❒Other: _____

Please Check any special programs that your child has been assigned to in the past:

❒Consultant Services	❒Resource Room	❒Bilingual Education
❒Special Classes	❒Occupational Therapy	❒Speech Therapy
❒Physical Therapy	❒Counseling	❒Other:

UPK Parents Only:

Did your child attend: ❒UPK-3 Location:_____

❒Head Start Location:_____

Please list all previous schools beginning with most recent:

Name of School: _____
Address: _____
Phone: _____

Name of School: _____
Address: _____
Phone: _____

Name of School: _____
Address: _____
Phone: _____

Child Developmental & Medical History

Student's Name:	Grade: ◯M/F◯ Date of Birth:
Birth:	Developmental:
Term: Weight:	First Tooth Age: Sat Alone Age:
Delivery:	Crawled Age: Walked Age:
Conditions:	Talked at Age:
Abnormalities:	

1. **Were problems experienced during pregnancy which required medical intervention? If yes, what were they:**

   _____

2. **Were there any complications at birth?(*premature, prolonged labor, need for oxygen, difficult delivery):***

   _____

3. **Please note any congenital conditions present at birth:**

   _____

4. **Did your child proceed through developmental stages normally?**

   _____

5. **Were there any particular difficulties as a preschooler? (*difficulty watering, sleeping, bedwetting, etc)***

   _____

6. **Any diseases, illnesses, or injuries which required medical attention?**

   _____

7. **Any undiagnosed illnesses? (*prolonged high fever, convulsions, seizures, etc.)***

   _____

8. **Any hospitalizations? If so, for what reason?**

   _____

9. **Has your child had surgery for any reason? If yes, when and for what?**

   _____

10. **Have hearing or visual aides ever been required for your child? If yes, when and what for?**

    _____

11. **Has your child been on medication for any reason?**

    _____

12. **Have there been any neurological problems diagnosed on your child, birth to present? If so, please explain**

    _____

13. **Attention problems or hyperactivity problems? Has medication been prescribed? If yes, what med and when started?** _____

14. **Previous or current cancer treatments? Please explain:**

    _____

15. **Please explain any other pertinent medical , dental or psychological history:**

    _____

16. **Is your child a twin? If yes, birth order: Twin 1** _____**Twin 2**_____

Child Developmental & Medical History

Has your child had the following? (Please check ☑ and list date(s)):

Illness	☑ *Date*	*Illness*	☑ *Date*
Chicken Pox		Diabetes	
Scarlet Fever		Hepatitis	
Pneumonia		Seizures (List Type)	
Bronchitis		Asthma	
Breathing Difficulties		Allergy to bee stings	
Blood Disorders		Family history of bee allergy**	
Rheumatic Fever		Frequent Ear Infections/Aches	
Kidney Problems		Frequent Colds	
Tuberculosis		Frequent Strep Throat	
Family History of TB		Ear Condition	
Contact with TB		Ear Tubes	
Heart Disease		Vision Difficulties	
Heart Murmur		Cataracts	
Scoliosis		Speech Difficulties	
Frequent Nosebleeds		Emotional Problems	
Food Allergies (Please List)		Behavioral Problems	
Lactose Intolerant		Frequent Headaches	
other		Epilepsy	
		**Type of reaction to Bee Sting:	

Regarding Allergies:

Does your child have allergies: ☐Yes ☐No If yes, what allergies?_____

Does your child require medication for allergies? ☐Yes ☐No If yes, what medication?_____

Does your child require medication to stay in school? ☐Yes ☐No If yes, what medication? _____

Please note: regarding medications in school, both a signed doctor's note <u>and</u> a parent note are required in order for the school nurse to administer medications.

Family Doctor: _____ Phone:_____

Family Dentist: _____ Phone:_____

Parent Signature: _____ **Date:** _____

Dental Health Certificate- OPTIONAL

Parent/Guardian: New York State Law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started school, ask your dentist/dental hygienist to fill out Section 2. Return the completed for to the schools medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (PLEASE PRINT)

Child's Name: _____

Date of Birth: _____ **Sex:** ❒Male ❒Female Will this be their first oral health assessment: ❒Yes ❒No

School Name: _____ **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/Guardian Signature: Date:

Section 2. To be completed by the Dentist/Dental Hygienist

I. The dental health condition of _____ on _____(date of assessment). The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one of the following:

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

NOTE: Not in fit condition of dental health means that a condition exists that interferes with the student's ability to chew, speak, 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/Dental Hygienist's Name and Address:
(Please Print or Stamp)

_____
_____
_____

Dentist's/Dental Hygienist's Signature:

_____

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 the 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 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)_____

II. 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.

Middleburgh Central School District

Proof of Residency/Housing

Name of Student:_____

If registering more than one student, you can list them below.

Student:	Gender:	Date of Birth:	Grade:

Please check one: ❒**Own** ❒**Rent** ❒**Reside with a district resident** ❒**Temporary living situation**

To enroll you must reside within the district. Solely owning property or a home does not constitute residency. Proof of residency is required before a student may be registered. Post office boxes will not be accepted. You must provide at least two (2) proofs from the following list:

If you own:	*If you rent:*
❒ **Tax Bill within 30 days**	❒ **Documents issued by the federal, state or local agencies**
❒ **House Deed**	❒ **Utility Bill within 30 days**
❒ **Mortgage Statement within 30 days**	❒ **Lease agreement (*must be signed with the landlord's name and phone number*)**
❒ **Current Homeowner's Insurance**	❒ **Current Renter's Insurance**
❒ **Utility Bill within 30 days**	
❒ **Voter Registration**	

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 certificates. 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?
❒ 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):
❒ In Permanent housing

This document will be retained in the student's file along with other required documents. Once this form is received by the District Registrar, residency will be verified.

Parent/Guardian Signature:_____ **Please Print Name:**_____

District Use: ***Approved by:*** ***Date:***

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

Office of P12

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

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*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	◯ English	◯ Other:	
2. What was the first language your child learned?	◯ English	◯ Other:	
3. What is the Home Language of each parent/guardian?	☐ Parent 1 _____ *specify* ☐ Guardian(s) _____ *specify*	☐ Parent 2 _____ *specify*	
4. What language(s) does your child understand?	◯ English	◯ Other:	
5. What language(s) does your child speak?	◯ English	◯ Other:	◯ Does not speak
6. What language(s) does your child read?	◯ English	◯ Other:	◯ Does not read
7. What language(s) does your child write?	◯ English	◯ Other:	◯ Does not write

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:*	

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? _____

_____ **Month:**_____ **Day:** __ **Year:** _____

Signature of Parent or of Person in Parental Relation

Relationship student: ❑ Parent ❑ 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: ❑ YES ❑ NO

****DATE OF INDIVIDUAL INTERVIEW:** _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
- ❑ ADMINISTER NYSITELL
- ❑ ENGLISH PROFICIENT
- ❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: **POSITION:**

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

NEW YORK STATE
MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)

☐ Work related to logging, harvesting, or initial processing of trees.

☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)

If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____)-_____-_____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____Grade_____

Student name: _____ Age _____Grade_____

To submit this referral please fax to 607-436-3606 or send by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.