

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 TWO 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:

Did your child attend:	<input type="checkbox"/> UPK-3	UPK Parents Only: Location: _____
	<input type="checkbox"/> 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)):

<i>Illness</i>	<input checked="" type="checkbox"/>	<i>Date</i>	<i>Illness</i>	<input checked="" type="checkbox"/>	<i>Date</i>
Chicken Pox	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	
Scarlet Fever	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>		Seizures (List Type)	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	
Breathing Difficulties	<input type="checkbox"/>		Allergy to bee stings	<input type="checkbox"/>	
Blood Disorders	<input type="checkbox"/>		Family history of bee allergy**	<input type="checkbox"/>	
Rheumatic Fever	<input type="checkbox"/>		Frequent Ear Infections/Aches	<input type="checkbox"/>	
Kidney Problems	<input type="checkbox"/>		Frequent Colds	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>		Frequent Strep Throat	<input type="checkbox"/>	
Family History of TB	<input type="checkbox"/>		Ear Condition	<input type="checkbox"/>	
Contact with TB	<input type="checkbox"/>		Ear Tubes	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>		Vision Difficulties	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>		Cataracts	<input type="checkbox"/>	
Scoliosis	<input type="checkbox"/>		Speech Difficulties	<input type="checkbox"/>	
Frequent Nosebleeds	<input type="checkbox"/>		Emotional Problems	<input type="checkbox"/>	
Food Allergies (Please List)	<input type="checkbox"/>		Behavioral Problems	<input type="checkbox"/>	
Lactose Intolerant	<input type="checkbox"/>		Frequent Headaches	<input type="checkbox"/>	
other	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	
			**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 and a parent note are required in order for the school nurse to administer medications.

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Parent Signature: _____ **Date:** _____

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:

<input type="checkbox"/> Own	<input type="checkbox"/> Reside with a district resident
<input type="checkbox"/> Rent	<input type="checkbox"/> 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:
<input type="checkbox"/> Tax Bill within 30 days	<input type="checkbox"/> Documents issued by the federal, state or local agencies
<input type="checkbox"/> House Deed	<input type="checkbox"/> Utility Bill within 30 days
<input type="checkbox"/> Mortgage Statement within 30 days	<input type="checkbox"/> Lease agreement (must be signed with the landlord's name and phone number)
<input type="checkbox"/> Current Homeowner's Insurance	<input type="checkbox"/> Current Renter's Insurance
<input type="checkbox"/> Utility Bill within 30 days	
<input type="checkbox"/> 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: _____
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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:		
<i>First</i>	<i>Middle</i>	<i>Last</i>
DATE OF BIRTH:		GENDER:
		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to</i>

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:
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other:
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1 _____ <i>specify</i>	<input type="checkbox"/> Parent 2 _____ <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:
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other: <input type="checkbox"/> 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:

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.