



MIDDLEBURGH CENTRAL SCHOOL DISTRICT

UPK3 & UPK4 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
- Letter to Potential UPK3 Parents

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)

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

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)):

<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:** _____

**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.

- Type: _____
- Allergies**
 Medication/Treatment Order Attached Anaphylaxis Care Plan Attached
 Intermittent Persistent Other: _____
- Asthma**
 Medication/Treatment Order Attached Asthma Care Plan Attached
 Type: _____ Date of last seizure: _____
- Seizures**
 Medication/Treatment Order Attached Seizure Care Plan Attached
- Type: 1 2
- Diabetes**
 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	Lead Level	Date
		Date	Required for PreK & K	

TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Test Done	<input type="checkbox"/> Lead Elevated >5 µg/dL

System Review Within Normal Limits

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

- | | | | | |
|--|---|--|---------------------------------------|---|
| <input type="checkbox"/> HEENT | <input type="checkbox"/> Lymph nodes | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Extremities | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Back/Spine/Neck | <input type="checkbox"/> Skin | <input type="checkbox"/> Social Emotional |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Lungs | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Neurological | <input type="checkbox"/> 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

Table with columns: Vision, With Correction, Right, Left, Referral, Not Done. Rows include Distance Acuity, Near Vision Acuity, and Color Perception Screening.

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 Left Referral

Notes

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

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

*Family cardiac history reviewed – required for Dominic 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

Confirmed free of communicable disease during exam

IMMUNIZATIONS

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.

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 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: _____

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 1/2 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.



Housing Questionnaire

Name of Student: _____

Physical Address: _____

Student resides with Parents Mother Father Guardian Other: _____

If registering more than one, please list their names below:

Student Name	Gender	Date of Birth	Grade

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

- With another family/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 situations (please describe): _____
- In permanent housing (*submit 2 Proofs of Residency from list below*)

If you own please provide 2 of the following:

- Tax bill within 30 days
- House Deed
- Mortgage Statement within 30 days
- Current Homeowner's Insurance
- Utility Bill within 30 days
- Voter Registration

If you rent please provide 2 of the following:

- Documents issued by federal, state or local agencies
- Utility bill within 30 days
- Lease agreement (*must be signed and notarized with the landlord's name and phone number*)
- Current renter's insurance

Print Parent Name: _____

Parent Signature: _____

Date: _____



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:
<i>District Name (Number) & School:</i>	<i>Address:</i>

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.

Middleburgh Central School District
291 Main Street
Middleburgh, NY 12122

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

Greetings, Interested UPK3 Families!

Thank you for your interest in the UPK3 Classroom at Middleburgh Central School. This classroom is special not only because it is the place of our youngest students, but also because it represents 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 the Schoharie County Child Development Council. As the operator of Head Start and Early Head Start, Schoharie County Child Development Council (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 questions.

- 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 income. On occasion, children who do not meet the income guidelines for Head Start may still 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 the Schoharie County Child Development Council. They meet the state requirements for Pre-Kindergarten teachers. The classroom has an assigned Family Advocate who 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 child's home. 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, which 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, contact Rebecca at (518) 419-3875 or rebecca@scdcny.org.

We look forward to starting this 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
- Home Language
- Free and Reduced Price School Meals

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: _____



UNIVERSAL PRE-KINDERGARTEN PROGRAM

What is Universal Prekindergarten (UPK)?

In New York State, prekindergarten comes in many forms. Universal Prekindergarten, or UPK, is a state and federally funded prekindergarten program offered to families free of charge, but does not guarantee that every child will have access.

Is my child entitled to UPK services?

No. Although UPK stands for "universal prekindergarten," in New York State, prekindergarten is not universally available to all families in all school districts at this time. It is a goal New York State is working toward.

When can my child attend prekindergarten?

A family can register their child for:

UPK-3 if their child is three years old on or before December 1st.

UPK-4 if their child is four years old on or before December 1st.

Once registered, will my child be guaranteed a spot?

No. In districts where UPK is available, entry is based on eligibility age and the district lottery system.

If there are more eligible applicants than can be served in a given school year, the district will conduct a lottery-based system to determine who attends the program. The District will determine if a lottery is required by June 1st of each year.

If a lottery is required, students will be selected on a random basis. New York State UPK regulations prohibit a district from prioritizing eligible students for any reason, including economic background. Each child will be entered into the lottery as an individual student and will be selected at random.

If a lottery is not required, spaces will be filled as applications are received. Once all spaces are filled, a waitlist will be created.