STUDENT REGISTRATION CHECKLIST

Welcome to Lake George Central School District! In an effort to ensure a smooth registration process, we have created a checklist of items to complete prior to registering in our district office. Please contact Natalie Fullen, District Registrar, at fullenn@lkgeorge.org or (518) 668-5452 ext. 1211 with any questions.

Please complete the forms included in this packet and bring them with you to your registration appointment:

____ **Residency Questionnaire**
____ **Student Information Update**
____ **Authorization for Use or Disclosure of Protected Health Information**
____ **Health History**
____ **Dental Health Certificate** *(optional)*
____ **Mandatory New Student Questionnaire**
____ **Record Release Authorization**
____ **Transfer Student Service Worksheet**
____ **Digital Equity Survey**
____ **Application for Parent Portal Account** *(optional)*
____ **Affidavit – Family Residence**
____ **Home Language Questionnaire**

Please also bring the following documents to your registration appointment:

____ **Record of Physical Exam** *(Must be from within the last year)*
____ **Immunization Record**
____ **Proof of Residency** *(Must show the parent(s)/guardian(s) residential address)*

Documentation of Proof of Residency in the Lake George Central School District may include a copy of a residential lease, deed, or mortgage statement; or a notarized statement by a third-party landlord, owner, or tenant from whom the parent(s)/guardian(s) lease from or live with.

If parent(s)/guardian(s) are unable to provide any of the above documentation, the district may consider the following as proof of residency: utility bills; pay stub; income tax form; membership documents based upon residency; voter registration documents; official driver's license, learner's permit, or non-driver ID; state or other government issued identification; documents issued by federal, state, or local agencies; custody or guardianship papers.

____ **Proof of Student Age**

Documentation of proof of age may include a duly certified transcript of a birth certificate filed according to law, or a duly certified transcript of a record of baptism, giving the date of birth; or, if not available, a passport showing the date of birth of the child; or, if not available, other documentary evidence may include: official driver's license; state or other government issued ID; school photo ID with date of birth; consulate identification card; hospital or health records; military dependent identification card; documents issued by federal, state, or local agencies; court orders or other court-issued documents; Native American tribal documents; records from non-profit international aid agencies, etc.

____ **Parent Photo ID**
____ **Latest Report Card and/or Transcripts**
____ **IEP or 504 Plan** *(if applicable)*
____ **Custody Paperwork** *(if applicable)*

RESIDENCY QUESTIONNAIRE

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Grade_____
Month Day Year *(preschool-12)*

Address: _____ Phone: _____

_____

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.*)

- ☐ 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

_____ _____

Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____

Date

STUDENT INFORMATION UPDATE

School Year _____

Student Name _____ Student ID _____
Date of Birth _____ Grade _____
Teacher _____

Please complete the following areas and sign below.

1. Primary Address: _____
   Mailing Address (if different) _____

2. Parent(s)/Legal Guardian(s) with whom the student **resides**:
   Name _____ Relationship to Student _____
   Home Phone _____ Cell Phone _____ Work Phone _____
   Employer _____ Occupation _____
   Email Address _____

   Name _____ Relationship to Student _____
   Home Phone _____ Cell Phone _____ Work Phone _____
   Employer _____ Occupation _____
   Email Address _____

3. Parent(s)/Legal Guardian(s) with whom the student **does not reside**:
   Name _____ Relationship to Student _____
   Address _____
   Home Phone _____ Cell Phone _____ Work Phone _____
   Employer _____ Occupation _____
   Email Address _____

   Name _____ Relationship to Student _____
   Address _____
   Home Phone _____ Cell Phone _____ Work Phone _____
   Employer _____ Occupation _____
   Email Address _____

4. Person to be called in an emergency if parents are unavailable (please list additional contacts on the back):
   Name _____ Relationship to Student _____
   Home Phone _____ Cell Phone _____ Work Phone _____

5. List all siblings (please list any additional siblings on the back):
   Name _____ Date of Birth _____
   Name _____ Date of Birth _____
   Name _____ Date of Birth _____

Parent/Guardian Signature _____ **Date** _____

*PLEASE NOTIFY THE SCHOOL OF ANY CHANGES TO PHONE NUMBERS, ADDRESSES OR EMERGENCY CONTACTS MADE DURING THE SCHOOL YEAR.

LAKE GEORGE ELEMENTARY SCHOOL

69 SUN VALLEY DRIVE LAKE GEORGE, NEW YORK 12845-3900
TELEPHONE 518-668-5714 FAX 518-668-5876

Authorization for Use or Disclosure of Protected Health Information

In order to share protected health information with the school district, your healthcare provider may require completion of the form below to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Please complete, sign and give the form to your healthcare provider and/or to your school nurse to avoid delays in care for your child.

I, _____ guardian for _____, DOB: ____/____/____
authorize the medical records of my child, to be released to the district from their healthcare provider and authorize the school district to share relevant school information with my healthcare providers.

Healthcare provider(s) listed below:

Name_____Phone_____Fax_____
Name_____Phone_____Fax_____
Name_____Phone_____Fax_____

The healthcare provider may disclose the following information:

* Immunizations * Health Appraisals
* Past/current medical conditions and its impact on attendance, athletics, school programming or therapy.
* Other_____

The Protected Health Information may be used, disclosed or received for the following purpose(s):

- To develop care or therapy plans for routine and emergent school management
- To design appropriate educational, school, or athletic programs
- To assess the impact of the medical condition(s) on school programming and/or attendance
- To share school observations/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring
- Medication delivery or therapy prescriptions
- At patient's request with no specified purpose
- Other_____

PARENT: Please select one.

❒ This authorization is valid for the duration of attendance within the school district
or
❒ This authorization is valid for the entire academic school year 20___- 20____
or
❒ This authorization shall expire on ____/_____/_____

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at my healthcare provider's office and to the District Administration Building. I understand that the revocation of this authorization is not effective if the Healthcare Provider or District has used the authorization for disclosure of the Protected Health Information before receiving my written revocation notice. I understand that any Protected Health Information disclosed as a result of this Authorization to anyone not covered by the state and federal privacy laws and regulations may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that my child's treatment is not dependent on my agreement to release or withhold information. I acknowledge that the district will share relevant school information with my healthcare providers and when applicable with those governmental agencies as required for reimbursements. I give permission for the school representatives above to share and disclose information as indicated above with the health care provider listed.

_____

Signature of Parent/Guardian (or student if over 18) Relationship Date

HEALTH HISTORY

To be completed by Parent/Guardian

Student Name _____ Date of Birth _____ Grade _____

	Yes	No		Yes	No
Medication Allergy (to what?) _____			Headaches/Migraines		
Food Allergy (to what?) _____			Head Injury/Concussion		
Seasonal/Environmental Allergies (to what?) Ex. pets, mold, dust, trees _____			Heart Problem/Murmur		
Insect (bee) sting allergy			Mononucleosis		
Does your child have an Epipen?			Pneumonia		
ADD/ADHD			*SEIZURE DISORDER		
Asthma Has Inhaler Has Nebulizer meds			Strep/frequent sore throat Has your child been seen by an ENT? Or allergy specialist?		
Bladder/Kidney Injury, disease, problem			Stomach Problems (reflux, lactose intolerance)		
Colds			Celiac disease		
*DIABETES			Tonsillitis		
Ear Infections Tubes			Developmental delay		
Hearing loss/Hearing aids			Physical Therapy		
Vision/Eye Problem			Speech Therapy		
Wears glasses or contacts			Any other health conditions? Please explain: _____		
Fracture/Sprain (please list) _____			Birth Weight: _____ _____ Normal pregnancy/delivery?		
List Hospitalizations, Operations, Injuries Date: Explanation/Reason: _____ _____ _____			Has your child been to a Dentist? Name of Dentist: _____ Date of last exam: _____ Any dental problems? _____ Has orthodontic braces		

Child's Physician's Name: _____

Does your child take any medication(s)? No _____ Yes _____

If yes, please list the name and dosage of medication(s) and when taken: _____

_____

_____

Are there any medical, emotional, behavioral or developmental conditions requiring special attention? _____

_____

_____

Is your child receiving counseling services? _____

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

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, Pre-K or K, 1, 3, 5, 7, 9, & 11. 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 the 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: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's 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's 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:

☐ 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/ 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 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):_____

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.

MANDATORY NEW STUDENT QUESTIONNAIRE

Student Name: _____

	Yes	No
Has your child ever received special education services? If so, when? _____ *(*Every parent/guardian has the right to have their child evaluated for the purposes of special education services and programs pursuant to applicable federal and state laws.)*		
Does your child have an IEP?		
Does your child have a 504?		
Has your child repeated a grade? If so, which one? _____		
Has your child ever been in a Gifted & Talented Program?		
Has your child ever had remedial reading?		
Has your child ever been inducted into the National Junior or Senior Honor Society?		
Has your child ever been enrolled in the Lake George School District? If so, when? _____		
Are you living in a shelter, with a relative or others due to lack of housing; in an abandoned apartment/building, in a motel/hotel, camping ground, car, train/bus station or other similar situation due to the lack of alternative, adequate housing; or temporarily housed in a shelter awaiting an OCFS permanent foster care placement? *(*Information required by the No Child Left Behind Act of 2001)*		
Does your child have a parent, step parent or guardian serving as a full-time active duty member of the United States Armed Forces?		
Do you have any custody limitations? *(*Must be documented with legal paperwork in district folder)*		
Is this student a foster child? If yes, attach form DSS-2999		
Does your child require transportation?		

What ethnicity is your child? Please circle all that apply:

A) American Indian or Alaskan Native B) Asian C) Black (Not Hispanic Origin)
D) Hispanic E) Pacific Islander F) White (Not Hispanic Origin)

Please provide name, number and address of your child's before/after school child care provider:

_____

_____

What is the main reason for moving to our school district? Please explain: _____

_____

Please describe anything that the counselor should know about your child (immediate health concerns, behavior concerns, academic concerns, etc.): _____

_____

_____

<u>Note</u>: The Lake George Central School District may occasionally use student photographs, video recordings or work on the district website and/or in district and community publications. Any parent or guardian who does not wish to have his/her child(ren)'s picture or work used for these purposes must notify the building principal in writing.

For Office Use Only					
	☐	New Student		Effective Date:	_____
	☐	Re-Entry		Student ID:	_____
	☐	Move Out: _____	→ Indicate:		
	☐	Transfer: _____	☐ Parent Placement		
	☐	Change:	☐ School Placement	Year Entered High School:	

LAKE GEORGE CENTRAL SCHOOL DISTRICT
381 CANADA STREET, LAKE GEORGE, NY 12845
PHONE: (518) 668-5452 FAX: (518) 668-2285

RECORD RELEASE AUTHORIZATION

Student's Name:	Date of Birth:	Grade:

I hereby give permission for the following school to release records to Lake George Central School District:

School Name:	City/State:
School Phone:	**School Fax/Email:**

RECORDS REQUESTED	
Academic transcripts and report cards	Attendance records
Academic intervention service records	Disciplinary records
Special education records (IEP, 504 plan)	Standardized test scores
Psychological evaluations	Local assessments
Health records (last physical, immunization record)	Record of NYS Science Investigations (if applicable)
Record of birth	Custody paperwork

Please release all records requested pertaining to this student to Lake George Central School District. This release may not, in any way, be construed as permission to forward this information to a third party.

Records may be sent to Natalie Fullen, District Registrar. Thank you for your assistance.

Fax: (518) 668-2285 **Email: fullenn@lkgeorge.org**

_____ _____

Parent/Guardian Signature School District Employee

Date: _____ Date: _____

* *The attached scholastic records are released to you under allowable provisions of Public Law 93-380 Section 438 of the condition that you will not permit any other party to have access to these records or will not release this information contained therein in personally identifiable form to any other party without the written consent of the student (if under 17 years of age and not attending an institution of post-secondary education).*

* *The Final Regulations Family Rights and Privacy Act dated June 1976, no longer requires written parental consent to release student educational records between schools. These rules state that school officials in school systems in which the student may intend to enroll may release and receive a student's records without a written consent for such release.*

TRANSFER STUDENT SERVICES WORKSHEET

Student Name: _____ Grade: _____

Parents/Guardians: Please complete this worksheet to the best of your knowledge so that we can develop appropriate services for your child as soon as possible. Thank you.

Please check if your child has previously had services and/or was currently getting these services in the school they last attended.

Regular Education Support	Previously had	Currently has
Reading Support – Pull-out of classroom		
Reading Support – Within the classroom		
AIS – Academic Intervention Services		
Section 504 Classification		
Special Transportation		

Special Education Services	Previously had	Currently has
Consultant Services (Support provided by special education teacher in the regular classroom)		
Resource Room (Supplemental support in a separate location outside the regular classroom)		
Integrated Class (Academic classes taught to classified and non-classified students together by a regular AND special education teacher)		
Self-Contained Class (Academic classes taught to classified students only by a special education teacher)		
Speech/Language Therapy		
Physical Therapy		
Occupational Therapy		
Counseling Services		
Assistive Technology Services		

_____ **My child is not currently receiving any extra support in school.**

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

DIGITAL EQUITY SURVEY

Student Name: _____

In efforts to ensure that all students have access to a device appropriate for learning and sufficient broadband access, the New York State Education Department has developed a Digital Equity Survey that must be completed for every student.

"*Collecting accurate data regarding digital resource access for our New York students will greatly help educators to better serve their students and families. In order to accomplish this, the New York State Education Department is asking parents or guardians to complete a Digital Equity survey (for each student in the family) in grades Kindergarten – Grade12. This survey will provide information on student access to devices and internet access in their places of residence. To assist us in this process, please answer each question below and follow any additional instructions provided for submitting or returning the survey. Thank you for your time and cooperation.*"

Question 1: Did the school district issue your child a dedicated school or district-owned device for their use during the school year?

A) YES B) NO

Question 2: What is the device your child uses most often to complete learning activities away from school? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.) Please circle only one.

A) DESKTOP B) LAPTOP C) TABLET
D) CHROMEBOOK E) SMARTPHONE F) NO DEVICE

Question 3: Who is the provider of the primary learning device identified in Question 2? (This can be a school-provided device or another device, whichever the student is most often using to complete their schoolwork.)

A) SCHOOL B) PERSONAL C) NO DEVICE

Question 4: Is the primary learning device (identified in Question 2) shared with anyone else in the household?

A) SHARED B) NOT SHARED C) NO DEVICE

Question 5: Is the primary learning device (identified in Question 2) sufficient for your child to fully participate in all learning activities away from school?

A) YES B) NO

Question 6: Is your child able to access the internet in their primary place of residence?

A) YES B) NO

Question 7: What is the primary type of internet service used in your child's primary place of residence?

A) RESIDENTIAL BROADBAND B) CELLULAR C) MOBILE HOTSPOT
D) COMMUNITY WIFI E) SATELLITE F) DIAL UP
G) DSL H) OTHER I) NONE

Question 8: In their primary residence, can your child complete the full range of learning activities, including video streaming and assignment upload, without interruptions caused by slow or poor internet performance?

A) YES B) NO

Question 9: What, if any, is the primary barrier to having sufficient and reliable internet access in your child's primary place of residence?

A) AVAILABILITY B) COST C) NONE D) OTHER

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

LAKE GEORGE CENTRAL SCHOOL DISTRICT

SchoolTool Parent/Guardian Access Request Form

The Lake George Central School District is pleased to provide parents and guardians with access to student information records via the SchoolTool Parent Portal. In order to protect the confidentiality of student records, all parents/guardians who would like access are required to complete this form and return it in person to your child's school. For security purposes, a photo ID is required when you return this form.

Parents and Guardians are required to adhere to the following SchoolTool Parent Portal guidelines:

- Parents/Guardians will access data solely in regard to their children.
- Parents/Guardians will not access any account assigned to another user.
- Please do not share your password with anyone, including your children.
- Please do not allow your computer to "remember" your Parent Portal password.

Parent/Guardian Name: _____
**One name per form*
Parent/Guardian Home Address: _____

Parent/Guardian Email Address: _____
**Only one email address per application. Your email address will be your username.*

Please list all children who are or will be enrolled at Lake George Central School District (Student Name)	What is your relationship to this student? (Mother/Father/Guardian)	Do you reside at the same address as this student? (Yes or No)	Grade
You only need to fill this form out once. New children will automatically be added.			

I have read the SchoolTool Parent Access Form and agree to abide by and support the guidelines. I certify that all of the above information is true and I have legal authority to access the records of the student(s) listed above.

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

Important: Once the information on this form is received, verified, and processed, you will receive notification via email that your SchoolTool Parent Portal account has been created. The email will also contain instructions to complete the registration process.

Office Use Only:

___ ID Verified	Verified by: _____	Date: _____
___ Account Created.	Created by: _____	Date: _____

STATE OF NEW YORK)
)ss.:
COUNTY OF WARREN)

AFFIDAVIT – FAMILY RESIDENCE

I, _____, being duly sworn, deposes and says:
[Name of Parent/Guardian]

1. I[We] am[are] the ___parent(s)/guardian(s)__ of _____.
[Name(s) of Student(s)]

2. I[We] reside at:

_____.
[Address of Parent/Guardian]

The Student(s) reside(s) at:

_____.

3. The Student(s) began living at the current residence on _____ and will continue to reside there until _____.

4. I[We], the Parent(s), began living at the current residence on _____ and will continue to reside there until _____.

I[We] understand that this affidavit has been completed to establish me[us], the Parent(s), and the Student as residents, living within the Lake George Central School District (the "District") boundaries. As a result of the representations made by me(us) in this affidavit, the District may admit the Student to its schools on a tuition free basis. If any such representations are untrue, the District may be damaged, at least in the amount of tuition it should have received for the education of the Student.

Therefore,

I[We] certify that all the information provided on this affidavit is true and accurate.

I[We] understand that:

If I[We] provide false information on this affidavit to the Lake George Central School District, I[We] may be committing the crime of perjury in the third degree (a class A misdemeanor);

If I[We] provide false information on this affidavit to the Lake George Central School District with the intent to defraud the Lake George Central School District, I[We] may be committing the crime of perjury in the second degree (a class E felony); and

I[We] may be prosecuted on criminal charges for such false information.

_____
Signature (Parent/Guardian)

Sworn to before me this
_____ day of _____, 20_____

_____
Notary Public

_____
Signature (Parent/Guardian)

Sworn to before me this
_____ day of _____, 20_____

_____
Notary Public

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

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:		GENDER:
Month	*Day*	*Year*
❑ 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	*specify*
2. What was the first language your child learned?	❑ English	❑ Other	*specify*
3. What is the Home Language of each parent/guardian?	❑ Parent 1 *specify*	❑ Parent 2 *specify*	❑ Guardian(s) *specify*
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ 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:*	

Home Language Questionnaire (HLQ)—Page Two

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 ***Date***

Relationship to 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: ❑ **NO** ❑ **YES**

****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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: