Attestation of Student Registration Information

Central Registration Office
15 Croft Road
Poughkeepsie, New York 12603
(845) 463-7800
Email: CentralRegistration@sufsdny.org

Welcome to the **Spackenkill Union Free School District**. Our school district is comprised of two elementary schools (one K-2, one 3-5), one middle school (6-8) and one high school (9-12) within a compact, six-square-mile area situated in the southern part of the Town of Poughkeepsie. Beginning with the 2022-23 school year, we are piloting a limited Universal Pre-K program. Because the school district is situated between the City of Poughkeepsie, Arlington Central, and Wappingers Central School Districts, we strongly advise checking with the Spackenkill District Office (845-463-7800) to confirm an address before enrolling your student. Residency (where you live) determines where your child or children are entitled to attend school.

The district also has a non-resident K-12 tuition program: https://www.spackenkillschools.org/parents/online_registration/tuition_program

In order to enroll a child in Spackenkill schools, the school district must receive verification of the child's date and place of birth, Spackenkill residency, legal custody, appropriate immunizations and academic status. Parents/guardians may verify the information by providing the documentation and completed forms on the checklist provided on the following pages. If missing, forms and documentation must be provided within 3 days of request. **Please note,** student registration is not complete and your child **will not be enrolled** until all requirements have been met.

WARNING: Any person or persons who willfully provide false information regarding residence, may be subject to criminal penalties. A false statement regarding residence or entitlement to a tuition-free education from the Spackenkill Union Free School District may be punishable as a Class A misdemeanor. In addition, if it is determined that a registrant's child resides outside of the Spackenkill Union Free School District, the District may take legal action to collect tuition charges. Such tuition may exceed $13,463.00 (Regular Ed. Pre-K-6); $18,058.00 (Regular Ed. 7-12); $34,628 (Special Ed. Pre-K-6); $38,623 (Special Ed. 7-12) per child per year if the student is not legally entitled to receive a tuition-free education from the District. The District reserves the right to investigate any student's residency by any legal means available including, but not limited to, public records, site visits, and other lawful methods of investigation.

I hereby attest that all registration information provided to the Spackenkill Union Free School District for the child named on this form is accurate. I understand that providing any false information will prohibit this child from attending Spackenkill schools and may result in other penalties.

Parent Name:_____ ***Child:_____***
please print *please print*

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

Sworn to before me this _____ Day Of _____, 20 _____

_____ (Notary)

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Child's Name:_____

CHECKLIST - Required Documents and Forms for Registering a Student

In order to enroll a child in Spackenkill schools, the school district must receive verification of the child's date and place of birth, residency status, legal custody, appropriate immunizations and academic status. Parents/guardians may verify the information by providing the following documents. If missing, forms and documentation must be provided within 3 days of request. **Please note,** student registration is not complete and your child **will not be enrolled** until all requirements have been met.

☐ **1. ATTESTATION OF STUDENT REGISTRATION INFORMATION -** must be notarized

☐ **2. CHECKLIST OF REQUIRED KINDERGARTEN DOCUMENTS AND FORMS**

☐ **3. HOUSING QUESTIONNAIRE**

☐ **4. PROOF OF RESIDENCY (not required for Tuition Students)**

If You Are a Homeowner (2 proofs of residency):

- Copy of mortgage agreement containing matching names, addresses, and phone information OR copy of a recent land tax bill OR Deed.

AND

One (1) additional proof of residency in your name (must be dated within 30 days of of submitting documentation):

- Monthly utility bill – electric, cable, water, fuel (bill must state "for service at")
- Voter registration card
- Income tax form that shows your address
- Post Office change of address or mail with the yellow post office label

If You Are Renting an Apartment or Home (2 proofs of residency):

- Rent receipt with your address, the Landlord's signature, and telephone number OR Signed and current lease agreement for apartment or condo.

AND

- One (1) additional proof of residency in your name (must be dated within 30 days of submitting documentation):
  - Monthly utility bill – electric, cable, water, fuel (bill must state "for service at")
  - Voter registration card
  - Income tax form that shows your address
  - Post Office change of address or mail with the yellow post office label

If You Are Renting/Living in a Private Home or Rental Unit - If the address where you reside is listed under someone else's name, *ALL* of the following documentation is required:

- Named resident's (owner) two (2) proofs of residency .
- Notarized Owner's Affidavit from the named resident (owner). Please make sure that the proper name of the resident (owner), parent/guardian and student(s) are stated in this affidavit.
- Notarized Renter's Affidavit - required even if not paying rent
- Two (2) additional proofs of residency in your name:
  - Monthly utility bill – electric, cable, water, fuel (bill must state "for service at")
  - Voter registration card
  - Income tax form that shows your address
  - Post Office change of address or mail with the yellow post office label

☐ **5. DRIVER'S LICENSE OR PASSPORT PHOTO OR OTHER PICTURE ID** (of parent/guardian)

☐ **6. AUTHENTIC BIRTH CERTIFICATE** for each child being registered. We must be able to see the raised seal or a copy that has been certified. Passport is also acceptable if there is no authentic birth certificate. ***Child must turn 5 by December 1 of the school year to start kindergarten.***

7. UP-TO-DATE IMMUNIZATIONS AND PHYSICAL from a physician's office or Department of Health. There is a 14-day grace period during which the student can obtain the necessary documentation. The physical must be performed by a New York State licensed provider.

- ☐ Child's Updated Immunization Record
- ☐ Child's Updated Physical

8. A COPY OF THE:

- ☐ student's transcript
- ☐ most recent report card
- ☐ IEP (if applicable)
- ☐ 504 accommodation plan (if applicable)
- ☐ most recent psychological evaluation (if applicable)
- ☐ most recent re-evaluation (if applicable)

☐ **9. GUARDIANSHIP:** If the student does not live with the Parent/Guardian, **written** proof of guardianship is required, such as a court document.

☐ **10. CUSTODIAL DOCUMENTS:** In the event of divorced or separated parent/guardians, **written** proof of custody is required.

11. COMPLETED REQUIRED FORMS

- ☐ Kindergarten Screening Inventory
- ☐ Health Office Form
- ☐ Release of Student Information
- ☐ Spackenkill Student Transportation Request **(not for tuition students)**
- ☐ Home Language Questionnaire (HLQ)
  - *Required by NY State to identify English Language Learners.*
  - *Please indicate all languages spoken in household regardless of proficiency*

12. COMPLETED ADDITIONAL REQUIRED FORMS - if Applicable

- ☐ Request for Daycare Transportation **(not for tuition students)**
- ☐ Owner's Affidavit - must be notarized
- ☐ Renter's Affidavit - must be notarized
- ☐ Custodial Affidavit - must be notarized
- ☐ Migrant Education Program Survey

FOR OFFICE USE ONLY

THIS STUDENT HAS BEEN APPROVED FOR TUITION REGISTRATION EFFECTIVE DATE: _____

By _____

SUPERINTENDENT OF SCHOOLS

HOUSING QUESTIONNAIRE

Name of LEA: Spackenkill Union Free School District

Name of Student: _____

Gender: ☐ Male
☐ Female
☐ Non-Binary

Date of Birth: _____
Month Day Year

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 only **one**)*

- ☐ 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") - **Permanent situation**
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up") - **Temporary situation**
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ In permanent housing

_____ _____

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

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

☐ Check here if unaccompanied homeless youth

_____
Date

****

FOR OFFICE USE:

Name of School_____

Grade: _____
(PreS-12)

ID Number: _____

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KINDERGARTEN ONLY
Screening Inventory/Home Survey
Spackenkill Union Free School District

Date: _____

Child's Name: _____ **DOB**: _____

Child's Address: _____

School: _____

Person Completing Form: _____

In order to help us better understand your child and meet his/her educational needs, please take a few minutes to answer the following questions:

Family History

Parent/Guardian Name _____ Relationship_____

Parent/Guardian Name _____ Relationship_____

Parent/Guardian Name _____ Relationship_____

Parent/Guardian Name _____ Relationship_____

Please list below all children of your household ranging from birth to 21 years.

Child's Name (last name, first name)	Age	Date of Birth	Gender	Grade

Parents' Marital Status: Married ☐ Divorced ☐ Separated ☐ N/A ☐

With whom does the child reside?_____

Language Skills

What is your child's first language?_____ What languages are spoken at home? _____

Do you think your child may have any difficulties or conditions that affect his/her ability to understand, speak, read or write in English or any other language? Yes ☐ No ☐

If yes, please explain:_____

Has your child ever received English as a New Language (ENL/ESL) Services Yes ☐ No ☐

If yes, please explain with dates/grades_____

Does anyone in the family have a history of learning difficulties? Yes ☐ No ☐

If yes, please explain:_____

Medical History

Was the pregnancy full term? Yes ☐ No ☐

If not, please explain:_____

Were there any complications during pregnancy? Yes ☐ No ☐

If yes, please explain:_____

Baby's birth weight: _____ Was oxygen required for the baby? Yes ☐ No ☐

Did the baby cry immediately? Yes ☐ No ☐

Did the baby stay longer in the hospital than the mother? Yes ☐ No ☐

If yes, please explain: _____

During the hospital stay did the baby have yellow jaundice, rash, blue spells? Yes ☐ No ☐

If yes, please explain: _____

Child's Health

Has your child ever been hospitalized? Yes_O_ No_O_
If yes, please explain:_____
Has your child had surgery?Yes_O_ No_O_
If yes, please explain: _____
Does your child have any allergies? Yes_O_ No_O_
If yes, please explain: _____
Has your child ever had trouble seeing?Yes_O_ No_O_Hearing? Yes_O_ No_O_
If yes, please explain:_____
Has your child had frequent ear infections? Yes_O_ No_O_
If yes, please explain:_____
Has your child ever had any seizures, fainting or black outs? Yes_O_ No_O_
If yes, please explain:_____
Does your child have any current medical problems or is he/she on any medications? Yes_O_ No_O_
If yes, please explain:_____

Development

When did your child sleep through the night?_____
When did your child sit up? _____ Crawl?_____ Walk?_____
When did your child say his/her first words?_____Speak in sentences?_____
Does your child have difficulty speaking? Yes_O_ No_O_
If yes, please explain?_____
Can strangers understand your child's speech? Yes_O_ No_O_
If yes, please explain:_____
When was your child completely toilet trained?_____
Does your child eat with or without assistance? Yes_O_ No_O_
Does your child dress himself with or without assistance? Yes_O_ No_O_
Can he/she button? Yes_O_ No_O_ Zip? Yes_O_ No_O_
Does your child have any difficulty sleeping? Yes_O_ No_O_ Eating? Yes_O_ No _O_
Can your child separate easily from you? Yes_O_ No_O_
Does your child cry easily? Yes_O_ No _O_
How would you describe your child: Highly active?_O_ Average?_O_ Very Quiet?_O_

School History

Has your child attended nursery school or preschool? Yes_O_ No_O_
If yes, where? _____
How long? _____
Has your child received any special services (e.g., speech, occupational or physical therapy) or been identified as a Preschool Child with a disability? Yes_O_ No_O_
If yes, please explain:_____
Does your child show a preference for the right or left hand? _____
Does your child have proper pencil grasp? Yes_O_ No _O_
Can your child ride a bicycle? Yes_O_ No _O_ Throw and catch a ball? Yes_O_ No _O_
Does your child get along with other children? Yes_O_ No _O_
If no, please explain:_____
How do you discipline your child? What do you think works best and how does he/she respond to discipline?_____
Does your child like books? Yes_O_ No _O_ Puzzles? Yes_O_ No _O_

Additional Information

Is your child covered under any health insurance? Yes ___ No___

If yes, please indicate the name of the individual(s) that the student is insured under:

Policy Holder's Name_____

Relationship_____

Address_____

Phone_____ Insurance Company_____

Policy Number_____ Group ID:_____

Are there any circumstances or experiences in y our child's life that may impact your child's performance in school?

Yes ___ No___ If yes, please explain:

Is your child homeless? Yes ___ No___

If yes, please list the last school your child attended and former district of residence:

Is child a foster child? Yes ___ No___

If yes, please provide name, phone number, and email address of case worker:

In an effort to better know your child, please use the area below to offer additional information that you wish to share with us.

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Spackenkill Union Free School District Student Registration
HEALTH OFFICE FORM

Dear Parents/Guardians:

New York State Education Law requires new entrants to a school to have a physical examination by a provider licensed in New York State. **A copy of the completed physical along with up-to-date immunizations must be provided to the school health office within 14 days of entrance to school. Dental certificates, if available, may also be provided. The required immunizations for school attendance are:**

- **DTaP/DTP**: for Gr. K-3, 5 doses unless 4th dose was given at 4 yrs or older / for Gr. 4 & 5, 5 doses unless 4th dose was received at 4 yrs or older / Gr 6-9, 3 doses / and Gr 10-12, 3 doses.
- **Tdap**: Gr 6-12, 1 dose
- **Polio**: for Gr K-3 and 6-8 / 4 doses (3 if 3rd does was given at age 4 or older)/ for Gr 4-5 and 10-12, 3 doses
- **MMR**: 2 doses for all students
- **Hepatitis B**: 3 doses for all students (or 2 doses of adult hepatitis B vaccine (Recombivax for Gr. 6-12))
- **Meningococcal:** by Grade 6, 1 dose / 12th Grade , 1 dose

Please make arrangements for your child to have a physical examination as soon as possible. A copy of a physical exam completed no more than twelve months prior to the commencement of the school year is acceptable. If documentation is not received, the school physician will examine your child.

Please contact the school nurse with any questions:			
	Nora Bergstraser, MSN, RN	Nassau	463-6390
	Sharon Dooley-Russo, RN	Hagan	463-8398
	Alyssa Karcz, RN	Todd	463-6527
	Elizabeth Giancaspro, BSN, RN	High School	463-2043

Very truly yours,
Spackenkill School Nurses

****

Student Name_____ Grade_____

_____ My child has been examined by his/her personal physician. Certificate to be provided within 30 days of registration.

_____ My child may be examined by the school physician.

Medications_____ None ☐

Health conditions_____None ☐

Allergies_____None ☐

Parent signature_____ Date_____

Printed name_____

Spackenkill Union Free School District Student Registration
HEALTH OFFICE FORM

Student's legal name (print)_____ ◯M ◯F

Date of birth_____ Place of birth:_____

Legal residence_____

Parent/Guardian name_____ Employer_____

Phone (w)_____ (c)_____ (h)_____ Custodial parent? ◯Yes ◯ No

Parent/Guardian name_____ Employer_____

Phone (w)_____ (c)_____ (h)_____ Custodial parent? ◯Yes ◯ No

Physician's name_____ Phone_____

Dentist's name_____ Phone_____

Allergies_____

Current medications_____

Any medications in school?_____

Medical conditions_____

Significant medical history:

Does your child wear glasses or contacts? ◯Yes ◯No If yes, are they needed for near work?

◯Yes ◯No Distance? ◯Yes ◯No

Does your child receive any of the following special services? Check any that apply.

Resource Room ☐ Special Class ☐ Counseling ☐ Speech ☐ OT ☐ PT ☐

Academic Intervention for _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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

Notes

Hearing Screening: 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.**

<u>If Restrictions Apply</u> – 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 <u>ONLY</u> 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*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*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.

Spackenkill Union Free School District Student Registration

RELEASE OF STUDENT INFORMATION

for Spackenkill Union Free School District

I hereby authorize (Name and address of former school) _____

_____

_____

Phone: _____ Fax: _____

to release any and all school and health records and any other pertinent information concerning my child

_____

(please print /type student name above)

It is understood that the privileged and confidential nature of such records will be preserved.

_____ _____

Parent/Guardian Signature Date

****

FOR OFFICE USE ONLY

Please mail, fax, or email student records to the schools/office checked off below. Records include:

_____ **Transcript**
_____ **Report Card**
_____ **Discipline Records**
_____ **Attendance Records**
_____ **Home Language Questionnaire (HLQ)**
_____ **NYSITELL/NYSESLAT**
_____ **Health Records** ***(immunization; physical examinations; psychiatric, psychological, and neurological evaluations)***

_____ **IEP**
_____ **504**
_____ **Test Data & Scores**
_____ **NYS Science Investigations**
_____ **Other**

Please send records to:

___ **Spackenkill District Office**
15 Croft Road
Poughkeepsie, NY 12603
Phone: (845) 463-7800
Fax: (845) 463-7804

___ **Hagan Elementary School**
42 Hagan Drive
Poughkeepsie, NY 12603
Phone: (845) 463-7840
Fax: (845) 463-7881

___ **Nassau Elementary School**
7 Nassau Road
Poughkeepsie, NY 12601
Phone: (845) 463-7843
Fax: (845) 463-7842

___ **O.A. Todd Middle School**
11 Croft Road
Poughkeepsie, NY 12603
Phone: (845) 463-7825
Fax: (845) 463-7832

___ **Spackenkill High School**
112 Spackenkill Road
Poughkeepsie, NY 12603
Phone: (845) 463-7822
Fax: (845) 463-7877

Release Mail Date _____ Release Fax _____

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SPACKENKILL SCHOOL TRANSPORTATION REQUEST

(not for tuition students)

The Spackenkill Union Free School District provides bus transportation to:

- Elementary students who live more than ½ mile from either Hagan or Nassau School
- Todd Middle School students who live more than ¾ mile from the school
- High School students who live more than 1 mile from the school
- Students who reside within Spackenkill District but attend a private or parochial school must provide two proofs of residency (see Request for Private/Parochial Transportation form)
- Students who reside within Spackenkill District (provide two proofs of residency) with preschool or afterschool daycare that is also within the Spackenkill boundaries. (see Request for Daycare Transportation form)

If your student meets the above criteria, the Transportation Office will call to inform you of which bus route and bus stop along with the pickup and drop off times for your student.

Name of Student: _____
(Please print student's name)

Home Address: _____

To School: _____Grade:_____

Parent /Guardian Name: _____

Phone Number(s): _____

FOR OFFICE USE:

BUS ROUTE: _____

BUS STOP: _____

PICKUP TIME: _____ DROP-OFF TIME: _____

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

Lissette Colón-Collins, Assistant 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 Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes 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.

Please write clearly when completing this section.

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 Student*

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?	☐ Mother _____ *specify*	☐ Father _____ *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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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: ◯ **Mother** ◯ **Father** ◯ **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:

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

Lissette Colon-Collins, Assistant 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

Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

Estimados padres o tutores:
Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal.
Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.
Gracias.

Por favor escriba con claridad al completar esta sección.

NOMBRE DEL ESTUDIANTE:

Nombre *Segundo nombre* *Apellido*

FECHA DE NACIMIENTO: GÉNERO:

Mes *Día* *Año*

○ Masculino
○ Femenino

INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL

Apellido *Primer Nombre* *Relación con el estudiante*

CÓDIGO DEL IDIOMA DEL HOGAR

Conocimientos de idiomas

(Por favor, marque todas las opciones que sean aplicables)

1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante? ☐ Inglés ☐ Otro _____ *especifique*
2. ¿Cuál fue el primer idioma que su hijo(a) aprendió? ☐ Inglés ☐ Otro _____ *especifique*
3. ¿Cuál es el idioma primario de cada padre / tutor? ☐ Madre _____ *especifique* ☐ Padre _____ *especifique* ☐ Tutor(es) _____ *especifique*
4. ¿Qué idioma o idiomas entiende su hijo(a)? ☐ Inglés ☐ Otro _____ *especifique*
5. ¿Qué idioma o idiomas habla su hijo(a)? ☐ Inglés ☐ Otro _____ *especifique* ☐ No sabe hablar
6. ¿Qué idioma o idiomas lee su hijo(a)? ☐ Inglés ☐ Otro _____ *especifique* ☐ No sabe leer
7. ¿Qué idioma o idiomas escribe su hijo(a)? ☐ Inglés ☐ Otro _____ *especifique* ☐ No sabe escribir

TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

Cuestionario de Idioma del Hogar (HLQ) — Página Dos

Historial Educativo

8. Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____

9. ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.

*Sí** *No* *No se sabe*

* En caso afirmativo, por favor explique :_____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ☐ Poca gravedad ☐ Algo grave ☐ Muy grave

10a. ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ☐ No ☐ Sí* * *Por favor, llene 10b.*

10b. **Si se le ha recomendado alguna vez una evaluación,* ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?

☐ No ☐ Sí – Explique, que forma o formas de educación especial recibió:

_____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

☐ De nacimiento a 3 años (Intervención Temprana) ☐ 3 a 5 años (Educación Especial) ☐ 6 años o mayor (Educación Especial)

10c. ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ◯ No ◯ Sí

11. ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
(*Por ejemplo, talentos especiales, problemas de salud, etc.)*

12. ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

_____ Mes: Día: Año: _____

Firma del padre/madre o de la persona en relación paternal *Date*

Relación con el estudiante: ◯ Madre ◯ Padre ◯ Otra:_____

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