



**CORNING-PAINTED POST
AREA SCHOOL DISTRICT**

Students are the center of all we do.

Office Use Date: _____ Building: _____ Student ID#: _____
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Student Name _____ **Grade** _____ **Gender** Male Female
last first middle

Student DOB _____ **Place of Birth** _____
mm/dd/yyyy city state country

Language other than English spoken in home _____

Residence Address _____
house number street name apt or lot #

_____ city state zip code

Mailing Address (if different from Residence) _____
PO Box

_____ city state zip code

Student resides with Both Father & Mother Mother Only Father Only
 Legal Guardian (specify relationship to child)

Information on Adults who are Living with Children	1st Adult Guardian Living at Above Address	2nd Adult Guardian Living at Above Address
Relationship to Children	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent Other (specify) _____	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent Other (specify) _____
Parent/Guardian Name (last, first, MI)		
Home Telephone (xxx-xxx-xxxx)		
Cell Phone (xxx-xxx-xxxx)		
Employer		
Work Telephone (xxx-xxx-xxxx, ext)		
Email Address		

Please enter the name and date of birth for ALL children living in the household.

Brothers in Home				Sisters in Home					
Last	First	DOB	Grade	School	Last	First	DOB	Grade	School

If the natural mother and/or father do not live with the student, please list their information below.

Parent/Guardian Information	1st Parent NOT living at Above Address	2nd Parent NOT living at Above Address
Relationship to Children	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Parent
Parent/Guardian Name (last, first, MI)		
Address (street address) (city, state, zip)		
Home/ Cell Phone (xxx-xxx-xxxx) (please specify)		
Employer		
Work Telephone (xxx-xxx-xxxx, ext)		
Email Address		
Is this Parent allowed contact with the student?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Should this parent receive mailings such as report cards	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If both parent do not reside in the same household, please answer below and provide documentation of custody agreement.

Custody is Sole Joint Protection order

Physical Custody with _____ Legal Custody with _____

Is this student under your care as a foster child? No Yes (if yes, please complete below)

In what school district does the student's parents reside? _____

Please also list Caseworker Name & Telephone Number _____

CONFIDENTIAL INFORMATION BOX 1

Complete this box only if (1) it reflects your child's current living situation; or (2) your living situation if you are a youth not living with a parent or guardian. (Your answer will help school staff with school enrollment and may enable the student to receive additional services). **Check one box if you are living:**

- | | |
|--|--|
| <input type="checkbox"/> in a shelter | <input type="checkbox"/> with relatives or others due to lack of housing |
| <input type="checkbox"/> at a train or bus station, park or in a car | <input type="checkbox"/> in an abandoned apartment/building |
| <input type="checkbox"/> temporarily housed in shelter awaiting a DCFS permanent foster care placement | |
| <input type="checkbox"/> in a motel/hotel, camping ground, or other similar situation due to the lack of alternative, adequate housing | |

If any box is checked, please complete a STUDENT RESIDENCY QUESTIONNAIRE



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Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

YES, Hispanic NO, not Hispanic

Select one or more races from the following five racial groups. Check (✓) all group that apply to your child; check at least one box:

American Indian or Alaska Native: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. E.g. Cherokee, Mohawk, Inuit.

Asian: A person having origins in any of the original peoples of the far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Black: A person having origins in any of the black racial groups of Africa.

White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Previous School Information

Name of Last School Attended _____

District Name & Address _____

Years/Grades in Attendance _____

Has this student ever attended a Corning-Painted Post School District building before? NO YES

Corning-Painted Post building attended _____

Has the student ever attended another New York State school? NO YES _____

If yes, how many years has this student attended a NYS school

Does your child receive and/or attend any of the following (please check yes or no)

Speech Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Special Class	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Occupational Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	15:1 <input type="checkbox"/>	12:1:1 <input type="checkbox"/>	
Physical Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	8:1:1 <input type="checkbox"/>		
Gifted and Talented Services	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Resource Room	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IEP	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Consultant Teacher	<input type="checkbox"/> YES	<input type="checkbox"/> NO
504 Accommodation Plan	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AIS Services	<input type="checkbox"/> YES	<input type="checkbox"/> NO



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It is mandated, **in case a parent or legal guardian cannot be reached during the school day**, to give the names to two relatives or reliable neighbors who will come for and take care of your child should he/she become ill or injured during the school day. **All attempts will be made to reach parents first.** If they are not reachable, the school will attempt to reach the emergency contacts below:

Adults other than Parents or Legal Guardians	First Emergency Contact	Second Emergency Contact
Emergency Contact Name (last, first)		
Contact Telephone (xxx-xxx-xxxx)		
Relationship to Children (i.e., Grandparent, Neighbor, Sitter)		
Cell Phone (xxx-xxx-xxxx)		

Please print, sign and date the completed registration form and return to the secretary of the school your child is registering to attend.

_____ signature of person completing form

_____ date

OFFICE USE ONLY

Registered by _____ **School** _____

Date Starting School _____ **Student ID#** _____

Teacher Name _____

Other Requirements

- Statement of Residence Required
- Custody Papers
- Approved, Transfer Student
- Home School
- Immunization Record
- Cohort Year
- One Picture ID Required

Hand Outs To New Student

- Emergency Card
- School Handbook
- Code of Conduct Summary
- Acceptable Use Policy (AUP)
- School Calendar/Packet
- Locker Assigned (if Applicable)
- Agenda Book (if Applicable)
- Reduced Lunch Form (if Applicable)

Proof of Name/Birth

- Birth Certificate
- Passport
- Visa
- Other _____

Activities

- Band
- Chorus
- Sports _____
- Other _____



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

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING
 MO. DAY YR.

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