



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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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. GRADES 1-12 CHECKLIST OF REQUIRED DOCUMENTS AND FORMS**
- 3. HOUSING QUESTIONNAIRE**
- 4. PROOF OF RESIDENCY** (all registrations require a first and second proof; not required for Tuition Students)

FIRST PROOF

- A. Homeowners, Proof of Ownership** – Copy of mortgage agreement containing matching names, addresses, and phone information OR copy of a recent land tax bill OR Deed.
- B. Renting an Apartment or Home** – Rent receipt with your address, the Landlord's signature, and telephone number OR Signed and current lease agreement for apartment or condo. In the event that the lease agreement is for a "month-to-month" situation, please be advised that the school can request an update from the family at any point during the school year to ensure that residency requirements are still being met.
- C. Renting/Living in a Private Home that you do not own** - see additional requirements below**

SECOND/Additional Proof (must be dated within 30 days of registration)

- monthly utility bill – electric, cable, water, fuel (bill must state "for service at")
- voter registration card
- auto insurance
- post office change of address or mail with the yellow post office label

****Renting/Living in a Private Home that you do not own** – If the address where you reside is listed under someone else's name, **all** the following documentation is required:

- Owner's two (2) proofs of residency (as referenced above)
- 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 (from the choices above).

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

Student Additional Information

Health Office Form

Release of Student Information

Spackenkill Student Transportation Request

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

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: _____

Last/First/Middle

Gender: ___ Male

___ Female

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 permanent housing
- ☐ 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 shelter
- ☐ In a hotel/motel/car/park/bus/train/campsite
- ☐ Unaccompanied Youth - Youth who is not in the physical custody of a parent or guardian

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

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

Date

FOR OFFICE USE:

Name of School _____

Grade: _____
(PreS-12)

ID Number: _____

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Spackenkill Registration Form/Student Information

Page 1 of 3

Child's First and Last Name _____ Grade _____ Date _____

1. Has your child ever attended school at Spackenkill? Yes ☐ No ☐

If Yes, please list with dates:

2. Has your child ever attended school in other districts? Yes No

If Yes, please provide last school district name, school name, grade, school address, and school phone number.

3. Is your child currently under suspension from another school district? Yes No

If Yes, please explain:

4. Has your child repeated a grade? Yes No

If Yes, please explain and list grade(s) repeated:

5. Is your child receiving special education services? Yes No

If Yes, please explain:

6. Does your child have a 504 Plan? Yes No

If Yes, please explain:

7. Has your child received remedial math? Yes No

If Yes, please explain and list in which grades received:

8. Has your child ever received remedial reading and/or writing services? Yes No

If Yes, please explain and list in which grades received:

9. Has your child ever received speech or language services? Yes No

If Yes, please explain and list in which grades received:

10. What is your child's first language? _____

11. Which languages are spoken in the home? _____

12. 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:

13. Has your child ever received English as a New Language (ENL/ESL) services? Yes No

If Yes, please explain with dates/grades:

14. Has your child participated in a Gifted and Talented Program? Yes No

If Yes, please list school district and name of the program:

15. Has your child ever had difficulties in school (attendance, behavior, academic, etc.)? Yes No

If Yes, please explain:

16. Are there circumstances or experiences in your child's life that may impact your child's performance in school? If Yes, please explain: Yes No

17. Is your child homeless? Yes No

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

18. Is child a foster child? Yes No

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

19. Are parents separated/ divorced? Yes No NA

If Yes, who has custody?

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

Name: _____ Relationship: _____

Address: _____

Phone: _____

Name of Insurance Company: _____

Policy Number: _____

Group ID: _____

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

--

22. Please list below all children in your household ranging from birth to age 21 years.

[illegible]

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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 HEALTH CARE 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				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
School:				DOB:	
				Grade:	
				Exam Date:	
HEALTH HISTORY					
Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached			
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached			
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached		Date of last seizure: <input type="checkbox"/> Seizure Care Plan Attached	
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached			
Risk Factors for Diabetes or Pre-Diabetes: <i>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.</i>					
BMI _____ kg/m2					
Percentile (Weight Status Category): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and>					
Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done			Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done		
PHYSICAL EXAMINATION/ASSESSMENT					
Height:		Weight:		BP:	
				Pulse:	
				Respirations:	
Laboratory Testing		Positive Negative		Date	
TB- PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Sickle Cell Screen-PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Lead Level Required Grades Pre- K & K				Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$					
<input type="checkbox"/> System Review and Abnormal Findings Listed Below					
<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes		<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Dental		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> Back/Spine	
<input type="checkbox"/> Neck		<input type="checkbox"/> Lungs		<input type="checkbox"/> Genitourinary	
				<input type="checkbox"/> Extremities	
				<input type="checkbox"/> Skin	
				<input type="checkbox"/> Neurological	
				<input type="checkbox"/> Speech	
				<input type="checkbox"/> Social Emotional	
				<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:				Diagnoses/Problems (list) ICD-10 Code*	
<input type="checkbox"/> Additional Information Attached				*Required only for students with an IEP receiving Medicaid	

Name:				DOB:	
SCREENINGS					
Vision (w/correction if prescribed)	Right	Left	Referral	Not Done	
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Near Vision Acuity	20/	20/		<input type="checkbox"/>	
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>	
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
Notes					
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK					
<input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <div style="margin-left: 20px;"> <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> Other Restrictions: </div>					
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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____					
<input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached					
IMMUNIZATIONS					
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS					
HEALTH CARE PROVIDER					
Medical Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form To Your Child's School 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
_____ Test Data & Scores

_____ Discipline Records
_____ Attendance Records
_____ IEP
_____ 504

_____ Home Language Questionnaire (HLQ)
_____ Health Records (*immunization; physical
examinations; psychiatric, psychological, and neurological
evaluations*)
_____ 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

The Spackenkill Union Free School District provides bus transportation to:

- Elementary students who live more than $\frac{1}{2}$ mile from either Hagan or Nassau School
- Todd Middle School students who live more than $\frac{3}{4}$ 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

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

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? _____

Signature of Parent or of Person in Parental Relation

Month: Day: Year:

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:



Lisette 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)

- ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante? ☐ Inglés ☐ Otro *especifique*
- ¿Cuál fue el primer idioma que su hijo(a) aprendió? ☐ Inglés ☐ Otro *especifique*
- ¿Cuál es el idioma primario de cada padre / tutor? ☐ Madre *especifique* ☐ Padre *especifique*
☐ Tutor(es) *especifique*
- ¿Qué idioma o idiomas entiende su hijo(a)? ☐ Inglés ☐ Otro *especifique*
- ¿Qué idioma o idiomas habla su hijo(a)? ☐ Inglés ☐ Otro *especifique* ☐ No sabe hablar
- ¿Qué idioma o idiomas lee su hijo(a)? ☐ Inglés ☐ Otro *especifique* ☐ No sabe leer
- ¿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:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

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 ☐ Si

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: