HUDSON CITY SCHOOL DISTRICT

Do you speak any language other than English at home? Yes____ No ____ Language _____

আপনি ইংরেজী ছাড়া অন্য কোন ভাষায় এ কথা বলতে পারি? হ্যাঁ ___ কোন ____ ভাষা

¿Hablas cualquier idioma distinto del Inglés en casa? Sí ___ No ____ Idioma _____

Ou pal nenpoòt lòt lang ke angle nan kay la? Wi ___ Non ____ Lang _____

هل تتكلم أي لغة أخرى غير الإنجليزية في البيت؟ نعم ___ لا ____ اللغة _____

Registration Form and Procedures

Please provide the following documents when registering your child(ren):

Proof of student(s) age: Documents that will be accepted by the HCSD to prove a student's age are:

- Certified copy of a Birth Certificate (Foreign or Domestic)
- Record of Baptism
- Passport (Foreign or Domestic)

If you are unable to provide any of the above listed documents the district will also accept one of the following if it has been established and in existence for a minimum of 2 (two) years:

- Official driver's license
- State or other government issued identification
- School photo identification with date of birth
- Hospital or health records
- Military dependent identification card
- Federal, state or local agency documents. (E.g. Department of Social Services, Federal Office of Refugee Resettlement.)
- Court orders or other court-issued documents
- Native American Tribal documents
- Non-Profit International Aid Agency or Volunteer Agency records

Proof of Residency: Documentation that the district will accept establishing that the parent / guardian reside within the boundaries of the Hudson City School District is:

- Utility Bill
- School Tax Bill
- A copy of a deed or mortgage statement proving home ownership or residential lease
- A sworn / unsworn statement by a third-party landlord, owner or tenant form whom the parent leases or shares property
- A statement from a third party establishing the parent's physical presence in the district, along with one of the above-mentioned documents.

.

Custody Documentation: If applicable please provide the district with copies of placement orders, custody orders or orders of protection. Copies of Care, Custody and Control affidavits may be requested as acknowledgement of transfer of custody from a parent to a guardian at the time of registration.

Immunization Records: Please bring copies of your child(s) immunization records.

School Records: Please bring copies of any current school records you have including an IEP if applicable.

Parent / Guardian Photo Identification: Please bring a copy of your photo identification when registering.

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:			GENDER:
Month	*Day*	*Year*	❑ 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:		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: _____ (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:

Registration Form

Student's Name: _____ _____ _____ Male ___ Female ___ Birth Date: ___/___/____
Last First M

Residential Address: Mailing Address / P.O. Box

_____ _____

_____ _____

_____ _____

Home Phone Number: _____ Cell Number: _____

Mother's Maiden Name: _____ Marital Status at this time? _____

Parent / Guardian 1 - _____

Employer: _____ Work Number: _____ Email Address: _____

Parent / Guardian 2 - _____

Employer: _____ Work Number: _____ Email Address: _____

Grade ____ Grades 9 -12: What year did student first enter the 9th Grade? _____

Grades 6 – 8: Foreign Language (please choose one) Spanish ___ Italian ___

Has student ever been enrolled in the Hudson City School District? If so when? _____

Is Student in Foster Care? Y ____ N_____
Please provide copy of placement order.

If parents are divorced or separated, is there a court appointed custody document? Yes____ No____
Please provide copy of custody order.

Who retains legal custody? _____ If Joint who has residential custody? _____

Relationship to child? _____ Relationship to child? _____

Will student be residing with Parent / Guardian? Yes____ No____

When a parent relinquishes custody of a student to another person and there is no court order to establish a change in guardianship, this district requires an affidavit from the parents acknowledging their transfer of custody and control to the child's custodian. Also a Custodial Affidavit is required as proof that the adults with whom the student is living provides for the student's care and supervision.
Copies of Care, Custody and Control Affidavits are available from the registration office.

Are there any restraining orders or orders of protection filed against any person or persons? Yes ___ No ___

If so, please give the name(s) of the person(s) and attach all legal documents which indicate such restrictions

Please sign and date below to complete this form:

Signature: _____ Relationship to Child: _____ Date: _____

Student Information Form

PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM CAREFULLY BEFORE YOU RESPOND.

[For question (1) check the one that best describes your child.] Check only ONE.

1. **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

2. **Select one or more races from the following five racial groups** [For question (2) check all groups that apply to your child. Check **at least** ONE.]

   ___ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   ___ **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 OR AFRICAN AMERICAN:** 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.

List in order of preference, the individuals to be notified in case of illness, injury or another emergency.

Name: _____ Phone 1: _____ 2: _____ Relationship: _____

Name: _____ Phone 1: _____ 2: _____ Relationship: _____

Name: _____ Phone 1: _____ 2: _____ Relationship: _____

Brothers and Sisters

Name:_____ Grade: _____ Do they live in the same home? _____ DOB:_____

Name:_____ Grade: _____ Do they live in the same home? _____ DOB:_____

Name:_____ Grade: _____ Do they live in the same home? _____ DOB:_____

Signature of Parent / Guardian: _____

Release of Records

Contact information and request for records from last school student attended:

School Name_____ Contact Person_____

Address_____ Counselor_____

Phone Number: _____ Fax: _____

Does student have an IEP? Yes _____ Does student have a 504? Yes _____ Please include a copy of the most recent IEP or 504 Plan.

CSE Contact_____ Phone #_____ Fax #_____

School Nurse_____ Phone #_____ Fax #_____

Student Name:_____ Date of Birth_____ Grade_____

The above mentioned student will be enrolling in the Hudson City School District. Please fax or send transcript, including previous grades, current course load, and health records to the grade appropriate school.

M.C. Smith Elementary School – 102 Harry Howard Avenue, Hudson, NY Grades K-5

Phone: 518-828-4360 Ext 1117 – Guidance Office Fax: 518 -697-8733

Hudson Junior High School – 215 Harry Howard Avenue, Hudson, NY Grades 6-8

Phone: 518-828-4360 Ext: 8308 – Guidance Office Fax: 518 -697-8791

Hudson Senior High School – 215 Harry Howard Avenue, Hudson, NY Grades 7-12

Phone: 518-828-4360 Ext: 3111 – Guidance Office Fax: 518 -697-8568

HCSD Student Services Department – 215 Harry Howard Avenue, Hudson, NY

Phone: 518-828-4360 Ext: 2111 or 2112 Fax: 518 -697-8481

Please send copies of all related Special Education records for the student listed above to the HCSD Student Services Department. Be sure to include the following: IEP, Psychological Reports – including testing, Social History and Related service evaluation results.

It is understood that such releases shall include only that information necessary and pertinent and that all such information shall be treated in a confidential and professional manner.

Signature of Parent or Guardian:_____ Date:_____

Income Verification Section

Part 1 – Family Members in Household - Please list all members of your family that reside in your household. Answer all questions - use the codes listed below for Ethnicity, Language, Education Level, Employment and Education questions.

Name	Sex – M or F	Date of Birth	Relationship to Child	Employment	Student – School of Attendance

Employment:	School:
FT – Full Time PT – Part Time / Less than 35 Hrs S – Seasonal U – Unemployed D - Disabled	A – JLE B – MCS C – Jr/Sr HS D – College- please name O – Please name

Part 2 – Household Income - Proof of Income includes all income received in the last twelve months.

Name of Household Member	Date	Source of Income (see codes below)	Amount	Annual Amount	No Income
	____/____/____ to ____/____/____		$_____ Every _____	$_____	☐
	____/____/____ to ____/____/____		$_____ Every _____	$_____	☐
	____/____/____ to ____/____/____		$_____ Every _____	$_____	☐

Employment Verification Codes:
PS – Pay Stub SSI – Supplemental Security Income WC – Worker Compensation EL – Employment Letter
CS – Child Support A – Alimony TANF – Temp. financial Assistance Program FC – Foster Care
W2 – W-2 Form IT – Income Tax Form O – Please list

I certify that all of the information on this form is true and that I have disclosed all family income for the time period stated.

Signature: _____ **Print Name:** _____ **Date:** _____

HUDSON CITY SCHOOL DISTRICT

Immediate Medical Needs and Concerns Fact Sheet

Current Date: _____ **Date of Student Enrollment: _____**

Student Name: _____ Date of Birth: _____

School Student Attends: John L Edwards: ___ MCSIS: ___ Jr/Sr High School: ___ Other: ___

To Be Completed by Student's Parent or Guardian:

1. Does your child have a chronic or potentially life threatening disorder, dangerous medical condition or severe allergy (for example: nuts, latex, insect bites or stings) that school personnel should be aware of? Please give details and supply any supporting documentation:

_____
_____
_____
_____.

2. What is the treatment plan you have in place to care for this/these medical condition(s)? Please give details and supply any relevant supporting documentation:

_____
_____
_____
_____.

3. Does the student have any current physical restrictions or gym/recess concerns? Please give details and supply any relevant supporting documentation:

_____
_____
_____
_____.

4. Current medications student will need to take in school:

_____
_____
_____.

5. Current medications student takes at home:

_____
_____
_____.

Pediatrician / Healthcare Provider's Name: _____ Phone Number: _____

Parent / Guardian's Printed Name: _____ **Signature: _____**

Address: _____

Home Phone: _____ **Cell Phone: _____** **Work Phone: _____**

School nurse may contact healthcare provider for further instructions or clarity regarding medical condition and/or medications.

Hudson City School District

HEALTH CERTIFICATE / APPRAISAL FORM / PHYSICAL

Name: _____ Date of Birth: _____ **Gender: ❑ M ❑ F**

Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral: ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History:

_____

_____

_____ ☐ See attached

Allergies: ☐ Food: _____ ☐ Insect: ☐ Seasonal ☐ Medication: _____

☐ Other: _____

☐ Life Threatening Allergy ☐ Not a Life Threatening Allergy

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

				Referral
Body Mass Index: _____ _____ . _____ Weight Status Category (BMI Percentile): ❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th ❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Vision - without glasses/contact lenses	R	L	
	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing ❑ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed):

_____

_____

_____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

I assess this student to be self-directed: ☐ Yes ☐ No Student may self-carry and self-administer medication: ☐ Yes ☐ No

Note: Nurse will also assess self-direction for the school setting.

Hudson City School District

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, rifle, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school**: _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

OPTIONAL INFORMATION:

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension

☐ Other: _____

ADDITIONAL SPACE (IF NEEDED FROM FRONT):

_____

_____

_____

_____

Provider's Signature: _____

Phone: _____

Provider's Fax: _____

Provider's Name/Address (stamp below):

PLEASE FAX THIS FORM TO THE APPROPRIATE HEALTH OFFICE:

Hudson Jr./Sr. High School Fax Number: 518-697-8798

M.C. Smith Intermediate School Fax Number: 518-697-8797

John L. Edwards Primary School Fax Number: 518-697-8516

HUDSON CITY SCHOOL DISTRICT

Health History and Consent for Physical Form

The New York State Education Department requires an annual physical exam for new entrants, students in Grades K, 2 ,4, 7 and 10, sports, working permits and triennially for the CSE. Please complete the following health history and explain any YES answers.

- ☐ **Allergies to: Food:_____ Insect:_____ Other:_____**
- ☐ **Asthma:_____**
- ☐ **Anemia:_____**
- ☐ **Arthritis:_____**
- ☐ **Bladder / Kidney Problem or Injury:_____**
- ☐ **Diabetes:_____**
- ☐ **Injury to the Spleen:_____**
- ☐ **Rheumatic Fever:_____**
- ☐ **Stomach Ulcer:_____**
- ☐ **Lyme Disease:_____**
- ☐ **Headaches:_____**
- ☐ **Head Injury / Concussion:_____**
- ☐ **Convulsions / Seizures:_____**
- ☐ **Fainting Spells:_____**
- ☐ **Elevated Blood Pressure:_____**
- ☐ **Heart Problems / Murmur / Chest Pain:_____**
- ☐ **Family History of Heart Attack / Cardiac Issues under the Age of 50:_____**
- ☐ **Eye Problems / Vision Loss:_____**
- ☐ **Ear Problems / Hearing Loss:_____**
- ☐ **Dental Problems:_____**
- ☐ **Nose Fracture:_____**
- ☐ **Neck Injury:_____**
- ☐ **Back Pain / Injury:_____**
- ☐ **Knee Pain / Injury:_____**
- ☐ **Ankle Injury:_____**
- ☐ **Fracture / Dislocation:_____**
- ☐ **Operations:_____**
- ☐ **Medical Conditions Not Listed Above:_____**

Prescription Medications – Please list name and dosage / frequency: _____
_____

Private Physical

It is recommended that physicals be done by your own private health care provider which will ensure consistency. Physical form included in registration packet.

Date of Physical: _____ Parent Signature: _____ Date: _____

School Physical

I give consent for the HCSD to arrange for my child to have a physical at school with the district Physician

Parent Signature: _____ Date: _____

Reviewed by HCSD School Physician

Provider's Signature: _____ Date: _____

School nurse may contact healthcare provider for further instructions or clarity regarding medical condition and/or medications.

Hudson City School District
Hudson, New York 12534

Parent and Prescriber's Authorization for Administration of Medication in School

Section 1 – To be completed by the Parent or Guardian

I request that my child, _____ (Grade _____), receive the medication as prescribed below by our licensed health care prescriber. *The medication is to be furnished by me in the properly labeled original container from the pharmacy.* I understand that the School Nurse, or other designated person in the case of the absence of the School Nurse, will administer the medication.

Signature (Parent/Guardian): _____

Address: _____

Telephone: Home _____ Work _____ Date: _____

Section 2 – To be completed by the Licensed Health Care Prescriber

I request that my patient, as listed below, receive the following medication at school:

Name of Student: _____ DOB: _____

Diagnosis: _____

Name of medication, prescribed dosage, frequency, route of administration: _____

_____

Time to be taken during school hours: _____

Duration of treatment: _____

Possible side effects or adverse reactions: _____

Other recommendations: _____

Name & Title of Licensed Prescriber (please print): _____

Address: _____

Phone: _____

Prescriber's signature: _____ Date: _____

Hudson Jr./Sr. High School Fax Number: 518-697-8798
M.C. Smith Intermediate School Fax Number: 518-697-8797
John L. Edwards Primary School Fax Number: 518-697-8516

Please turn over for Self-Medication Release Form information

Administration of Medication in School

New York State Education Law requires a physician's written order and a parent/guardian's authorization for school personnel to administer all medications, including nonprescription drugs, in school.

Before medications can be dispensed, the following must be on file with the school:

- Physician's written order
- Parent/Guardian written authorization
- Bottle properly labeled with:
    - Name of child
    - Name of doctor
    - Prescription number
    - Name of drug
    - Strength of drug
    - Dosage
    - Frequency of administration
    - Date of issue

OTC (over-the-counter) medications must be in the original manufacturer's container

Medication must be delivered to the Health Office by a responsible adult.

All medications must be kept in a locked cabinet or separate locked drawer in the Health Office.

A Daily Medication Log is kept on all students receiving medication.

Students receiving medications on a long-term basis are evaluated periodically by the School Nurse.

Medication orders must be renewed annually or when there is a change in medication or dosage.

Willing unlicensed persons, who have been appropriately instructed and approved by school nursing personnel, may assist self-directed students with the taking of their own oral, topical and inhalant medications.

When an oral medication is to be administered off school grounds or after school hours, it should be placed in a single dose medication envelope by school nursing personnel and properly labeled with:

- Student's name
- Name of medication and dosage
- Date and time to be given
- Special instructions
- Possible side effects

Self-Medication

When any member of school staff observes a student carrying or taking medication, that individual has the responsibility to refer the student to the Nurse. The Nurse will contact the parent/guardian and set up the proper procedure for administration.

Under certain conditions, it may be necessary to allow a student to self-administer his/her own medication. In such cases, the Nurse must have on file a Self-Medication Release Form in addition to the routine district medication form.

HUDSON CITY SCHOOL DISTRICT

HOME OF THE BLUEHAWKS

Transportation Information Form

Child's Name: _____

Residential Address: _____

_____

Location of house or nearest landmark: _____

_____

School Bus Arrangements

Will your child need to take a bus to or from a location other than their home or assigned bus stop?

Yes____ No____

IF YES:

Please give specific details, including A.M. and/or P.M. and the day(s) of the week that the student will be coming or going to a location other than their home or assigned bus stop:

_____

_____

Babysitter Name: _____

Address: _____

Phone #: _____

We understand the importance of child care and want to make arrangements that are safe and convenient for you and your child. Lack of consistency or constant bussing changes are confusing and dangerous for all parties involved.

With that in mind, please be advised that unless there is an emergency:

Please give 48 hours advanced notice in writing for any bus changes.
Unless it is an emergency, no bus changes will be taken over the phone.

Parent Signature: _____ Date: _____

HUDSON CITY SCHOOL DISTRICT

HOME OF THE BLUEHAWKS

McKinney / Vento Form

You may be eligible to receive assistance (tutoring, advocacy, transportation, clothing, free lunch, etc.) from the McKinney-Vento Homeless Assistance Act if your child(ren) is:

- Sharing housing of others due to loss of housing, economic hardship or similar reason
- Living in motels, hotels, temporary trailer parks, or camping grounds due to the lack of alternative accommodations
- Living in a car, park, public space, abandoned building, substandard housing, bus or train stations or similar settings
- Abandoned in hospitals
- In emergency or transitional shelters
- In a residential program for runaways and homeless
- Awaiting foster care placement
- A child from a migrant family who qualifies as homeless because he or she is living in circumstances described above
- An unaccompanied youth for whom no parent or person in parental relation is available

Name of Student: _____
Last First Middle

Gender: ___Male ___Female Date of Birth: _____/_____/_____ Grade: _____
MM DD YYYY Preschool - 12th

Name of Parent / Guardian / Responsible Party: _____

Current Address: _____ Phone: _____

_____

PLEASE BE SURE TO FILL OUT THE FOLLOWING:

Last School Attended: _____
Name

_____ _____
Address **Phone Number**

Last Address: _____

_____ **How long did you live there?** _____

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

IF YOU ARE IN PERMANENT HOUSING STOP HERE.

- ☐ **In a shelter**
- ☐ **With another family or other person because of loss of housing or as a result of economic hardship**
- ☐ **In a hotel / motel**
- ☐ **In a car, park, bus, train or campsite**
- ☐ **Other temporary living situation**
  (Please describe):_____

_____

_____.

The answers you give 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, immunizations records, or birth certificates.
Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

ID#_____
School district will complete

(October 2009)

_____ _____ _____
Print Name of Parent, Guardian, or Student (unaccompanied homeless youth) **Signature** of Parent, Guardian, or Student (unaccompanied homeless youth) Date

HUDSON CITY SCHOOL DISTRICT

HOME OF THE BLUEHAWKS

FORMULARIO DE SERVICIOS ADICIONALES EDUCATIVOS
PARA FAMILIAS QUE HAN TRABAJADO EN LA AGRICULTURA EN TRABAJOS DE FINCA.

Mary K. Kline
Migrant Education Outreach Program - Herkimer County BOCES
352 Gros Boulevard
Herkimer, NY 13350
315-867-2079
mkline@herkimer-boces.org

Dentro de los últimos tres años, Ud o/ alguien con Ud ha trabajado o/ esta/ trabajando en la agricultura, en una procesadora de comida o/ en un trabajo en una finca?

- ☐ **Heno**
- ☐ **Productos lácteos**
- ☐ **Cosechas**
- ☐ **Aves**
- ☐ **Cultivo de peces**
- ☐ **Vivero / Invernaderos**
- ☐ **Frutas / Vegetales**

Favor de contestar: _____ SI _____ NO

Si contesta no pare aquí

En caso afirmativo termine el formulario

Alguien del programa le contactarà para hacer una evaluación completa, determinar su elegibilidad de los servicios y para explicarle el programa.

Nombre del estudiante:

_____ _____ _____
Primer nombre Segundo nombre Apellido

Sexo: **Fecha de nacimiento:** **Grado:** **Idioma Hablado en casa:**

___hombre ___mujer _____/_____/_____ _____ _____
Mes día ano

Nombre del padre / madre / guardián persona responsible:

_____

Hermanos:

_____

_____

Dirección actual:

_____

_____

Número del teléfono:

_____

El Programa de Educación Migrante esta autorizado por el Congreso para ayudar a estudiantes elegibles a mantener la continuación de su educación. Esta autorizado bajo el Titulo I, Parte C de ESEA. Este programa proveè apoyo educacional a los estudiantes ya a sus familias.

(August 2009)

Yo doy permiso para que este formulario se mande al Programa de Educación Migrante

_____ _____ _____
Escriba en imprenta el nombre del Padre, madre ó guardián. **Firma del padre, madre ó guardián** **Fecha**

HUDSON CITY SCHOOL DISTRICT

HOME OF THE BLUEHAWKS

FOR FAMILIES WHO ARE CURRENTLY OR PREVIOUSLY IN AGRICULTURAL / FARM WORK.
ELIGIBILITY FORM FOR ADDITIONAL EDUCATIONAL SERVICES

Migrant Education Outreach Program - Herkimer County BOCES
352 Gros Boulevard
Herkimer, NY 13350
315-867-2079
mkline@herkimer-boces.org

Within the last 3 years, have you or anyone living with you, worked or are currently working, in Agricultural, Food Processing or Farm Work?

- **Hay**
- **Dairy**
- **Crops**
- **Poultry**
- **Fish Farming**
- **Nursery / Greenhouse**
- **Fruits / Vegetables**

Please answer: _____ Yes _____ NO

If "No" stop here

If "Yes" continue

Someone from the Outreach Program will contact you to explain the program and do a full screening which will determine your eligibility for services. If you have any questions please call the number above.

Name of Student:

_____ _____ _____
First Middle Last

Gender: **Date of Birth:** **Grade:** **Home Language:**

___Male ___Female _____/_____/_____ _____ _____
MM DD YYYY

Name of Parent / Guardian / Responsible Party: **Siblings:**

_____ _____

_____

Current Address: **Phone #:**

_____

_____

_____

The Migrant Education Outreach Program was authorized by Congress to help eligible students maintain continuity in their education. It is authorized by Title 1, Part C of the ESEA. This program provides educational support to both students and their families.

(October 2009)

By signing below, I am giving permission for the Hudson City School District to release this document and the pertaining information to the Migrant Education Outreach Program.

_____ _____ _____
Print Name of Parent or Guardian **Signature** of Parent or Guardian Date