Pre-School (11-19)

SMITHTOWN CENTRAL SCHOOL DISTRICT
Smithtown, New York 11787

ENROLLMENT FORM

Student Name: _____ Phone: _____

Address: _____ Town: _____ Zip _____

Nearest Street Intersection to Home: _____

Date of Birth: _____ Sex: _____ Place of Birth: _____
City State/Country

Entering School _____ Grade _____ Foreign Exchange Student _____

Has child attended the Smithtown Central School District previously? _____

If Yes, list School, Grade, Year: _____

Previous Out of District School Attended: _____

_____
Address Grade(s)

Mother's Name: _____ Father's Name: _____

Employer's Name: _____ Employer's Name: _____

Employer's Address: _____ Employer's Address: _____

Cell Phone #: _____ Cell Phone #: _____

Daytime Phone #: _____ Daytime Phone #: _____

E-Mail Address: _____ E-Mail Address: _____

ETHNICITY (must select one):
Hispanic Origin ☐
Not Hispanic Origin ☐

RACE (must select at least one):
African American ☐
American Indian / Alaskan Native ☐
Asian ☐
Native Hawaiian /Pacific Islander ☐
White ☐

RESIDENCY/HOUSING:
Other Situation ☐
Abandoned Apartment ☐
In a Motel/Hotel ☐
In a Shelter ☐
Temporary Housing ☐
Train/ Bus Station ☐
With Relative ☐
Permanent Housing ☐
Train/Bus/Car ☐
Park/Campsite ☐

Languages spoken in the home: _____
Mailing required in a language other than English? ☐Yes ☐ No

Are there any Divorce, Separation, Guardianship or Adoption issues? ☐Yes ☐No

Parent I.D.: _____

01/16

_____
Signature of Parent / Guardian

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

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

HEALTH HISTORY

Child's Name _____ Date of Birth _____

Your Name _____ Relationship to Child _____

Pregnancy/Birth History	Yes	No	Explain "Yes" Answers
1. Did mother have any health problems during this pregnancy or delivery?	☐	☐	
2. Was child born more than 3 weeks early or late?	☐	☐	
3. What was child's birth weight?			☐ lbs. ☐ oz.
4. Was anything wrong with child in the nursery?	☐	☐	
5. Did child or mother stay in hospital for medical reasons longer than usual?	☐	☐	
Hospitalizations and Illnesses			**Explain "Yes" Answers**
6. Has child ever been hospitalizied or operated on?	☐	☐	
7. Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?	☐	☐	
8. Has child ever had a serious illness?	☐	☐	
Health Problems			**Explain "Yes" Answers**
9. Does child have frequent ☐ sore throat ☐ cough ☐ urinary infections or trouble urinating ☐ stomach pain, vomiting, diarrhea	☐	☐	
10. Does child have diffuculty seeing (squint, cross eyes, look closely at books)?	☐	☐	Was last checkup more than one year ago?
11. Is child wearing (or supposed to wear) glasses?	☐	☐	
12. Does child have problems with ears/hearing (pain, earaches, discharge, rubbing one ear)?	☐	☐	
13. Has child ever had a convulsion or seizure? Is child taking medicine for seizures?	☐	☐	When did it last happen? What medicine?
14. Is child taking any other medicine now? (Special consent form must be signed to administer any medication.)	☐	☐	What medicine? Will it be given while child is at school? ☐ Yes ☐ No How often?

15. Is child now being treated by a physician or a dentist?

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

16. Has child had: (please check)

☐ Chicken Pox ☐ German Measles ☐ Measles ☐ Mumps
☐ Eczema ☐ Scarlet Fever ☐ Whooping Cough

17. Has child had: (please check)

☐ Bleeding Tendencies ☐ Epilepsy ☐ Liver Disease
☐ Heart/Blood Vessel Disease ☐ Sickle Cell Disease ☐ Diabetes
☐ Rheumatic Fever ☐ Asthma

18. Does child have any allergy problems (rash, itching, swelling, difficulty breathing, coughing, sneezing)?

☐ When eating any foods ?
☐ When taking any medications ?
☐ When near animals, furs, insects, dust, etc. ?

If "Yes" please explain

What foods ? _____
What medicine ? _____
What things ? _____
How does child react ? _____
_____

19. Does your child take a nap? ☐ No ☐ Yes Describe when and how long.

_____

20. Does your child sleep less than 8 hours a day or have trouble sleeping (such as being fretful, having nightmares, wanting to stay up late)? ☐ No ☐ Yes If "yes", describe arrangements (own room, own bed, and so forth.) _____

21. How does your child tell you he/she has to go to the toilet? _____

22. Does your child need help in going to the toilet during the day or night, or does your child wet his/her pants?

☐ No ☐ Yes If "yes", please describe. _____

23. Children learn to do things at different ages. We need to know what each child already can do or is learningto do easily and where they might be slow or need help.

	Age Completed:		Age Completed:
a. Sit up Without Help		d. Talk	
b. Crawl		e. Feed & Dress Self	
c. Walk		f. Learn to Use Toilet	

24. Does your child have any difficulties saying what he/she wants to do or do you have any trouble understanding your child? ☐ No ☐ Yes If "yes", please describe: _____

Parent Signature: _____ Date : _____

Smithtown Central School District
Yearly Health Survey

Student Info

School:

Student Name:
Street:
City, State Zip:
Home Phone:
Mailing Street:
Mailing City, State Zip:

Student ID:
Gender:
Grade:
Date of Birth:

PARENTS: Please make any necessary changes and/or additions, sign back and return.

The health office will not release a student to anyone other than those listed below.

Father

Custody (Yes/No):
Name:
Other Info:
Beeper:
Cell Phone:
Business Address:
Daytime Phone:

Mother

Custody (Yes/No):
Name:
Other Info:
Beeper:
Cell Phone:
Business Address:
Daytime Phone:

Guardian

	Guardian 1	Guardian 2
Custody (Yes/No):		
Name:		
Other Info:		
Relationship:		
Daytime Phone:		

Medical

Doctor Name:
Doctor Phone:
Dentist Name:
Dentist Phone:

Emergency Contact Information

1 Name:
Relationship:
Phone:

2 Name:
Relationship:
Phone:

3 Name:
Relationship:
Phone:

4 Name:
Relationship:
Phone:

Please update the medical information on the back of this form.

Please verify the information below and update if necessary.

Past Year Illness

Has your child had any illness or operations during the past year ? Yes ☐ No ☐

Explain: _____

Previous illnesses or operations on record: _____

Understand Better

Is there anything concerning the general health of your child which would aid the School in a better understanding of this student ? Explain: _____

Previous comment on record: _____

Medications

Name	Dosage	Frequency

Eyes/Ears

Glasses (Yes/No):
Re-Exam Date:
Contact Lenses:
Re-Exam Date:
Hearing Problem (Yes/No):

Other

Allergies

Allergies (Yes/No):
Explain:

Asthma

Asthma (Yes/No):
Explain:

Email

Parent email: **Please supply one parent email address, for internal use only.**

Note: All new entrants and students entering grades 2, 4, 7 & 10 will require a physical examination during the calendar year.

Parents Signature: _____ **Date:** _____

12/12

A signed copy of this form must be returned for every student.

Smithtown Central School District

26 New York Avenue, Smithtown, New York 11787

Russell Stewart
Interim Superintendent of Schools
(631) 382-2006

TO: Parent/Guardian of _____

RE: Special Education/Special Services

Was your child in any special education program or in need of any special services?

YES ○ NO ○

For Preschool Students:

Is your child currently receiving Early Intervention (EI) services?

YES ○ NO ○

Parent/Guardian Signature _____

COMMITTEE ON PRESCHOOL EDUCATION
CPSE PARENTAL REQUEST FOR EVALUATION

Name of Student _____
Date of Birth _____
Address _____
Home Phone (if applicable) _____
Parent 1 - Name and Cell Phone _____
Parent 2 – Name and Cell Phone _____

Please describe your child's language skills.
This includes the understanding and use of language, the ability to follow directions, the ability to answer simple questions, use of pronouns/grammatical markers, and sound production/ability to be understood.
If you have no concerns indicate – "No Concerns or N/C"

Please describe your child's fine motor development.
This includes small muscle movements, such as grasp when picking up and holding objects, ability to hold cup and to use utensils, use of school materials and hand strength.
If you have no concerns indicate – "No Concerns or N/C"

Please describe your child's gross motor development.
This includes large muscle movements, use of play equipment, balance, navigational skills, motor coordination. Does your child appear clumsy? Does your child trip or fall more often than you would expect?
If you have no concerns indicate – "No Concerns or N/C"

Please describe your child's social skills.
This includes interactions with adults and peers, sharing, turn taking, following rules related to group activities
If you have no concerns indicate – "No Concerns or N/C

Please describe your child's behavioral management needs (in both the home and school settings).
This includes compliance with directions, transitioning between activities, engaging in tasks presented.
If you have no concerns indicate – "No Concerns or N/C

Please describe any other concerns not listed above.

Describe what strategies, if any, you have used to help your child prior to this referral.

Did your child's preschool teacher or pediatrician suggest you have your child evaluated?
Teacher: Yes_____ No_____
Pediatrician: Yes_____ No_____
If yes, what concerns did the teacher or pediatrician present to you if different than described above).

Is there any medical information you would like to share about your child?
(Please note you are not required to disclose medical information/diagnoses on this form; however, it may be useful information for educational planning for your child).

EARLY INTERVENTION INFORMATION
Does your child now or has your child ever received Early Intervention Programming?
Please check: Never_____ Past_____ Current_____

If your child receives Early Intervention Programming, please list the Ongoing Service Coordinator and frequency of current service (2x/week, 1x/month, # of units). If your child had a service that was discontinued, please mark "D" on the line provided by that service:
Name of Ongoing Service Coordinator _____
Contact Number, if available _____
Agency, if known _____

Does your child now or did your child ever have:
Special Instruction _____ ABA Yes ___ No___
Speech _____
OT _____
PT _____
Vision _____
Parent Training _____
Other _____

PRESCHOOL INFORMATION:
Does your child attend an early childhood program?
(This includes any private preschool or licensed day care program). If yes:

Name of Preschool or Daycare: _____
Name of Teacher or Leader: _____
Phone Number _____
Address _____
Please circle which days in attendance M T W TH F
Please indicate the hours in attendance _____
******* Please initial that you have been notified it is sometimes necessary to contact the teacher/leader to ask for information about the child's development, to participate in a scheduled CPSE meeting or to share CPSE documents, such as the Individual Education Plan (IEP) Initial:_____

EVALUATION INFORMATION:
Is your child exposed to a language other than English? Yes_____ No_____
If yes, please indicate the language(s)
**The chairperson will determine if a Multidisciplinary Evaluation is required based on the Home Language Survey.

_____ _____ _____
Printed Name Signature Date