

MINISINK VALLEY CENTRAL SCHOOL DISTRICT  
STUDENT REGISTRATION FORM

Rev. 12/16

Student Name: \_\_\_\_\_ Bus #: \_\_\_\_\_  
(last) (first) (middle) (office use)

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Gender: M / F

Entry Grade: \_\_\_\_\_ If Foster Student – Agency/Case Worker: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Contact Name/Number: \_\_\_\_\_  
(in case you cannot be reached)

Physical Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
(if different than physical)

Previous School: \_\_\_\_\_  
(Name of School and complete address)

Previous Home Address: \_\_\_\_\_

Any Special Needs or Considerations: \_\_\_\_\_

Student with one or more parent who is a member of the Armed Forces and on Active Duty? Yes/No

Has student previously attended Minisink Valley C.S.D.? Yes / No If yes, what year(s)? \_\_\_\_\_

Is the student Hispanic, Latino, or of Spanish Origin? Yes, Hispanic \_\_\_\_\_ No, Non-Hispanic \_\_\_\_\_

Race: American Indian or Alaskan Native \_\_\_\_\_ Asian \_\_\_\_\_ Black or African American \_\_\_\_\_  
Native Hawaiian or Other Pacific Islander \_\_\_\_\_ White (Caucasian) \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Education Level: \_\_\_\_\_

Mother's Home Address: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mother's Business Address: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Education Level: \_\_\_\_\_

Father's Home Address: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Father's Business Address: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Step Mother/Father: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Brothers/Sisters Name Birthdate Grade Gender

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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

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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.		
<b>STUDENT NAME:</b>		
<i>First</i>	<i>Middle</i>	<i>Last</i>
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
		<input type="checkbox"/> Male
<i>Month</i>	<i>Day</i>	<i>Year</i>
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
<i>Last Name</i>	<i>First Name</i>	<i>Relation to Student</i>

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	_____	<input type="checkbox"/> Father	_____
	<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	_____	<input type="checkbox"/> Does not speak
			<i>specify</i>	
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not read
			<i>specify</i>	
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____	<input type="checkbox"/> Does not write
			<i>specify</i>	

### 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

<b>Educational History</b>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes*    *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: \_\_\_\_\_

<b>OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ</b>	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
<b>NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW</b>	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO.    DAY    YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
<b>NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL</b>	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO.    DAY    YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

# Minisink Valley Central School District

P.O. Box 217 – Route 6 – Slate Hill, New York 10973-0217

Telephone: (845) 355-5110

## Living Arrangements of Child Form

\*This is a federally required form for all new registrants.

Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_  
Last First Middle

Gender: Male Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_ ID#: \_\_\_\_  
Female Month Day Year (preschool-12)

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.

### Where is the student currently living? (Please check **one** box.)

- In Permanent housing
- In a shelter
- With another family member or other person because of loss of housing or as a result of economic hardship (sometimes referred to as “doubled-up”)
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe):  
\_\_\_\_\_

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

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

**MINISINK VALLEY CENTRAL SCHOOL**  
**Slate Hill, NY 10973**

*Health History for School Year 20 \_\_\_ - 20\_\_\_*

**\*\*\*YOU MUST BRING PROOF OF IMMUNIZATIONS AT TIME OF REGISTRATION IN ORDER TO REGISTER A STUDENT.**

**Dear Parent:**

**When your child enters school, we establish a cumulative health file for him/her to enable us to have a greater understanding of your child's needs. All information will be kept confidential, so please print clearly and answer every question. Thank you.**

Student's Name: \_\_\_\_\_ Male / Female      Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Physician: \_\_\_\_\_ Dr's Phone Number: \_\_\_\_\_ Dr's Fax Number: \_\_\_\_\_

Child lives with (fill in only what applies):

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

(Other) Name and Relationship to child: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**PHYSICAL REQUIRED for all students entering grades 1 through 12.**

**(Note: Entering kindergarten students MUST have the physical done by their private physician.)**

- I will be having the physical done by my private physician.
- I give permission for the school's physician to do the required physical.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Directions: Please answer ALL of the following questions about the student's medical history. Please respond to all questions.**

1. Has your child had or currently have:
  - a. An injury or illness since your last exam y / n / don't know
  - b. A chronic or ongoing illness (such as diabetes or asthma) y / n / don't know
    1. Use an inhaler or other prescription medicine to control asthma? y / n / don't know
  - c. Any prescribed or over the counter medications that you take on a regular basis? y / n / don't know
  - d. Surgery, hospitalization or any emergency room visit(s)? y / n / don't know
  - e. Any allergies to medications? y / n / don't know
  - f. Any allergies to bee stings, pollen, latex or foods? y / n / don't know
    1. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.)
    2. Take any medication/Epi pen taken for allergy symptoms? (List on back.)
  - g. Any anemias or blood disorders? y / n / don't know

2. Has your child had or currently have any of the following head-related conditions since your last physical:
- a. Concussion requiring a physician's evaluation? y / n / don't know
    - 1. How often and when? (Answer on back page.)
  - b. Memory loss or been knocked out? y / n / don't know
  - c. A seizure? y / n / don't know
  - d. Frequent or severe headaches? y / n / don't know
    - 1. Medication required? (List on back) y / n / don't know
3. Has your child had or currently have any of the following heart-related conditions since your last physical:
- a. Chest pain? y / n / don't know
  - b. Heart murmur? y / n / don't know
  - c. High blood pressure or elevated cholesterol level? y / n / don't know
  - d. Restriction from sports for heart problems? y / n / don't know
4. Has your child had or currently have any of the following eye, ear, nose, mouth or throat conditions since your last physical:
- a. Vision problems? y / n / don't know
    - 1. Wear contacts, eyeglasses or protective eye wear? (Circle which type.)
  - b. Hearing loss or problems? y / n / don't know
    - 1. Wear hearing aides or implants? y / n / don't know
  - c. Nasal fractures or frequent nose bleeds? y / n / don't know
  - d. Wear braces, retainer or protective mouth gear? y / n / don't know
  - e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? y / n / don't know

***\*It is advised that every child wearing eyeglasses should receive periodic eye examinations. The school would appreciate a report of exam and name of examiner together with his/her recommendations for the school.***

5. Has your child had or currently have any of the following neuromuscular/orthopedic conditions since your last physical:
- a. Upper or lower back pain? y / n / don't know
  - b. Fracture(s) or stress fracture(s)? y / n / don't know
  - c. Do you wear any protective braces or equipment for any prior injury? y / n / don't know
6. Has your child had or currently have any of the following general or exercise related conditions since your last physical?
- a. Difficulty breathing? During exercise? (Circle one.) y / n / don't know
    - 1. After running one mile y / n / don't know
    - 2. Coughing, wheezing or shortness of breath in weather changes? y / n / don't know
    - 3. Exercise-induced asthma y / n / don't know
      - i. Controlled with medication? (List below.) y / n / don't know
      - ii. Experience dizziness, passing out or fainting? y / n / don't know
  - b. Viral infections (e.g. mono, hepatitis)? y / n / don't know
  - c. Any of the following skin conditions: y / n / don't know
    - 1. Acne, contact dermatitis, ringworm, warts, herpes? y / n / don't know
    - 2. Sun sensitivity? y / n / don't know
  - d. Weight gain/loss (greater than or less than 10 pounds)? y / n / don't know
  - e. Ever had feelings of depression? y / n / don't know
  - f. Heat-related problems (dehydration, dizziness, fatigue, headache)? y / n / don't know
    - 1. Heat exhaustion (cool, clammy, damp skin)? y / n / don't know
    - 2. Heat stroke (hot, red, dry skin)? y / n / don't know

7. Females only:
- Age of onset of menstruation:
  - Date of last menstruation:
  - Most number of days between menstruation cycle(s):

Explain all "yes" (include relevant dates) below and on the back of this page, if needed.

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***I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.***

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## *Please Help Transportation*

We appreciate your help by filling out this form. This information will help drivers and monitors know your child's needs better and give your child the safest bus ride to and from school. *All information will be confidential.*

I.D. # \_\_\_\_\_

Child's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

School: HS MS INTM ELEM OTIS      Grade: \_\_\_\_\_ M / F: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Circle One)

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Parent /Guardian Name(s): \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Emergency / Work #: \_\_\_\_\_

Cell Phone #'s: \_\_\_\_\_

Relative / Neighbor to call if you cannot be reached:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Please answer yes / no to the following questions. If a "yes" answer is indicated, please provide us with information that will help us help care for your child:

1. Does your child take medication that may cause him / her to experience an adverse effect during his bus ride? Yes No  
If yes, please explain: \_\_\_\_\_
2. Is your child speech and / or hearing impaired? Yes No  
If yes, please explain: \_\_\_\_\_
3. Is your child allergic to anything (insects, candy, etc.)? Yes No  
If yes, please explain: \_\_\_\_\_
4. Does your child have seizures? Yes No  
If yes, please explain: \_\_\_\_\_
5. Does your child have any behavioral concerns that you feel will be helpful for the driver / monitor to know? Yes No  
If yes, please explain: \_\_\_\_\_
6. Would you suggest any special seating arrangements for your child (i.e. car seat, support vest, etc.)? Yes No  
If yes, please explain: \_\_\_\_\_
7. Any additional information regarding transportation? \_\_\_\_\_
8. Name of a brother or sister already attending school: \_\_\_\_\_

This helps the computer locate your residence ---- thank you for all your help ----- Minisink Valley Transportation

# MINISINK VALLEY CSD TECHNOLOGY ACCEPTABLE USE AGREEMENT

*The Minisink Valley Central School District provides network technology access, including Internet, to all faculty staff and students to enhance the educational mission and instructional goals of the District. In accordance with the NYS Learning Standards for Mathematics, Science, and Technology, students will use technology as a resource to access, generate, process, and transfer information.*

The following information serves to describe the District technology services and student responsibilities regarding the use of those services. A signed user agreement must be on file with the Building Principal, in order to initiate and maintain student use of the District technology network. A breach of this agreement may be considered an act of insubordination, which may result in discipline under the student code of conduct and pursuant to law.

## **NETWORK COMPUTER USE**

### **RESPECT FOR PROPERTY-**

- I will use the computers, printers, hardware, and software in a responsible manner.
- I will not tamper with, illegally enter, steal, or willfully vandalize equipment.
- I will not make changes to the network systems or attempt to disarm security systems.

### **RESPECT FOR OTHERS-**

- I will access, change, or delete only those files belonging to me.
- I will keep my password confidential.
- I will not use profane, obscene, disrespectful, or threatening words or pictures.
- I will not publish any information which violates or infringes upon the rights of others or which can be considered abusive, profane or sexually offensive.
- I will respect the rights and ideas of others, giving credit to the source (copyright law & citation).

## **INTERNET USE**

Internet and telecommunications access is provided through the District network. The use of this Internet service is solely in support of school based research, instruction, and curricula. The District Internet, in compliance with federal law, is filtered at all access points. Any attempt to disable this filtering is a violation of the agreement.

- I will only access telecommunications and/or the Internet under the direct and immediate charge of a supervising adult who must be present during the entire duration of the process.
- I will only use telecommunications and/or the Internet for school related research and/or communication.
- I will use the appropriate language and etiquette in electronic transmission and information searches.
- I will not provide personal information and/or email addresses via the Internet.
- I will not download or upload computer programs or files without permission from a supervising adult.

## **Minisink Valley CSD Technology Acceptable Use Agreement**

I, the undersigned, have read and agree to the terms and conditions set forth in the Minisink Valley CSD Technology Acceptable User Agreement. I understand that any violation of these regulations may cause my access privileges to be revoked, and school disciplinary action and/or appropriate legal action be taken.

A student and parent/legal guardian must sign this agreement.

\_\_\_\_\_  
STUDENT USER (Print)

\_\_\_\_\_  
STUDENT USER (Signature)

\_\_\_\_\_  
Student ID#

\_\_\_\_\_  
Date

I, the parent/legal guardian of the above named student, have read the contents of this agreement, understand it and agree to be bound by its terms and conditions.

Parent/Legal Guardian (Signature)\_\_\_\_\_

Date \_\_\_\_\_