



Greater Johnstown School District Kindergarten Registration Package 2024-2025

Children who turn **5** years old on or before December 1, 2024 are eligible for Kindergarten. This packet includes all forms necessary for registration into the Kindergarten program. Each form must be filled out in its entirety. Please ensure that you have signed all applicable areas of the packet.

All forms and supporting documentation can be brought to Pleasant Avenue Elementary School starting on March 4, 2024 between the hours of 8:00 am and 3:00 pm. Please do not submit applications prior to that date.

Please check off each form as you complete it:

- _____ Registration/Residency Form
- _____ Racial/Ethnic Identification Form
- _____ School Entrance Health History
- _____ Home Language Questionnaire

You must also provide the following when submitting the application:

- _____ Copy of Original Legal Birth Certificate with Seal
(A copy will be made when you bring in the application)
- _____ Immunization Records from your pediatrician
- _____ Custody paperwork, if applicable
- _____ **TWO** Proofs of Residency (for example)
 - *Drivers License (with current address)
 - * Pay Stub
 - *Utility bill or other bill
 - *Copy of Deed

If you have any questions regarding the registration process, please call 518-762-4611 ext 3120 or email registration@johnstownschoools.org



REGISTRATION FORM
GREATER JOHNSTOWN SCHOOL DISTRICT
 1 Sir Bills Circle, Johnstown, NY 12095

Student's Full Legal Name: _____
 (First) (Middle) (Last)

Sex: _____ Male _____ Female Grade: _____ Date of Birth: _____

Street Address (Actual Residence not PO Box): _____
 _____, New York Street number and Name
 _____ City/Village Zip Code: _____

Mailing Address (PO Box Acceptable): _____

Parent/Guardian: _____
 Name

Home Telephone: _____

Cell Number: _____

Work Number: _____

E-mail address: _____

Custody: Child's legal custodian is _____ Relationship: _____

Child lives with: _____ Relationship: _____

Is there a custody issue? _____

*If custodial rights have been altered, then proof must be in writing. See below for acceptable proof.

Order of Protection* _____ (*If an order of protection exists, it must be submitted to building principal at time of student enrollment)

Parent/Guardian Information

	Name	Home Address	Work Place and Phone Number
Mother (include maiden name)			
Father			
Step Mother			
Step Father			
Legal Guardian			

Is this a foster placement: _____ Yes _____ No

If yes, name of county _____

If yes, copy of DSS 2999 Form required

Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement _____ (living arrangements). If box is checked, please complete STAC-202 form. The answer 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, immunization records or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Brother(s) and Sister(s) Information

Name (First and Last)	Sex	Birth Date	Living at Home	Present Grade	School Attending

What Mode of Communication does/do the Parent(s) prefer:

- Written Notice Phone Calls Email Person to Person

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

Business Office Signature	Date

PROOF OF VERIFICATION OF AGE PROVIDED:

- Birth Certificate
 Baptismal Certificate
 Other (see list below): _____

EVIDENCE OF CUSTODY PROVIDED:

- Judicial Custody Papers
 Guardianship papers
 Signed affidavits

PROOF OF RESIDENCY PROVIDED:

- Copy of Deed
 Copy of Purchase Contract, with Letter from Attorney (including date/time of closing)
 Lease Agreement or Statement from Landlord, Owner or Tenant from whom you lease or live with
 Third party statement establishing the physical presence of the parent(s)/guardian(s) in the school district
 Other (see list below): _____

Other proofs of Age:

- Passport;
 Official driver's license;
 State or other government issued identification;
 School photo identification with date of birth;
 Consulate identification card;
 Hospital or health records;
 Military dependent identification card;
 Documents issued by federal, state or local agencies;
 Court orders or other court-issued documents;
 Native American tribal documents'

Other proofs of Residency:

- Pay Stub;
 Income tax form;
 Utility or other bills;
 Membership documents based upon residency (e.g. library cards)
 Voter registration document(s)
 Official driver's license, learner's permit or non driver ID
 State or other government issued ID
 Documents issued by federal, state or local agencies

GREATER JOHNSTOWN SCHOOL DISTRICT
1 Sir Bills Circle, Suite 101
Johnstown, NY 12095

Racial/Ethnic Identification – please answer both of the following questions.

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

Yes ____ No ____

2. Select one or more races from the following five racial groups: (Check all groups that apply to your child.)

- American Indian or Alaska Native – a person having origins in any of the original peoples of North America
- Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent
- Native Hawaiian or other Pacific islander – a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands
- Black – a person having origins in any of the black racial groups of Africa
- White – a person having origins in any of the original peoples of Europe, North Africa or the Middle East

3. What language does/do the parent(s) prefer to speak?

English

Other: _____
(Please specify)

Signature of person filling out form

Relationship

Date

Greater Johnstown School District
Johnstown, NY 12095

EMERGENCY CONTACT INFORMATION AUTHORIZATION

In order to adequately care for your child when he/she is in school, we need to have up-to-date information about your child's care, as well as a current health and medical history. Please complete this form and return it to the school immediately.

Student's Name _____
Last First M.I. Grade Building

Birthdate _____ Sex _____

Siblings attending Johnstown Schools (include name, grade and school) _____

Student lives with: Parents Mother Father Guardian

Father/Guardian Home Address Home Phone Work Phone

Mother/Guardian Home Address Home Phone Work Phone

Children will be released to parent/guardians and only those others listed below. This includes releases for any purpose, at any time, including at dismissal. Be sure to list all individuals that you may delegate for this responsibility and include all information. If there are any changes during the year, please contact the main office of your child's school to report them.

Name Relationship Address Phone

Name Relationship Address Phone

Name Relationship Address Phone

Name Relationship Address Phone

Name Relationship Address Phone

Name Relationship Address Phone

Name Relationship Address Phone

Please complete back of form
Revised 2/14

GREATER JOHNSTOWN SCHOOL DISTRICT

Administration Center
1 Sir Bills Circle, Johnstown, NY 12095
Phone 518-762-4611
Fax 518-762-5654

SCHOOL ENTRANCE HEALTH HISTORY

Dear Parents/Guardians:

Please complete this questionnaire to the best of your ability and return it to the Health Office of your child's school. This information is for the school medical record kept for each child and is of great help to the school nurse and doctor in understanding and helping to safeguard your child's health. Thank you very much.

SCHOOL _____ Grade _____

CHILD'S NAME _____ Nickname _____

Birthdate _____ Place of Birth _____ Sex _____

Father's Name _____ Place of Employment _____
Phone _____

Mother's Name _____ Place of Employment _____
Phone _____

Home Address _____ Phone _____

Name of Doctor _____ Address _____

Name of Dentist _____ Address _____

Other Children in Family:

Birthdates:

1. Is your child currently being treated for an illness or ongoing condition? _____
If yes, please describe _____

2. Is your child currently taking any medication? _____
If yes, what medication? _____
Why? _____

3. Do you consider your child's health to be: Good _____ Fair _____ Poor _____

4. Can your child participate in all school activities? _____
5. Does your child have any allergies (Foods, animals, medicines, bee stings, dust, pollen, other) _____

If he/she is allergic to bee stings, what actions do you want school personnel to take? _____

6. Please check if your child has had any problems with:
- | | | | |
|------------------------------|-----|----------------------------|-----|
| Asthma | () | Persistent cough or wheeze | () |
| Eczema | () | Tiring Easily | () |
| Frequent headaches | () | Stomach aches or vomiting | () |
| Dizziness or fainting spells | () | Bowel movements | () |
| Convulsions and/or Epilepsy | () | Hernia | () |
| More than 3-4 colds per year | () | Kidney/urinary problems | () |
| Tonsils or adenoids | () | Painful joints | () |
| Strep throat | () | Feet or walking | () |
| Frequent nosebleeds | () | Bedwetting | () |
| Anemia | () | Frequent temper tantrums | () |
| Heart problems | () | Rapid changes of mood | () |
| Diabetes | () | Eating problems | () |

If so, is the condition under the care or observation of a doctor?
If YES, a statement from your physician is required.

7. Has your child had any:
- | | | | |
|-------------------|-------|----------|-------|
| Serious injuries | _____ | Describe | _____ |
| Serious illnesses | _____ | Describe | _____ |
| Accidents | _____ | Describe | _____ |
| Operations | _____ | Describe | _____ |

8. Has your child had any of the following diseases?
- Measles _____ Chicken Pox _____ Rheumatic Fever _____
- German Measles _____ Mumps _____ Pneumonia _____ Scarlet Fever _____

9. When did your child last have a complete physical examination? _____

10. Does your child have any eye problems? (difficulty seeing, crosses eyes, frequently reddened or watery eyes)

11. Does your child wear glasses? _____

12. Does your child have any ear or hearing problems? (frequent earaches, draining from ears, difficulty hearing)

13. Does your child wear a hearing aid? _____

14. Has your child worn braces or corrective shoes? _____ Are they still being worn?

15. Does your child have any speech problems (stuttering, difficult to understand, delayed speech development) _____

16. Is a language other than English spoken at home? _____

17. Will your child require any special health care in school? _____
If yes, please describe: _____

18. Do you have any concerns about your child's general health, behavior, or emotional well-being of which the school should be aware?

19. Was this a normal, full-term pregnancy? _____

20. At what age did your child walk? _____ Talk? _____ Toilet train? _____

21. How did your child develop compared to other children the same age?
Faster _____ Slower _____ About the same _____

22. Please check if your child had any of the following experiences which might influence his social or physical development:

- Frequent changes in residence ()
- Death in family ()
- Fires ()
- Accidents/Injuries ()
- Other ()

23. Please check if you expect that your child may have any of the following problems when he/she begins school:

- Leaving home for the first time ()
- Getting along with a new adult ()
- Dressing, eating, toileting by himself ()
- Getting along with other children ()

24. Family History: Please check any that apply to your immediate family and explain the persons relationship to your child (mother, father, sister, aunt, grandmother, etc.)

- Physical disability (describe) _____
- Epilepsy _____
- Diabetes _____
- Intellectual and Developmental Disabilities _____
- Depression _____
- Vision Problems _____
- Hearing Problems _____
- Thyroid Problems _____
- Scoliosis/back problems _____
- Convulsions _____
- Heart Problems _____
- Other _____

25. Are there other concerns regarding your child that you feel the school should be aware of: _____

Parent/Guardian Signature _____ Date _____



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:		GENDER:
Month	Day	Year
<input type="checkbox"/> Male <input type="checkbox"/> Female		
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

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

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

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
_____	_____
<i>District Name (Number) & School</i>	<i>Address</i>

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: