Greater Johnstown School District
Universal Prekindergarten
Application Package
2024-2025

Children who turn **4** years old on or before December 1, 2024 are eligible for Prekindergarten. This application package includes all forms necessary for consideration into the pre-k program. Each form must be filled out in its entirety.

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.

If greater than 54 pre-k applications are received by April 10, a lottery will take place on Friday, April 12 at Pleasant Avenue Elementary School.

Please check off each form as you complete it:

_____ Registration/Residency Form (Form #1)
_____ Racial/Ethnic Identification Form (Form #2)
_____ School Entrance Health History (Form #3)
_____ Home Language Questionnaire (Form #4)

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
_____ Lead Screening Results
_____ 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
*Lease Agreement

If you have any questions or if at any time you decide not to participate in the program, please call 518-762-4611 ext 3120 or email: registration@johnstownschools.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): _____
Street number and Name
_____, New York Zip Code: _____
City/Village
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

Revised 2/26/21
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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 _____

October 2017

NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for Prekindergarten Students[i]

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father ☐ other _____

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?
☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?

17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no

If yes, in what language(s)?

19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no

If so, what goals do they describe?

20. Please describe anything special you did to prepare your child to begin Prekindergarten.

[1] For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.