PORT JERVIS CITY SCHOOL DISTRICT
OFFICE OF CENTRAL REGISTRATION
10 ROUTE 209 – REGISTRATION MODULAR
PORT JERVIS, NEW YORK 12771
PHONE: (845) 858-3100 EXT. 16601 FAX: (845) 856-9155
EMAIL: phess@pjschools.org

Student Registration Instructions

The Port Jervis City School District welcomes you.
We are looking forward to helping prepare your student for an exciting educational experience.

The parent or legal guardian must be present at the time of registration (child does not need to attend registration).

Registration is held Monday through Friday 8:00AM to 11:00AM
Pre-School Registration is held on Monday and Friday only 8:00AM to 11:00AM

Proof of Age

- Birth Certificate (including certified transcript of foreign birth certificate)
- Passport

Proof of Immunizations

- The Port Jervis City School District requires an updated record of immunizations before the student is enrolled in school

Proof of Residency

- IF YOU ARE A HOMEOWNER, please provide (1) either a copy of your most recently paid tax bill or mortgage statement, and (2) a recent utility bill. The name and address on these documents must match the name and address of the parent or legal guardian of the student being registered. *If you have just recently closed on a new home, please provide (1) your Settlement/Closing Statement or the Certificate of Occupancy or Deed, and (2) a homeowner's insurance policy or utility hook-up receipt.
- IF YOU ARE A RENTER, please provide (1) your signed lease agreement with the term listed, and (2) a current cable, electric, water or fuel delivery bill (or utility hook-up receipt if you have just recently moved in.)
- IF YOU RENT WITHOUT A LEASE, (on a month-to-month basis) the following should be provided: (1) a notarized letter from the property owner (a blank form will be provided) and (2) a current cable, electric, water or fuel delivery bill (or utility hook-up receipt.)
- IF YOU LIVE WITH A DISTRICT RESIDENT, (ex: parent, grandparent, friend) and do not pay rent, a living with others affidavit, which will be provided to you. The affidavits must be completed as follows: The first is to be signed by the district resident and notarized, and who must provide proof of residency as stated above.

Proof of Parental Relationship

- Students will be registered when proper proof of parental relationship is presented. The parent/legal guardian must be present at the time of registration and must provide valid photo ID.

New York State Law, Section 3202, states, "A child must reside with one or both of his/her parents unless they are deceased, imprisoned or committed to an institution, having deserted or abandoned the child, or reside outside New York State." In such cases, only legally appointed guardians or foster parents may assume custody and responsibility for the care of the child.

Foster Children: A DSS Representative (not the Foster Parent) must register the child. A DSS2999 form and a signed custody order are required at the time of registration.
Guardianship: If you have legal guardianship, documents signed by a court officer are required. **Separated or Divorced Parents**: Document signed by a court officer stating parent has physical custody of the child is required.

School Records

- Any school records that you have from the past school is very helpful in speeding up the entry process including IEP's.

PORT JERVIS CITY SCHOOL DISTRICT

LIVING ARRANGEMENTS OF CHILD FORM

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

Date:_____

Name of Student:_____

Gender: Male_____Female_____

Address:_____ Phone:_____

_____ Cell:_____

_____ Work:_____

Prior Address before coming to Port Jervis:_____

_____

_____

Prior School before coming to Port Jervis:_____

_____

_____

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 relatives or others due to loss of housing, economic hardship, or similar reason.
( ) Is this living arrangement temporary or permanent (please circle one)
( ) In a hotel/motel
( ) In a car, bus, train, or campsite
( ) Other – please describe_____

_____

_____

Please list everyone who is living there:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Print Name_____ **Date**_____

Signature_____

PORT JERVIS CITY SCHOOL DISTRICT
HEALTH HISTORY

Student name _____ M or F Grade_____
(Last Name, First Name, Middle Name) (circle one)

Date of Birth_____ Birthplace_____Home Language_____

Student Cell Phone Number (if he/she has one)_____

Ethnic ( ) White ( ) Black ( ) Hispanic ( ) American Indian/Alaskan Native ( ) Asian/Pacific Islander

Home Address_____ Apt. # _____
(number) (street)
_____ Telephone Number_____
(city) (state) (zip)
Mailing address_(if different)_____

Previous School District Attended_____
Previous School Address_____
Has child ever attended Port Jervis Schools? Yes or No If Yes, When?_____

Name of Brothers and Sisters

Name (Last, First, Middle)	School	Name	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Child lives with: Both Parents_____ Mother_____Father_____Guardian_____Step-Parent_____Other_____

Parent / Guardian Name_____
Address (if different)_____
Relationship to student _____ Date of Birth_____
Employer's Name_____ Work Phone _____
Cell Phone_____Email_____

Parent / Guardian Name_____
Address (if different)_____
Relationship to student _____Date of birth_____
Employer's Name_____Work Phone _____
Cell Phone_____Email_____

If parent / guardian cannot be reached:
Emergency Contact _____Relationship_____
Address_____
Home_____ Cell_____Work_____

Student with one or more parent who is a member of the **Armed Forces and on Active Duty**? Yes_____ No_____

Are there any **CUSTODY** issues we should be aware of? Be specific_____
_____

Does your child have –OR- has your child ever had any of the following (check all that apply):

☐ Eating issues ☐ Weight Issues ☐ Head Injury / Concussion ☐ Eye Injury ☐ Vision Problems ☐ Glasses / Contacts
☐ Seizures ☐ hearing problems ☐ speech problems ☐ Other_____

Does your child have FREQUENT:

☐ colds ☐ sore throats ☐ sinus infections ☐ tonsillitis ☐ headaches ☐ migraines ☐ ear infections
☐ bronchitis ☐ eczema ☐ rashes ☐ other: _____

Does your child have a history of –OR- currently being treated for any of the following: (Please indicates dates, treatment or medication)

ADHD_____ Scoliosis_____ Diabetes_____
Thyroid problems_____Toileting problems_____ Kidney/Urinary problems_____
Heart murmur_____ Heart Disease_____Blood Disorder_____
Operations_____Hospitalizations_____ Broken bones/fractures_____
Other: _____

When was the last time your child went to the dentist: _____

ASTHMA: Does your child have asthma that has been diagnosed by a doctor? ☐ Yes ☐ No
If YES, what type: ☐ chronic ☐ bronchial ☐ exercise ☐ other: _____
ASTHMA MEDICATION:** What type of asthma treatment ** does your child use? * Be Specific *
☐ INHALER ☐ NEBULIZER ☐ PILL: _____ ☐ OTHER_____
ALLERGIES: Does your child have ANY allergies? ☐ Yes ☐ No known allergies
Which allergies have been diagnosed / confirmed by a doctor? _____

Please list ALL allergies and your child's REACTION (Be specific)
FOODS_____LACTOSE INTOL_____ BEES _____ INSECTS _____
ANIMALS_____ENVIRONMENTAL/SEASONAL_____
DRUGS/ANTIBIOTICS_____ OTHER_____
What medication** / treatment does your child take for allergies?_____

Do you have any OTHER HEALTH CONCERNS about your child? _____

** MEDICATION NOTE** In order for a child to receive ANY medication in school, over the counter or prescription, the following is required:

1. MEDICATION FORM COMPLETED BY DOCTOR AND SIGNED BY PARENT
2. MEDICATION MUST BE IN ORIGINAL CONTAINER
3. CONTAINERS MUST HAVE STUDENT'S NAME ON IT
4. MEDICATION MUST BE BROUGHT TO SCHOOL BY AN ADULT. STUDENTS ARE NOT PERMITTED TO CARRY MEDICATION.

NEW YORK STATE MANDATED PHYSICALS AND SCHOOL HEALTH SCREENINGS:

PHYSICALS are required as follows:
→ All new entrants → Kg, gr. 1, gr. 2, gr. 3, gr. 5, gr. 7, gr. 9, and gr. 11 → participation in sports → working papers

The district supplies the examinations, at no charge, for students who have their physicals done in school.
_____ I request the School Doctor/Nurse Practitioner do the Physical.

_____ My child's physical will be done by our private physician: _____

*** Proof of physical or appointment date must be provided within 30 days. If no response is received within 30 days, the student will have a physical with the school doctor/nurse practitioner.**

SCREENINGS are done by school personnel as follows: → Scoliosis: (Girls) gr. 5 and gr. 7 (Boys) gr. 9
→ → Vision/Hearing: gr. Kg, 1, 3, 5, 7, 11 and All New Entrants

I understand confidential and discreet use of the above information as well as any health evaluation by the school nurse practitioner will be shared as needed to meet my child's health and educational needs.

_____ _____
Parent / Guardian Signature **Date**

PORT JERVIS CITY SCHOOL DISTRICT
CONSENT TO RELEASE GRADES

Registration Office
10 Route 209
Port Jervis, NY 12771
845-858-3100 Ext. 16601
Fax: 845-856-9155
Email: phess@pjschools.org

Previous School District_____
Previous School_____

Student Name_____ Date of Birth_____ Grade_____

_____ **Port Jervis High School**
10 Rt. 209
Port Jervis, NY 12771
Guidance Office (845) 858-3100 Ext. 11601
Fax (845) 858-3239
Nurses Office (845) 858-3100 Ext. 11700
Fax (845) 858-3113

_____ **Port Jervis Middle School**
118 East Main Street
Port Jervis, NY 12771
Guidance Office (845) 858-3100 Ext. 12601
Fax (845) 858-2761
Nurses Office (845) 858-3100 Ext. 12700
Fax (845) 858-3226

_____ **Anna S. Kuhl Elementary School**
10 Rt. 209
Port Jervis, NY 12771
Main Office (845) 858-3100 Ext. 13502
Fax (845) 858-2894
Nurses Office (845) 858-3100 Ext. 13700
Fax (845) 858-3157

_____ **Hamilton Bicentennial Elementary School**
929 Rt. 209
Cuddebackville, NY 12729
Main Office (845) 858-3100 Ext. 14501
Fax (845) 754-7355
Nurses Office (845) 858-3100 Ext. 14700
Fax (845) 754-2968

_____ **For Special Education Students:**
Committee on Special Education
10 Rt. 209
Port Jervis, NY 12771
(845) 858-3100 Ext. 16501
Fax (845) 858-3191

Please release all grades, standardized test results, IEP, social, educational, psychological and medical And Medical information.

_____ _____
Print Name of Parent/Guardian **Date**

_____
Signature of Parent/Guardian

PORT JERVIS CITY SCHOOL DISTRICT
RELEASE FROM SCHOOL AUTHORIZATION

STUDENT:_____
Last Name First Name Middle Name

_____ _____ _____
Age Grade School

Listed below are the people authorized to pick up my child at the school office:

First Emergency Contact

Name_____
Relationship_____
Address_____
Home Phone_____Cell_____Work_____

Second Emergency Contact

Name_____
Relationship_____
Address_____
Home Phone_____Cell_____Work_____

Third Emergency Contact

Name_____
Relationship_____
Address_____
Home Phone_____Cell_____Work_____

Fourth Emergency Contact

Name_____
Relationship_____
Address_____
Home Phone_____Cell_____Work_____

_____ _____
Print Name of Parent/Guardian **Date**

_____
Signature of Parent/Guardian

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:
			❑ Male ❑ Female
Month	*Day*	*Year*	

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: