BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Early Bridges Application

The ***Early Bridges*** program is a collaborative partnership between the Boquet Valley Central School District and Adirondack Community Action Program, Inc's Head Start. This partnership created a pre-Kindergarten program that is led by certified teachers and supported by Head Start staff. The program follows the school calendar and runs 8:00 AM-3:00 PM. Please note that completing an application for your child doesn't necessarily mean your child has been selected for the ***Early Bridges.***

Who: Any child who will be three or four years old on or before December 1, 2020 that lives within the merged ELW District is eligible for applying for the free Early Bridges program. Any child who resides outside of the aforementioned area may apply, but would pay tuition.

What is needed to apply:

- Child's Birth Certificate or Baptismal Certificate
- Immunization records
- Income verification
- Proof of residency

What will be required before officially entering in Early Bridges:

- Completed physical form
- Dental Health certificate

If you have any questions, please feel free to contact Jolene Sayward, Early Bridges Family Worker at 518-225-5162.

Early Bridges ANNUAL GENERAL CONSENT FORM

I hereby give permission for my child _____ to participate in the following:

	Yes	No	N/A
Health Screenings:			
Hearing/Vision	☐	☐	☐
Height/Weight/BMI	☐	☐	☐
Blood Pressure	☐	☐	☐
Dental Examination	☐	☐	☐
Developmental Screenings	☐	☐	☐
Social/Emotional Screening	☐	☐	☐

Pictures & Videos used in Slideshows, ACAP and or BVCS website, newspapers, newsletters, brochures, public relations articles, etc. (Child's last name will not be used.) ☐ ☐ ☐

Other:

Local library	☐	☐	☐
Field trips	☐	☐	☐
Transportation to/from site	☐	☐	☐
Application of sunscreen	☐	☐	☐
HS counselor's group observation 2x/year	☐	☐	☐
To join a therapist during a session	☐	☐	☐
Transition information to school/Early Bridges	☐	☐	☐

which ***may*** include:

Transitional observation

Health records (physical and dental exams,immunization records,and/or birth certificate)

Family contact information

Observation by local school personnel

Child Assessment Summary

Special Services Record

I understand that the Early Bridges Program deems these services necessary, advisable and are typical elements of the preschool experience. The purpose and nature of any examinations, screenings, and/or observations have been explained to me. Any/all results may be shared. This permission is valid for one program year after the signature.

Parent/Guardian_____ Date_____

Staff _____ Date_____

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Student Registration Record

www.boquetvalleycsd.org

Registration Date: _____ Entry Date: _____ Grade: _____

Full Name of Child: _____ Sex: ○ Male/Female ○
First Middle Last

Date of Birth _____ SSN: _____

Mailing Address: _____

Home Phone: _____ Cell: Phone: _____ Email Address: _____

Proof of Age: Birth Certificate: ☐ Baptismal Certificate: ☐ Place of Birth: _____

Race (please check one):
☐ Asian
☐ Black
☐ White
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander

Ethnicity: Is the child Hispanic, Latino or of Spanish Origin? ○ **YES** / ○ **NO**

Parent/Guardian One Information:

Name: _____ Sex: ○ Male / ○ Female

Mailing Address: _____ Physical Address: _____

City/Town: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Employer: _____ Work Phone: _____

Employer Address: _____

Parent/Guardian Two Information:

Name: _____ Sex: ○ Male / ○ Female

Mailing Address: _____ Physical Address: _____

City/Town: _____ State: _____ Zip: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Employer: _____ Work Phone: _____

Employer Address: _____

Over

Parenting Relationship Information:

☐ Married ☐ Widow(er)

☐ Divorced

☐ Separated

☐ Not married, but living in the same household

Legal Custody:

☐ Mother

☐ Father

☐ Guardian

☐ Joint Custody

Proof of Custody

☐ Yes (must be presented)

☐ No

Visitation Restrictions (if any)

List all persons living in the household

First and Last Name	Relationship to Child	Date of Birth	Place of Birth

Child's Previous Educational Experience

School Name: _____ School Address: _____

School Phone Number: _____ School Fax Number: _____

Has/Is the childe receiving any Special Education or Remedial Services : ◯ (Yes) ◯ (No)

Daycare Information

Daycare provider name: _____ Provider Phone Number: _____

Daycare Provider Address: _____

*****If there are any changes in the above information during the school year, please notify the school immediately. It is important we have this information to serve your child in case of an accident or sudden illness. All information provided on this form is for school use only. We do not release any information to anyone without prior written signed consent.*

_____ _____

Parent/Guardian Signature Date

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Pre-Kindergarten Registration Form

Child's Name: _____

Parent's Name: _____

Name of Pediatrician: _____ Contact Number: _____

Pediatrician Address : _____

Do you have any health concerns regarding your child's development (circle one): YES NO

Number in Household: _____

Household Income(s):

☐ $0 - $11,770	☐ $24,250 $24,809	☐ $ 40,890 - $40,45-049
☐ $11,771 - $15,930	☐ $24,810 - $32,569	☐ $ 45,050 - $49,203
☐ $15,931 - $20,089	☐ $32,570 - 36,729	☐ $ 49,204 - or more
☐ $20,090 - $24,249	☐ $36,730 - $40,889	

Social Services Received (check all that apply) ☐ TANF ☐ SNAP ☐ MD

Does anyone in the household receive SSI? ◯ Yes ◯ No If yes, who? _____

Did your child participate in a Preschool or Headstart program? ◯ Yes ◯ No

If YES, which program? _____ Name of School: _____

If NO, did your child participate in daycare? ◯ Yes ◯ No If yes, who? _____

If YES, name of daycare: _____ Was the daycare registered? _____

Is the child in foster care? ◯ Yes ◯ No

Does your child have an IEP through CPSE or early education services? Circle YES NO

Does your child have any special needs? Please explain: _____

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Student Medical Information

www.boquetvalleycsd.org

Student Name: _____ _____
Last First M. Date of Birth

Parent/Guardian Information: _____ ◯ Male / ◯ Female

Mailing Address: _____

911 Address: _____

Employer:: _____

Employer Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone _____

Parent/Guardian Information: _____ ◯ Male / ◯ Female

Mailing Address: _____

911 Address: _____

Employer:: _____

Employer Address: _____

Cell Phone: _____ Work Phone: _____ Home Phone _____

Student's Health Care Provider: _____ Phone: _____

Address of Health Care Provider: _____

Does your child wear glasses/contact lenses? ☐ Yes ☐ No

Does your child wear a hearing device? ☐ Yes ☐ No

Does your child wear a dental appliance? ☐ Yes ☐ No

Does your child take any medication **daily**? ☐ Yes ☐ No

If yes, please list _____

Does your child take medication as needed? ☐ Yes ☐ No

If yes, please list _____

Please indicate if any of the following applies your child's medical history by checking **Yes or No** below. If you checked Yes, please provide a brief description.

Yes **No**

☐ ☐ Allergies (Please describe) Food, Medication? _____

Other_____

_____ Epi-Pen ☐ Y ☐ N

☐ ☐ Asthma (Seasonal, chronic)_____

☐ ☐ Blood Disorder _____

☐ ☐ Diabetes _____

☐ ☐ Ear Conditions_____

☐ ☐ Frequent Colds _____

☐ ☐ Head Injury _____

☐ ☐ Heart Disease _____

☐ ☐ Kidney Issues (Renal) _____

☐ ☐ Muscular/Skeletal Condition _____

☐ ☐ Pneumonia _____

☐ ☐ Seizure Disorder (Epilepsy) _____

☐ ☐ Operations (Please explain & provide dates) _____

☐ ☐ Serious Injuries (Please explain)_____

_____

☐ ☐ Other medical issues, not listed above? _____

_____

Is this child covered by Health Insurance? ☐ Yes ☐ No Type:_____

_____ _____

Parent/Guardian Signature Date

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

Food Allergy and Sensitivity Notification

Dear Parent/Guardian:

Please inform the Health Office on the note below if your child is allergic to any food items. Please note food allergies and sensitivities are different than food likes and dislikes. A food allergy is when an anaphylactic incident will occur if your child is exposed to a particular food item. **Anaphylaxis is a serious life threatening incident; please provide BVCSD with an Epi-Pen for your child's allergies.**

If you have any questions or concerns please contact the Health Office at 518-873-6371, ext. 506.

Student's Name: _____ Grade: _____

☐ My child has **no** food allergies or sensitivities that I am aware of at this time.

Food Allergy: _____

Food Sensitivity: _____

(e.g. lactose intolerance, foods that cause gastric upset, etc.)

_____ _____

Parent/Guardian Signature Date

BOQUET VALLEY
CENTRAL SCHOOL DISTRICT

STUDENT EMERGENCY FORM

Please supply all information requested below and return this form to school. This form will be kept on file in the district office for the current school year. If more than one form is needed per family, please contact the office for additional forms.

Student Name: _____ DOB: _____ Grade: _____

Mailng Address: _____

Physical Address: _____

Home Telephone: _____ Cell Phone: _____ Email Address: _____

Parent/Guardian Information: *To serve your child in case of an accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification; it is necessary that you furnish the following information for emergency calls:*

Mother: (full name) _____

Employer: _____

Employer Address: _____

Employer Phone: _____ Cell Phone: _____ Email Address: _____

Father: (full name) _____

Employer: _____

Employer Address: _____

Employer Phone: _____ Cell Phone: _____ Email Address: _____

Emergency Contacts: Designate **two** emergency contacts *to assume temporary care of your child in case of an accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification; it is necessary that you furnish the following information for emergency calls:*

Emergency Contact #1: (full name) _____ Relationship to child _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact #2: (full name) _____ Relationship to child _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medical Information:

Physician (full name) _____

Address: _____ Business Phone: _____

Hospital: _____

Address: _____ Business Phone: _____

I, the undersigned, do hereby authorize officials of the Boquet Valley Central School District to contact the persons named on this form and do authorize named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

Signature: _____ Date: _____

Student Residency Questionnaire

NOTE: PLEASE REMOVE ALL INFORMATION IN THIS BOX BEFORE USING THIS FORM; UPDATE THIS FORM TO REFLECT THE NEEDS AND SPECIFICS PERTAINING TO YOUR DISTRICT. This form is an example of what most districts in Texas have found useful to include in their student enrollment packets to help identify students in homeless situations as required by the McKinney-Vento Homeless Assistance Improvements Act, 42 U.S.C.11435. Answers to this residency information help determine the services the student may be eligible to receive. This form is adapted from one developed by Cypress Fairbanks ISD.

Name of School _____

Name of Student: _____ Sex: ☐ Male ☐ Female
Last First Middle

Birth Date ____/____/____ Age: _____ Social Security #: _____
Month / Day / Year *(or student identification number)*

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? ☐ Yes ☐ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?
☐ Yes ☐ No

If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.

Where is the student presently living? (*Check one box.*)

- ☐ In a motel
- ☐ In a shelter
- ☐ With more than one family in a house or apartment
- ☐ Moving from place to place
- ☐ In a place not designed for ordinary sleeping accomodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardians(s) _____

Address _____ Zip _____ Phone _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian _____ Date _____

Please send a copy to _____ at the Central Office.

Fax:

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

_____ _____
Date McKinney-Vento Liaison Signature

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:

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