



# PREKINDERGARTEN REGISTRATION

Complete the forms within this packet using Adobe Reader on your computer or smartphone. You can download the app here:



Need assistance completing the forms?  
Call our offices at (585) 262-8140  
Hours: Monday - Friday  
8:00 a.m. - 4:30 p.m.

Return these forms by email to [prek@rcsdk12.org](mailto:prek@rcsdk12.org)

## PLEASE NOTE:

Families should submit scans and/or photographs of their valid photo ID, child's birth certificate, and proof of residency. by e-mail to [prek@rcsdk12.org](mailto:prek@rcsdk12.org) with their application.

Immunization records and the child's most recent physical are also requested. Both are required to attend, but they are not required to complete registration.

Rochester City School District  
Preschool Registration Form

Program Choices:  
(complete list can be found at [www.rocprek.org](http://www.rocprek.org))

1: \_\_\_\_\_  
2: \_\_\_\_\_  
3: \_\_\_\_\_

And/Or please refer my child to:  
ABC Head Start    IBERO Head Start    VOA Head Start

RCSD Office Use Only
Student ID: _____
Assigned School: _____
Program Start Date: _____
Completed by: _____

**Student Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male    Female

Federal Ethnic Category:    Hispanic/Latino    Not Hispanic Latino

Federal Race (Please check all that apply):    American Indian or Native Alaskan    Asian  
Black or African American    Native Hawaiian or Other Pacific Islander    White

<b>Does the student receive special education services?</b> Yes    No    I am concerned			
To request evaluation, a letter must be written by the parent/guardian stating the concerns.			
If yes, please list services: _____			
Early Intervention	Transfer from other district:		

	Parent/Legal Guardian	Adult #2
Name		
Relationship		
Street Address, Apt#		
City, State, Zip Code		
Home Phone		
Cell Phone		
Work Phone		
Email Address		
Preferred Contact	Phone    Email    Letter	Phone    Email    Letter
Translator Required	Yes    No	Yes    No
Language		

Sibling Names (Brothers & Sisters)	Birthdate	School	Same Address?

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



## HOUSING QUESTIONNAIRE

Name of LEA:	Rochester City School District		
Name of School:	RCSD PreK		
Name of Student:			
Gender:	Male Female	Date of Birth: Grade: PreK	Student ID#:
Address, Apt# City, State, Zip		Home Phone	
		Cell Phone	
Previous Address City, State, Zip			

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. 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.

<b>Where is the student currently living?</b> (Please check <u>one</u> box.)	
	In a Shelter
	With Extended Family 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
	In Foster Care
	Other Temporary Living Situation (Please describe)
	In Permanent Housing
	Unaccompanied Youth

Parent/Guardian Name

Signature

Date

Electronic Submission. Please call 585-262-8140 if you need assistance.

If **ANY box other than "In Permanent Housing" is checked**, then the student/family should be immediately referred to the MV Liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

## Emergency Contact/Student Release Form

### Student Information

Student ID: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male Female

In the event of an emergency, when the child's primary guardian(s) cannot be reached, the following adults (over 18 years old) may be contacted for care and transportation:

Name (as appears on ID):	Relationship to Child:
Phone Number(s):	Email Address:

Name (as appears on ID):	Relationship to Child:
Phone Number(s):	Email Address:

Name (as appears on ID):	Relationship to Child:
Phone Number(s):	Email Address:

Name (as appears on ID):	Relationship to Child:
Phone Number(s):	Email Address:

If any of the above persons should be contacted BEFORE the child's primary guardian(s), please indicate with an asterisk (\*).

### Mailing Address (Optional)

If you have a mailing address that is different from your home address or if you would like another person to receive mailings for your child, please fill out the box below.

Name	
Relationship	
Address, Apt#	
City, State, Zip Code	
Language*	

\*If the person requires communications to be translated, please indicate the preferred language

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



**NEW YORK STATE EDUCATION DEPARTMENT  
Emergent Multilingual Learners Language Profile for  
Prekindergarten Students<sup>1</sup>**

[NYS Education Department EMLL Website](#)

*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.*

Student Information	
Date Profile Completed:	
Student Name:	
Gender:	Male      Female
Date of Birth:	
District or Community Based Organization Name: RCSD	
Student ID (if applicable):	
Electronic Submission. Please call 585-262-8140 if you need assistance.	

**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:  
 In what language(s) would you like to receive information from the school?  
     English      Other language(s):

**Language in the Home**

- In what language(s) do you (parents or guardians) speak to your child at home?  
     English      Other Language(s):
- What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)  
     English      Other Language(s):
- Is there a caretaker in the home?      Yes      No  
 If yes, what language(s) does the caretaker speak most frequently?  
     English      Other Language(s):
- What language(s) does your child understand?  
     English      Other Language(s):
- In what language(s) does your child speak with other people?  
     English      Other Language(s):

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?

English    Other Language(s):

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

In what language?    English    Other Language(s):

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

In what language?    English    Other Language(s):

8. In what language does your child pretend play?

English    Other Language(s):

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?    English    Other Language(s):

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

English    Other Language(s):

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?      Yes      No  
 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)?      English      Other Language(s):  
 17b. Does your child pretend to write?      Yes      No      Unsure  
 If yes, in what language(s)?      English      Other Language(s):

18. Does your child tell the stories from his/her favorite books or videos?      Yes      No  
 If yes, in what language(s)?      English      Other 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.

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<sup>i</sup> For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email [OEL@nysed.gov](mailto: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](mailto:OBEWL@nysed.gov).

# **Rochester City School District**

## Student Health Services Information

Parent or Guardian please fill as part of your child's registration packet  
The following information is needed to complete your child's Health Record.

Student's Legal Name	Date of Birth	PreK Grade/HR	M	F
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Doctor's Name	Phone Number
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Does the Child Have Medical Insurance:    Yes    No

Insurer: \_\_\_\_\_

Does your Child Wear Glasses:    Yes    No

Does your Child have any Hearing Issues:    Yes    No

If Yes, Explain: \_\_\_\_\_

### ***TO BE COMPLETED BY PARENT OR GUARDIAN***

**My child has one of the following life-threatening conditions and will need an emergency care plan completed by the school nurse and myself with written guidance from our private physician. I understand that it is my responsibility to provide physician orders and any prescribed lifesaving medication to the school nurse. I understand that if my child needs to carry lifesaving medications, I must receive prior administrative approval and must provide a second dose in the school health office in the event my child misplaces the lifesaving medicine.**

**Please Specify:**

<b>Life-threatening allergy</b>	<b>Food</b>	<b>Insect</b>	<b>Medicine</b>
<b><i>Asthma</i></b>			
<b>Diabetes</b>			
<b>Seizures</b>			
<b>Severe swallowing problems/choking</b>			
<b>Significant heart disease</b>			
<b>Other</b>			





ROCHESTER CITY SCHOOL DISTRICT  
 School Health Services  
 131 West Broad Street  
 Rochester, New York 14614

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (HIPAA)

Student Name	Date of Birth:
Healthcare provider (doctor):	Phone:
Address:	Fax:
Healthcare provider (doctor):	Phone:
Address:	Fax:

<input checked="" type="checkbox"/>	<b>Monroe County Health Dept. Clinics</b>					
<input checked="" type="checkbox"/>	<b>Lead Testing</b>	<input checked="" type="checkbox"/>	<b>TB Clinic</b>	<input checked="" type="checkbox"/>	<b>Immunization Clinic</b>	<b>Other:</b>

I hereby authorize my/my child's physician(s) listed above to exchange the following information with Rochester City School District, including:

**All**

**Or Specified:**

- |                        |                                                                         |
|------------------------|-------------------------------------------------------------------------|
| School nurse           | Immunizations to comply with NYS regulations                            |
| Medical officer        | Physical exams to comply with NYS regulations and sports requirements   |
| Physical Therapist     | Authorization for medications during the school day or on school trips  |
| Occupational Therapist | Medical condition/ treatment plans that may have an impact in school    |
| Speech Therapist       | Medical orders required for therapy needs, evaluations                  |
| Audiologist            | Physician referral for services (OT, PT)                                |
| Vision Department      | Medical clearances as needed following an injury or change in condition |
| Special Education      |                                                                         |
| Other:                 |                                                                         |

This information will be used to provide a safe and healthful environment and develop an appropriate program for this student at school. Enrollment is not contingent upon signing this release, however, in order to plan the most appropriate program for this student, the information may be required. Specific immunizations per NYS regulations ARE required for enrollment. Positive results on lead testing are shared on a need to know basis between the health services and the educational team to develop suitable programming to address any problems associated with high lead levels.

This release expires on the last day of the enrollment of the above student in the Rochester City School District, and may be revoked at any time by sending a written and signed request to cancel this permission to the address above. Such revocation will not affect any disclosure made prior to its receipt by the District. Protected health information will not be disclosed without consent pursuant to the Family Educational Rights and Privacy Act (20 U.S.C. § 1232g) and implementing regulations (34 C.R.F. § 99). **A copy of this release has been provided to me. I understand that it will be sent to the appropriate provider when requests are made, and I consent to the release of the information to the Rochester City School District by the healthcare providers listed above.**

\_\_\_\_\_  
 (Signature of student over 18 or Parent/Guardian)\*\*

\_\_\_\_\_  
 (Date)

\*\*If student is under 18 years of age, parent or legal guardian must sign consent form. If other representative is signing, state authority to act on student's behalf:

\*\* If student is over 18 years of age and is a student with a disability as defined by the Individuals with Disabilities Education Act and the information requested pertains thereto, then the parent/guardian must also sign consent form.

**Rochester City School District**  
**Office of Prekindergarten Programming**  
**Office of Student Equity and Placement**  
**131 W. Broad St. – Rochester, NY 14614**

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**Pre-Kindergarten Enrollment Form**

**Parent Preference/Managed Choice Policy**

Rochester City School District (RCSD) Board Policy #5153 Parent Preference/Managed Choice established three distinct attendance zones and allows students to apply only to those (elementary) schools within their zone, and to one citywide school. To ensure equitable access to schools in high demand, a student assignment algorithm is used to assign students to schools. A primary goal of the Parent Preference/Managed Choice Policy is to establish and maintain an equitable system for assigning students to school(s), providing a space at “home” schools for students that live in a designated zone, while also allowing students from outside the zone an opportunity to enroll at the school and minimizing student mobility, with the intent of supporting overall school improvement. Zones are determined by a student’s home address.

Parent/Guardian Acknowledgement:

I, the parent/guardian of \_\_\_\_\_, acknowledge that my child may be assigned to a pre-kindergarten site/location that is not in my zone. I understand that, in accordance with Board Policy #5153, when my child transitions to kindergarten, I will need to participate in the school selection process to apply for my child’s placement in a school within my home zone, or a citywide school through the school choice lottery process.

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

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

Student Name: \_\_\_\_\_

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

*To be completed by prekindergarten selection specialist*

Parent/Guardian Name: \_\_\_\_\_ Student Name: \_\_\_\_\_

Student ID: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ School Zone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prekindergarten School/Location Assignment: \_\_\_\_\_

School Assignment Specialist’s Name/Signature: \_\_\_\_\_



## Authorization for Participation and Release of Information

The *Get Ready to GROW* screening project provides early childhood screening for vision, hearing, dental, language, social, emotional, physical growth, and other developmental areas.

I give permission for Rochester Hearing & Speech Center (RHSC), The Association for the Blind and Visually Impaired (ABVI), Children’s Institute, Rochester City School District (RCSD), staff and students of Nazareth College, St John Fisher College, Monroe Community College, Parents As Teachers – Hillside (PAT), Monroe County Early Intervention, and my child’s center or home care staff and affiliated site staff, including volunteers, to conduct direct or telehealth hearing, vision, language, speech, motor, cognitive, height and weight (BMI), social and emotional, dental, protective factors, adverse life events, and social determinants of health and education screenings of my child and family and provider recommendations and strategies that will support my child and our family.

**Release Screening Results to Health Professionals:** I authorize ABVI, RHSC, Children’s Institute, RCSD, PAT, and/or my childcare provider to release the results of my child’s screenings to my child’s doctor, dentist, insurance company, Monroe County Early Intervention, and other professionals that I have designated below.

**Release Screening Results to Track My Child’s Progress:** I authorize RHSC, ABVI, RCSD, Nazareth College, St. John Fisher College School of Nursing, PAT, my child’s doctor, my child’s dentist, and my child’s center or home care staff to release the results of my child’s screenings to Children’s Institute and COMET Informatics, a web-based system that facilitates my child’s progress tracking, referral, and follow up care.

**Release De-Identified Results to Project Funders:** Reports may be shared with grant funders of this project including, but not limited to: Rochester Area Community Foundation, Greater Rochester Health Foundation, United Way of Greater Rochester, City of Rochester, Finger Lakes Performing Provider System (FLPPS), and ROC the Future and will **not** include children’s or family’s identifying information. Only aggregate or group data will be shared.

When applicable, the director or classroom teacher of my child’s childcare provider will meet with me to discuss my child’s progress, make recommendations, and provide information regarding programs and resources available in the community. I understand the information obtained from this screening process is an initial step to meeting my child’s needs and does not take the place of a professional examination.

When needed, I understand that it is my responsibility to seek a professional examination and follow-up services should my child need more services. I understand that I may ask for help from GROW staff. I will not hold any of the above agencies accountable for errors of omission.

I understand that signing this authorization for and participation in the GROW screening project is voluntary. This authorization will remain in effect until I revoke it. I understand that I have the right to revoke this authorization at any time by communicating my request in writing to Children’s Institute, see contact information below.

Child’s Name:				Child’s Birthdate:			
Parent/Guardian:				Email:			
Address, City, State, Zip Code:							
Phone (home):				Phone (mobile):			
Best Way(s) to Contact:		Phone	Text	Email			
Best Day(s) to Contact:		M	T	W	R	F	Best Time(s):
				A.M. 8-12		P.M. 12-5	
				P.M. 5-8			
Primary Doctor’s Name:				Doctor’s Phone:			
Dentist’s Name:				Dentist’s Phone:			
Insurance:				Medicaid: Yes			
Other professionals to release screening information to (name and contact information):							
Parent or Guardian Signature:						Date:	
We will provide you access to your child’s screening results online using the GROW Parent Portal unless you tell us otherwise. All information will be confidential and only accessible to you.							
Please do <b>not</b> provide me screening results online. (Put an ‘X’ here <b>only if you do not want</b> access to your child’s screening information)							



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