Pre K Start Smart

PREKINDERGARTEN REGISTRATION

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

GET IT ON Google Play Download on the App Store

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

Submit Application

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 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:	RCSD Office Use Only
1:	Student ID:
2:	Assigned School:
3:	Program Start Date:
Please refer my child to: ☐ ABC Head Start ☐ IBERO Head Start ☐ VOA Head Start	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

Does the student receive special education services? ◯ 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		
Physical Address		
Address	Zip _____ Apt _____	Zip _____ Apt _____
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: _____

Rochester City School District
Housing Questionnaire

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at the top page of registration materials that the District shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

Name of Leading Education Agency: Rochester City School District

Name of School: To be determined

Name of Student: _____
Last First Middle Initial

Gender: Male ☐ Female ☐ Date of Birth: _____ Grade Entering: PreK (preschool-12) ID#: _____
Month/Day/Year

Address: _____ Phone: _____ (home)

(cell)

Previous Address: _____

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 a proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinny-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check ONE box)

- ○ In a shelter
- ○ With another 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
- ○ Other temporary living situation (Please describe): _____
- ● In permanent housing
- ○ Unaccompanied Youth

_____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____ _____
Signature of Parent, Guardian, or Student (for unaccompanied homeless youth) Date (Month/Day/Year)

_____ _____
Name of District Staff Assisting With This Form Date (Month/Day/Year)

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.

NOTE TO SCHOOLS/LEAS: If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

Rochester City School District
Emergency Information/Student Release Form

Student Last Name: _____ First: _____ Middle Initial: _____

Male ☐ Female ☐ Date of Birth: _____

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)

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	
Address	
Language	

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

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: ☐ Male ☐ Female
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:

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?

☐ English Other Language(s):

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

☐ English Other Language(s):

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?

☐ English Other Language(s):

5. 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?

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.

[i] 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.

Rochester City School District
Student Health Services Information

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 life saving medication to the school nurse. I understand that if my child needs to carry life saving 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 life saving medicine.

Student's Legal Name (First and Last) Date of Birth (Month/Day/Year)

Prekindergarten Male ☐ Female ☐
Grade/HR Sex

Doctor's Name Phone

Does the Child Have Medical Insurance: Yes ◯ No ◯

Insurer: _____

Does you 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:

Life-threatening allergy: ☐ Food ☐ Insect ☐ Medicine _____

Asthma _____

Diabetes _____

Poorly Controlled Seizures _____

Severe swallowing problems or choking _____

Significant heart disease _____

Other _____

Rochester City School District
Authorization for use or disclosure of health information (HIPAA)

Student Legal Name (First and Last): _____ Date of Birth: _____

Healthcare Provider (doctor): _____ Phone: _____

Address: _____ Fax: _____

Healthcare Provider (doctor): _____ Phone: _____

Address: _____ Fax: _____

☐ Monroe County Health Dept. Clinics:

☐ Lead Testing ☐ TB Clinic ☐ Immunization Clinic ☐ Other _____

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

☐ All
Or Specified:
☐ School nurse
☐ Medical officer
☐ Physical Therapist
☐ Occupational Therapist
☐ Speech Therapist
☐ Audiologist
☐ Vision Department
☐ Special Education
☐ Other_____

☐ Immunizations to comply with NYS regulations
☐ Physical exams to comply with NYS regulations and sports requirements
☐ Authorization for medications during the school day or on school trips
☐ Medical clearances as needed following an injury or change in condition
☐ Medical orders required for therapy needs, evaluations
☐ Physician referral for services (OT, PT)
☐ Medical condition/ treatment plans that may have an impact in school
☐ 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 teams 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 school nurse. 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.

Return completed form to the NURSE at the school this child attends.

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

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: _____

STUDENT OPT-OUT FORM FOR 2019-20 SCHOOL YEAR ONLY

To Parents, Guardians, and Students 18 or Older:

Some student information, including images of your child, can be shared without your consent. If you are concerned about protecting the privacy of your Rochester City School District student, please read this letter carefully. **You must complete a new form for the 2019-2020 school year.**

U.S. military recruiters, colleges, and outside agencies that work with our schools may request directory information on students. Information that the District may share with these groups includes the student's name, address, phone number, date and place of birth; major field of study; height and weight of members of athletic teams; dates of attendance; degrees and awards received; photographs; and the name of the previous school the student attended.

The law allows parents or guardians, or high school students over 18, to say no to disclosing this information. **If you do not want information shared with any or all of the organizations below, please check the appropriate boxes and sign the form below.**

You must check "no" in the appropriate box and return this signed form to the main office of your child's school no later than September 20, 2019, if you do not want information disclosed. If no documentation is on file, we will assume that you are granting permission to release directory information and/or photo or video images.

Please complete a separate form for each child

Student Name _____

School _____

Home Address _____

Phone _____

Date of Birth _____ Student ID# _____

DO NOT RELEASE DIRECTORY INFORMATION TO: (check all that apply)

Pre-K-12th Graders: ☐ **Outside Agencies** ☐ **Colleges** ☐ **Military Recruiters**

DO NOT RELEASE PHOTOS OR VIDEOS OF MY CHILD:

At times, photographs or videos may be taken of students for use in District publications, digital communications, including websites and social media, and for use by the news media. This may include stories published or broadcast by news media, or in District communications for distribution to employees and the public. Separate photo release forms are not required. You must check the box below to prevent photos and videos from being shared.

Pre-K-12th Graders: ☐ **Do not release photographs or video images**

By completing, signing, and returning this form to the school of the student named, I am directing the Rochester City School District as to my wishes regarding disclosure of directory information and photographs or video images.

_____	_____	_____
(PRINT) Parent or Guardian Name*	(SIGNATURE) of Parent or Guardian	Date

**Students who are 18 years old must sign their own form.*

Authorization for Participation and Release of Information

The GROW Rochester Three Year Old Screening Project provides early childhood screening including developmental, hearing, vision, and dental.

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) and my child's center or home care staff and affiliated screening site staff, including volunteers, to conduct hearing, vision, language, speech, motor, cognitive, social and emotional, and dental screenings of my child and provide recommendations and strategies that will support my child.

Release Screening Results to Health Professionals: I authorize ABVI, RHSC, Children's Institute, RCSD, and/or my childcare provider to release the results of my child's screenings to my child's pediatrician, dentist and/or the other health care professionals that I have designated below, as applicable.

Release Screening Results to Track My Child's Progress: I authorize Rochester Hearing & Speech Center (RHSC), The Association for the Blind and Visually Impaired (ABVI), Children's Institute, Rochester City School District (RCSD) and my child's center or home care staff and affiliated screening site staff to release the results of my child's screenings to the COMET Informatics system, a web-based system that facilitatesmy child's progress tracking, referral and follow up care. Reports that will not include children's identifying information will be shared with the 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 and ROC the Future partners.

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.

I understand it is my responsibility to seek a comprehensive examination, when needed, and follow up services should my child be referred. I will not hold any of the above agencies accountable for errors of omission.

I understand that signing this authorization and participation the GROW Rochester Three Year Old Screening Project is voluntary. This authorization will remain in effect as long as the child is a participant of the program. I understand that I have the right to revoke this authorization at any time by communicating my request in writing.

Name of Child: _____ Birthdate:

Parent or Guardian: _____ Address: _____ Zip Code: _____

Parent or Guardian Phone: _____ Best time to contact: _____

Parent or Guardian E-mail: _____

Pediatrician Name: _____ Pediatrician Phone #: _____

Dentist Name: _____ Dentist Phone #: _____

Parent or Guardian Signature:_____ Date: _____ _____ _____
Mo Day Year

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: _____
Last First Middle

Birth Date: _____ Sex ☐ Male ☐ Female Will this be your child's first visit to a dentist? ☐ Yes ☐ No
Month Day Year

School: _____ Grade PreK

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities?
☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent or Guardian Signature:_____ Date:

Section 2. To be completed by the Dentist

I. The Dental Health condition of_____on _____ (date of exam) The ctate of the exam needs to be within 12 months of the start of the school year in which it is requested.
Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

_____ _____

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

☐Yes ☐ No Caries Experience/Restoration History- Has the child ever had a cavity (treated or untreated)? [A filling (temporary/ permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐Yes ☐ No Untreated Caries - Does this child have an open cavity? [At least½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐Yes ☐ No Dental Sealants Present

Other problems (Specify): _____

Ill. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.