



**OFFICE OF STUDENT EQUITY
AND PLACEMENT**

Rochester City School District

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



Return these forms by email to studentregistration@rcsdk12.org

Need assistance completing the forms?

Call our offices at (585) 262-8241

Hours: Monday - Friday

8:00 a.m. - 4:30 p.m.

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 studentregistration@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.

Some forms will need to be signed in person at the placement office. Parents and/or guardians will be contacted by placement staff for a follow-up appointment.

**Rochester City School District
Student Registration Form**

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

Male Female Non-Gender Date of Birth: / / Grade Entering: Repeating?

Does student receive special education services? Yes No List service(s)

Does the student have a 504 Plan? Yes No Are you on Active Duty in the Armed Forces? Yes No

Federal Ethnic Category: Hispanic or Latino Not Hispanic or Latino

Federal Race: American Indian or Alaska Native Black or African American White
 Native Hawaiian/ or Other Pacific Islander Asian

Adult Information

	Parent/Legal Guardian	Adult #2
Name		
Relationship		
Address/Zip Code		
Home Phone		
Work Phone		
Cell Phone		
Email		

Previous Address if within NYS: _____

Sibling Information

Name of sister(s) or brother(s)	Age	Name of sister(s) or brother(s)	Age

New York State Law requires that a Home Language Questionnaire be completed for all new entrants to the Rochester public schools. Remember to follow the directions on the Home Language Questionnaire (separate form) relative to referring students to the Language Placement Center.

Parent Signature _____

FOR OFFICE USE ONLY			
Student I.D. # _____	Start Date _____	Cohort Year _____	<input type="checkbox"/> Transportation (1)
School Assigned _____	Grade Level _____		<input type="checkbox"/> Close to home (2)
Pre-K Only: AM Sessions _____	PM Session _____	Full Day _____	<input type="checkbox"/> Location (3)
<input type="checkbox"/> Transfer within District from			<input type="checkbox"/> Sibling (4)
<input type="checkbox"/> Entering from non-public school			<input type="checkbox"/> Sped Prgm. Avail. (5)
<input type="checkbox"/> Entering from out of District			<input type="checkbox"/> Academic Prgm. (6)
<input type="checkbox"/> Home School/Other, specify			<input type="checkbox"/> No Option (7)
Registration completed by _____	Zone _____	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: _____

Name of Student: _____
Last First Middle Initial

Gender: Male Female Non-Gender Date of Birth: ___ / ___ / ___ Grade Entering: ___ ID#: _____

Address: _____ Phone: _____

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 McKinney-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

Name of District Staff Assisting With This Form Date

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.



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lisette 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:

Month Day Year

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?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ <i>specify</i>	<input type="checkbox"/> Father _____ <i>specify</i>
	<input type="checkbox"/> Guardian(s) _____ <i>specify</i>	
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <input type="checkbox"/> Does not speak <i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <input type="checkbox"/> Does not read <i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other _____ <input type="checkbox"/> Does not write <i>specify</i>

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* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____ How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below
10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____ Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>MO. DAY YR.</small>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>MO. DAY YR.</small>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

Rochester City School District
Emergency Information/Student Release Form

Student Last Name: _____ First: _____ DOB: _____

Home Address: _____

Mother/Guardian: _____ Phone #'s: _____

Address if different from above: _____

Father/Guardian: _____ Phone #'s: _____

Address if different from above: _____

Other children in this school (first and last names): _____

EMERGENCY INFORMATION

In the event of emergency, illness, or injury, the person listed below will be contacted for care and transportation:

Name Relationship Phone #'s

Name Relationship Phone #'s

Student's Physician _____
Name Phone #'s

Student's Dentist _____
Name Phone #'s

Hospital/Clinic Preference (when possible) _____
Phone #'s

Student's Medical Insurance Carrier _____

Student Release Information

In order to ensure the safety of your child, please list responsible adults your child may be released to by school personnel.

Name	Relationship	Phone #'s

Parent Signature: _____ Date: _____

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

Student Legal Name: _____ 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:

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

Grade/HR Male Female Non-Gender
Sex

Doctor's Name Phone

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:

Life-threatening allergy: Food Insect Medicine _____

Asthma _____

Diabetes _____

Poorly Controlled Seizures _____

Severe swallowing problems or choking _____

Significant heart disease _____

Other _____

131 W. Broad Street
Rochester, NY 14614
PHONE: 585-262-8241
FAX: 585-295-2615

FAX

Rochester City School District Parent Information & Student Registration Center

Previous School: _____ From: RCSD

Fax: _____ Pages: _____

Phone: _____ Date: _____

Student: _____ DOB: _____

The above-named student wishes to register with the Rochester City School District, Rochester, NY. Please provide us with the following records as soon as possible.

_____ Date registering in the Rochester City School District ____ - ____ - ____

_____ Last Report Card

_____ Transcripts

_____ Immunization/Health Record

_____ Disciplinary Records

_____ Proof of age

_____ Current Schedule

_____ Test Scores

_____ Withdrawal grades

_____ IEP (If Applicable)

_____ Evaluation

_____ Other _____

ACCORDING TO THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT BUCKLEY AMENDMENT DATED JUNE 17, 1976, IT IS NO LONGER NECESSARY TO OBTAIN WRITTEN CONSENT TO RELEASE RECORDS TO ANOTHER SCHOOL SYSTEM IN WHICH THE STUDENT MAY ENROLL.

I, _____ parent/guardian of _____

Date of Birth _____, request that you release the above information to the Rochester City School District, Parent

Information and Student Registration Center, 131 W. Broad Street, Rochester, NY 14614

Signed: _____

Dated: _____

Please fax records to:
Parent Registration Center
(585) 295-2615

If you are unable to fax, please notify us by phone and send the requested information to the above address.
Thank you for your assistance.

WE'RE HERE TO HELP.

Placement staff will assist parents with every step of the registration process. We can also provide parents with information about the schools available to their children to help them make an informed choice.

Or contact us by phone:

Hours: Monday - Friday
8:00 a.m. - 4:30 p.m.

Student Equity and Placement
(585) 262-8241

or email

studentregistration@rcsdk12.org