Menands Union Free School District
19 Wards Lane, Menands, NY 12204-2197
Phone (518)465-4561
*Fax (518)434-2840 (Main Office)
www.menands.org

RELEASE OF RECORDS

NAME AND ADDRESS OF SCHOOL LAST ATTENDED

____

____

____

Does your child have an IEP (Individualized Education Program)? YES___ NO___

I hereby grant permission for copies of my child's school records, including academic, health and psychological materials to be sent by mail to:

Menands Union Free School District
19 Wards Lane
Menands, NY 12204

By Fax: 518-434-2840 or Email to smccormick@menands.org

Student's Name:____

Parent/Guardian Signature:________________________________ Date:_______

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

This message is confidential and intended for the addressee only. It may also be privileged or otherwise protected by work product immunity or other legal rules. If you have received it by mistake, please let us know. You may not copy this message or disclose its contents to anyone.

School Phone _______________
School Fax _______________
Sent ________

Menands Union Free School District - Student Information Sheet

School Year

Grade ____ Gender ____

Student Name ______________________________ Birthday ______________

Physical Address: ______________________________ Home Phone

Hispanic: **Y N**

Country of Birth:______________________________

Home Language ______________________________

Years in US Schools: ______________________________

Last School Attended:______________________________

Race:____________

___ American Indian
___ Asian
___ Black
___Native Hawaiian
___White

Did you Receive Free and/or Reduced lunch in your prior school?

Mother

Name: Employer: Active Military Y N Has Custody: Y N

Home Phone: Day Phone: Cell Phone:

Father

Name: Employer: Active Military Y N Has Custody: Y N

Home Phone: Day Phone: Cell Phone:

2nd Parent Mailing Information

Parent Name:

Address:

Parent or Guardian Emails <List as many as are appropriate)

E-Mail:

Emergency Contacts: Please list 2 adults **other than parents** who could be contacted in case of a medical emergency.

Name: Relationship: Phone:

Name: Relationship: Phone:

Physicial Information

Dr. Name: Dr. Phone:

Preferred Hospital: ______________ Dentist Name: Dentist Phone:

Medical Alert: Please list all pertinent information, i.e. Food allergies, bee sting, asthma, diabetes, etc.

Other Information

Adults Authorized to pick up my child (other than parent):

Siblings:

Other Adults living with Student:

PARENT/GUARDIAN SIGNATURE:______________________________ **DATE:** ______________

Registration Questionnaire Date:___________________

Student's Name ___________________________________ Grade ___________ Gender _________

The answer you give below will help the district determine what services you or your child may be able to receive under the McKiney-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.

Where is the student currently living: (Please check one)

_____ In a shelter

_____ with another family or person because of loss of housing 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 (house or apartment)

Custody Papers

(If applicable: Most recent court order. It must clearly state who has physical/legal custody of the child and must have judge's signature)

Custody Issues ____

____

Second Parent Mailing: Yes ____ No ____

Name of last school attended/length of time at last school/dates/reason for leaving.

____

____

_____ Did your child attend pre-K

_____ Length of time in pre-K

_____ IEP (Individualied Education Plan) from previous school district

_____ ESL

_____ Other support services ____

_____Medical Needs ____

AFFIDAVIT OF RESIDENCY - MENANDS UNION FREE SCHOOL DISTRICT

STATE OF NEW YORK COUNTY OF ___________________________

____being duly sworn, deposes and says:

(Name of Owner/Renter/Parent/guardian –Circle appropriate titles)

1. I reside at (legal residence) ____

Telephone number: ___________________

2. Names of all residents at above address:	Relationship to owner/renter
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

3. I make this affidavit for the purpose of establishing residency within the Menands Union Free School District. The student(s) belongings are kept at this address, they sleep at this address, and for all intents and purposes live at this address.

4. If the child's/children's other parent does not reside at the same location, then provide the following information:

_____________________________	_________________________________	______________________
(Other Parent's Name)	(Address)	(Telephone Number)

COMPLETE EITHER 5A OR 5B

5A. In support of the above, as a home owner, I have attached a mortgage document and two of the following proofs of my residency.

____ Property tax bill ____ Water tax bill ____ Driver's license/photo ID ____ Electric bill ____ Bank statement

5B. In support of the above as a renter, I have attached the most recent copy of my lease listing all the residents in the apartment/home and two of the following proofs of my residency. Place a check in front of each item attached.

_____ Rent Receipt _____ Driver's license/photo ID ____ Electric bill ____ Bank statement

If you are a renter, complete the following:

Landlord's name__________________________ Landlord's phone number_________________

By signing this affidavit, I am stating that the information that I provided above is accurate and truthful. If the information provided above changes, Menands School must be notified immediately. Should the District discover that this student is not living at this address, he or she will immediately be withdrawn as a student of the Menands School District and that I may be responsible for tuition payment, transportation costs, and other fees.

I agree that all information answered above is accurate and acknowledge that false information may result in denial of admission or revocation.

Parent/Guardian Signature: ____ Date: ______________________

Menands Union Free School District
19 Wards Lane, Menands, N.Y. 12204
Ph: 518-465-4561 x 109 Fax: 518-465-4572
School Nurse: Carin D'Ambro R.N.

STUDENT HEALTH HISTORY- 20____-20____

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian:	Home Phone: Cell Phone:	Date:

Check all that applies:	YES	NO	If Yes, please explain and include date:
Ongoing medical condition	☐	☐	
Followed by medical specialist	☐	☐	
Allergies: *If medication is prescribed please indicate below.	☐	☐	☐ Food_________ ☐ Environmental ☐ Insect ☐ Medication ☐ Other (Explain)
Hospitalization	☐	☐	
Surgery	☐	☐	
Injury that required an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Bone/muscle injury	☐	☐	
Loss of consciousness, concussion or serious head injury.* Please indicate approximate date.	☐	☐	
Convulsion/seizure	☐	☐	
Vision impairment or condition	☐	☐	☐ Glasses ☐ Contacts ☐ Prosthesis
Hearing impairment or condition	☐	☐	☐ Hearing aid ☐ Cochlear implant
Dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- ☐ ADHD
- ☐ Asthma/trouble breathing
- ☐ Autism/Asperger
- ☐ Dental Injuries
- ☐ Diabetes
- ☐ Ear Infections
- ☐ GI Conditions (ulcer, reflux, IBS)
- ☐ Headaches/migraines
- ☐ Heart Conditions
- ☐ High Blood Pressure
- ☐ Mental Health Condition (Depression, ODD, OCD, anxiety, etc.)
- ☐ Scoliosis
- ☐ Single Organ (☐kidney, ☐testicle)
- ☐ Skin Condition
- ☐ Speech Condition
- ☐ Urinary Condition

Please list any additional concerns: (use back of sheet if necessary) ____

CURRENT MEDICATIONS (Include as needed medications for allergies)	YES	NO	Please list medication name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐ Insulin/blood glucose monitoring ☐ Inhaler/nebulizer ☐ Special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes: ____

Parent/Guardian Signature:____Date:________________

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.

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*

HOME LANGUAGE CODE ____________

Language Background

(Please check all that apply.)

Question			
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* ❑ Guardian(s) ______ *specify*	❑ Father ______ *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*	

ENGLISH

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:

MENANDS UNION FREE SCHOOL DISTRICT
19 WARDS LANE
MENANDS, NEW YORK 12204

REQUEST FOR TRANSPORTATION

The request listed below is to be completed and returned to the Menands Union Free School District Office. Please give all information asked for and any other information or comments you wish to make.

I understand transportation will only be provided on the days Menands School is in session.
I hereby request transportation to and from school for the following:

School year ______________________

Name of Student	Age	Grade	School Student Will Attend	School Opening Time- A.M.	School Closing Time -P.M.

NO TRANSPORTATION NEEDED ☐ (Please check box if transportation is not requested and sign/date below.)

COMMENTS: ____

____

Date:______________ **Signature of Parent:** ______________________________

Address: ______________________________

____

Phone: ______________________________