# Early Childhood in Niagara Falls

## New and Exciting Additions to the Universal Pre-K Program

- **Early Head Start Program** – Serving infants and toddlers at two locations:

  Donovan Center – 1631 Main Street

  Community Education Center – 6040 Lindbergh Avenue

- **Head Start Program** – Serving 3 and 4-year-old child at the following sites:

  DiFrancesco Center – 901 24th Street

  Community Education Center – 6040 Lindbergh Avenue

- **Universal Pre-K 3 and Pre-K 4** classes will continue to be offered at all District elementary schools except, Abate Intermediate School.

## General Facts

| | |
|---|---|
| • All programs are full-day. | • Free to families residing in Niagara Falls |
| • Students must be the age of the program they are registering for on or before December 1st of the enrolling year. | • Translation support is available upon request. |
| • Guidance from the Committee on Pre-School Special Education is available upon request. | • Transportation is NOT provided. |
| • Complete registration packets must be completed to confirm enrollment.<br>• **Full registration packets are due by June 17, 2022. (see reverse)** | • Breakfast, lunch and a fresh fruit snack are served daily.<br>• Curriculum is aligned to the NYS Early Learning Standards. |

**Applications for the 2022-2023 school-year are available by hovering over the QR Code at the bottom of this page.**

# Registration Process

# 2022-2023

# Early Head Start / Head Start

- When registering for Early Head Start or Head Start programming, complete the application, then connect to www.nfschools.net_
- Click on the Academics Tab then the Pre-K Registration Packet.
- Full Registration packets are also available at the following locations:
  - The DiFrancesco Center - 901 24th Street
  - Community Education Center – 6040 Lindbergh Avenue
- All questions pertaining to both Early Head Start and Head Start can be directed to Sara Brydges (716) 804-7100.

## Niagara Falls City School District Pre-K 3 and Pre-K 4 Classes

- Complete the application, then connect to the District web page for the full Registration Packet www.nfschools.net
- Click on the Academics Tab/Pre-K.
- Registration Packets can also be picked up at all city Schools, Libraries and Pediatricians' Offices.
- Completed packets consist of:
  - ✓ The application
  - ✓ A copy of the parent's photo identification
  - ✓ A copy of child's birth certificate
  - ✓ Child's Immunization Record and copy of latest Physical Exam
  - ✓ Proof of residency
  - ✓ Health and Social History
  - ✓ Home Language Questionnaire
- For more information contact Cathy Sullivan (716) 286-4217.
- Families will receive a general letter of registration in July followed by information from the child's school/teacher in mid-August.

**Completed registration packets for the Niagara Falls City School District Pre-K program must be returned to the District's Registration Office (630 66th Street) by June 17, 2022.**

**Children will not be registered until the full registration packet has been completed and returned.**

# Frequently Asked Questions

1. **Are both the District and the Head Start programs free to all families living in the city of Niagara Falls?**

   Yes, both are offered free of charge to all Niagara Falls residents.

2. **If my child attended a Pre-K or Head Start program during the 2021-2022 school year, do I have to complete the registration process again for the 2022-2023 school-year?**

   No, children who were enrolled in the 2021-2022 school-year do NOT need to complete the registration process again.

3. **Is transportation provided for any of the early learning programs?**

   No, families will need to provide transportation to and from school each day.

4. **Can I select the school that I would like my child to attend?**

   When completing the application families are asked to select their school(s) of choice in order of preference. Once all seats are filled a waiting list is created.

5. **How will my child's teacher communicate with me?**

   Teachers communicate with families using email, text messages, phone calls, notes and apps connected to the curriculum.

6. **Are there opportunities for families to become involved in the educational program of their child?**

   Parents can participate in both individual school or program activities, as well as, District-wide activities. Information is available in on the District website.

7. **Are translation services available?**

   Translation services are available upon request (716) 286-4201.

8. **How can I see that my child continues to receive Special Education services?**

   To continue Early Childhood Special Education services call (716)286-4282.

9. **My child is still not fully independent in his toileting skills, will this prevent him from being accepted into a Pre-K 3 or Pre-K 4 classroom?**

   Lack of independence in toileting skills will not prevent entrance into a Pre-K classroom.

10. **Is after school programming offered to Pre-K students?**

    All after school programming begins in Kindergarten.

# 10 Reasons for Sending Children to Early Learning Programs

- Children socialize with other children.
- Children have the opportunity to interact with adults other than family members.
- Children learn the rituals and routines of an elementary school setting.
- Children listen and respond to great books.
- Children have multiple opportunities to play and explore using high-quality toys, games and puzzles.
- Children participate in art, music and physical education classes.
- Children and their families become acquainted with elementary school personnel and the routines of the school.
- Children benefit from the support of community agencies that offer guidance in areas other than academic.
- Children and their families meet and engage with other families in the community.
- Children listen to others and are engaged in oral conversations thus building their vocabulary.

**Children have fun, fun, fun!**

# SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS
## HEALTH SERVICES

**Pre-Kindergarten & Kindergarten Packet**

Dear Parent or Guardians:

You have filled out an application for your child to attend a pre-kindergarten in September. We would like your child to have a positive, successful and exciting school experience. In order for this to happen without difficulty for your child, certain regulations of New York State Education Laws and Public Health Laws must be fulfilled. **You must supply us with the following information when you register your child for school.**

1. **Immunization Record** for your child – attached is a copy of the Immunization Requirements for School Entrance/ Attendance (I-1a). **Failure to satisfy these requirements may result in exclusion from school.**

2. **Physical Examination** - this must be completed and signed by a licensed health care provider, submitted within 30 days of admission. Any physical completed within the last 12 months will be valid. **Failure to satisfy these requirements by November 2022 the District Medical Director/Nurse Practitioner will complete the physical exam.**

3. **Pre-Kindergarten Social History** (F-12a) and **Health History Form for Students** (F-8) – completed and signed by parents/guardians in order to help us understand your child and provide the safest education plan.

4. **Dental Health Certificates** – a report of a comprehensive dental examination, signed by a licensed dentist, will be requested for all public school students entering for the first time and students in grades 1, 3, 5, 7, 9 & 11. This law became effective September 1, 2008.

## IMPORTANT THINGS TO REMEMBER

1. The Niagara County Health Department provides immunizations by appointment only.
   Call **278-1903** for an appointment.

2. In order for your child to attend a pre-kindergarten program in New York State he or she must be four years old on or before December 1.

3. In order for your child to attend a kindergarten program in New York State he or she must be five years old on or before December 1.

If you have any questions, please contact your school nurse.

_____ _____ _____

School School Nurse Telephone

Sincerely,
Dr. Jo Silvaroli FNP

**Niagara Falls City School District**
**Health Services**
**Parent Notification/Request for Mandated Health Appraisal**

Dear Parent(s) or Guardian(s):
New York State law requires that each child in a school district have a health examination including body mass index before entering school for the first time, and again in grades 1, 3, 5, 7, 9, 11. Students wishing to play interscholastic sports or requesting work permits must have an annual health exam. A dental exam form is also requested, but not required at these same times.

Your child's health care provider is always the best choice for these exams especially for Pre-K and Kindergarten. We encourage you to call early as it may take several weeks to schedule exams during the busy summer and fall months.

We have included a form for your health provider to complete. We can accept any exam form dated before September 7, 2021. Your child's health care provider can fax a copy of the exam to 286-0758, or you can bring a copy into your child's school nurse.

If you do not provide an exam form by November 2022, an exam will be scheduled with our school medical director. While most parents choose not to attend, you may do so if you wish. Please let your child know they will be examined at school. In order that the physical examinations by the District Medical Director/Nurse Practitioner be thorough and of real value to the student, it will be necessary for the schdent to remove some clothing. Modesty will be maintained at all times.

Upon completion of in-school exam, you will be informed of any important findings and need to follow up with your health care provider.

Please Complete And Return The Bottom Portion To Your Building Health Office Today

.....✂.....

**Student's Name** _____ **Grade** _____

**Student's School** _____

☐ My child had a health exam on _____. I will return the completed form by the date above.

☐ My child has an appointment to have a physical with his/her health care provider on _____.
My child's MD/NP/PA will fax a copy to 286-0758, or I will return the form after the date above. **NOTE: Only Physical Exams completed by the district medical director will be accepted for sports for students in grades 7-12.**

☐ I need information on obtaining health insurance or finding a health care provider.

☐ Schedule the district Medical Director to complete the exam for my child. **So that the physical examinations completed by the district medical director be thorough and of real value to the student, it will be necessary for the student to remove some clothing. Modesty will be maintained.**
- ☐ I would like to attend my child's school physical exam
- ☐ I will **NOT** be attending my child's school physical exam

Parent Name _____ Date _____

Parent's Signature _____

Parent Phone Contact (  ) _____

This document is adopted from the NYS Center for School Health Website www.schoolhealthny.com (1/10/20)

Niagara Falls City School District
Health Services

## Student Yearly Health History (To Be Completed by Parent/Guardian)

Student name_____ School _____ Grade_____

Address_____ Home Phone_____

Date of Birth_____ Place of Birth_____ Gender at birth M____ F_____

Mothers Name_____ Address_____ Phone_____
Mothers Place of Employment_____ Work Phone_____
Fathers Name_____ Address_____ Phone_____
Fathers Place of Employment_____ Work Phone_____
Emergency: 1. Name_____ Phone_____
2. Name_____ Phone _____
Describe your child's current state of health (circle one) Excellent Good Fair Poor

| **Has your child ever:** | **YES** | **NO** | **If Yes, please explain and include date:** |
|---|---|---|---|
| Had an ongoing medical condition | ☐ | ☐ | |
| Seen a medical specialist | ☐ | ☐ | |
| Had allergies: | ☐ | ☐ | ☐food ☐environmental ☐insect ☐medication ☐other |
| Been hospitalization | ☐ | ☐ | |
| Had an operation | ☐ | ☐ | |
| Had an injury requiring an Emergency Room visit | ☐ | ☐ | |
| Missed 5 days of school in a row due to illness/injury | ☐ | ☐ | |
| Had a bone/muscle injury | ☐ | ☐ | |
| Passed out, had a concussion or serious head injury | ☐ | ☐ | |
| Had a convulsion/seizure | ☐ | ☐ | |
| Had a vision problem or condition | ☐ | ☐ | ☐ glasses ☐ contacts |
| Had a hearing problem or condition | ☐ | ☐ | ☐ hearing aid ☐ cochlear implant |
| Worn 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, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition
Females Age Menstruation began _____
Date of last menstrual period _____

Is there any condition that would prevent your child from participating in physical education or sports? ☐ No ☐ Yes

***PLEASE LIST & SIGN FOR ALL MEDICATIONS YOUR CHILD WILL NEED AT SCHOOL.***

MEDICATION DOSE TIMES

_____

_____

I request that my child receive the medication as prescribed by our health care provider. THE NEW YORK STATE EDUCATION DEPARTMENT REQUIRES THAT ALL MEDICATION IS TO BE FURNISHED BY ME IN A PROPERLY LABELED ORIGINAL CONTAINER FROM THE PHARMACY AND MUST BE BROUGHT TO THE SCHOOL HEALTH OFFICE BY A PARENT OR GUARDIAN. It is the policy of the School District of the City of Niagara Falls that these procedures must be followed or the school will not be responsible for the administration of the medication. I understand that the school nurse, or other assigned person will administer the medication. I agree if my child's health care provided allows HIM/HER to self-carry the approved medication Yes _____ No _____ Parent Initials _____

Signature (Parent or Guardian) _____ Date_____

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM F-8 2/22

Niagara Falls City School District
Health Services

All medications have side effects and for your child's safety it is important for the School Nurse to have this information.
PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES AT HOME ONLY:

_____

_____

_____

HAS YOUR SON/DAUGHTER:

Ever been a patient in a hospital?
Explain_____

Had any operations?
Explain_____

Had any accidents?
Explain_____

Is your son/daughter under a physician's care now?
Explain _____

Is he/she allergic to any medication?
Explain_____

Has he/she had any psychological testing?
Explain_____

PLEASE ADD ANY ADDITIONAL PERTINENT FAMILY MEDICAL HISTORY: _____

_____

_____

_____

PLEASE LIST ANY ADDITIONAL CONCERNS: _____

_____

_____

Parent/Guardian Signature_____ Date _____

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**The below signature is optional:**

**Release of medical information**

I _____ hereby grant permission for the medical staff of the Niagara Falls City School District to obtain medical information from my child's health care provider's listed below, pertaining to the health and wellbeing of my child for the 2022-2023 SY. 1. _____HCP

2._____ Specialist 3. _____ Specialist.

_____ _____ _____

Parent/Guardian Signature Parent/guardian printed name Date

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**
**TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**
**IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

**Note:** NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

**STUDENT INFORMATION**

| Name | Sex: ☐ M ☐ F | DOB: |
|---|---|---|
| School: | Grade: | Exam Date: |

**HEALTH HISTORY**

| | |
|---|---|
| **Allergies** ☐ No<br>☐ Yes, indicate type | Type:<br>☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached |
| **Asthma** ☐ No<br>☐ Yes, indicate type | ☐ Intermittent ☐ Persistent ☐ Other :<br>☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached |
| **Seizures** ☐ No<br>☐ Yes, indicate type | Type: Date of last seizure:<br>☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached |
| **Diabetes** ☐ No<br>☐ Yes, indicate type | Type: ☐ 1 ☐ 2<br>☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached |

**Risk Factors for Diabetes or Pre-Diabetes:** *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

**BMI**_____kg/m2

**Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

**Hyperlipidemia:** ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

**PHYSICAL EXAMINATION/ASSESSMENT**

**Height:** **Weight:** **BP:** **Pulse:** **Respirations:**

| Laboratory Testing | Positive | Negative | Date | List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ) |
|---|---|---|---|---|
| TB- PRN | ☐ | ☐ | | |
| Sickle Cell Screen-PRN | ☐ | ☐ | | |
| **Lead Level Required Grades Pre- K & K** | | | **Date** | |
| ☐ Test Done ☐ Lead Elevated ≥5 µg/dL | | | | |

☐ **System Review and Abnormal Findings Listed Below**

| | | | | |
|---|---|---|---|---|
| ☐ HEENT | ☐ Lymph nodes | ☐ Abdomen | ☐ Extremities | ☐ Speech |
| ☐ Dental | ☐ Cardiovascular | ☐ Back/Spine | ☐ Skin | ☐ Social Emotional |
| ☐ Neck | ☐ Lungs | ☐ Genitourinary | ☐ Neurological | ☐ Musculoskeletal |

| | |
|---|---|
| ☐ Assessment/Abnormalities Noted/Recommendations:<br><br>☐ Additional Information Attached | Diagnoses/Problems (list) ICD-10 Code*<br><br>*Required only for students with an IEP receiving Medicaid |

| Name: | | | DOB: |
|---|---|---|---|
| **Vision & Hearing SCREENINGS** - Required for PreK or K, 1, 3, 5, 7, & 11 | | | |
| **Vision** (w/correction if prescribed) | **Right** | **Left** | **Referral** / **Not Done** |
| Distance Acuity | 20/ | 20/ | ☐ Yes ☐ No / ☐ |
| Near Vision Acuity | 20/ | 20/ | / ☐ |
| Color Perception Screening ☐ Pass ☐ Fail | | | / ☐ |
| Notes | | | |
| **Hearing** Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz. | | | **Not Done** |
| Pure Tone Screening | **Right** ☐ Pass ☐ Fail | **Left** ☐ Pass ☐ Fail | **Referral** ☐ Yes ☐ No / ☐ |
| Notes | | | |
| **Scoliosis** Screen Boys in grade 9, and Girls in grades 5 & 7 | **Negative** | **Positive** | **Referral** / **Not Done** |
| | ☐ | ☐ | ☐ Yes ☐ No / ☐ |

**RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK**

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

**Developmental Stage for Athletic Placement Process ONLY required** for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

**Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

**MEDICATIONS**

☐ **Order Form for Medication(s) Needed at School Attached**

**IMMUNIZATIONS**

☐ Record Attached ☐ Reported in NYSIIS

**HEALTH CARE PROVIDER**

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

**Please Return This Form To Your Child's School When Completed.**

Niagara Falls City School District
Health Services

# DENTAL HEALTH CERTIFICATE (To Be Completed by Child's Dental Office)

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 year, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible.

## SECTION 1. TO BE COMPLETED BY PARENT/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**

**School:** _____ **Grade**_____
**Have you noticed any problem 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 Signature_____ Date_____

## SECTION 2. TO BE COMPLETED BY THE DENTIST

1. **The Dental Health condition of** _____ **on** _____ **(date of exam). The date of 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 school.**

____**No, the student listed above is not in a fit condition of dental health to permit his/her attendance at school.**

**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. This may include pain, swelling or infection related to clinical evidence of open cavities. **The designation of "not in fit condition" 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, 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 least 1/2mm 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 cavitated lesion is also present.)
___Yes ___No **Dental Sealants Present**

Other Problems_____

**III Treatment Needs**: ___No obvious problem. Routine dental care recommended. Visit your dentist regularly.
___ May need dental care. Please schedule an appointment with your dentist as soon as possible
___ Immediate dental care required. Please schedule an appointment with your dentist

Niagara Falls City School District
Health Services

# PRE-K & K SOCIAL HISTORY

Child's Name_____ Date of Birth_____
School Entering_____ Today's Date_____
Brothers/Sisters_____ Date of Birth_____
_____ Date of Birth_____
(USE BACK IF NECESSARY)

PLEASE ANSWER **YES OR NO** TO ALL QUESTIONS. THIS WILL HELP US BETTER UNDERSTAND THE HEALTH NEEDS OF YOUR CHILD.

| **Birth Information** | Yes | No |
|---|---|---|
| Did you have: | | |
| Premature birth | ___ | ___ |
| Cesarean delivery | ___ | ___ |
| Any newborn problems | ___ | ___ |
| Any problems the First year | ___ | ___ |
| Normal pregnancy | ___ | ___ |
| Full term pregnancy | ___ | ___ |
| Normal delivery | ___ | ___ |
| Birth Weight _____ | | |
| Breast fed | ___ | ___ |
| How long?_____ | | |
| Comments:_____ | | |
| _____ | | |
| _____ | | |
| Growth and Development/Skills | | |
| Any problems with: | | |
| Feeding | ___ | ___ |
| Crawling | ___ | ___ |
| Walking | ___ | ___ |
| Talking | ___ | ___ |
| Hopping | ___ | ___ |
| Counting numbers | ___ | ___ |
| Naming colors | ___ | ___ |
| Dressing self | ___ | ___ |
| Eating | ___ | ___ |
| Muscle coordination | ___ | ___ |
| Speech | ___ | ___ |
| Did your child attend | | |
| Preschool | ___ | ___ |
| Head start | ___ | ___ |
| Day Care | ___ | ___ |
| Name_____ | | |
| Comments_____ | | |
| _____ | | |

| **Behavior Development** | Yes | No |
|---|---|---|
| Would you say your child: | | |
| is friendly | ___ | ___ |
| is secure | ___ | ___ |
| is talkative | ___ | ___ |
| is shy | ___ | ___ |
| is helpful | ___ | ___ |
| is cooperative | ___ | ___ |
| listens well | ___ | ___ |
| follows directions well | ___ | ___ |
| adjusts well to new situations | ___ | ___ |
| has stayed overnight away from mother | ___ | ___ |
| is eager to start school | ___ | ___ |
| separates easily from family | ___ | ___ |
| plays well with other children | ___ | ___ |
| plays well alone | ___ | ___ |
| relates well to other adults | ___ | ___ |
| has temper tantrums | ___ | ___ |
| is disobedient | ___ | ___ |
| talks back | ___ | ___ |
| is destructive | ___ | ___ |
| has nightmares | ___ | ___ |
| has fears | ___ | ___ |
| is jealous | ___ | ___ |
| sucks thumb | ___ | ___ |
| has uncontrolled bowel movements | ___ | ___ |
| constipation | ___ | ___ |
| wetting | ___ | ___ |
| wets the bed | ___ | ___ |
| has had any unusual or unexpected stresses | ___ | ___ |
| does your child have any habits that concern you | ___ | ___ |

Do you have any concerns as a Parent
_____
Comments_____
_____

Parent/Guardian Signature_____ Date _____

F-12a 1/00

School Year 2022 - 2023

City School District Of the City Of Niagara Falls
Consolidated Permission Form for Releasing Information to the US Military,
Using District Computer Systems, Online Art Gallery and Media Release and Publication on-line.

**Please complete this form and return it to your child's school on or before September 30, 2022**
Put your **initials** in the appropriate box, **Yes** I give my permission or No I do not give my permission.

**Student Name** _____ Student ID Number _____

**School** _____ **Class/Homeroom Teacher** _____

☐ Yes ☐ No

**Release of information to the US Military (Grades 11 and 12 only)**
The No Child Left Behind Law of 2002 requires high schools to release the name, address, and phone number of any 11th or 12th grade student to the United States Military. In order to receive federal funding, the City School District Of the City Of Niagara Falls must comply with this mandate unless parents provide written notification via this form that they do not want this information released.

☐ Yes ☐ No

**Computer Acceptable Use (all grades)**
Parents and guardians can obtain a copy of the District's Acceptable Use Policy by visiting any school or www.nfschools.net. All student computer use must comply with this policy. Internet Safety is part of the State curriculum and learning to use technology responsibly is an important part of education. Unless a parent provides written notification via this form, students will have access to the District's computer system in accordance with the Districts AUP.

☐ Yes ☐ No

**Online Art Gallery (all grades)**
I give permission to the City School District Of the City Of Niagara Falls to share my child's artwork along with his/her **first name** on the Online Art Gallery on the School District's Website, www.nfschools.net

☐ Yes ☐ No

**Photographs ,Videos, Interviews District Website Release (all grades)**
I give my permission to City School District Of the City Of Niagara Falls that photographs, and/or video tapes and/or interviews of my child may be taken and used by the District only for public relations, educational, or other purposes consistent with the purposes and mission of the District, including use of any photograph and/or image and/or interview on the District Website or other District electronic resources such as social media. I understand that my permission allows the District to use my child's first and last name for public relations and educational purposes. I further agree that said materials will become the property of the District and I hereby release and discharge the District and it representatives from any
and all claims that may result by reason of taking of such photographs and/or videotapes and/or interviews.

☐ ☐

Yes No

**Media Release (all grades)**
I give permission to the City School District Of the City Of Niagara Falls to use my child's photograph, likeness and/or work and/or interviews in any compilations to be distributed within the community. Specifically photographs of students may be used in the District newsletter(s), in pamphlets or brochures, or on flyers. Such images may also be distributed to local media, either print or video, or may be used on the OSC-TV Channel 21, or be used or distributed in like manner.

**If in the future you wish to reverse any permission, you may do so by notifying your child's principal in writing.**

Parent/ Guardian Name: (Please Print) _____
Date_____

**Parent/ Guardian Signature:** _____

**Niagara Falls City School District Student Residency Questionnaire**

Name of LEA: School District of the City of Niagara Falls, New York

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female

Date of Birth: _____/_____/_____ (*Month Day Year*)

Grade: _____ (*preschool-12*)

ID#: _____ (*optional*)

Address: _____

Phone: _____

**Where is the student currently living?** (*Please check **one** box.*)

- ☐ In permanent housing
- ☐ 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): _____

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

_____
**Signature** of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
**Date**

NOTE: The answer you give 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. 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.

**ATENCIÓN ESCUELAS Y DISTRITOS: Ofrezca asistencia a los estudiantes y familias para completar este formulario.** No incluya este formulario en el paquete de inscripción sin advertencias apropiadas. Por ejemplo, tendrá que cambiar partes del paquete de inscripción que requieren que se entreguen prueba de inscripción antes de matricular. Estudiantes elegibles según el Acto de McKinney-Vento, no necesitan entregar prueba de residencia y otros documentos normalmente requeridos antes de matricular.

# FORMULARIO DE INSCRIPCIÓN – CUESTIONARIO DE RESIDENCIA

Nombre del Distrito Escolar: _____

Nombre de la Escuela: _____

Nombre del Estudiante: _____
Apellido Primer Nombre Segundo Nombre

Género: ☐ Hombre ☐ Mujer Fecha de Nacimiento: ____ / ____ / ____ Grado: ____ ID#: ____
*Mes Día Año (jardín de infantes – 12) (opciónal)*

Dirección: _____ Teléfono: _____

Su respuesta abajo permitirá al distrito escolar definir los servicios que puede aprovechar su hijo/hija según el Acto de McKinney-Vento. Los estudiantes elegibles tienen derecho a la inscripción inmediata en la escuela, aun si ellos no tienen los documentos necesarios tales como: prueba de residencia, documentos escolares, documentos de inmunización, o partida de nacimiento. Los estudiantes elegibles según el Acto de McKinney-Vento tienen además derecho al transporte gratuito y otros servicios que ofrece el distrito escolar. Si el estudiante **NO** vive en un hogar permanente, **no se requieren prueba de domicilio** u otros documentos normalmente requeridos para inscripción **y el estudiante debe ser matriculado inmediatamente.** Después de que el estudiante sea matriculado, el distrito o la escuela debe pedir los documentos escolares, incluyendo los documentos de inmunización, al distrito o la escuela anterior. El enlace del distrito debe ayudar al estudiante conseguir cualquier otro documento necesario o inmunización.

**¿Donde está el estudiante viviendo actualmente?** (*Por favor marque **una** caja.*)

- ☐ En un hogar permanente
- ☐ En un refugio
- ☐ Con otra familia o otra persona debido a la pérdida del hogar o a dificultades económicas
- ☐ En un hotel/motel
- ☐ En un carro, parque, autobús, tren, o camping
- ☐ Otra vivienda temporal (Por favor describa):

_____

_____ _____

**Nombre** de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

**Firma** de Padre, Guardián, o Estudiante (para jóvenes sin acompañamiento)

_____

**Fecha**

**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:

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

Lissette Colon-Collins, Assistant Commissioner
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# Cuestionario de Idioma del Hogar ("HLQ" por sus siglas en inglés)

*Estimados padres o tutores:*
*Con el fin de proporcionar la mejor educación posible a su hijo(a), necesitamos determinar el nivel del habla, lectura, escritura y comprensión en el inglés, así como conocer su educación previa e historial personal. Por favor, llene con su información las secciones "Conocimientos de idiomas" e "Historial educativo". Apreciamos mucho su colaboración respondiendo a estas preguntas.*
*Gracias.*

**Por favor escriba con claridad al completar esta sección.**

**NOMBRE DEL ESTUDIANTE:**

*Nombre* *Segundo nombre* *Apellido*

**FECHA DE NACIMIENTO:**

*Mes* *Día* *Año*

**GÉNERO:**

❑ Masculino
❑ Femenino

**INFORMACIÓN DE LOS PADRES/PERSONA EN RELACIÓN PARENTAL**

*Apellido* *Primer Nombre* *Relación con el estudiante*

**CÓDIGO DEL IDIOMA DEL HOGAR**

## *Conocimientos de idiomas*
*(Por favor, marque todas las opciones que sean aplicables)*

**1. ¿Qué idioma(s) se habla(n) en el hogar o residencia del estudiante?** ❑ Inglés ❑ Otro _____ *especifique*

**2. ¿Cuál fue el primer idioma que su hijo(a) aprendió?** ❑ Inglés ❑ Otro _____ *especifique*

**3. ¿Cuál es el idioma primario de cada padre / tutor?** ❑ Madre _____ *especifique* ❑ Padre _____ *especifique* ❑ Tutor(es) _____ *especifique*

**4. ¿Qué idioma o idiomas entiende su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique*

**5. ¿Qué idioma o idiomas habla su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique* ❑ No sabe hablar

**6. ¿Qué idioma o idiomas lee su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique* ❑ No sabe leer

**7. ¿Qué idioma o idiomas escribe su hijo(a)?** ❑ Inglés ❑ Otro _____ *especifique* ❑ No sabe escribir

## TO BE COMPLETED BY THE DISTRICT IN WHICH THE STUDENT IS REGISTERED

**SCHOOL DISTRICT INFORMATION:**

*District Name (Number) & School* *Address*

**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**

PARA LLENAR POR EL DISTRITO EN EL QUE EL ESTUDIANTE SE HA INSCRITO

# Cuestionario de Idioma del Hogar (HLQ) — Página Dos

## *Historial Educativo*

**8.** Indique con un número el total de años que su hijo(a) lleva inscrito en una escuela: _____

**9.** ¿Cree usted que su hijo(a) pueda tener dificultades, interferencias o problemas educacionales que le afecten su capacidad para entender, hablar, leer o escribir en inglés o en cualquier otro idioma? En caso afirmativo, por favor descríbalos.

*Sí** *No* *No se sabe*
❑ ❑ ❑ * En caso afirmativo, por favor explique :_____

¿Qué gravedad considera usted que tienen estas dificultades educacionales? ❑ Poca gravedad ❑ Algo grave ❑ Muy grave

**10a.** ¿Alguna vez se ha recomendado a su hijo(a) a tener una evaluación de educación especial? ❑ No ❑ Sí* * *Por favor, llene 10b.*

**10b.** **Si se le ha recomendado alguna vez una evaluación,* ¿ha recibido su hijo(a) alguna vez alguna forma de educación especial?

❑ No ❑ Sí – Explique, que forma o formas de educación especial recibió:

_____

Edad en la que recibió la intervención o forma de educación especial *(favor de marcar todas las opciones que sean aplicables):*

❑ De nacimiento a 3 años (Intervención Temprana) ❑ 3 a 5 años (Educación Especial) ❑ 6 años o mayor (Educación Especial)

**10c.** ¿Tiene su hijo(a) un Programa de Educación Individualizada ("IEP" por sus siglas en inglés)? ❑ No ❑ Sí

**11.** ¿Considera que hay alguna otra información importante que la escuela deba saber sobre su hijo(a)?
*(Por ejemplo, talentos especiales, problemas de salud, etc.)*

**12.** ¿En qué idioma(s) quiere usted recibir la información de la escuela? _____

_____ Mes: Día: Año: _____
***Firma del padre/madre o de la persona en relación paternal*** ***Date***
**Relación con el estudiante:** ❑ Madre ❑ Padre ❑ Otra:_____

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