SAGAPONACK COMMON SCHOOL

REGISTRATION

FOR THE

LITTLE RED SCHOOL HOUSE

2010-2011 SCHOOL YEAR
GRADES 1-4

FOR MORE INFORMATION CALL (631) 537-0651

Sagaponack Common School
P. O. Box 1500
Sagaponack, NY 11962
Telephone (631) 537-0651
Fax (631) 537-2342

Dear Parents/Guardians:

This form is for students entering Sagaponack School in first through fourth grades.

Enclosed is a registration packet that contains the following:

- Registration Form
- Records Release Form
- Proof of Residency (Sagaponack Residents)
- Transportation Request Form
- Health Registration Form
- Physical Examination Form
- Home Language Questionnaire

Please read and complete and return all of the enclosed as soon as possible.

If you have any further questions, please feel free to call our Secretary, Jeanette Krempler in the office, at the Sagaponack Common School at (631) 537-0651 during school hours between 8:30 a.m. and 2:30 p.m.

Welcome to Sagaponack Common School. We look forward to getting to know you and your child/children.

Sincerely,

Mrs. Diana McGinniss
Head Teacher

Sagaponack Common School
P. O. Box 1500
Sagaponack, NY 11962
Telephone (631) 537-0651
Fax (631) 537-2342

___ Resident

___ Non-Resident

Registration Form

Student Information: Today's Date: ____________________

Student's Name: ______________________________ Telephone: ______________________

Entering Grade: ________________________ Cell Phone:______________________

Physical Address: ____

Mailing Address: ____

Sex: ___ M ___ F Date of Birth: _______________ Place of Birth: _________________

Parent/Guardian Information:

Mother's Name: ___________________________ Mother's Work # _________________

Father's Name: __________________________ _ Father's Work # __________________

Guardian's Name: _________________________ Guardian's Work # ________________

Language Spoken at Home: ____

Status in Family: Child lives with: Check One.

___ Both parents _____ Father ___ Mother ___ Step Parents ___ Guardian(s)

Has there been a divorce: ______ Who has Legal Custody? ________________________

Other Children in the Family:

____ Grade: _____ DOB ____________

____ Grade: _____ DOB ____________

____ Grade: _____ DOB ____________

Last School Student Attended: ________________________________ Phone#: ___________

Last School's Address: ____

Special Services: ____
(If applicable)

Parent/Guardian's Signature: ____

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Date: ____________________

To Whom it May Concern:

______________________________________ has registered in the ____ grade in our school.

Please send us the following information for our records.

1. A copy of all grades while attending your school.
2. Transcripts for any previous schools, if a transfer student.
3. Current Health records.
4. Any standardized testing: IQ and/or Achievement Tests.
5. Psychological reports if any.
6. Any IEP or CSE/Annual Review information.
7. An overall summary from the student's classroom teacher.
   Feel free to ask the teacher to call me during school hours (8:00 am to 3:00 pm) should it be more convenient. (631) 537-0651.
8. Complete the Student Survey sheet enclosed with this letter.
9. Any other pertinent information that you feel would assist us in placing this student.

I am acknowledging and requesting that my child's records to be released to the Sagaponack Common School at your earliest convenience.

Parent's Signature: ______________________________ Date: ______________

Thank you for your cooperation and assistance in this matter.

Sincerely,

Diana McGinniss
Head Teacher, Sagaponack Common School

DOCUMENTS REQUIRED FOR REGISTRATION

- BIRTH CERTIFICATE OF CHILD
- CURRENT IMMUNIZATION RECORD OF CHILD
- PHOTO I.D. OF PARENT/ GUARDIAN
- PROOF OF RESIDENCY (1 of the following)
  - Electric or phone bill
  - Deed or tax bill

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Transportation Request Form

Directions: Please complete and return to the Head Teacher at the school as soon as possible.

_____ New or Returning Student _____ Change of Address

Name of Student(s)	Grade
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Parent/Guardian's Name: ______________________________
Phone Number: ______________________________
Home Address: ______________________________
____
____

Previous Address: ______________________________
(If you have received bus service in this District) ______________________________
____

Parent/Guardian's Signature: ______________________________
Date: ______________________________

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HEALTH REGISTRATION FORM

Name: ____ Date of Birth: _____________
Last First Middle

Social Development:

1. Language child usually speaks at home ____________________________
2. Is your child right handed? ☐ left handed? ☐
3. Does your child do simple household tasks? ☐ Yes ☐ No
4. Does your child prefer to socialize with peers or alone? (Circle one)
5. Do you consider your child overly shy? ☐ Yes ☐ No
6. Do you consider your child over-active? ☐ Yes ☐ No
7. Has your child ever had a sleeping problem? ☐ Yes ☐ No
8. Has your child ever had an eating disorder? ☐ Yes ☐ No

Physical Development:

1. Do you think your child is average in height? ☐ Yes ☐ No Weight? ☐ Yes ☐ No
2. Does your child fall frequently? ☐ Yes ☐ No
3. Does your child bump into objects around him/her? ☐ Yes ☐ No
4. Rate your child on the following skills compared with other children the same age (circle one):

Walking	Good	Average	Poor
Running	Good	Average	Poor
Throwing	Good	Average	Poor
Catching	Good	Average	Poor
Athletic Ability	Good	Average	Poor
Writing	Good	Average	Poor

Family History:

1. Circle any of the following diseases that your child's parents, grandparents, aunts, uncles, brothers, sisters have had. (Also circle M to indicate maternal or P to indicate paternal.)

   Tuberculosis (M P) Diabetes (M P) Asthma (M P)
   Mental Illness (M P) Epilepsy (M P) Cancer (M P)
   Allergic Reactions (M P) To what substance? ____________________________________
   Inherited Diseases (M P) Other ____

2. Are the child's parents both in good health? ☐ Yes ☐ No

3. What is the general health of brothers and sisters? _________________________________

Birth History:

1. Was the child adopted? ☐ Yes ☐ No

2. Normal pregnancy? ☐ Yes ☐ No

3. If pregnancy wasn't normal, please explain (spotting, toxemia, premature, illnesses, accidents, etc.):
   ____
   ____

4. If premature, how many weeks? _____

5. Any marks on baby? ☐ Yes ☐ No

6. Do any foods disagree with him/her? ☐ Yes ☐ No If yes, please explain: ______
   ____

7. Does he/she often have diarrhea? ☐ Yes ☐ No

8. Has constipation ever been much of a problem? ☐ Yes ☐ No

9. Are immunizations complete? ☐ Yes ☐ No

10. Was your child born with any congenital diseases or abnormalities? ☐ Yes ☐ No
    If yes, please explain (Sickle Cell Anemia, kidney disease, PKU, congenital hip, club foot?)
    ____

Current Health Status: (Check if applicable)

____ Allergies ________________________________ onset ___________
____ Asthma, onset ___________
____ Any pain or lumps in your groin? ☐ Yes ☐ No
____ Broken bones? Specify _________________ Right ______ Left ______
____ Chest pain ____ High blood pressure _____
____ Chicken pox, when? ____________________
____ Convulsive disorder/seizure (due to high fever, etc.), onset ___________
____ Diabetes, onset ___________
____ Discharge from penis? ☐ Yes ☐ No
____ Epilepsy, onset ___________
____ Frequent colds and/or sore throats
____ Frequent headaches
____ Has menstruation begun? ☐ Yes ☐ No If yes, month ____ year ____
____ Are periods painful? ☐ Yes ☐ No Regularly? ☐ Yes ☐ No
____ Hearing difficulties and/or infections
____ Operation (specify) ____
____ Pains in extremities or joints
____ Physical handicap (specify) ____________________________________
____ Pneumonia
____ Rheumatic fever, onset ___________
____ Scarlet fever, onset ___________
____ Scoliosis, onset ___________
____ Serious injury, specify ____
____ Serious burns, specify ____
____ Skin conditions, specify _______________________________________
____ Special or poor eating habits
____ Speech difficulties
____ Tuberculosis, onset ___________
____ Urinary conditions (specify) Pain _____ Burning _____ Blood _____
____ Vision – wears glasses? ☐ Yes ☐ No
Other (specify) ____

____ Currently under a physician's care? ☐ Yes ☐ No
Name of Physician: ____

____ Currently under a dentist's care? ☐ Yes ☐ No
Name of Dentist: ____

____ Medication (Please indicate name and dosage of any medication your child is taking)
____

____ Ever been hospitalized? ☐ Yes ☐ No If yes, when? _______________________
Condition? ____

____ Is there anything else you would like to tell us about your child to help him/her to have a positive school experience? ____
____
____
____

Emotional:

1. Is he/she doing well in school? ☐ Yes ☐ No

2. Does he/she get along well with peers? ☐ Yes ☐ No

3. Circle any of the following which your child has:

Nail biting	Irritable	Thumbsucking
Breath holding	Won't mind	Bad temper
Jealousy	Nightmares	Bedwetting

4. Other concerns: ____
____

5. How much time does your child spend watching TV each day? ____________________
Favorite TV program? ____

6. Does he/she play alone? ☐ Yes ☐ No

7. Does he/she play quiet games? ☐ Yes ☐ No Active games? ☐ Yes ☐ No

8. Does he/she interact with peers? ☐ Yes ☐ No

9. Does your child participate in organized activities or take part in other classes?
☐ Yes ☐ No (Please explain) ____

10. Has your child ever experienced family moving? ☐Yes ☐No How many times? ____

11. Has your child ever lived with someone other than his/her parents? ☐ Yes ☐ No
When? ___________________________ With whom? ___________________________

12. Has your child had a traumatic experience lately? ☐Yes ☐No If so, please explain:
____

13. Has your child ever experienced a death in the family? ☐ Yes ☐ No
Whom? ___________________________ When? _______________________________

14. Has your child ever experienced a parent or other family member with a long illness?
☐ Yes ☐ No

15. Has your child had periods of sadness or depression? ☐ Yes ☐ No

_______________________________________ ________________ _____________

Signature of person completing form Relationship to child Date

Revised 9/10

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PHYSICAL EXAMINATION FORM

Name: ____
(Last) (First) (Middle)
Address: ____

Height: ______________ Weight: ______________
Eyes: ______________ Ears (Otoscopic): ______________
Lymph nodes: __________ Thyroid: ______________
Nose: ______________
Tonsils: ______________ Teeth: ______________
Heart: ______________ Lungs: ______________
Hernia: ______________

Orthopedic Problem: Structural: ______________________
Posture: ______________________
Feet: ______________________
Scoliosis: ____________________________________

Skin: ____________________________________

Genito-Urinary: ____________________________________

Nervous System: ____________________________________

Speech: ____________________________________

Nutrition: ____________________________________

Blood Pressure: ______________________ (all students)

Name of any Defect, Allergy, Disability: ______________________

____

Teacher: ____________________________________

School: ____________________________________ Grade: _____

Is this child taking medication on a regular basis? ☐ Yes ☐ No

____
If yes, please provide name of drug, dosage and frequency

Is this child able to participate in physical education? ☐ Yes ☐ No

____
If not, what restrictions?

If this student is a new entrant, a complete immunization schedule is required!
Does this child need an immunization of any type? ☐ Yes ☐ No

List date of latest immunization or booster: **THIS IS NOT AN IMMUNIZATION RECORD UNLESS ALL DATES ARE RECORDED.**

Measles: ______________ DPT: ______________
Mumps: ______________ D-T: ______________
Rubella: ______________ Sabin (TOBV): ________
MMR #1: __________ MMR#2: __________ Varivax: __________
Hepatitis B#1: ________ Hepatitis B#2: ________ Hepatitis B#3: ________
Chest X-ray: ______________ Tuberculin Test: ____________

Other: ____

Physician's Name (print): ______________________________

Signature: ____

Physician's Address: ______________________________

Telephone: ______________ Date of Exam: ______________

Other Comments: ______________________________

____

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

Please print or type clearly

DISTRICT

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION: ❑ Possible LEP ❑ English Proficient

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ English ❑ Other ________ *specify*
2. What language(s) are spoken most of the time to the student, in the home or residence? ❑ English ❑ Other ________ *specify*
3. What language(s) does the student understand? ❑ English ❑ Other ________ *specify*
4. What language(s) does the student speak? ❑ English ❑ Other ________ *specify*
5. What language(s) does the student read? ❑ English ❑ Other ________ *specify* ❑ Does Not Read
6. What language(s) does the student write? ❑ English ❑ Other ________ *specify* ❑ Does Not Write
7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

Signature of Parent/Guardian/Other ________ *Date* Month: Day: Year:

HLQ (2/00) 99-337 PM

The University of the State of New York • The State Education Department • Office of Bilingual Education
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CUESTIONARIO SOBRE EL IDIOMA QUE SE HABLA EN EL HOGAR

("Home Language Questionnaire, HLQ") – Spanish

Estimado Padre/Madre o Guardián:

Para poder ofrecer a su hijo(a) la mejor educación posible, necesitamos determinar cuán efectivamente él o ella entiende, habla, lee y escribe el idioma inglés. Su ayuda será apreciada si contesta estas preguntas.

Gracias.

PARA SER COMPLETADO POR EL PERSONAL ESCOLAR (TO BE COMPLETED BY SCHOOL PERSONNEL)

DISTRITO (District) — *IMPRIMA O ESCRIBA CLARAMENTE (Please print or type Clearly)*

ESCUELA (School) — GRADO (Grade)

NOMBRE DEL ESTUDIANTE (Student Name)

FECHA DE NACIMIENTO (Date Of Birth) — Mes: (Month) Día: (Day) Año: (Year)

NUMERO DE IDENTIFICACION DEL ESTUDIANTE (Student Identification Number)

PAIS NATAL O ASCENDENCIA (Country of Birth / Ancestry)

NUMERO DE AÑOS MATRICULADO EN ESCUELA(S) FUERA DE LOS E.U. (Number of years enrolled in school outside the U.S.)

NOMBRE/POSICIÓN DEL PERSONAL ESCOLAR LLENANDO ESTA SECCION (Name/Position School Personnel Completing This Section)

DETERMINACIÓN: (Determination) — ❑ Posiblemente LEP (Possibly LEP) ❑ Dominante en Inglés (English Proficient)

(✔ Marque las casillas que aplican)

1. ¿Qué idioma(s) se habla en el hogar o residencia del estudiante? ❑ Inglés ❑ Español ❑ Otro ________ *(Especifique cuál)*
2. ¿En qué idioma(s) se le habla al estudiante la mayor parte del tiempo en el hogar o residencia? ❑ Inglés ❑ Español ❑ Otro ________ *(Especifique cuál)*
3. ¿Qué idioma(s) entiende el estudiante? ❑ Inglés ❑ Español ❑ Otro ________ *(Especifique cuál)*
4. ¿Qué idioma(s) habla el estudiante? ❑ Inglés ❑ Español ❑ Otro ________ *(Especifique cuál)*
5. ¿En qué idioma(s) lee el estudiante? ❑ Inglés ❑ Español ❑ Otro ________ *(Qué idioma)* ❑ No lee
6. ¿En qué idioma(s) escribe el estudiante? ❑ Inglés ❑ Español ❑ Otro ________ *(Qué idioma)* ❑ No escribe
7. ¿En su opinión, qué tan bien el estudiante entiende, habla, lee y escribe inglés?

	Muy bien	Un poco	Nada
Entiende Inglés	❑	❑	❑
Habla Inglés	❑	❑	❑
Lee Inglés	❑	❑	❑
Escribe Inglés	❑	❑	❑

Firma del Padre/Madre/Guardián/Otro (Signature of Parent/Guardian/Other)

Fecha (Date) — Mes: (Month) Día: (Day) Año: (Year)

HLQ (2/00) 99-337 PM