



Coxsackie-Athens Central School District
Office of the Registrar
24 Sunset Boulevard
Coxsackie, New York 12051-1199
518-731-1702 Fax 518-731-1729
Email: slatera@cacsd.org
Andrea Slater
Central Registrar

Welcome to the Coxsackie-Athens Central School District
Registration for all new students will take place at the District's Registrar's Office located at:

24 Sunset Boulevard, Coxsackie, New York 12051

Hours of Registration are by appointment

Monday through Friday

Please call for appointment.

518-731-1702

This registration packet is for registering children for CPSE services.

The following documentation is required in order to enroll your child for school in the Coxsackie-Athens Central School District:

Proof of Residency: Three (3) proofs of residency within the school district that include the name and address of a parent or guardian and are dated within the previous 30 days.

Documents accepted: executed lease agreement, executed purchase offer agreement, tax bill, rental agreement, mortgage statements, utility bill-{gas, oil, electric, telephone, cable, etc}, income tax return,)

Proof of Date of Birth: Your child's original birth certificate or passport

Immunization Record / Physician Health Form

(Public Health Law 2164 requires immunizations be received prior to a child being allowed to enter school.)

****Please see sheet in this packet for age specific requirements.**

Picture I.D. of the Parent/Guardian: (drivers license, non driver I.D.)

Custody Papers: if applicable are required

Academic records, including transcripts, recent report cards and any **Special Education Plan** should be presented at registration. If your child has received special education services or accommodation through an Individualized Education Program (IEP) or a Section 504, please sign consent for the release of special education records so that special education services can begin as soon as possible.

Permission to Publish Student Pictures

At times throughout the school year we may publish student pictures in newspaper articles, school newsletters or on our website. If you **DO NOT** want your child's picture published please notify the school district at 731-1710 or e-mail aplegatej@cacsd.org

Registrar Fax 518-731-1729

Please print the packet single sided.



Coxsackie-Athens Central School District

Inspiring Extraordinary Success

CPSE

Date _____ Grade Entering _____

Student Name _____ Gender _____

Date of Birth _____ Place of Birth _____ Country (if not US) _____

Home Address _____ City _____ State _____ Zip _____

Transportation Info: Brief description of residence including color and type of house.

Mailing Address (if different) _____

Race (choose all that apply) ___ Asian ___ Black ___ Native American/Native Alaskan ___ White ___ Pacific Islander

Ethnicity: Is the child of Hispanic origin? ___ Yes ___ No

Dominant Home Language _____ ENL ___ Yes ___ No

Does the Student have Special Education/Individualized Education Plan (IEP) or (Section 504) services ___ Yes ___ No

Family Status ___ Married ___ Separated ___ Divorced ___ Single Parent

If parents are separated who has residential custody of the child _____

Name of last school attended _____

Address of last school attended _____

If in High School: date entered 9th grade _____

Has student ever attended Coxsackie-Athens? ___ yes ___ no last grade completed here _____

Parent/Guardian Information

Parent/Guardian Name _____ Contact Priority _____

Relationship to student _____ Email Address _____

Telephones and Call Order

Home _____ 1 2 3 Cell _____ 1 2 3 Work _____ 1 2 3

Address (if different than student) _____

Parent/Guardian Name _____ Contact Priority _____

Relationship to student _____ Email Address _____

Telephones and Call Order

Home _____ 1 2 3 Cell _____ 1 2 3 Work _____ 1 2 3

Address(if different than student) _____

Emergency Contact Information-Other Than Parent/Guardian:

1. Name _____ Relationship to child _____ Gender _____

Resides in Same Household ____ Yes ____ No

If different household:

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

2. Name _____ Relationship to child _____ Gender _____

Resides in Same Household ____ Yes ____ No

If different household:

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Other Children Who Reside in Household

Name _____ DOB _____ Gender _____

Name _____ DOB _____ Gender _____

Name _____ DOB _____ Gender _____

Name _____ DOB _____ Gender _____

I declare under penalty of perjury under the laws of the State of New York that I have read and understand the information contained in this registration application and that my response and any accompanying attachments are true and correct.

Parent/Guardian Signature _____ Date _____

Please return all forms to Registrar in District Office at 24 Sunset Blvd Cocksackie NY 12051

Information collected by (name of Registrar) _____ Date _____

2026-27 School Year

New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:
All children must be age-appropriately immunized to attend school in New York State. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the [ACIP-Recommended Child and Adolescent Immunization Schedule](#). Doses received before the minimum age or intervals shown on the schedule are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in gradeless classes must meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements **MUST** be read with the footnotes of this schedule

Vaccines	Pre-Kindergarten (Child Caring Center, Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus tox- oid-containing vaccine and Pertussis vaccine (DTaP/DTP/ Tdap/Td) ²	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older and the series was started at less than 1 year of age or 3 doses if 7 years or older and the series was started at 1 year or older	3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap) ³	Not applicable		1 dose given at age 10 years or older	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose	2 doses		
Hepatitis B vaccine ⁶	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 years through 15 years		
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses		
Meningococcal conjugate vaccine (MenACWY) ⁸	Not applicable		Grades 7, 8, 9, 10 and 11: 1 dose given at age 10 years or older	Grade 12: 2 doses or 1 dose if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib) ⁹	1 to 4 doses	Not applicable		
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses	Not applicable		

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019, and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

*Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.

c. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

d. For further information, refer to the [Catch-Up Guidance for Children 4 Months through 6 Years of Age](#).

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 12: 10 years).

a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap given at age 10 years or older.

b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above.

c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

d. For further information, refer to the [Catch-Up Guidance for Children 7 through 9 Years of Age](#).

e. For further information, refer to the [Catch-Up Guidance for Children 10 through 18 Years of Age](#).

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.

b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.

c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.

d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward New York State school polio vaccine requirements. Doses of OPV given before April 1, 2016, should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016, must not be counted.

e. For further information, refer to the [Catch-Up Guidance for Children 4 months through 18 Years of Age](#).

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. Measles: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.

c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.

d. Rubella: One dose is required for pre-kindergarten. One dose is required for grades kindergarten through 12.

6. Hepatitis B vaccine

a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute “dose 4” for “dose 3” in these calculations).

b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)

a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.

b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7 through 12: 10 years).

a. One dose of meningococcal conjugate vaccine is required for students entering grades 7, 8, 9, 10 and 11.

b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.

c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.

c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.

d. If dose 1 was received at 15 months or older, only 1 dose is required.

e. Hib vaccine is not required for children 5 years or older.

f. For further information, refer to the [Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age \(PedvaxHIB only\)](#).

g. For further information, refer to the [Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age \(ActHIB, Hiberix, Pentacel, Vaxelis, or Unknown\)](#).

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)

a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.

b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.

c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.

d. If one dose of vaccine was received at 24 months or older, no further doses are required.

e. PCV is not required for children 5 years or older.

f. For further information, refer to the [Catch-Up Guidance for Children 4 months through 4 Years of Age](#). *Depending on vaccine brand, schedule may change.

For further information, contact:

New York State Department of Health
Division of Vaccine Excellence
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437
OSAS@health.ny.gov

New York City Department of Health and Mental Hygiene
School Compliance Unit, Bureau of Immunization
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433
school_immunizations@health.nyc.gov

2370

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/prevention/immunization/schools/

6/2026

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ Allergies	Type:	
	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ Asthma	Type: ☐ Intermittent ☐ Persistent ☐ Other:	
	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
☐ Seizures	Type:	☐ Date of Last Seizure:
	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ Diabetes	Type: ☐ 1 Type: ☐ 2	
	☐ Medication/Treatment Ordered Attached	☐ Diabetes Medical Management Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History 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: ☐ Yes ☐ No ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL
Sickle Cell Screen-PRN	☐	☐		

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings—List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)**

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list): ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for New Entrants, PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction ☐ Yes ☐ No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
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		☐
Notes:					
Scoliosis Screening Required for Boys grade 9 and Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		☐	☐	☐	☐
Notes:					
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
☐ Family cardiac history reviewed – required for sports (Dominic Murray Sudden Cardiac Arrest Prevention Act)					
☐ Student may participate in all activities without restrictions.					
If Restrictions Apply , complete the information below.					
☐ Student is restricted from participation in:					
☐ Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, or Wrestling.					
☐ Limited Contact Sports: Baseball, Fencing, Softball, or Volleyball					
☐ Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.					
☐ Other Restrictions:					
☐ Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
☐ Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
☐ Confirmed free of communicable disease during exam			☐ Record Attached ☐ Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

Student: _____ **Date of Birth:** _____ **Grade:** _____

(LAST) (FIRST)

2. Parent/Guardian: _____ Phone 1: _____ Phone 2: _____

NAME	RELATIONSHIP	PHONE
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2. _____

Health Conditions

Please note any health condition not listed above: _____

Allergy	Reaction	Treatment

- Medications - Taken Both At Home and at School**

Name	Dose	Time Administered

Parent/Guardian Signature _____ Date _____





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

Elisa Alvarez, Associate 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 Person in Parental Relation:

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:

Month Day Year

☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name

First Name

Relation to

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?

☐ Parent 1

☐ Parent 2

specify

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:

**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* 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: ☐ Parent ☐ 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:	

New York State Housing Questionnaire

Identifying and serving students in temporary housing under the McKinney-Vento Act and NYS Ed Law §3209

This form is to be completed when a student first enrolls, and any time a change in housing status occurs. There are no wrong answers. This form may be filled out independently, or the McKinney-Vento Liaison can assist. To access a list of McKinney-Vento Liaisons, please visit <https://www.nysteachs.org/liaisons>

District or LEA Coxsackie-Athens Central School District	School Name
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About this form and your rights

Schools are required by federal and state law to identify students living in temporary housing and ensure they can enroll, attend, and succeed in school. The **McKinney-Vento Homeless Assistance Act**, together with **New York State Education Law Section §3209**, protects students and families who no longer have a permanent, stable place to live; families who have lost housing; are staying with others temporarily; or are living somewhere that was never meant to be a home.

Eligible students have the right to:

- ✓ Stay in the school they attended when last permanently housed (called the school of origin), for as long as they are in temporary housing.
- ✓ Immediately enroll in the local school where they are temporarily staying (the school of current location).
- ✓ Receive free transportation to and from the school of attendance, as well as after-school activities (If within 50 miles).
- ✓ Receive free school meals without income paperwork as well as access to other school services including McKinney-Vento Grant resources, if available.

This information is confidential and will be shared only with school staff who have a legitimate educational need to support student access to McKinney-Vento rights and services. Providing this information is voluntary and will be used only to determine eligibility for services under the McKinney-Vento Act and NYS Education Law §3209. Please note that this information will not affect your immigration status, your child's enrollment, or your eligibility for other school services.

STUDENT INFORMATION:

Student Name (Last, First)	Student Grade Level (Preschool-12)
Student Gender ☐ M ☐ F ☐ X= Nonbinary	Student Date of Birth (Month/Day/Year)
Parent, Legal Guardian Name	
Phone Number	E-Mail Address
Address where the student is currently living	

Where is the student residing right now?

Under the McKinney-Vento Act, students are protected when their nighttime residence is not **fixed, regular, and adequate**. Check every box that describes where **the student** is residing right now.

- ☐ Permanent housing: you own, rent or lease a fixed, regular, and adequate home
- ☐ Doubled-up: staying with another family or person due to a loss of housing, economic hardship, eviction, or other similar reason
- ☐ In an emergency, transitional, or domestic violence shelter. Shelter or program name: _____
- ☐ In a hotel or motel because there is no other alternative, adequate place to stay
- ☐ In a car, park, campsite, bus/train station, abandoned building, or another place not meant for stable habitation or established dwelling
- ☐ In a place with no heat, running water, or electricity, or that is otherwise structurally unsafe or inadequate to reside in
- ☐ Displaced by a fire, flood, natural disaster, or other emergency
- ☐ Another temporary situation not listed here: _____

Is there anything else you would like us to know about your situation? (optional)

Is the student an Unaccompanied Homeless Youth (UHY)?

The McKinney-Vento Act identifies students who are not living with a parent or legal guardian, and are not residing in permanent housing, as **Unaccompanied Homeless Youth (UHY)**. UHYs have the right to enroll in school and to complete and sign this form independently, without a parent or adult present. The McKinney-Vento Liaison can assist UHYs with this process.

☐ Please check the box if you believe the student identified above may meet the McKinney-Vento eligibility criteria described above.

Additional Children within the Household?

To help us identify and support all eligible children and youth, please list every child who is currently living with you, regardless of age or school enrollment status. This includes infants, preschool-aged children, and school-aged children.

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Accuracy of Information and Signature

The person completing this form certifies that the information provided above is correct and accurate to the best of their ability.

Name (print): _____

Signature: _____ Date: _____

An unaccompanied homeless youth may sign on their own behalf.

Need help? Contact the McKinney-Vento Liaison listed at the top of this form or call the NYS-TEACHS Helpline at 800-388-2014. Visit nysteachs.org for more information.

OFFICIAL USE ONLY (School Staff)

Date received: _____ Received by: _____ Eligibility: ☐ Eligible ☐ Not Eligible ☐ Pending

Homeless Primary Nighttime Residence Code (SIRS):

☐ D = Doubled-up ☐ S = Shelter ☐ H = Hotel/Motel ☐ U = Unsheltered ☐ T = Transitional Housing

Unaccompanied Homeless Youth (UHY): ☐ Yes ☐ No

Designation Form: ☐ Yes ☐ N/A ☐ Coded in Student Information System (SIS)

Liaison notified (initials): _____ Date: _____ ☐ Family declined to provide information

Notes:

2. Has this child experienced any parental separations, divorces, or death? No _____ Yes _____
 If yes, when? _____ How old was the child? _____
 Who has primary custody of this child? _____
 How often does the other parent see this child? (please check one)
 ___ Weekly or more often ___ Once or twice a month ___ A few times a year ___ Never
3. What do you enjoy most about this child? _____

4. What do you find most difficult about raising a child? _____

5. What activities does your child enjoy? _____
6. Does your child have friends: at school? _____ outside of school? _____
7. Has this child's interest in participating in these activities declined recently? No _____ Yes _____
 If yes, please describe: _____

Birth and Developmental History

8. Was this a planned pregnancy? Yes _____ No _____
9. Was the mother under a doctor's care? Yes _____ No _____
10. Please check any of the following complications that occurred during pregnancy:
 _____ Toxemia _____ High Blood Pressure _____ Vaginal Bleeding _____ Anemia
 _____ Excessive Vomiting _____ Abnormal Weight Gain _____ Preeclampsia/eclampsia
 Other _____
- Hospitalization during pregnancy? No _____ Yes _____
 If yes, please describe: _____
- Alcohol used during pregnancy? No _____ Yes _____ If yes, frequency: _____
- Cigarettes used during pregnancy? No _____ Yes _____ If yes, frequency: _____
- Other drugs used during pregnancy? No _____ Yes _____ If yes, please list:

Type	Frequency	Prescription?	
		NO	YES
		NO	YES
		NO	YES

11. Was your child born premature? No _____ Yes _____ If yes, gestational age: ___weeks ___days
12. How was your child delivered? Vaginal _____ Cesarean _____

13. Please list any complications that occurred during birth:

14. Did your child require a stay in the NICU? No _____ Yes _____ Length of stay: _____

Reason for stay: _____

15. At what ages did your child first do the following:

Skill	Age	Skill	Age
Turn Over		Understand words	
Sit Alone		Speak 1 st words	
Crawl		Speak in sentences	
Walk Alone			

16. Did these skills appear to develop later than other children of the same age? No _____ Yes _____

If yes, please describe: _____

17. During the child's *first 4 years*, were any special problems noted in the following areas? If yes, please describe.

			Comment
Eating	YES	NO	
Motor Skills	YES	NO	
Excessive temper tantrums	YES	NO	
Sleeping too little	YES	NO	
Failure to thrive	YES	NO	
Excessive crying	YES	NO	
Separating from parents	YES	NO	

18. Has your child experienced any of the following problems at any time during development? If yes, please describe.

			Comment
Walking difficulty	YES	NO	
Unclear speech	YES	NO	
Sleep problems	YES	NO	
Eating problems	YES	NO	
Under/Overweight	YES	NO	
Difficulty learning to ride a bike	YES	NO	
Difficulty learning to skip	YES	NO	
Difficulty learning to throw/catch	YES	NO	

Medical History

19. Please indicate any illnesses your child has had and the age at which it occurred.

Illness	Age	Illness	Age
Chicken Pox		Mumps	
Asthma		Meningitis	
Measles		Anemia	
Broken Bones		Whooping Cough	
Sustained High Fever		Head Injury	
Coma, or any loss of consciousness		Scarlet Fever	
Bed Wetting (after age 5)		Allergies	
Surgery (please list)		Other:	

20. Has your child ever been diagnosed with any of the following?

	Age at diagnosis		Age at diagnosis
ADHD		Autism	
Aspergers		PDD-NOS	
Anxiety Disorder		Bipolar Disorder	
Mood Disorder		Depression	
Obsessive Compulsive Disorder		Tourette Syndrome	
Traumatic Brain Injury		Post Traumatic Stress Disorder	
Central Auditory Processing Disorder		Sensory Processing Disorder	
Dyspraxia		Other:	

21. Does your child have any problems with vision? No ____ Yes ____

22. Does your child wear glasses or contacts? No ____ Yes ____

23. Please list any/all medications your child currently takes:

Medication	Reason Why	Longer than 6 months?

24. Is there any family history (parent, grandparent, sibling, aunt, uncle, cousin, etc.) of the following:

	Who		Who
ADHD		Learning Disability	
Autism Spectrum Disorder		Medical Problems	
Neurological Condition		Mental health disorder	

Behavior

25. Please indicate whether your child currently (within the past 6 months) exhibits any of the following behaviors. If yes, please describe.

Is easily overstimulated	YES	NO	
Has short attention span	YES	NO	
Lacks self-control	YES	NO	
Seems unhappy most of the time	YES	NO	
Withholds affection	YES	NO	
Hides feelings	YES	NO	
Seems overly energetic in play	YES	NO	
Seems impulsive	YES	NO	
Overreacts when faced with a problem	YES	NO	
Seems shy	YES	NO	
Requires a lot of parental attention	YES	NO	
Has trouble relating or playing with others	YES	NO	
Fights frequently with playmates	YES	NO	
Has difficulty making friends	YES	NO	
Prefers to play alone	YES	NO	

26. Does your child receive counseling outside of school? No _____ Yes _____

If yes, with whom?

Do we have permission to speak with the individual? No _____ Yes _____

If yes, phone number/email?

Educational History

27. Please list all the schools your child attended:

	Name of School	Dates Attended
Preschool		
Elementary		
Middle		
High		

28. Has your child ever been retained? No _____ Yes _____ If yes, at what grade? _____

29. Has your child ever received any of the following services?

	Age		Age
Early Intervention		Speech Therapy	
Occupational Therapy		Physical Therapy	
Special Education		Counseling (through school)	

30. Was your child ever evaluated (early intervention, preschool, school age) and did NOT qualify for services? No _____ Yes _____ If yes, where?

31. Has your child ever received an outside evaluation (developmental pediatrician, neuropsych evaluation, another specialist, etc.) No _____ Yes _____ If yes, and not already on file, please provide a copy.

32. Does your child have any problems with the following:

	When did it start?		When did it start?
Reading		Math	
Speech		Fine Motor	
Gross Motor		Social Skills	

33. What does your child enjoy about school?

34. What are your concerns for this child currently?

35. Please include any information you feel will be helpful for us to know about your child.

Part B PROCEDURAL SAFEGUARDS NOTICE

New York State Education Department PROCEDURAL SAFEGUARDS NOTICE May 2024

Procedural Safeguards Notice: Rights for Parents of Preschool and School-Age Students with Disabilities

As a parent, you are a vital member of the committee on special education (CSE) or committee on preschool special education (CPSE) in New York State. The CSE/CPSE is responsible for developing recommendations for special education programs and services for your child. You must be given opportunities to participate in the CSE/CPSE discussion and decision-making process about your child's needs for special education. The following information concerns procedural safeguards that are your legal rights under federal and State laws to be informed about and involved in the special education process and to make sure that your child receives a free appropriate public education (FAPE).

A copy of this procedural safeguards notice must be provided to you one time a year and:

- upon initial referral or your request for an evaluation of your child.
- whenever you request a copy.
- upon receipt of the first due process complaint in a school year requesting mediation or an impartial hearing.
- the first time in a school year when the school district receives a copy of a State complaint that you submitted to the New York State Education Department (NYSED).
- when a decision is made to suspend or remove your child for discipline reasons that would result in a disciplinary change in placement.

The Procedural Safeguards Notice has been adapted from the model form developed by the United States Department of Education (USDE). Information was added regarding New York State's requirements.

The full document can be found on our Coxsackie-Athens Central School District website (<https://www.cacsd.org/page/parent-resources>), See Menu>District Services>Special Education>Parent Resources. A copy can be mailed or sent electronically, upon request. Please call our office at (518) 731-1725.



The University of the State of New York
New York State Education Department
Office of Special Education



COXSACKIE-ATHENS CENTRAL SCHOOL DISTRICT

24 Sunset Boulevard
Coxsackie, New York 12051
Phone: 518-731-1725 Fax: 518-731-1820

**Parent Referral to the
Committee on Preschool Special Education (CPSE)**

Child's Name: _____

Date of Birth: _____

Parent/Guardian: _____

Phone/Email: _____

I am the parent/guardian of the child named above. I am requesting that my child be referred to the Committee on Preschool Special Education (CPSE) because I have concerns about my child's development and believe that my child may have a disability that may require special education services and/or programs.

Please briefly describe your concerns and the reason for this referral:

New York State regulations require a preschool referral to identify the extent to which the child has received services prior to the referral. Please identify any services, interventions, evaluations, or supports your child currently receives or has previously received, such as Early Intervention, speech/language therapy, occupational therapy, physical therapy, counseling, preschool supports, or other services. If none, please write "None" below.

Previous evaluations/reports are attached: ☐ Yes ☐ No

By signing this form, I am making a written referral of my child to the CPSE. My signature on this referral is not consent for an initial evaluation or provision of special education services.

After the school district receives this referral, the CPSE will provide the parent with the required notice regarding the proposed initial evaluation, information regarding the evaluation process and approved preschool evaluators. Separate written parental consent for the initial evaluation will be sent. The parent will also select an approved preschool evaluation site, from a provided list. The initial evaluation will not begin until the district has received the parent's written consent to evaluate.

A copy of the Procedural Safeguards Notice: Rights for Parents of Children with Disabilities, Ages 3–21 is included with this packet. The Procedural Safeguards Notice is required upon an initial referral or parental request for evaluation.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____

For District Use Only

Date Referral Received: _____

Procedural Safeguards Notice Provided:

☐ Yes, with referral forms ☐ No, include with consent forms

Initial Evaluation Consent/Prior Written Notice Sent: _____