Required Documentation for Webutuck Central School Registration:

- Student's birth certificate
- Current immunizations records
- Two (2) proof of residency

REQUIREMENTS TO VERIFY RESIDENCY IN THE WEBUTUCK (NORTHEAST) CENTRAL SCHOOL DISTRICT

REMEMBER: Education law (Section 3202.1) states that the residency of the student is the residency of the parent.

If you move from the Webutuck (Northeast) Central School District and do not withdraw your children at the time you move, you will be responsible for the tuition.

To verify residency at the time of registration:

For Homeowners: Two original documents required

Either a. tax receipt

b. signed closing statement, not a signed contract to purchase

AND

Either c. a utility bill (NYSEG or other)

d. cable TV bill or tax return

For renters:

Required: Affidavit of Landlord

OR

Either a. a rent receipt (within 30 days) that indicates the address

b. a signed lease

AND

Either c. a utility bill (NYSEG or other)

d. cable TV bill or tax return

When parent(s) and students live with a friend or family member three documents are required:

1. Affidavit of Landlord

2. and 3. Two documents (see above for homeowner or renter) verifying the residency of the friend or family member.

Webutuck (Northeast) Central School District
Affidavit of Landlord

In the matter of the Investigation of the Residence Status of:

____
Name(s) of Lessee/Renter

Pursuant to Section 3202 of the Educational Law

STATE OF NEW YORK

ss,:

COUNTY OF DUTCHESS

_________________________________ being duly sworn deposes and says:
(Name of landlord)

1. I am the owner or corporate officer of the owner of the property within Webutuck (Northeast) Central School District, located at:

____
(complete address)

2. I have rented or leased occupancy of the premises described above to:

_____________________________ and the person or persons as follows:

a.______________________ b.______________________

c.______________________ d.______________________

e.______________________ f.______________________

To the best of my knowledge and information, the persons named above are residents of the described premises.

3. I state that the foregoing statements are true and correct. They are made by me on the knowledge that the information I have given will be used by Webutuck (Northeast) Central School District in making determinations based upon the accuracy of my statements.

4. Should it be determined that I have provided incorrect or false information on this form, I understand that I may be charged with perjury.

____
Signature of Landlord

Sworn before me on this __________ day, 201__

____
Notary Public

Approved 12/1/1994

Birth Certificate: ________ Custody Papers________ Migrant Student ____
Proof of Residency: ______ Guardianship Papers____ Foster Child ________
Immunizations: _________ Restraining Order______ ID# 90000
McKinney-Vento____ Entry Date: ________________

BUS NUMBER: AM: PM: *This box for office use only*

Webutuck Central School Registration Form

Grade Entering: ____________________

Student Information:

____ ______
Student's Last Name First Name Middle Name M/F

Date of Birth: ______________________ Place of Birth ______________________
City/State/Country

If born outside of USA when did student enter the country (month/year) __________ When did student start school (month/year) ______________

Mailing Address: ____

Residence Address: ____
(For Bus transportation)

Is this address a permanent or temporary residence? ______________

Are you living in a shelter or other arrangement due to a lack of housing? Yes___ No___

Is this a shared residence (are you living with another family member or friend?) Yes___ No___

Phone Number: ______________________________
Area Code/number

Parent/Guardian Information:

Mother's Name: ______________________ Phone: ______________
Address: ______________________ Cell-Phone: ______________
Employment: ______________________ Phone: ______________
Email address: ______________________________

Father's Name: ______________________ Phone: ______________
Address: ______________________ Cell-Phone: ______________
Employment: ______________________ Phone: ______________
Email address: ______________________________

Student Resides with (name):______________________ Relationship: ___________

Health / Emergency Information:

Physician's Name/Town: ______________________________ Phone: ____________________

Please list any allergies the student has: ______________________________

____

Please list any medications the student is taking:

____

____

Emergency Contact: (Person to be contacted if parents/guardians cannot be reached. This person will be authorized to act for the parent).

____

Name | Home Phone | Cell Phone Number | Work Phone Number | Relationship

____

Address

Student's Special Program/Services

Does your child receive Special Education Services? Yes____ No ___

Does your child have an IEP? Yes___ No ___

Please check if your child receives any of the following:

Counseling____ Speech_____ Special Education Services_____ Academic Intervention Services ____

Other (explain) ______________________________

Has your child ever been retained (repeated a grade?) _____ If Yes, what grade? ________

Previous Schools Attended

Did student attend a pre-school or nursery/daycare program? __yes __no if yes please list below.

School Name	School Address/Phone	Grade	Year

Other children in household

Name	Date of Birth	Grade	Male	Female

I verify that the above information is correct:

____

Signature of person registering student | ***Print name*** | ***Relationship to student*** | ***Date***

I give permission for the school to release health information to staff and faculty. This information will only be released to alert the staff/faculty to any health issues they should be aware of:

For instance (but not solely): Medications, Allergies, Glasses, Diabetic, and Chronic/Acute Illness

Signed: ______________________________

Webutuck Central School District
Webutuck Elementary School
P.O. Box 400, 175 Haight Road
Amenia, New York 12501
845-373-4100 ext. 1111 Fax: 845-373-4125

RELEASE OF RECORDS

Date: ______________________

Name of Student: ____ DOB: _______________

Grade of Student: ____________

I, ____, hereby grant permission to the below mentioned school to send the following:

1. Transcript
2. Health Records
3. Recommendations and Comments
4. Psychological Reports – including all testing,
5. Special Education Records (IEP)

Name of Previous School and Address:

____

____

____

Phone number of school: __________________________________

Fax number of school: ___________________________________

Please send the requested records to:

Webutuck Elementary School
P.O. Box 400, 175 Haight Road
Amenia, New York 12501
Fax: 845-373-4125

____
Signature of Parent/Guardian

Webutuck Central School Registration Form
Student Racial and Ethnic Identification

To the Parent/Guardian: The Webutuck Central School District in compliance with federal regulations requires the collection and recording of the ethnic identity of students in the Webutuck Central School District in accordance with the federal categories and definitions. This information is used to:

- Report information to the State and Federal Education Departments

Student Name: Last, First, Middle	Grade Level:

School District Student Identification Number: *Webutuck Central School*	Date of Birth (Month/Day/Year): Place of Birth:

DIRECTIONS TO PARENT/GUARDIAN
PLEASE ANSWER QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (√) the box that best describes your child.] Check (√) only ONE box.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture of origin, regardless of race.

- ☐ **Yes, Hispanic**
- ☐ **No, not Hispanic**

2. Select one or more races from the following five racial groups [For question (2) Check (√) all groups that apply to your child; check (√) at least ONE box.

- ☐ **AMERICAN INDIAN OR ALASKA NATIVE**: A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition. For example: Cherokee, Mohawk, Inuit.
- ☐ **ASIAN**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- ☐ **BLACK**: A person having origins in any of the black racial groups of Africa.
- ☐ **WHITE**: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

______________________________ ______________
Signature of Parent/Guardian/Other Date

Relationship to Student (please Check (√) one box below):

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): ______________

Webutuck Central School District
Transportation Department
158 Haight Road
PO Box 405
Amenia, NY 12501

Phone: 845-373-4100 ext. 4401 Fax: 845-373-7077

Transportation Request Form

Please Print and Complete Form

Date: ____________________

Student's Name: ____
(Last) (First)

Home Addres: ____
(Street Address – No P.O. Boxes please)

City: ______________________________ State: ____________ Zip: ____________

Home Telephone: _________________________ Cell: __________________________

Emergency Contact: ____
(Full Name) (Phone#) (Relationship)

School Year: ________ Grade: _______ Date of Birth: _____________

Parents/Guardians: ____
(Name) (Phone#)

Parents/Guardians: ____
(Name) (Phone#)

If your child goes to/from a child care provider at a different address than above, please complete the form below including the name, address, and telephone number of the childcare provider.

Pick Up	Drop Off
Check One: __Home ___Childcare Provider	Check One: __Home ___Childcare Provider
Provider's Name: ____________________	Provider's Name: ____________________
Provider's Address: __________________ ______________________________	Provider's Address: __________________ ______________________________
Provider's Phone: ___________________	Provider's Phone: ___________________
Check Days: ___Mon ___Tues ___Wed ___ Thurs ___	Check Days: ___Mon ___Tues ___Wed ___ Thurs ___

Parent/Guardian Signature______________________________ Date: ______________

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

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)

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	❑	❑	❑

______________________ ______________________ Month: Day: Year:

Signature of Parent/Guardian/Other *Date*

WEBUTUCK CENTRAL SCHOOL DISTRICT
PO Box 405, Amenia, NY 12501
845-373-4100

HEALTH REGISTRATION

STUDENT NAME ______________________________

DOB: ______________ PLACE OF BIRTH ______________

HOME PHONE ______________________________

STREET ADDRESS ______________________________

City State Zip Code

______________ Father's Name ______________ Mother's Name

______________ Place of Employment ______________ Place of Employment

______________ Employment Phone # ______________ Employment Phone #

______________ Cell Phone # ______________ Cell Phone #

FAMILY PHYSICIAN: ______________ DENTIST: ______________

PHONE # ______________ PHONE # ______________

****

ALLERGIES (insects, food, medications) ______________

Is your child taking any medication? (Do not list vitamins) ______________

____

If your child is to receive medication at school, it is necessary to have a written order from the doctor and written parental permission. Forms are available from the school nurse.

****

EMERGENCY CONTACT:

The school nurse needs the telephone number of a friend or relative to be called in case your child is injured or becomes ill at school and parents cannot be reached.

Name of Emergency Contact ______________ Phone # ______________

Address ______________________________

Exact location of your home ______________________________

______________________________ Signature of Parent or Legal Guardian Date

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?

Vision Problems:	Yes	No
If yes, what: ______		
Glasses ______ Corrective lenses ______ Wears for distance ______ Close book work ______		
Chronic ear infections:	Yes	No
Tubes in ears	Yes	No
Date inserted: ______		
Hearing aids	Yes	No
Other hearing problems	Yes	No
If yes, what? ______		
Asthma:	Yes	No
Use of Inhaler		
If yes, what inhaler? ______		
Use of Nebulizer	Yes	No
Severe reactions to insect bites:	Yes	No
If yes, medication used (if any) ______		
Heart problems:	Yes	No
If yes, what? ______ Heart Surgery	Yes	No
Epilepsy:	Yes	No
If yes, list any medication: ______		
Recent seizures? ______		
Type of seizure: ______		
Date of diagnosis: ______		
Diabetes:	Yes	No
If yes, on Insulin?	Yes	No
Type and dosage ______		
Date of diagnosis ______		
Lyme Disease:	Yes	No
Date of diagnosis: ______		
Hemophilia (free bleeding)	Yes	No
Rheumatic Fever	Yes	No
Cystic Fibrosis	Yes	No
Muscular Dystrophy	Yes	No
Cancer:	Yes	No
If yes, what? ______		
Physical Challenges:	Yes	No
If yes, what? ______		
Other health problems:	Yes	No
If yes, what? ______		

Has your child ever seen, or is your child currently seeing, a medical specialist (for example: cardiologist, neurologist, psychologist, psychiatrist, ophthalmologist, optometrist, speech clinic, other).. ____yes ____no

If yes, what type of specialist? ____________________

Reason for seeing the specialist ____________________

Has your child ever been hospitalized? .... ____yes ____no

If yes, date hospitalized ____________________ Reason for hospitalization:

____

____

Has your child ever had a serious accident (for example: broken bones, bad cuts, involved in a car accident, poisoning)? .... ____yes ____no

If yes, what? ____________________

____

Date ____________________

Has your child been seen by a dentist in the last year? .... ____yes ____no

****

Has your child had Chicken Pox? .... ____yes ____no

Has your child had the Varicella Vaccine? .... ____yes ____no

DOES YOUR CHILD NOW HAVE, OR HAD IN THE LAST YEAR ANY OF THE FOLLOWING PROBLEMS?

	NO	Current Condition	In the past year
Headaches			
Problems with eyes (for example: squinting, crusting lid, wandering eye)			
Chronic colds (more than 6 in one year, or a cold lasting more than 3 weeks)			
Shortness of breath			
Severe cough			
Throat infection			
Ear infection			
Tooth pain, cavities, mouth sores			
Swollen glands			
Stomach aches			
Eating or drinking too much			
Eating or drinking too little			
Weak urinary system (frequent urination)			
Pain or burning upon urination			
Bed wetting			
Constipation			
Diarrhea			
Unusual difficulty standing or walking			
Trouble sleeping			
Tiring easily			
Joint pain			
Seizures, convulsion			
Bleeding problems (for example: bruising easily, frequent nose bleeds)			

If your child has now or in the past had any of the above conditions, please give any necessary information (for example: medication and treatment)

___

___

___

Other health issues (please indicate) ___

___

___

___

****

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT PREGNANCY, LABOR, OR DELIVERY OF YOUR CHILD.

Did the mother have difficulties during the Pregnancy, labor, or delivery of your child? __yes/___no

If yes, what? ___

___

During pregnancy did the mother consume alcohol __yes/__no; drugs ___yes/___no
Smoke cigarettes during pregnancy ___yes/___no
Did the mother visit a physician or medical clinic during her pregnancy? ___yes/___no
Was your child born at home or at any place other than a hospital or medical facility? _yes/__no

If yes, where? ___

___

Did your child have difficulties at birth or shortly after (for example: jaundice (yellow skin), breathing problems, infection, high fever, feeding problems)? ___ yes/___ no

If yes, what? ___

___

___

APGAR score at delivery (if you know) ___
Did your child weigh less than 5 ½ pounds at birth? .... ___ yes/___ no

If yes, how much did the child weigh? ___

Was your child born prematurely (early)? .... ___ yes/___ no

If yes, by how many weeks? ___

___

Was your child born post-maturely (late)? ....___ yes/___ no

***If yes*, by how many weeks?** ___

___

Was your child placed in a neonatal intensive care nursery or high risk nursery after birth? ___ yes/___ no

If yes, for how many days? ___

___

___

PLEASE CHECK TO MAKE SURE YOU HAVE ANSWERED EVERY ITEM. THEN WRITE IN THE SPACE BELOW ANY ADDITIONAL COMMENTS YOU HAVE ABOUT YOUR CHILD'S HEALTH HISTORY.

COMMENTS: