

UNIVERSAL PRE-K REGISTRATION

To be eligible for the North Syracuse UPK program, children must live in the North Syracuse Central School District and be four years old on or before December 1. Site locations will be assigned in mid March and letters will go out to parents on or around March 29. This program is partially funded by a state grant and is subject to the passage of the New York State budget. If your child qualifies for the program, they will be enrolled at one of the following sites below based on address or babysitter location. All programs will be five days a week and follow the North Syracuse School District calendar.

Program	Hours	Address	Contact Info.
Learn As You Grow	9:15-3:15	5684 South Bay Rd. Cicero, NY 13039	Katie Polhamus, LAYG Director (315) 699-7189
Learn As You Grow	9:15-3:15	8381 Elta Dr. Cicero, NY 13039	Katie Polhamus, LAYG Director (315) 699-7189
Northminster Early Childhood Center	9:15-3:15	7444 Buckley Rd. North Syracuse, NY 13212	Soheila Yaddow, Northminster Director (315) 458-2669 opt. 2
North YMCA at Roxboro Road Elementary School	9:00-3:15	200 Bernard St. Mattydale, NY 13211	Lynnet Lamb, YMCA Director (315) 451-2562 - extension 210
North Syracuse Early Education Program	12:00-2:30 (½ day) 9:00-2:30 (full day) *Transportation is NOT provided*	205 SouthMain St. North Syracuse, NY 13212	Dawn Hussein, NSEEP Principal (315) 218-2200

Visit <http://www.nscsd.org/tfiles/folder1365/UPK%20Home%20School%20Listing%202022-23.pdf> to view the elementary school/UPK attendance zones, listed by street name.

Registration

Due to capacity constraints, we utilize a random lottery system for all applicants. Acceptance into the program is **NOT on a first come first served basis**. We will begin accepting applications for UPK on February 1st and will continue accepting applications until March 1. To register for the UPK program, please complete all components of this registration packet. Registrations will continue to be accepted after March 1 but will not be included in the lottery. Registrations received after March 1 will be added to a waitlist and parents will be notified if/when an opening occurs.

Registration forms cannot be submitted until you complete all sections of this packet and submit the required documents to the registrar. Completed packets and documents can be submitted by email to REGISTRAR@NSCSD.ORG, by mail to 5355 W Taft Rd. North Syracuse, NY 13212. Or in person at the Registration office (5355 W Taft Rd). Online registration is also available at the following link <http://cns.schooltool.cnyric.org/schooltoolweb/onlinepreregistration>, DOCUMENTS MUST BE EMAILED TO REGISTRAR@NSCSD.ORG. For questions regarding registration or the program please contact Julia Shannon 315-218-2147.

UPK Registration Checklist:

- **Completed registration packet**
- **Photo identification of registering Parent/Guardian** - If you are not the birth parent, proof of custody/legal guardianship will be required.
- **Parent's proof of residency** - To register your child, you must be a district resident and provide one of the following documents:
 - Current lease or rental agreement;
 - Current utility bill (gas, electric, landline phone, cable);
 - Recent property/school tax bill, deed, closing document, mortgage statement;
 - Recent documents issued by government agencies such as social services;
 - If none of the above are available to prove residency, please speak with the registrar (315-218-2145).
- **Proof of birth documentation** - Child's original birth certificate, a passport, immigration card or certified hospital transcript.
- **Additional items** if applicable:
 - Special Education: Copy of student's IEP or 504 Plan;
 - Custody Papers;
 - Foster Children: Provide social worker contact information and Form DSS-2999 from the County Department of Social Services.

PHYSICAL & IMMUNIZATION RECORDS ARE NOT REQUIRED TO COMPLETE REGISTRATION. UPK site locations will contact families to obtain these after the lottery is completed.

THIS SECTION FOR OFFICE USE ONLY	Student ID:
	Feeder Pattern:

**North Syracuse Central School District
UPK STUDENT REGISTRATION FORM**

STUDENT: First Name:	Middle Name:	Last Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	
Country of Birth: <input type="checkbox"/> USA <input type="checkbox"/> Other:	Date of entry into USA (if applicable):	
Student's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other:		
Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native American Indian/Native Alaskan <input type="checkbox"/> Native Hawaiian/Pacific Islander		
Student <u>Current</u> Home Address		
Student <u>Previous</u> Home Address		

	Does this child receive any special education services or have an IEP or 504 plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide a copy at registration. Known services: _____</i>
	Does your child have any major medical conditions we should alert the nurse to? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please note concerns on the health form attached.</i>

OTHER CHILDREN IN HOME:		
Name	Date of Birth	Relationship to Student

Important information for parents/guardians:
***PARENTS/LEGAL GUARDIANS MAY PICK UP THEIR CHILD UNLESS WE HAVE DOCUMENTATION
(CUSTODY/RESTRAINING ORDERS) ON FILE TO SHOW OTHERWISE.***
**Provide a copy of the custody order or temporary guardianship papers if applicable.*

CONTACT 1 (PARENT/LEGAL GUARDIAN)		CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	<input type="checkbox"/> Can pick up student and receive them from bus. <input type="checkbox"/> Should receive mail <input type="checkbox"/> Give Parent Portal access <i>(must provide an email)</i> Custody Order?* <input type="checkbox"/> None <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Visitation <input type="checkbox"/> Temp
Full Name:		
Relationship to student:		
Home Address:		
Email Address:		
Home Phone:	Work Phone:	
Cell Phone:	Employer:	

CONTACT 2 (PARENT/LEGAL GUARDIAN)		CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	<input type="checkbox"/> Can pick up student and receive them from bus. <input type="checkbox"/> Should receive mail <input type="checkbox"/> Give Parent Portal access <i>(must provide an email)</i> Custody Order?* <input type="checkbox"/> None <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Visitation <input type="checkbox"/> Temp
Full Name:		
Relationship to student:		
Home Address:		
Email Address:		
Home Phone:	Work Phone:	
Cell Phone:	Employer:	

ADDITIONAL EMERGENCY CONTACT		CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	<input type="checkbox"/> Can pick up student and receive them from bus if a parent/guardian is not available.
Full Name:		
Relationship to student:		
Home Phone:	Cell Phone:	

ADDITIONAL EMERGENCY CONTACT		CHECK ALL THAT APPLY:
Title:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	<input type="checkbox"/> Can pick up student and receive them from bus if a parent/guardian is not available.
Full Name:		
Relationship to student:		
Home Phone:	Cell Phone:	

NSCSD Residency Questionnaire

The answers you give below 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.

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

- 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): _____
- In permanent housing

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

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

Date

If the student is **NOT** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled**. The district's LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

NSCSD Transportation Application

Note: Each UPK site has an [attendance zone](#), which is determined by either your home address OR your babysitter's address (within the North Syracuse CSD). If you have a preference for a certain site, and you live outside of the assigned attendance zone, you must be able to transport your child to and from the UPK program.

Will your child need transportation?

Note: Students must be 4 years old to ride the bus. If your child is not 4, please call Transportation (315-218-2107) one week before their birthday and we will set up bussing.

If you answered yes (above), please complete the information below.

AM Pickup Address:

PM Drop Off Address:

If you answered no (above), please select your site preference in ranked order.

Learn As You Grow (South Bay Road) -FULL DAY Program

Learn As You Grow (Elta Drive) -FULL DAY Program

Northminster Early Childhood Center -FULL DAY Program

North Area YMCA at Roxboro Road Elementary School -FULL DAY Program

North Syracuse Early Education Program -HALF DAY Program (note: transportation is not provided by the district)

By signing below, I attest that all of the information in this UPK application is accurate and truthful, to the best of my knowledge.

Parent/Guardian Signature

Date

**NORTH SYRACUSE CENTRAL SCHOOL DISTRICT
HEALTH RECORD AND HISTORY FORM**

Name:	DOB: Grade: Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:
Physician:	Phone #:	Date of last physical exam:

I give permission for the above student to have a school physical: **YES** **NO**

Has your child ever:	YES	NO	If YES, please explain and include date:
Had an ongoing medical condition			
Seen a medical specialist			
Had allergies:			<input type="checkbox"/> Food <input type="checkbox"/> Environmental <input type="checkbox"/> Other <input type="checkbox"/> Insect <input type="checkbox"/> Medication
Been hospitalized			
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:			<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Color Blind
Had a hearing problem or condition:			<input type="checkbox"/> Hearing Aid <input type="checkbox"/> 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 or other serious health Issues			

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> GI Conditions (Ulcer, Reflux, IBS) | <input type="checkbox"/> Scoliosis | History of: |
| <input type="checkbox"/> Asthma/Trouble Breathing | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Single Organ (Kidney, Testicle) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Autism/Asperger | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Dental Injuries | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Speech Condition | <input type="checkbox"/> Reoccurring Strep Throat |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Health Condition:
(Depression, Eating Disorder,
Anxiety, OCD, ODD, etc.) | <input type="checkbox"/> Urinary Condition | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Ear Infections | | | <input type="checkbox"/> Tuberculosis |

CURRENT MEDICATIONS	YES	NO	Please list: NAME/DOSE/TIME(S)
Given at School			
Taken at Home			
ASSISTIVE EQUIPMENT at SCHOOL	YES	NO	Please Check All That Apply
During or Outside of School:			<input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other
TREATMENTS	YES	NO	Please Check All That Apply
During or Outside of School			<input type="checkbox"/> Insulin <input type="checkbox"/> Blood Glucose Monitoring <input type="checkbox"/> Inhaler/Nebulizer/Peak Flow Monitoring <input type="checkbox"/> Special Diet

Has your child tested positive for COVID-19:

Yes: _____ No: _____ Date: _____

Is there any condition that would prevent your child from participating in physical education or sports? YES NO

Please list any additional concerns: (Use back of sheet if necessary): _____

PARENT/GUARDIAN SIGNATURE _____ **DATE:** _____

Student Name: _____ Grade: _____ DOB: _____

North Syracuse Central School District
FOOD ALLERGY AWARENESS INFORMATION

Does your child have any known food allergies/intolerances? YES (Continue) NO (Stop/Sign Form)

FOOD ALLERGY

What age was the student diagnosed with an allergy? _____

Specific food allergies? _____

Pure food, list allergies: _____

As an ingredient, list allergies: _____

Reaction signs: _____

Is medication required? _____

Is antihistamine in Nurse's Office? _____

Is Epinephrine (Epi-Pen) in Nurse's Office? _____

NON MEDICAL DIETARY RESTRICTIONS: _____

FOOD INTOLERANCE:

Pure food, list food intolerance(s): _____

As an ingredient, list specific ingredients(s): _____

Reaction signs: _____

- If lactose intolerant, is it:
- Milk
 - Yogurt
 - Ice Cream
 - Cheese
 - All types of food or beverages that contain milk

Has the student been hospitalized as a result of an allergic reaction? YES NO

If student has **peanut** or **tree-nut** allergy, can student eat anything manufactured in a plant that processes items with peanuts and tree-nuts? YES NO

A physician's note must be submitted to the school nurse if you are reporting a food allergy/intolerance for the first time or there has been a change in your child's allergy/intolerance status. A physician's note can be faxed or submitted in person to appropriate school.

Please read the school's Student Food Allergies Policy (8101.2) located on the district website, www.nscsd.org.

Signature indicates agreement to allow the NSCS D to share information on this document with appropriate personnel.

Parent/Guardian Signature: _____ Date: _____



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 Relationship 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 _____ Father _____
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 _____ Does not speak
Specify
6. What language(s) does your child read? English Other _____ Does not read
Specify
7. What language(s) does your child write? English Other _____ Does not write
Specify

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

<i>Educational History</i>
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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____ How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe
10a. Has your child ever been <i>referred</i> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>Please complete 10b below</i>
10b. <i>If referred for an evaluation, has your child ever received any special education services in the past?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____
Age at which services received <i>(Please check all that apply)</i> : <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> Yes
11. Is there anything else you think is important for the school to know about your child? <i>(e.g., special talents, health concerns, etc.)</i> _____ _____
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 *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: <input type="checkbox"/> No <input type="checkbox"/> Yes													
**DATE OF INDIVIDUAL INTERVIEW: _____				OUTCOME OF INDIVIDUAL INTERVIEW:		<input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM							
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL													
NAME:				POSITION:									
DATE OF NYSITELL ADMINISTRATION:		PROFICIENCY LEVEL ACHIEVED ON NYSITELL:		<input type="checkbox"/> Entering		<input type="checkbox"/> Emerging		<input type="checkbox"/> Transitioning		<input type="checkbox"/> Expanding		<input type="checkbox"/> Commanding	
MO. DAY YR													
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:													