



Greater Johnstown School District  
Universal Prekindergarten  
Application Package

This application package includes all forms necessary for consideration into the prekindergarten program. Each form must be filled out in its entirety. **Due to financial constraints, school district transportation to the prek program may not be provided.**

Please check off each form as you complete it:

- Residency Form (Form #1)  
(must be verified in person by Alice Sise, Business Manager, 1 Sir Bills Circle—before application can be submitted)
- Registration Form (Form #2)
- School Entrance Health History (Form #3)
- Home Language Questionnaire (Form #4)
- School Volunteer Application (Form #5)

You must also provide the following when returning the application:

- Copy of Original Legal Birth Certificate with Seal  
(The school secretary will make a copy when you bring in the application)
- Immunization Records from your pediatrician
- Lead Screening Results

After residency is verified, please return  
completed packet to:

Warren Street School  
110 Warren Street  
Johnstown, New York 12095



If at any time you decide not to participate in the program, please call Warren Street School at 762-3715.

RESIDENCY VERIFICATION FORM
GREATER JOHNSTOWN SCHOOL DISTRICT
1 Sir Bills Circle, Johnstown, NY 12095
(To be completed prior to registration of student)
Complete all information carefully. Please print.

Student's Full Legal Name: (First) (Middle) (Last)
Sex: Male Female Grade Date of Birth:

Street Address: (Actual residence not PO Box) Street number and name
City/Village, New York Zip Code:

Mailing Address: (PO Box acceptable): Street number and name
City/Village, New York Zip Code:

Parent/guardian: Name Name

Telephone: Home: Work: Cell:

Custody: Child's legal custodian is Relationship
Child lives with Relationship

Siblings in the same household

Name: Grade
Name: Grade
Name: Grade
Name: Grade

Is this a foster placement: Yes No If yes, name of county
If Yes, copy of DSS 2999 Form required

Check here (and provide details) if student lives in a shelter, abandoned apartment/building, motel/hotel, camping ground, car, or train/bus station; if the student lives with relatives or others due to lack of housing or other similar situation; or if the student is temporarily housed in a shelter awaiting permanent foster care placement. (living arrangements) If box is checked, please complete STAC-202 form.

PROOF OF VERIFICATION PROVIDED:

- Current Utility Bill Copy of Deed
Copy of Purchase Contract Letter from Attorney (including date/time of closing)
Lease Agreement
Other:

Parent/Guardian Signature: Date

Table with 2 columns: Business Office Signature, Date

**REGISTRATION FORM**  
**GREATER JOHNSTOWN SCHOOL DISTRICT**  
*1 Sir Bills Circle, Johnstown, NY 12095*

Student's Name: \_\_\_\_\_ Sex \_\_\_\_\_

Home Address: \_\_\_\_\_ Street number and name \_\_\_\_\_ City/Village \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Number: \_\_\_\_\_ E-mail address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_ Nickname \_\_\_\_\_

**Order of Protection \*** \_\_\_\_\_ (\*If an order of protection exists, it must be submitted to building principal at time of student enrollment)

Parent Marital Status \_\_\_\_\_ Is there a custody issue on this child? \_\_\_\_\_

If yes, who has custody? \_\_\_\_\_ Relationship \_\_\_\_\_

Is child known by any other name? If so, what is the name? \_\_\_\_\_

Parent/Guardian Information				
Name	Birth Year	Home Address	Work Place and Phone Number	Highest Level of Education
Mother (include maiden name)				
Father				
Step Parent				
Legal Guardian				

(Secretary/Registration Clerk will check the following when forms copied) Birth Certificate \_\_\_\_\_ Immunization Record \_\_\_\_\_  
 Custody \_\_\_\_\_

Please complete both sides of form

Brother(s) and Sister(s) Information

Name (First and Last)	Sex	Birth Date	Living at Home	Present Grade	School Attending

Racial/Ethnic Identification – please answer both of the following questions.

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 or origin, regardless of race. Yes \_\_\_ No \_\_\_

2. Select one or more races from the following five racial groups (Check all groups that apply to your child.)

- American Indian or Alaska Native – a person having origins in any of the original peoples of North America
- Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent
- 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

Previous School Attended \_\_\_\_\_ Phone Number \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

Services at previous school: AIS Math \_\_\_ AIS Reading \_\_\_ IEP \_\_\_ 504 Plan \_\_\_ Speech \_\_\_ Counseling \_\_\_ Other \_\_\_

If there is anything you wish to tell us regarding your child, please explain: \_\_\_\_\_

Signature of person filling out form \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_

# GREATER JOHNSTOWN SCHOOL DISTRICT

Administration Center  
1 Sir Bills Circle - Suite 101, Johnstown, NY 12095  
Phone 518-762-4611  
Fax 518-762-3127

Robert A. DeLilli  
*Superintendent of Schools*

James J. Robare  
*Director of Athletics, Physical  
Education, Health & Recreation*

## SCHOOL ENTRANCE HEALTH HISTORY

Dear Parents/Guardians:

Please complete this questionnaire to the best of your ability and return it to the Health Office of your child's school. This information is for the school medical record kept for each child and is of great help to the school nurse and doctor in understanding and helping to safeguard your child's health. Thank you very much.

SCHOOL \_\_\_\_\_ Grade \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ Nickname \_\_\_\_\_

Birthdate \_\_\_\_\_ Place of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Father's Name \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Doctor \_\_\_\_\_ Address \_\_\_\_\_

Name of Dentist \_\_\_\_\_ Address \_\_\_\_\_

Other Children in Family: \_\_\_\_\_ Birthdates: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Is your child currently being treated for an illness or ongoing condition? \_\_\_\_\_  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Is your child currently taking any medication? \_\_\_\_\_  
If yes, what medication? \_\_\_\_\_  
Why? \_\_\_\_\_

3. Do you consider your child's health to be: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_
4. Can your child participate in all school activities? \_\_\_\_\_
5. Does your child have any allergies (Foods, animals, medicines, bee stings, dust, pollen, other) \_\_\_\_\_

If he/she is allergic to bee stings, what actions do you want school personnel to take? \_\_\_\_\_

6. Please check if your child has had any problems with:
- |                              |     |                            |     |
|------------------------------|-----|----------------------------|-----|
| Asthma                       | ( ) | Persistent cough or wheeze | ( ) |
| Eczema                       | ( ) | Tiring Easily              | ( ) |
| Frequent headaches           | ( ) | Stomach aches or vomiting  | ( ) |
| Dizziness or fainting spells | ( ) | Bowel movements            | ( ) |
| Convulsions and/or Epilepsy  | ( ) | Hernia                     | ( ) |
| More than 3-4 colds per year | ( ) | Kidney/urinary problems    | ( ) |
| Tonsils or adenoids          | ( ) | Painful joints             | ( ) |
| Strep throat                 | ( ) | Feet or walking            | ( ) |
| Frequent nosebleeds          | ( ) | Bedwetting                 | ( ) |
| Anemia                       | ( ) | Frequent temper tantrums   | ( ) |
| Heart problems               | ( ) | Rapid changes of mood      | ( ) |
| Diabetes                     | ( ) | Eating problems            | ( ) |

If so, is the condition under the care or observation of a doctor? \_\_\_\_\_

If YES, a statement from your physician is required.

7. Has your child had any:
- |                   |       |          |       |
|-------------------|-------|----------|-------|
| Serious injuries  | _____ | Describe | _____ |
| Serious illnesses | _____ | Describe | _____ |
| Accidents         | _____ | Describe | _____ |
| Operations        | _____ | Describe | _____ |

8. Has your child had any of the following diseases?
- Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_
- German measles \_\_\_\_\_ Mumps \_\_\_\_\_ Pneumonia \_\_\_\_\_ Scarlet Fever \_\_\_\_\_

9. When did your child last have a complete physical examination? \_\_\_\_\_

10. Does your child have any eye problems? (difficulty seeing, crosses eyes, frequently reddened or watery eyes) \_\_\_\_\_

11. Does your child wear glasses? \_\_\_\_\_

12. Does your child have any ear or hearing problems? (frequent earaches, draining from ears, difficulty hearing) \_\_\_\_\_

13. Does your child wear a hearing aid? \_\_\_\_\_

14. Has your child worn braces or corrective shoes? \_\_\_\_\_ Are they still being worn? \_\_\_\_\_

15. Does your child have any speech problems (stuttering, difficult to understand, delayed speech development) \_\_\_\_\_

16. Is a language other than English spoken at home? \_\_\_\_\_
17. Will your child require any special health care in school? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_
18. Do you have any concerns about your child's general health, behavior, or emotional well-being of which the school should be aware? \_\_\_\_\_  
\_\_\_\_\_
19. Was this a normal, full-term pregnancy? \_\_\_\_\_
20. At what age did your child walk? \_\_\_\_\_ Talk? \_\_\_\_\_ Toilet train? \_\_\_\_\_
21. How did your child develop compared to other children the same age?  
Faster \_\_\_\_\_ Slower \_\_\_\_\_ About the same \_\_\_\_\_
22. Please check if your child had any of the following experiences which might influence his social or physical development:
- Frequent changes in residence ( )
  - Death in family ( )
  - Fires ( )
  - Accidents/Injuries ( )
  - Other ( )
23. Please check if you expect that your child may have any of the following problems when he/she begins school:
- Leaving home for the first time ( )
  - Getting along with a new adult ( )
  - Dressing, eating, toileting by himself ( )
  - Getting along with other children ( )
24. Family History: Please check any that apply to your immediate family and explain the person's relationship to your child (mother, father, sister, aunt, grandmother, etc.)
- Physical disability (describe) \_\_\_\_\_
  - Epilepsy \_\_\_\_\_
  - Diabetes \_\_\_\_\_
  - Retardation \_\_\_\_\_
  - Depression \_\_\_\_\_
  - Vision Problems \_\_\_\_\_
  - Hearing Problems \_\_\_\_\_
  - Thyroid Problems \_\_\_\_\_
  - Scoliosis/back problems \_\_\_\_\_
  - Convulsions \_\_\_\_\_
  - Heart Problems \_\_\_\_\_
  - Other \_\_\_\_\_
25. Are there other concerns regarding your child that you feel the school should be aware of: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



# 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			
DISTRICT		<i>Please print or type clearly</i>	
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:		<input type="checkbox"/> Possible LEP <input type="checkbox"/> 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 \_\_\_\_\_       Does Not Read  
*specify*

6. What language(s) does the student write?       English       Other \_\_\_\_\_       Does Not Write  
*specify*

7. In your opinion, how well does the student understand, speak, read and write English?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
Understands English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Month: Day: Year:

Signature of Parent/Guardian/Other

Date

**GREATER JOHNSTOWN SCHOOL DISTRICT**

## ADMINISTRATION CENTER

1 Sir Bills Circle, Suite 101 • Johnstown NY 12095  
Telephone (518) 762-4611 • Facsimile (518) 762-6379  
[www.johnstownschoools.org](http://www.johnstownschoools.org)

**BOARD OF EDUCATION**

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SUPERINTENDENT OF SCHOOLS

**Patricia N. Kilburn**  
DIRECTOR OF CURRICULUM,  
TESTING & PERSONNEL

**Alice M. Sise**  
SCHOOL BUSINESS MANAGER

Dear Parents and Guardians:

The School District very much appreciates the valuable service volunteers provide as classroom helpers, field trip chaperones, PTSA members, and in offering assistance with extra-curricular activities.

Greater Johnstown School District Policy No. 3150 states that all volunteers shall be subject to screening procedures, which may include, but are not limited to, reference checks, a criminal history check and request of information regarding previous criminal convictions, and investigation to determine whether a volunteer has a history of child abuse.

In an effort to protect the safety and security of children and school staff, it is required that volunteers complete a School Volunteer Application containing a consent to a criminal background check regarding convictions for child abuse or endangerment, sex or drug related offenses, or crimes of violence. While a prior criminal history will not automatically prohibit an individual from performing as a volunteer, any individual who refuses to consent to a criminal background check may be ineligible to be a volunteer in the Greater Johnstown School District.

A Volunteer Application form is attached and additional copies are available at each school. Applicants with children in more than one building need only submit paperwork at one site. Volunteers who are approved will be added to a District-Wide registry for the school year. District employees who volunteer will not have to go through an additional background check if they have already undergone background clearances.

It is hoped that everyone will understand that for the safety of our students and staff, these requirements are essential.

Thank you.

# GREATER JOHNSTOWN SCHOOL DISTRICT

ADMINISTRATION CENTER

1 Sir Bills Circle, Suite 101 • Johnstown NY 12095  
Telephone (518) 762-4611 • Facsimile (518) 762-6379

## SCHOOL VOLUNTEER APPLICATION

NOTICE: PURSUANT TO DISTRICT POLICY, ALL VOLUNTEERS SHALL BE SUBJECT TO SCREENING PROCEDURES WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, 1) REFERENCE CHECKS, 2) A CRIMINAL HISTORY CHECK AND REQUEST OF INFORMATION REGARDING PREVIOUS CRIMINAL CONVICTIONS, AND 3) INVESTIGATION TO DETERMINE WHETHER A VOLUNTEER HAS A HISTORY OF CHILD ABUSE.

Volunteer Name: \_\_\_\_\_  
(First) (Middle) (Last)

Maiden/Alias/Other Names: \_\_\_\_\_

Your Date of Birth: \_\_\_\_\_  
Month/Day/Year

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

If at current address less than five years, list previous residence(s): \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Are you currently an employee of the Greater Johnstown School District?  No  Yes Position/Building \_\_\_\_\_  
(Employees who have already received background clearances do not have to go through an additional background check)

Are you a (circle one) parent/guardian/family member of a student in the Greater Johnstown School District?  Yes  No

Child(ren) Name(s)	Grade/Teacher	School
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please respond to the following questions truthfully. Disclosure of a prior criminal history will not automatically prohibit volunteer status.

- |    | Yes                      | No                       |  |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of child abuse or endangerment? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you required to register as a sex offender?              |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been convicted of a felony?                    |

MY SIGNATURE BELOW INDICATES THAT I CONSENT TO A CRIMINAL BACKGROUND CHECK FOR CONVICTIONS OF CHILD ABUSE OR ENDANGERMENT, SEX AND DRUG OFFENSES, AND CRIMES OF VIOLENCE; THAT I WILL ABIDE BY ALL APPLICABLE SCHOOL RULES AND BOARD OF EDUCATION POLICIES AND REGULATIONS; AND THAT THE INFORMATION PROVIDED BY ME IS TRUE, COMPLETE AND CORRECT.

Application Date: \_\_\_\_\_  
\_\_\_\_\_  
(Signature of Volunteer Applicant)

### FOR SCHOOL USE ONLY:

APPROVED \_\_\_\_\_ DISAPPROVED \_\_\_\_\_ DATE: \_\_\_\_\_ SIGNATURE OF PRINCIPAL: \_\_\_\_\_