

MINNESAUKE ELEMENTARY SCHOOL  
PRE-KINDERGARTEN REGISTRATION

INSTRUCTION SHEET

Kindergarten registration will be held for both you and your child at Minnesauke Elementary School. Registration and screening procedures will take approximately one hour. **Please do not bring other children to the screening.** We do not have enough room or supervision for them. We are also trying to keep a quiet, comfortable atmosphere. Your help is greatly appreciated.

**Parking** – Please park in the rear of the building or along the west end of the main parking lot. The large middle area of the parking lot must remain free for arrival and dismissal of school buses.

Personnel assisting in the registration and screening process will wear name tags.

**Procedures:**

- a) When you arrive, please check in with a PTA volunteer. He/she will check that you have brought all the necessary paperwork and call you for the next step.
- b) You and your child will then meet with Mrs. Kelly McCabe, our psychologist, or Ms. Laura Jankowski, our social worker. At this station, you will be discussing your child's growth and development. Your child will then be escorted to a series of play-type activities comprising our screening process. You will at the same time be meeting with the school secretary, Mrs. Koch, for registration, and with the school nurse, Mrs. Weiner, for health and medical forms.

When these visits are completed, please sit by the exit to wait for your child to finish the screening process. It is expected that your child will go through the screening alone, however you will be nearby.

**Questions and Inquiries:**

- a) Questions about development, ability or readiness for school should be directed to Mrs. McCabe or Ms. Jankowski.
- b) Questions about health forms or health services should be directed to Mrs. Weiner.
- c) General questions about school information may be asked when you submit your registration papers to Mrs. Koch.
- d) Questions not covered may be submitted with your registration forms. Mrs. Bienia, principal, or Mrs. Essinfeld, assistant principal, will be in touch with you to answer your questions.

**Screening Results:** You will receive a summary of your child's screening results in the mail approximately a month after the screening. If we have any serious concerns we will contact you sooner. Most children do very well and enjoy the screening activities. Parents who wish to discuss the results of their child's screening may do so by contacting Mrs. McCabe at 730-4214.

**June Orientation:** On June 2<sup>nd</sup> 9:45 a.m., we will host an Orientation for parents and incoming Kindergarten students. At that time, students will visit a Kindergarten classroom and participate in a very short bus ride. Our experience tells us that children greatly enjoy the visit and bus ride. Parents will meet with the building administrators in the auditorium.

**THREE VILLAGE CENTRAL SCHOOL DISTRICT**

100 Suffolk Avenue  
Stony Brook, New York 11790

Dear Parents:

In order to help ensure a successful initial school experience for your child, it is important to know something of your child's development and preschool experiences and any special concerns or considerations you may feel are important to share. Please complete the following and return it at your child's kindergarten registration.

**Kindergarten Social Development History**

Child's name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Child lives with: mother, father, stepfather, stepmother (circle all that apply)

Stepparent's Name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Stepparent's name: \_\_\_\_\_ Age: \_\_\_\_ Education: \_\_\_\_\_

Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

If parents are divorced, please indicate who has custody of the child:

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Custody Instructions:

Custodial Parent Name \_\_\_\_\_ Phone# \_\_\_\_\_

Court Documentation YES / NO

**Children living inside the home:**

Name, grade, age and school: \_\_\_\_\_

Name, grade, age and school: \_\_\_\_\_

Name, grade, age and school: \_\_\_\_\_

Name, grade, age and school: \_\_\_\_\_

**Other children living outside the home:**

Name and age: \_\_\_\_\_

Name and age: \_\_\_\_\_

Other persons living in the home: \_\_\_\_\_

Check if child is: Foster child \_\_\_\_\_ Adopted \_\_\_\_\_ Age when placed: \_\_\_\_\_

**Birth and Infancy**

**A. Prenatal and Birth:**

1. Mother's general health during pregnancy: \_\_\_\_\_

2. Labor and delivery: Normal \_\_\_\_\_ Complications \_\_\_\_\_

3. Specify any complications during pregnancy, labor and/or delivery: \_\_\_\_\_  
\_\_\_\_\_

4. Birth weight: \_\_\_\_\_ 5. Infant's days in hospital: \_\_\_\_\_

**B. Infancy:**

1. Check one:            **Early**                      **Average**                      **Later than peers**

Age of sitting	_____	_____	_____
Age of crawling	_____	_____	_____
Age of walking	_____	_____	_____
Using single words	_____	_____	_____
Using sentences	_____	_____	_____
Toilet training	_____	_____	_____

2. Please specify any concerns regarding your child's development:  
\_\_\_\_\_

### Health History

1. Has your child had any serious illnesses, accidents, operations or hospitalizations?

Yes \_\_\_\_ No \_\_\_\_ If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

2. Is your child taking medication on a regular basis? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe: \_\_\_\_\_

3. Please check any particular health problems your child has:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Earaches
<input type="checkbox"/> Faulty elimination	<input type="checkbox"/> Headaches	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Repeated colds	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Stomachaches
<input type="checkbox"/> Other, please describe _____		

### Speech and Language History

1. Can you understand your child's speech?

All/most of the time \_\_\_\_ Some of the time \_\_\_\_ Little of the time \_\_\_\_\_

2. Can others understand your child's speech?

All/most of the time \_\_\_\_ Some of the time \_\_\_\_ Little of the time \_\_\_\_\_

3. What is the primary language spoken in your home? \_\_\_\_\_

4. Are any other languages spoken in your home? Yes \_\_\_\_ No \_\_\_\_\_

If so, please list: \_\_\_\_\_

5. Uses language effectively to communicate with peers, adults? Yes \_\_\_\_ No \_\_\_\_\_

6. Maintains eye contact during conversation? Yes \_\_\_\_ No \_\_\_\_\_

### Hearing and Vision History

1. Has your child's hearing ever been checked? Yes \_\_\_\_ No \_\_\_\_\_

If so, where? \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Results: \_\_\_\_\_

2. Do you have any concerns regarding your child's hearing? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe \_\_\_\_\_

3. Has your child had a lot of ear infections? Yes \_\_\_\_ No \_\_\_\_ At what ages? \_\_\_\_\_

4. Has your child's vision ever been checked? Yes \_\_\_\_ No \_\_\_\_\_

If so, where? \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Results: \_\_\_\_\_

5. Do you have any concerns regarding your child's vision? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe: \_\_\_\_\_

6. Does your child have listening or attentional problems (e.g., easily distracted short attention span, darts from one activity to another)? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe:  
\_\_\_\_\_

### General Information

1. How many different places has your child lived? \_\_\_\_\_

2. Has your child attended preschool? Yes \_\_\_\_ No \_\_\_\_\_

If so, where and when \_\_\_\_\_

How did your child respond to this experience?  
\_\_\_\_\_

3. Are there any illnesses or special circumstances in the home which affect your child?

Yes \_\_\_\_ No \_\_\_\_ If so, please describe

4. Have there been any changes in your child's life that may have been stressful or upsetting?

Yes \_\_\_\_ No \_\_\_\_ If so, please describe \_\_\_\_\_

5. Does your child have any nervous habits or special fears? Yes \_\_\_\_ No \_\_\_\_\_

If so, please describe \_\_\_\_\_

6. Do you feel your child is shy? Yes \_\_\_\_ No \_\_\_\_\_

7. Has your child received any educational support services (e.g., special education/OT/PT/speech/language)? Yes \_\_\_\_ No \_\_\_\_

If so, please describe \_\_\_\_\_

8. What are your child's favorite activities and interests? \_\_\_\_\_

9. What does your child do that causes him/her to be disciplined most often? \_\_\_\_\_

10. What is the most effective discipline for your child? \_\_\_\_\_

11. Compared with other children his/her age, how well does your child:

Not As Well   About the Same   Better

Get along with siblings?	_____	_____	_____
Get along with friends?	_____	_____	_____
Behave with parents?	_____	_____	_____
Play alone?	_____	_____	_____
Play with others?	_____	_____	_____

12. What is your child's attitude toward starting school?

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13. Please check any areas of concern you have about your child:

_____ Eating	_____ Getting along with adults	_____ Bed-wetting
_____ Fears	_____ Uses baby talk	_____ Nightmares
_____ Sulking	_____ Nervous habits	_____ Whining
_____ Speech	_____ Wants to be babied	_____ Nail biting
_____ Coordination	_____ Doesn't sleep alone	_____ Destructive
_____ Daydreaming	_____ Temper tantrums	_____ Cries easily
_____ Fighting	_____ Restless sleeping	_____ Overly neat
_____ Teasing	_____ Complains of being sick	_____ Separation difficulty
_____ Jealousy	_____ Getting along with other children	_____ Shy in new situations
_____ Disobedience	_____ Lack of concern for other children	_____ Reaction to birth of siblings

14. Please note anything else you think may be helpful in making your child's school experience successful:

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**Name of person completing form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to child:**

If questionnaire was completed by an interviewer, please sign below:

**Interviewer:** \_\_\_\_\_ **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

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

## TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT *Please print or type clearly*

SCHOOL

GRADE

STUDENT NAME

DATE OF BIRTH

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  English  Other \_\_\_\_\_  
home or residence? *specify*

2. What language(s) are spoken most of the time  English  Other \_\_\_\_\_  
to the student, in the home or residence? *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>
<b>Understands English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Speaks English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reads English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Writes English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>