

NOTE TO SCHOOL / LEAS: **Please assist students and families filling out this form.** This form should be included as the top page of registration materials that the district shares with families. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, the student **is not required** to submit proof of residency and other required documents that may be part of the registration process.

HOUSING QUESTIONNAIRE

Name of LEA _____

Name of School _____

Name of Student _____

Last

First

Middle

Gender _____ Date of Birth ____/____/____ Grade _____ ID # _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____

The answer 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 an 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) _____
- Is loss of housing due to natural disaster? If yes please explain _____
- Permanent housing

Print Name of Parent / Guardian

Signature of Parent / Guardian

If ANY box other than "In Permanent Housing: is checked, then the student/family should be immediately referred to the MV Liaison. In such cases, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. After the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records. The district's LEA liaison must help the student get any other necessary documents or immunizations.



LIBERTY CENTRAL SCHOOL DISTRICT

CENTRAL REGISTRATION OFFICE
(845) 292-5400 EXT 2331 FAX-(845) 292-1164



REQUEST FOR RECORDS

DATE: _____

TO: _____

School Name

School Address

School Phone Number

School Fax Number

RE: _____ DOB _____ GRADE _____

The above named student is in the process of enrolling in our school. Please send the following information:

_____ Transcript

_____ Health Records, including proof of last physical and required immunizations

_____ Quarterly grades as well as grades at time of withdrawal and standardized test scores

_____ **NYS Science Investigations (3-8)** include a copy of answer packets for all completed or a written attestation of successful completion

_____ IEP, psychological evaluations and other special education records

_____ Birth Certificate

_____ Attendance Records

_____ Discipline Records

I hereby authorize the above information to be released to the Liberty Central School District.

Signature of Parent/Guardian _____

Relationship to student _____ Date _____

Please fax any special education records including IEP's and evaluations to the Student Services Office at 845-295-9203.

Thank you.

Liberty Elementary School
201 North Main Street
Liberty NY 12754
(845) 292 5400 ext. 2503
Fax - (845) 295-9201

Liberty Middle School
145 Buckley Street
Liberty NY 12754
(845) 292 5400 ext. 2311
Fax - (845) 292-5691

Liberty High School
125 Buckley Street
Liberty NY 12754
(845) 292 5400 ext. 2006
Fax - (845) 292-7262



LIBERTY CENTRAL SCHOOL DISTRICT



Student Information

Student Last Name	First Name	Middle Name
Date of Birth	Place of Birth / City, State	
Home Phone	Grade	Gender
Mailing Address		City / State / Zip
Physical Address		City / State / Zip
Previous Address before moving to the Liberty Central School District		

Race : Caucasian (White) Black or African American Asian
 American Indian or Alaskan Native Native Hawaiian or other Pacific Islander

Ethnicity: Hispanic or Latino **Primary Language spoken at home** _____

RESIDENCY

LIVING WITH:

<input type="checkbox"/> Both Biological Parents	<input type="checkbox"/> Foster Parents (2999 Form needed) **
<input type="checkbox"/> Biological Mother ONLY	<input type="checkbox"/> Self (Unaccompanied Youth)
<input type="checkbox"/> Biological Father ONLY	<input type="checkbox"/> Group Home or Court Placed Residence (COURT DOCUMENTS)
<input type="checkbox"/> Mother / Stepfather	<input type="checkbox"/> Father / Stepmother
<input type="checkbox"/> Other (explain) _____	

Parental Military Information

Are either parents active in the Armed Forces? Yes/No If yes what branch of the military? _____

Estimated Date _____ Anticipated Discharge Date _____

Parent / Guardian Signature _____

Student Name: _____ Grade: _____ DOB: _____

Mother		_____			
	Primary Contact	First Name	Last Name		
	Receives Mail	_____			
	Pick Up	Mailing Address		City	State Zip
	Custody Alert	_____			
	Custody Papers	Physical Address	City	State	Zip
	Parent Portal	Home	Cell	Work	
		Email _____ Parent Portal? Yes / No			
Father		_____			
	Primary Contact	First Name	Last Name		
	Receives Mail	_____			
	Pick Up	Mailing Address		City	State Zip
	Custody Alert	_____			
	Custody Papers	Physical Address	City	State	Zip
	Parent Portal	Home	Cell	Work	
		Email _____ Parent Portal? Yes / No			
Step Parent		_____			
	Primary Contact	First Name	Last Name		
	Receives Mail	_____			
	Pick Up	Mailing Address		City	State Zip
	Custody Alert	_____			
	Custody Papers	Physical Address	City	State	Zip
	Parent Portal	Home	Cell	Work	
		Email _____ Parent Portal? Yes / No			
Guardian		_____			
	Primary Contact	First Name	Last Name		
	Receives Mail	_____			
	Pick Up	Mailing Address		City	State Zip
	Custody Alert	_____			
	Custody Papers	Physical Address	City	State	Zip
	Parent Portal	Home	Cell	Work	
		Email _____ Parent Portal? Yes / No			

Student Name: _____ Grade: _____ DOB: _____

EMERGENCY INFORMATION - 2 people that can pick your child up in case parent / guardian can not be reached

FIRST CONTACT		
Name: _____	Home _____	Cell _____
Relationship _____	Work Phone _____	Extension _____
SECOND CONTACT		
Name: _____	Home _____	Cell _____
Relationship _____	Work Phone _____	Extension _____

Family Medical Insurance _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

General Health ___ Poor ___ Fair ___ Good ___ Excellent

Full Term Pregnancy ___ Yes ___ No Complications during the pregnancy?

Any serious injuries, operations or illnesses? _____

Asthma ___ Yes ___ No Medication required? _____

	Dates	Yes	No		Dates	Yes	No
Chicken Pox				Tuberculosis			
German Measles				Heart Disease			
Measles				Rheumatic Fever			
Mumps				Diabetes			
Scarlet Fever				Hepatitis			
Whooping Cough				Epilepsy			
Frequent Sore Throats				Convulsions			
High Fevers				Allergies			
Frequent Earaches							

Does Student have or ever had a problem related to:

	Dates	Yes	No		Dates	Yes	No
Vision				Hearing			
Dental				Orthopedic			
Neurological				Emotional			

Health Office

Recommendations: _____

Parent / Guardian Signature

Date

Date _____

Student Name: _____ Grade: _____ DOB: _____

Siblings / Children Living at Same Address

NAME	GENDER	BIRTH DATE	GRADE	PRESENT SCHOOL

Student's Educational Background

PREVIOUS SCHOOL NAME	ADDRESS	PHONE	GRADES ATTENDED

Student's Special Programs

_____ Counseling	_____ Math AIS	_____ Reading AIS	_____ ESL
_____ Speech	_____ Section 504 Plan	_____ Other (explain)	

Does your child have an IEP? Yes _____ No _____ **COPY RECEIVED** _____ Yes _____ No

I verify that the above information is correct.

Parent / Guardian Name (print)

Parent / Guardian Signature

Date



LIBERTY CENTRAL SCHOOL DISTRICT



Student Evacuation Plan 2025-2026

Student Name: _____ Grade: _____ DOB: _____

The following information will be kept on file to be used in the event of a true emergency or disaster which might require **STUDENT DISMISSAL FROM AN ALTERNATE SITE AND** will be used to dismiss your child during any Mock Emergency Evacuation Drills.

Your child will be dismissed **ONLY** from the alternate location as follows:

PLEASE PICK ONLY 1 OF THE FOLLOWING:

My child, _____ is to:

RIDE BUS HOME _____

RIDE BUS TO _____
Name and Physical Address

WALK HOME _____
Address

WALK TO _____
Name and Physical Address

PICKED UP BY _____
Name and Phone Number

Parent / Guardian Name _____ Phone Number _____

Parent / Guardian Signature _____ Date _____

Any additional information we should be aware of?

PLEASE MAKE SURE YOUR CHILD KNOWS THAT HE/SHE MUST FOLLOW THESE PLANS AS YOU HAVE STATED ABOVE: Disciplinary action, including suspension from school, will be taken for deviation from this plan.



LIBERTY CENTRAL SCHOOL DISTRICT



Acceptable Use Policy Computer Network and the Internet

2025-2026

Student and Parent/Guardian Signature Page

DIRECTIONS

The student and his or her parent/guardian should complete the form below and return it to their teacher and / or librarian. An Internet Passport (identification card) will be issued and access to the Internet provided.

STUDENT

I have read and I understand the Acceptable Use Policy of the Liberty Central School District (in the student handbook). By signing below, I agree to the terms for the appropriate use of the DCN and the Internet. I understand that failure to follow the rules will result in suspension and/or revocation of privileges, and depending on the violation, possible criminal and/or financial penalties.

Printed Name of Student

Student Signature

Date

Grade

PARENT / GUARDIAN

I have read and I understand the Acceptable Use Policy of the Liberty Central School District (in the student handbook). By signing below, I agree to allow my child the privilege of using the DCN and the Internet. I understand that failure to follow the rules will result in suspension and/or financial penalties. I also reserve the right to cancel this privilege in writing at any time and at my own discretion.

Printed Name of Parent/ Guardian

Parent / Guardian Signature

DATE



LIBERTY CENTRAL SCHOOL DISTRICT



Photo / Medical / Field Trip / Auto Call PERMISSION

2025-2026

Student Name: _____ Grade: _____ DOB: _____

1. I give my permission to release medical information regarding my child to staff that needs to know.

_____ YES _____ NO

2. I give my permission to photograph my child to highlight special events, projects, and competitions. I understand that these photographs may be sent to local newspapers, posted on Facebook, school calendar, school newsletter, etc.

_____ YES _____ NO

3. I give my permission to use my child's photograph in the yearbook.

_____ YES _____ NO

4. I give permission for my child to participate in all field trips to other Liberty Central School District buildings that are offered during the school year. I understand that if I do not wish my children to participate in a specific trip, I will contact the teacher directly.

_____ YES _____ NO

5. I give permission for Liberty Central School District to use auto calls to notify me about attendance / closings etc.

_____ YES _____ NO

Parent / Guardian Signature

Date



LIBERTY HIGH SCHOOL



Guidance Office
125 Buckley Street
Liberty NY 12754
(845) 292-5400 Ext. 2006

September 1, 2024

Dear Parents/Guardians:

In accordance with the No Child Left Behind Act that was passed in January 2002, the Liberty Central School District must disclose the names, addresses, and telephone numbers of students to military recruiters and institutions of higher learning who request the information.

Parents, or students who are at least 18 years old, may ask the district in writing to withhold the information listed above when requested by a military recruiter or institution of higher learning. You must sign the statement below and return it to the Guidance office on or before October 1, 2025.

Please note that when your child registers for the selective service or registers to vote, his/her information will be accessible to military recruiters and other institutions. If you have any questions, please contact the Guidance office at (845) 292-5400 ext. 2006.

NOTIFICATION TO SCHOOL DISTRICT

Please DO NOT release the name, address, and telephone number of my child to military recruiters or institutions of higher learning.

Student Name (please print)

Parent / Guardian Signature

Date

Student Signature (if 18 years or older)

Date



LIBERTY CENTRAL SCHOOL DISTRICT

Committee on Special Education

Student Services Office

145 Buckley Street

Liberty NY 12754



MEDICAID CONSENT

DATE:
RE:
DOB:
Client ID# (CIN):

Dear Family of:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education plan (IEP).

This consent allows the school district to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____ have received a written notification from the school district that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District may access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/ my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid;
- I have the right to withdraw consent at anytime; and
- The school district must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

RECORDS TO BE SHARED (RECORDS OR INFORMATION ABOUT SERVICES YOUR CHILD RECEIVES)

IEP	Medication Administration Report
Special Transportation Log	Evaluation Reports
Other Personally Identification Information	Written Order
Any other Specific Records Pertaining to Student's Services or Program	Session Notes

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent / Guardian Signature _____ Print Name _____

Date _____



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.

First	Middle	Last
Month	Day	Year
		<input type="checkbox"/> Male <input type="checkbox"/> Female
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<i>specify</i>	_____
	<input type="checkbox"/> Guardian(s)	_____	<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

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? _____

 Signature of Parent or of Person in Parental Relation

Month: Day: Year:

 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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
 MO. DAY YR. ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:



LIBERTY CENTRAL SCHOOL DISTRICT



NEED OF IMMUNIZATION RECORDS FORM

This form is to be sent to the school nurse.

Date Registration Completed: _____

The following student(s) are not up to date with their mandated immunization requirements or did not provide up-to-date records upon registering with the Liberty Central School District.

_____	LES LMS LHS	_____
Student Name	Circle One	Date
_____	LES LMS LHS	_____
Student Name	Circle One	Date
_____	LES LMS LHS	_____
Student Name	Circle One	Date
_____	LES LMS LHS	_____
Student Name	Circle One	Date
_____	LES LMS LHS	_____
Student Name	Circle One	Date

** Note: Parents / Guardians have up to 14 days to provide proof of immunizations. For students new to the country or new to the state, the 14 day proof of immunizations may be extended to 30 days. Parents of a homeless student, or an unaccompanied homeless student, should be assisted with obtaining any necessary immunizations within the applicable grace period.*



**LIBERTY CENTRAL SCHOOL
DISTRICT**
Registration Department



I, _____ Parent / Guardian waive the right for

Student(s) Name to start school on the following day after completing the registration process.

My child(ren) will start attending school on the _____
Date

Parent Signature

Parent Name (print)

Date



LIBERTY CENTRAL SCHOOL DISTRICT
STUDENT SERVICES



NOTICE TO THE PARENTS
SPECIAL EDUCATION SERVICES

If you suspect that your child may have a physical, cognitive, or emotional disability, you have the right to refer your child to the District's Committee on Special Education for an evaluation and a determination as to whether your child is eligible to receive special education services and programs. More information regarding your rights is set forth in the New York State Education Department's Parent's Guide to Special Education in New York State for Children Ages 3 - 21, available at:

<http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf>.

To refer your child to the Committee on Special Education, or to obtain more information regarding the District's special education services and programs, please contact:

Director of Student Services
Liberty Central School District
145 Buckley St
Liberty NY 12754
(845) 292-5400 x 5113

FAXED BY _____

DISTRICT _____



NEW YORK STATE MIGRANT EDUCATION PROGRAM IDENTIFICATION & RECRUITMENT OFFICE PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Every Student Succeeds Act (ESSA). The MEP provides a variety of educational services to families who work in agriculture, regardless of their nationality or legal status. This program is free of charge to all eligible families and may include tutoring, free lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take few minutes to complete this questionnaire.

**Have you or has someone in your family worked on a farm?
Have you moved during the past three years?**

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answer YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____ City/Town _____

Telephone number: (____)-____-____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

**To submit this referral please fax to 845-257-2953 or mail to Mid-Hudson Migrant Education Program-
353 VH Annex 1 Hawk Drive New Paltz, NY 12561**





FAXED BY _____ DISTRICT _____
PROGRAMA DE EDUCACIÓN PARA MIGRANTES DEL ESTADO DE
NEW YORK

OFICINA DE IDENTIFICACIÓN Y RECLUTAMIENTO- ENCUESTA PARA PADRES

El programa de Educación para Migrantes (MEP), está autorizado por el Título I, Parte C de la Ley Cada Estudiante Triunfa (ESSA). EL MEP provee una variedad de servicios educativos para las familias que trabajan en la agricultura, **sin importar su nacionalidad o estado legal**. Este programa **es gratuito** para aquellas familias elegibles y puede incluir servicios de tutorías, elegibilidad de almuerzo gratuito, excursiones, programa de verano, actividades de involucramiento para padres, programa de emergencias y referidos a otras organizaciones o agencias.

Por favor tome unos minutos para completar este cuestionario.

¿Usted o alguien en su familia ha trabajado en la agricultura?

¿Se han mudado durante los últimos 3 años?

- Cualquier trabajo agrícola (como plantando, seleccionando, o cosechando frutas o vegetales, cultivando o cortando flores o árboles, trabajo en lechería u otro rancho de animales, pescando, etc.)
- Trabajando en la cultivación o procesamiento de los árboles.
- Trabajando en una planta de procesamiento, empacando, lavando o cortando vegetales, frutas o carnes.



Si usted contestó que sí, por favor complete la siguiente información:

Nombre del Padre/Encargado: _____

Dirección Física: _____ Ciudad _____

Teléfono: (____)-____-____ Mejor tiempo para ser contactado _____ AM/PM

Dirección anterior: _____

Nombre del estudiante: _____ Edad _____ Grado _____

Nombre del estudiante: _____ Edad _____ Grado _____

Para someter este referido, por favor envíelo por fax a 845-257-2953, o por correo a Mid-Hudson Migrant Education Program- 353 VH Annex - 1 Hawk Drive New Paltz, NY 12561

