



LIBERTY CENTRAL SCHOOL DISTRICT



**Pre-K Student Registration Checklist - *For Office Use ONLY***

Date \_\_\_\_\_

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

Physical Parent/Guardian \_\_\_\_\_ Custody Paper Y / N

\_\_\_\_\_ Admission, Emergency Form, Student Health Form

\_\_\_\_\_ Proof of Residency

\_\_\_\_\_ Temporarily Displaced

\_\_\_\_\_ Picture ID of Parent / Guardian

\_\_\_\_\_ Emergency Dismissal Form

\_\_\_\_\_ Proof of Date of Birth

\_\_\_\_\_ Immunization Records

\_\_\_\_\_ Home Language Form

\_\_\_\_\_ Permission for Medical Info / Photo / Video / Field Trips

\_\_\_\_\_ Bus Information Form

\_\_\_\_\_ Custody Papers if applicable

\_\_\_\_\_ Physical Form

\_\_\_\_\_ Request for Records



# LIBERTY CENTRAL SCHOOL DISTRICT



## PK Busing Information Form

Date \_\_\_\_\_

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

Parents/Guardians \_\_\_\_\_

Student lives with \_\_\_\_\_

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

Mother Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Father Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

### Emergency Contacts

Name \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Name \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

**Please Note - ANY change in the students' busing requires prior written notification to the teacher.**

**\*Any student under the age of 4 must use a carseat on the bus.**

Pick up Address \_\_\_\_\_

Drop off Address \_\_\_\_\_

\_\_\_\_\_ **I will be transporting my child to and from school.**

Names of persons at drop-off that can take my child off the bus.

\_\_\_\_\_  
\_\_\_\_\_

Medical concerns bus driver should be made aware of : \_\_\_\_\_

Other Children living in the household attending school:

<u>Name</u>	<u>Grade</u>	<u>School Building</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____



# 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
- \_\_\_\_\_ NYSESLAT / NYSITELL Scores
- \_\_\_\_\_ Home Language Questionnaire

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  
Grades PK - 4  
201 North Main Street  
Liberty NY 12754  
(845) 292 5400 ext. 2503  
Fax - (845) 295-9201

Liberty Middle School  
Grades 5 - 8  
145 Buckley Street  
Liberty NY 12754  
(845) 292 5400 ext. 2311  
Fax - (845) 292-5691

Liberty High School  
Grades 9 - 12  
125 Buckley Street  
Liberty NY 12754  
(845) 292 5400 ext. 2006  
Fax - (845) 292-7262

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



## 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: \_\_\_\_\_

<b>Mother</b>		_____			_____		
<input type="checkbox"/>	<b>Primary Contact</b>	First Name		Last Name			
<input type="checkbox"/>	<b>Receives Mail</b>	_____			_____		
<input type="checkbox"/>	<b>Pick Up</b>	Mailing Address		City	State	Zip	
<input type="checkbox"/>	<b>Custody Alert</b>	_____			_____		
<input type="checkbox"/>	<b>Custody Papers</b>	Physical Address		City	State	Zip	
<input type="checkbox"/>	<b>Parent Portal</b>	Home _____	Cell _____	Work _____			
		Email _____		Parent Portal? Yes / No			
<b>Father</b>		_____			_____		
<input type="checkbox"/>	<b>Primary Contact</b>	First Name		Last Name			
<input type="checkbox"/>	<b>Receives Mail</b>	_____			_____		
<input type="checkbox"/>	<b>Pick Up</b>	Mailing Address		City	State	Zip	
<input type="checkbox"/>	<b>Custody Alert</b>	_____			_____		
<input type="checkbox"/>	<b>Custody Papers</b>	Physical Address		City	State	Zip	
<input type="checkbox"/>	<b>Parent Portal</b>	Home _____	Cell _____	Work _____			
		Email _____		Parent Portal? Yes / No			
<b>Step Parent</b>		_____			_____		
<input type="checkbox"/>	<b>Primary Contact</b>	First Name		Last Name			
<input type="checkbox"/>	<b>Receives Mail</b>	_____			_____		
<input type="checkbox"/>	<b>Pick Up</b>	Mailing Address		City	State	Zip	
<input type="checkbox"/>	<b>Custody Alert</b>	_____			_____		
<input type="checkbox"/>	<b>Custody Papers</b>	Physical Address		City	State	Zip	
<input type="checkbox"/>	<b>Parent Portal</b>	Home _____	Cell _____	Work _____			
		Email _____		Parent Portal? Yes / No			
<b>Guardian</b>		_____			_____		
<input type="checkbox"/>	<b>Primary Contact</b>	First Name		Last Name			
<input type="checkbox"/>	<b>Receives Mail</b>	_____			_____		
<input type="checkbox"/>	<b>Pick Up</b>	Mailing Address		City	State	Zip	
<input type="checkbox"/>	<b>Custody Alert</b>	_____			_____		
<input type="checkbox"/>	<b>Custody Papers</b>	Physical Address		City	State	Zip	
<input type="checkbox"/>	<b>Parent Portal</b>	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**

<b>FIRST CONTACT</b>		
Name: _____	Home _____	Cell _____
Relationship _____	Work Phone _____	Extension _____
<b>SECOND CONTACT</b>		
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

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 2026-2027



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

2026-2027

### 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

2026-2027

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 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.*

<b>STUDENT NAME:</b>		
First	Middle	Last
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
<b>PARENT/PERSON IN PARENTAL RELATION INFO:</b>		
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>	<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:





**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**

