



Dear Families,

We hope this letter finds you in good health and high spirits. As we gear up for the upcoming school year, we are thrilled to extend a warm welcome to all the new Pre-Kindergarten parents joining our community.

Starting school is a significant milestone for both parents and their little ones, and we want to assure you that we are here to make this transition as smooth and enjoyable as possible. Our commitment to providing a nurturing and enriching environment for your child is at the forefront of everything we do.

Enclosed you will find documents and information necessary to complete the Early Bridges enrollment process. Please complete these enclosed forms and return to the Lake View Campus Main Office by May 1st, 2026. The successful completion of these forms will allow us to effectively prepare for your child's Pre-K screening. We will complete a DIAL assessment with your child. The DIAL is a screening tool used to assess a child's motor, speech, and academic baseline to determine potential needs. This assessment will be completed by PK staff and related service providers and the results will be shared with your family.

We are enthusiastic about the upcoming school year and look forward to building a positive and collaborative relationship with you and your child. Together, we can create an educational journey filled with curiosity, discovery, and growth.

If you have any immediate questions or concerns, please do not hesitate to contact our school office. Once again, welcome to the Adirondack Community Action Programs, Inc. and Boquet Valley Central School District family!

Warm regards,

Mallory Finnegan Head Start
Head Start/Early Head Start Director
Adirondack Community Action Programs, Inc.

Lee Kyler
Principal, Lake View Campus
Boquet Valley Central School District



Early Bridges Enrollment

The **Early Bridges** program is a collaborative partnership between the Boquet Valley Central School and Adirondack Community Action Program, Inc.'s Head Start. This partnership created a Pre-Kindergarten program that is led by certified teachers and supported by Head Start staff. The program follows the school calendar and runs 7:45 AM to 3:10 PM. **Please note that completing this Enrollment packet for your child, does not necessarily mean that your child will be selected to participate in the Early Bridges program.**



Who: Any child who will be three or four years of age on or before December 1, 2026 will be eligible.

Items needed:

- Child's Birth Certificate or Baptismal Certificate
- Immunization records
- Income verification
- Proof of residency
- Completed physical form
- Dental Health Certificate

If you have any questions, please contact Lake View Campus at (518) 962-8244.



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.

STUDENT NAME:		
First	Middle	Last
DATE OF BIRTH:		GENDER:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
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	_____
			<i>specify</i>
			<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
			<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
			<input type="checkbox"/> Does not write

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:



Social Services Received (check all that apply): TANF SNAP Supplemental Security Income

Please state who receives Supplemental Security Income, if applicable. _____

Is the child in foster care? Yes No

Did your child participate in a Preschool or Head Start program? Yes No

If yes, which program? _____ Name of School: _____

If no, did your child participate in daycare? Yes No If yes, who? _____

Was the daycare registered? Yes No

Does your child have an IEP through CPSE or early education services? Yes No

Does your child have any special needs, including special education? (If So, Please explain)

Have there been any changes or additions in the family in the past year?

For example: Health issues, changes in marital status, changes in occupation, new siblings.

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Seizures	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI _____ kg/m²

Percentile (Weight Status Category): < 5th 5th- 49th 50th- 84th 85th- 94th 95th- 98th 99th and >

Hyperlipidemia: Yes Not Done **Hypertension:** Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		

System Review Within Normal Limits

Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached	*Required only for students with an IEP receiving Medicaid	

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/		<input type="checkbox"/>
Color Perception Screening	<input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
Notes					
Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.					Not Done
Pure Tone Screening	Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes		<input type="checkbox"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominic Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.					
<input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball.					
<input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.					
<input type="checkbox"/> Other Restrictions:					
Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level.					
Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V					
<input type="checkbox"/> Other Accommodations*: (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.					
*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

STUDENT EMERGENCY FORM

Please supply all information requested below and return this form to the school. This form will be kept on file in the district office for the school year. If more than one form is needed per family, please contact the office for additional forms.

Student Name:	Date of Birth:	Grade:
Mailing Address:	City:	Zip:
Physical Address:	City:	Zip:
Home Phone:	Cell Phone:	
Email Address:		

Parent/Guardian Information: To serve your child in case of accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification; it is necessary that you furnish the following information for emergency calls.

Mothers Name:	
Business Address:	
Business Phone:	Cell Phone:
Email Address 1:	Email Address 2:

Father's Name:	
Business Address:	
Business Phone:	Cell Phone:
Email Address 1:	Email Address 2:

Emergency Contacts: Please designate two emergency contacts who will assume temporary care of your child, if you cannot be reached in the event of an accident, sudden illness, emergency closing and/or other occurrence requiring immediate parental notification.

Contact #1:	Relationship to Student:	
Address:		
Home Phone:	Cell Phone:	Work Phone:

Contact #2:	Relationship to Student:	
Address:		
Home Phone:	Cell Phone:	Work Phone:

Medical Information:

Physician (Full Name):	
Address:	Phone Number:
Hospital/Dr. Office:	

I, the undersigned, do here authorize officials of the Boquet Valley Central School District to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of said child.

I will not hold the school district financially responsible for the emergency care and/or transportation of the child.

Date

Signature of Parent or Guardian



Allergy and Anaphylaxis Information

Child's Name: _____

Child has allergy to: _____

Child has Asthma: Yes _____ No _____

Child has had anaphylaxis: Yes _____ No _____

Child may carry medicine: Yes _____ No _____

Child may give him/herself medicine: Yes _____ No _____

(If child refuses/is unable to self-treat, an adult must give medication)

CONTACTS:

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

EMERGENCY CONTACTS:

Name: _____ Relationship: _____

Phone number(s): _____

Name: _____ Relationship: _____

Phone number(s): _____

DENTAL EXAMINATION REPORT

ACAP Inc., Early Head Start/Head Start
Ph: 518-873-3207 Fax: 1-838-831-1223

Child's Name: _____		Birth Date: _____	
Date of Exam: _____		Routine Exam _____	Follow up Treatment _____
Preventative Care Received Today:	Comments: _____		
<input type="radio"/> Cleaning	_____		
<input type="radio"/> Fluoride Application	_____		
<input type="radio"/> Dental Education	_____		
<input type="radio"/> Sealants	_____		
Oral Health Status:	Comments: _____		
<input type="radio"/> No Oral Health Disease	_____		
<input type="radio"/> Active Oral Health Disease	_____		
<input type="radio"/> Cavities (# _____)	_____		
Treatment Needed at Next Visit:	Approximate Number of Visits Needed: _____		
<input type="radio"/> No Treatment Needed	Date of Treatment Appointment(s): _____		
<input type="radio"/> Preventative Care	_____		
<input type="radio"/> Restoration	_____		
<input type="radio"/> Extraction	Date/Time of Next Routine Recall: _____		
Referrals:	Referred to: _____		
<input type="radio"/> Needs Referral to Pediatric Dentist	_____		
<input type="radio"/> Needs Treatment under General Anesthesia	_____		
	Appointment Date/Time: _____		
Dentist Signature: _____		Date: _____	
Dentist Printed Name: _____		Phone: _____	
Address: _____			



Early Bridges Annual General Consent Form

I hereby give permission for my child _____
to participate in the following:

Health Screenings:

Yes___ No___ Hearing/Vision
Yes___ No___ Height / Weight / BMI
Yes___ No___ Blood Pressure
Yes___ No___ Dental Examination

Yes___ No___ Developmental Screening

Yes___ No___ Social Emotional Screening

Yes___ No___ Pictures / Videos
(used for ACAP/BVCS internal and external social platforms)

Other:

Yes___ No___ Local Library
Yes___ No___ Field Trips
Yes___ No___ Transportation to / from Site
Yes___ No___ Application of Sunscreen
Yes___ No___ EB Counselor's Group Session (2x/yr)
Yes___ No___ Join a therapist during a session
Yes___ No___ Transition information to school / EB
(Which may include: Transitional observation, health records, family contact information, observation by local school personnel, child assessment summary or special service record.)

I understand that the Early Bridges Program deems these services necessary, advisable and are typical elements of the preschool experience. The purpose and nature of any examinations, screenings, and / or observations, have been explained to me. Any and all results may be shared. This permission is valid for one program year after the signature.

Parent / Guardian Signature _____ Date _____

Staff Signature _____ Date _____

Possible items used to verify income:

W-2's	Two consecutive pay stubs
SNAP Documentation	Income tax return form
Documentation of unemployment	Documentation of SSI
Child Support	Documentation of TANF
Statement of total wages signed and dated by your employer	Self-employment- copy of "Schedule C" income tax form

I would like the above, named applicant to be considered for enrollment in Early Bridges. I understand that my financial circumstances, residence, and child's age (if applicable) will be considered when determining eligibility and placement. I certify the above statements and income submitted are true and accurate to the best of my knowledge. I agree to give my full support and cooperation by visiting the site, volunteering, attending parent meetings, and welcoming staff for home visits.

Guardian/Applicant Signature: _____ Date: _____

EHS/HS Staff Signature: _____ Date: _____

For staff use only:	Staff Initial: _____
Personal Interview:	
On Site: _____ Home Visit: _____	
Phone Interview: _____	
Received Application by mail: _____	
Notes:	

Pre-Kindergarten Screening
Required Paperwork Checklist

Please use this checklist to help you prepare for Kindergarten screening. The following documents must be completed and on file with Boquet Valley Central School District in order for your child to begin school.

Please return all paperwork by May 1, 2026 at the latest!

- Home Language Questionnaire- (required) (2 pgs)
- Student Residency Questionnaire (required)
- Pre-Kindergarten Registration Form (2 pgs)
- Student Emergency Contact Form
- Consent Form
- Dental Form
- Health Exam Form (2 pgs)
- Food Allergy and Sensitivity Notification
- Provider/Parent Medication Attestation (if applicable)
- Income Verification
- Proof of Residency
- Birth Certificate (Copy)
- Vaccination Record (copy)

Thank you for your cooperation! If you have any questions, please do not hesitate to contact us at 518-962-8244.

Office use only: ready to enroll enrolled sent to ACAP: _____