Island Park Union Free School District

99 RADCLIFFE ROAD
ISLAND PARK, NEW YORK 11558

PHONE (516) 434-2630
FAX (516) 431-2372

VINCENT RANDAZZO
SUPERINTENDENT OF SCHOOLS

Kindergarten Registration

Dear Parent:

To register your child in the Island Park School District, the following items are necessary:

A. PROOF OF AGE:

Certified birth certificate or record of baptism (including a certified transcript of a foreign birth certificate or record of baptism) giving the date of birth. Where the birth certificate or record of baptism is not available a passport (including a foreign passport) may be used. If none of these documents are available, other documentary evidence in existence for two (2) years or more can be used to determine a child's age (examples include, but are not limited to, hospital or health records, official driver's license, state or other government issued identifications, school photo identification with date of birth, consulate identification card, military dependent identification card, documents issued by federal, state or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement), court orders or other court-issued documents, Native American tribal document, or records from non-profit international aid agencies and voluntary agencies).

B. PROOF OF RESIDENCY:

All parents or guardians registering students must be residents of the Island Park School District. Parents or guardians must submit three different pieces of documentation and/or information as evidence of the physical presence of the parent or guardian in the Island Park School District. Such documentation may include: (a) copy of a residential lease or proof of ownership of a house or condominium, such as a deed or mortgage statements; (b) a statement by 3rd party landlord or owner, or tenant from whom the parent or guardian leases or shares property within the Island Park School District; (c) statements by third parties relating to parent's or guardian's' physical presence in the Island Park School District; and/or (d) other forms of documentation and/or information establishing physical presence in the Island Park School District which may include, but not limited to, pay stub, income tax form, utility or other bills, membership documents based on residency, voter registration documents, official driver's license, learner's permit or non-driver identification, state or other government issued identification, documents issued by federal, state or local agencies (e.g., local social services agency, federal Office of Refugee Resettlement). All parents or guardians have three (3) business days after initial enrollment to submit documentation and/or information in support of the child's residency in the District.

Each Proof Must Show Your Current Island Park Address

C. IMMUNIZATION RECORDS:

Required under NYS Department of Health Immunization Requirements for School Entrance/Attendance, copy attached. (https://www.health.ny.gov/publications/2370.pdf)*

VACCINES	PRE-K	GRADE K - 5	GRADE 6 -10
DPT/DTap	4 doses	4-5 doses*	3 doses*
TDAP	N/A	N/A	1 dose*
POLIO	3 doses	4 doses*	4 doses*
MMR	1 doses	2 doses	2 doses
HEP B	3 doses	3 doses*	3 doses*
VARICELLA	1 dose	2 doses	2 doses
HIB	1-4 doses*	N/A	N/A
PCV13	1-4 doses*	N/A	N/A
MENINGOCOCCAL	N/A	N/A	1 dose*

All immunizations dates are mandatory and must have a doctor's signature

No child may be admitted to, or allowed to attend, school for more than 14 days without an appropriate immunization certificate or other acceptable evidence of immunization. A school principal may extend this to a 30-day period on a case-by-case basis when a student has transferred from another state or county and can show a good faith effort to get the necessary certificate or other evidence of immunization.

If you have any questions regarding immunizations, please call the school nurse at Francis X. Hegarty (434-2673) or at Lincoln Orens (434-2635).

D. CHECKLIST OF REQUIRED DOCUMENTS/FORMS

- ☐ Proof of age
- ☐ Proof of residency
- ☐ Pupil History
- ☐ Certificate of Immunization
- ☐ Health Examination Form
- ☐ School Admission Health Questionnaire
- ☐ Dentist's Examination Record
- ☐ Housing Questionnaire
- ☐ Home Language Questionnaire
- ☐ Medicaid Consent
- ☐ Authorization to Release Information
- ☐ Special Education History
- ☐ School District News Media Release Form (student's photo or work)
- ☐ Outside News Media Release Form (student's photo or work)
- ☐ Student Application for Use of Computer, Internet & Email
- ☐ Kindergarten Registration
- ☐ School Census
- ☐ Application for Free and Reduced Price School Meals/Milk

The school will contact you by phone and/or email if any information is missing or further clarification is required.

GRADE PLACEMENT

Finally, please note that grade placement may be dependent upon a review of your child's records and/or an educational evaluation of your child.

ISLAND PARK UNION FREE SCHOOL DISTRICT
99 Radcliffe Road
Island Park, New York 11558

PUPIL HISTORY

This form is to be completed by parent or guardian.
All reports dealing with your child will be treated confidentially.

Student's Name_____
(Last) (First) (Middle)

DOB (MM/DD/YYYY)_____ **Home Phone** (_____) _____ **Gender __M __F**

For Office use Only

Student # _____ **Current Grade** _____ **Grade in September** _____

Student's Home Street Address: _____

City, State Zip: _____

Entered District On: _____ Previous Address:_____

Federal Ethnicity and Race (Answer Both Questions)

1) Check one or more from the following five racial groups – Check all that apply to the student – check AT LEAST one:

__American Indian or Alaskan Native __ Asian __ White

__Native Hawaiian or Other Pacific Islander __ Black or African American

2) Is the student Hispanic, Latino, or of Spanish Origin?

____ Yes (Hispanic) ____No (Not Hispanic)

PLEASE LIST ALL SCHOOLS THE STUDENT HAS PREVIOUSLY ATTENDED

Name Address Dates Attended

_____

_____

_____

_____

Are there any custodial/parental restrictions or orders of protection on file? Yes____ No_____

If so, have you given documentation and copies to the registrar? Yes____ No_____

If you answered yes to any of the above, please add any comments that you feel will be helpful to us:

_____

_____

_____

PARENT / GUARDIAN INFORMATION

Parents: Married_____ Separated_____ Divorced_____ Widowed _____ Other_____

Mother's Name _____ Birthplace_____ DOB_____

Address (If Different From Student) _____

E-Mail: _____ Home Phone(_____)_____

Occupation_____ Cell Phone (_____)_____

Business Address_____ Work Phone(_____)_____

Does Student Reside With This Parent/Guardian? __Yes __ No

Does This Parent/Guardian Receive Mail? __Yes __ No

Father's Name _____ Birthplace_____ DOB_____

Address (If Different From Student) _____

E-Mail: _____ Home phone(_____)_____

Occupation_____ Cell Phone (_____)_____

Business Address_____ Work Phone(_____)_____

Does Student Reside With This Parent/Guardian? __Yes __ No

Does This Parent/Guardian Receive Mail? __Yes __ No

Guardian's Name (If Different from Above)_____

Address _____Relationship _____

E-Mail: _____ Home Phone(_____)_____

Occupation_____ Cell Phone (_____)_____

Business Address_____ Work Phone(_____)_____

Does Student Reside With This Parent/Guardian? __Yes __ No

Does This Guardian Have Custodial Rights? __Yes __ No

If separated or divorced, are duplicate mailings required? Yes____ No_____

Please provide Name and Address for second mailing if required:

_____

PLEASE LIST ALL OTHER CHILDREN IN HOUSEHOLD UNDER 18 YEARS OF AGE

Name	Date of Birth	Physical Problems	School Attending

PLEASE LIST ANY OTHER PERSONS RESIDING IN THE HOME OTHER THAN PARENTS OR GUARDIAN, BROTHERS OR SISTERS

Name Relationship to Student

_____

_____

_____

IS THERE ANY OTHER INFORMATION THAT WOULD BE IMPORTANT FOR US TO KNOW TO HELP YOUR CHILD?

_____

_____

EMERGENCY CONTACT INFORMATION

In the event parent(s) or guardian(s) cannot be reached, the persons on the next page (list only adults other than parents, who are 21 or older) have authorization to pick up my child. The following numbers must be "reachable" during normal school hours. Also, the persons listed must agree to assume responsibility for your child.

Emergency Contact 1

First Name: _____ **Last Name:**_____

Relationship to Student:_____ Home Phone: (_____) _____- _____

Cell Phone: (_____) _____- _____ Work Phone: (_____) _____- _____

Emergency Contact 2

First Name; _____ **Last Name:**_____

Relationship to Student:_____ Home Phone: (_____) _____- _____

Cell Phone: (_____) _____- _____ Work Phone: (_____) _____- _____

Emergency Contact 3

First Name; _____ **Last Name:**_____

Relationship to Student:_____ Home Phone: (_____) _____- _____

Cell Phone: (_____) _____- _____ Work Phone: (_____) _____- _____

Emergency Contact 4

First Name; _____ **Last Name:**_____

Relationship to Student:_____ Home Phone: (_____) _____- _____

Cell Phone: (_____) _____- _____ Work Phone: (_____) _____- _____

2022-23 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for **each** vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of **adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6, 7 and 8: 10 years; minimum age for grades 9 through 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 through 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

NYSED requires an annual physical exam for new entrants. Students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the committee on Special Education (CSE).

NEW YORK STATE LAW REQUIRES A CERTIFICATE OF IMMUNIZATION BEFORE ADMITTANCE TO SCHOOL

Demonstrated Serologic evidence of measles, mumps, rubella, hepatitis B or varicella (chickenpox) antibodies is acceptable proof of immunity. Diagnosis by a licensed health care provider (MD, NP, PA) of a child/student having had measles, mumps, varicella (chickenpox) is acceptable proof of immunity.

Diphtheria Toxoid – Containing Vaccine	1)__/__/__ 2)__/__/__ 3)__/__/__ 4)__/__/__ 5)__/__/__
Tetanus Toxoid Containing Vaccine and Pertussis (DTaP, Dt student born on or after 01/01/2005)	1)__/__/__ 2)__/__/__ 3)__/__/__ 4)__/__/__ 5)__/__ __
Tetanus, Diphtheria, & Pertussis Booster Tdap (Born on or after 01/01/94 and entering Grade 6)	1) / /
Polio (IPV or OPV)	1)__/__/__ 2)__/__/__ 3)__/__/__ 4)__/__/__ 5)__/__/__
Measles, Mumps & Rubella (MMR)	1)__/__/__ 2)__/__/__
Measles	1)__/__/__ 2)__/__/__
Mumps	1)__/__/__ 2)__/__/__
Rubella	1)__/__/__
Hepatitis B Pediatric	1)__/__/__ 2)__/__/__ 3)__/__/__ 4)__/__/__
Hepatitis B Adult	1)__/__/__ 2)__/__/__
Varicella (vaccine)	1)__/__/__ 2)__/__/__
Varicella (disease history)	1)__/__/__
Meningococcal conjugate (MenACWY)	1)__/__/__

ADDITION INNOCULATIONS AND TESTS

Mantoux Test	**Tine Test**	**Chest X-Ray**	**Lead Screening**	**Hepatitis A**	**Cholesterol**	**Other (Indicate)**
__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	_____
Result	**Result**	**Result**	**Result**	__/__/__	**Result**	__/__/__
_____	_____	_____	_____		_____	_____

PLEASE CHECK ONE:

_____ This is to certify the aforementioned student has completed all immunizations.

_____ This is to certify the aforementioned student will have completed all immunizations by _____.

_____ _____

Health Care Practitioner's Signature ***Address***

_____ _____

Phone Number ***Date***

_____

Physician Health Care Provider Stamp

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require a review by private healthcare provider and the school medical director.

Francis X. Hegarty Elementary School

100 RADCLIFFE ROAD
ISLAND PARK, NEW YORK 11558

PHONE (516) 434-2670
FAX (516) 431-2372

MR. ADAM FRANKEL
ACTING INTERIM PRINCIPAL

VINCENT RANDAZZO
SUPERINTENDENT OF SCHOOLS

Immunization Requirements for Students in Kindergarten, Grades 1, 2, 3, & 4

Dear Parent/Guardian,

New York State Law Section 2164 requires certain immunizations (shots) to enter kindergarten and attend school. Please check with your health care provider as soon as possible to make sure that your child has all the needed immunizations. They are listed below.

Required Immunizations for Kindergarten & Grades 1, 2, 3, & 4

Immunization	Number of Doses
Polio	**4 doses** or 3 if the 3rd dose at 4 years of age or older
Hepatitis B	**3 doses** or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years
Diphtheria/Tetanus/ Pertussis	**5 doses** or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older
Measles/Mumps/Rubella	**2 doses**
Varicella (Chickenpox)	**2 doses**

Please send proof of immunization to the school nurse where your child will be attending.

Proof of immunization must be **any 1 of the 3** items listed below:

- An immunization certificate signed by your health care provider
- Immunization Registry report (NYSIIS or CIR from NYC) from your health care provider or your county health department
- A blood test (titer) lab report that proves your child is immune to the diseases
  - For varicella (chickenpox), a note from your health care provider (MD, NP, PA) which says your child had the disease is also acceptable.

If you have questions or concerns about immunizations, please contact the school health staff.

Francis X. Hegarty Health Office
Ms. Emily Paolantonio, Nurse
(516)434-2673
epaolantonio@islandparkschools.org

Sincerely,
Adam Frankel
Acting Interim Principal

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	☐	☐		
Sickle Cell Screen-PRN	☐	☐		
Lead Level Required Grades Pre- K & K			**Date**	
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL				

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
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** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **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: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

ISLAND PARK UNION FREE SCHOOL DISTRICT
99 Radcliffe Road
Island Park, New York 11558

SCHOOL ADMISSION HEALTH QUESTIONNAIRE

Name of child _____ Grade _____

Date of birth _____ Age _____

1. Has your child had a routine health examination? Yes ___ No___

   If yes, date of last examination _____

2. Has you child had any illness or injury in the last year? Yes ___ No___

Did this illness/injury require hospitalization? Yes ___ No___

If yes, please give details: _____
_____
_____

3. Does your child have any disabilities? Yes ___ No___

   If yes, please state problem: _____
   _____
   _____

4. Is there any limitation on activities? Yes ___ No___

   If yes, please state limitations: _____
   _____
   _____

5. Does your child have any need for special attention because of health problems?

   Yes ___No____

   If yes, please describe: _____
   _____
   _____

6. HEALTH HISTORY:

   A. Allergies or reactions Yes ___ No___

   B. Hay fever, asthma, wheezing Yes ___ No___

   C. Eczema or frequent skin rash Yes ___ No___

D. Convulsions, seizures Yes ___ No___

E. Heart trouble Yes ___ No___

F. Diabetes Yes ___ No___

G. Frequent colds, sore throat, earaches (four or more per year) Yes ___ No___

H. Trouble with passing urine or with bowel movements Yes ___ No___

I. Shortness of breath Yes ___ No___

J. Speech problems Yes ___ No___

K. Dental problems Yes ___ No___

L. Allergy to medications Yes ___ No___

Please explain any condition you answered with a YES: _____

_____

_____

_____

_____

_____

7. Does your child take any medication regularly? Yes ___ No___

If yes, what medication? _____

Reason for medication? _____

_____

_____

Dosage Requirement _____

_____

Signature:_____ Date:_____

ISLAND PARK UNION FREE SCHOOL DISTRICT
99 Radcliffe Road
Island Park, New York 11558

DENTIST'S EXAMINATION RECORD

CHILD'S NAME _____

ADDRESS _____

TELEPHONE NUMBER _____

EXAMINATION DATE _____

This is to certify that I have examined the above named student and I hereby inform you that:

No treatment is necessary _____

Treatment is in progress _____

Treatment is completed _____

Comments: _____

_____

_____
Dentist's Signature

_____
Address

_____
Town, State, Zip

_____
Telephone Number

AUTHORIZATION TO RELEASE INFORMATION TO ISLAND PARK UNION FREE SCHOOL DISTRICT

99 Radcliffe Road
Island Park, New York 11558
(516) 434-2600 FAX: (516) 431-7550

DATE: _____

TO: (Student's previous school):

_____

_____

_____

FROM: **Island Park Union Free School District**

I hereby authorize you to release any and all pertinent records including, but not limited to, academic, health, psychological and all testing for the following pupil:

Student Name: _____ **Birthdate:** _____

Please forward record to the school indicated:

_____ **F.X. Hegarty Elementary School, 100 Radcliffe Road, Island Park, NY 11558 (K – 4)**

_____ **Lincoln Orens Middle School, 150 Trafalgar Blvd., Island Park, NY 11558 (5 – 8)**

Parent/Guardian: _____

Signature

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____ /____ /____ Grade: ____ ID#: _____
Month Day Year *(preschool-12)* *(optional)*

Address: _____ 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 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): _____
☐ In permanent housing

_____ _____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

NOTE TO SCHOOLS/LEAS: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

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*

❑ Male
❑ 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?	❑ English	❑ Other	*specify*	
2. What was the first language your child learned?	❑ English	❑ Other	*specify*	
3. What is the Home Language of each parent/guardian?	❑ Parent 1 *specify*	❑ Parent 2 *specify*		
	❑ Guardian(s)	*specify*		
4. What language(s) does your child understand?	❑ English	❑ Other	*specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak	
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read	
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ 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? _____

_____ Month: Day: Year:

Signature of Parent or of Person in Parental Relation ***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 _____
MO. DAY YR.

PROFICIENCY LEVEL ACHIEVED ON NYSITELL ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

ISLAND PARK UNION FREE SCHOOL DISTRICT
99 Radcliffe Road
Island Park, New York 11558

MEDICAID CONSENT

Dear Parent/ Guardian 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 Program (IEP). This consent allows the School District/ Nassau County to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose.

I, _____ the parent/guardian of _____
(Print Parent/Guardian name) *(Print Child's name)*
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 any time; 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/Municipality/Providers 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 (such as records or information about services your child)	
Prescription	Service Provider Attendance
Referral	"Under the Direction of' Certification
Treatment Logs	"Under the Supervision of" Certification
Individualized Education Program- IEP	"Under the Direction of" Logs
Attendance Records	"Under the Supervision of" Logs
Bus Logs	Calendar
Other unnamed documents needed to support a claim to Medicaid	

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: _____

ISLAND PARK UNION FREE SCHOOL DISTRICT
99 Radcliffe Road
Island Park, New York 11558

SPECIAL EDUCATION HISTORY

Student's Name:_____

Birthday:_____

Has your child been referred to or offered services by the Committee on Pre-School Education (CPSE)/Committee on Special Education (CSE) at any time in the past?

Yes _____ No _____

If so, please indicate below the school year and types of services offered:

School Year/ _____

District: _____

_____

_____

Service(s): _____

_____

_____

_____

My child has _____or has not _____received CPSE/CSE services.

Parent/Guardian:_____

Signature

Date: _____

Regulation #1602.1

ISLAND PARK UFSD
Island Park, New York

SCHOOL DISTRICT NEWS MEDIA RELEASE FORM: STUDENT INTERVIEWS, PHOTOGRAPHS, VIDEOS & WORK

Dear Parents/Guardians:

The Island Park Union Free School District publishes newsletters, calendars, websites, and press releases that highlight students and programs of our schools.

I consent for interviews, audio records, photographs, videotapes and/or other transmissions of any kind of my child to be taken and used by the District for public relations, educational or other purposes (in no event will they be used for commercial purposes), including but not limited to use on the District's website, calendars, newsletters, press releases, District's Facebook page or other social media. I further agree that these materials that have been captured will become property of the District. I hereby release and discharge the District and its representatives from any and all claims that may arise from the use at any time of such interviews, audio recordings, photographs, images, videotapes or other electronic transmissions of any kind.

Unless you object to your child participating in such coverage, we will assume that you give the District your permission. If you object, please complete this form and return it to your child's teacher as soon as possible.

Thank you for your cooperation.

Sincerely,

Mr. Adam Frankel, Francis X. Hegarty Elementary School Acting Interim Principal
Dr. Bruce Hoffman, Lincoln Orens Middle School Principal

……

Island Park UFSD
School District Media Release Form

[ ] I do not consent

CHILD'S NAME _____

CLASS or HOMEROOM TEACHER _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

Please complete and return this form to your child's teacher as soon as possible.

9/25/17

Regulation #1602.2

ISLAND PARK UFSD
Island Park, New York

OUTSIDE NEWS MEDIA AND ELECTED OFFICIALS RELEASE FORM: STUDENT INTERVIEWS, PHOTOGRAPHS, VIDEOS & WORK

Dear Parents/Guardians:

Periodically, outside news media representatives (the Herald, Tribune, Newsday, etc.) and elected officials from the Village, Town, County, State and Federal government (and their representatives) request permission to write a feature or news story about our schools and/or our students. Photographs, video recordings and/or quotes from children and their work often accompany the articles for print or broadcast purposes.

I consent for interviews, audio recordings, photographs, video recordings or other transmissions of any kind of my child or that include or identify my child to be taken and used by outside news media and elected officials for press, media print or broadcast purposes. I further agree that these materials that have been captured will become property of the applicable media agency or elected official and hereby release and discharge the Island Park Union Free School District and its representatives from any and all claims that may arise from the taking and use at any time of such interviews, photographs, videotapes or other electronic or other transmissions of any kind.

Unless you object to your child participating in such coverage, we will assume you give outside news media and elected officials your permission. If you object, please complete this form and return it to your child's teacher as soon as possible.

Thank you for your cooperation.

Sincerely,

Mr. Adam Frankel, Francis X. Hegarty Elementary School Acting Interim Principal
Dr. Bruce Hoffman, Lincoln Orens Middle School Principal

……

Island Park UFSD
Outside News Media and Elected Officials Release Form

[ ] I do not consent to release to outside news media

[ ] I do not consent to release to elected officials

CHILD'S NAME _____

CLASS OR HOMEROOM TEACHER _____

PARENT/GUARDIAN NAME (Please print.) _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

Please complete and return this form to your child's teacher as soon as possible.

3800 – INTERNET USE – ACCEPTABLE USE POLICY (AUP)

Island Park School District is committed to responsible, efficient, ethical, and legal use of its telecommunications facilities.

Acceptable use of telecommunications includes activities that support teaching and learning. Use of District accounts is limited to school-related activities or courses. Users are encouraged to utilize telecommunications services, which may include, but are not limited to, electronic mail, conferencing, bulletin boards, databases, and access to the Internet, including the World Wide Web, Telnet, and File Transfer Protocol (FTP).

Unacceptable Use

Activities that are not permitted on District accounts include:

- Plagiarism
- Use of profanity, obscenity, or language which may be offensive to others
- Reposting communications without the author's prior consent
- Copying software in violation of copyright laws
- Use of on-line services for profit, commercial or illegal activity
- Development or spread of computer viruses
- Engaging in vandalism

Employees' Responsibilities

District employees' staff will teach and/or model proper techniques and standards related to use of District computers, telecommunications equipment, the Internet, and e-mail accounts. Employees understand that abuse of the services by themselves or students for whom they are responsible to oversee may result in loss of such privileges and may be subject to additional school sanctions as well as other penalties under law.

Procedure for Obtaining Access

For student to obtain use of a District account, they and their parents must:

- Complete the form, ***Student Application for Use of Computer, Internet, and E-Mail,*** annually.
- Agree to the District's computer policies governing use of computer, internet, and email.
- Agree to training of students.

For Employees to obtain use of a District Account

Employees must:

- Complete the form, **Employee Application** for use of Computers, Internet and E-mail.
- Agree to the District's Policies (3800) governing use of Computer, Internet, and E-Mail and the related Rules and Regulations.
- Agree to the District's Policy (3850) regarding computer Resources and Data Management.
- Agree to request training pertaining to any related matters for which they require clarification or greater understanding.

This policy applies to all users of the District accounts and/or facilities.
(See Regulation 3800)

REGULATION **RE: POLICY NO. 3800**

RULES AND REGULATIONS OF TELECOMMUNICATIONS

Telecommunications users are expected to abide by the District Rules and Regulations of Telecommunications. They include (but are not limited to) the following:

1. All use of telecommunications must be in support of education and research and be consistent with the purposes of Island Park School District.

2. Any use of the on-line accounts for commercial or for-profit purposes, product advertisement or political lobbying is prohibited.

3. Use of the on-line accounts for personal and private business is prohibited.

4. Users shall not intentionally seek information about, obtain copies of, or modify files, data, or passwords, belonging to others.

5. Users shall not misrepresent themselves while on-line.

6. Communication and information accessible over the Internet is not secure. Therefore, users should not reveal personal information (address, phone number, social security number or credit card numbers) when on-line.

7. Users must not disrupt the access of others on the service.

8. Hardware or software may not be modified, destroyed, or abused in any way.

9. Hate mail, harassment, discriminatory remarks and other antisocial behaviors are prohibited.

10. Use of the District accounts to develop programs that harass others or infiltrate a computer or computing system and/or damage the software components of a computer or computing system is prohibited.

11. Standard copyright restrictions must be observed.

12. Use of the District accounts to access or process pornographic material, inappropriate text files, or files dangerous to the integrity of District computers and/or networks is prohibited.

13. From time to time, Island Park School District will review and update telecommunications policies and practices.

14. Use of the District's computers is a privilege not a right; inappropriate use will result in the suspension or revocation of that privilege.

No Privacy Guarantee

Users using the District's Computer Network should not expect, nor does the District guarantee privacy for electronic mail or any use of the District's Computer Network. The District reserves the right to access, view and/or disclose any material stored on District equipment or any material used in conjunction with the District's Computer Network.

ISLAND PARK UNION FREE SCHOOL DISTRICT

STUDENT APPLICATION FOR USE OF COMPUTER, INTERNET & EMAIL

Student Name _____ *Grade* _____
(Please Print)

School _____ *Homeroom* _____

- **I have read and understand the Use of Telecommunications Policy and Rules and Regulations of Telecommunications.**
- **I have discussed these policies with my parent or guardian.**
- **I agree to abide by their provisions. If I do not, I understand I will lose on-line access and related privileges, and I will be subject to school disciplinary action and legal action.**

Student Signature _____ *Date* _____

*** ***

PARENT OR GUARDIAN

- **I have read and understand the Use of Telecommunications Policy and Rules and Regulations of Telecommunications.**
- **I will accept responsibility for my child's appropriate use of District telecommunications equipment and his/her potential access to the worldwide Internet and on-line accounts while using the District account even when not in a school setting.**
- **I understand that my child will be subject to disciplinary consequences if he/she violates these rules.**
- **I agree to be legally and financially responsible for any misuse of the technology, internet and email by my child as stated in the District policies and defined by New York State Law.**
- **I will not hold Island Park Union Free School District responsible for controversial materials acquired while on-line.**
- **I understand these policies and/or asked for clarification.**
- **I certify that the information on this form is correct and I give permission for my child to use a District account.**

Print Name _____ **Date** _____

Signature _____

Home Address _____

Home Phone _____ **Business Phone** _____

ISLAND PARK UNION FREE SCHOOL DISTRICT
99 Radcliffe Road
Island Park, New York 11558

Parents can request a referral and evaluation of their child if they suspect that their child has a need for special education services or programs. Additional information can be found in the *publication Special Education in New York State for Children 3-21, A Parent's Guide*, which is available through the New York State Education Department at the following web address:

(English): http://www./p12.nysed.gov/specialed/publications/policy.parentguide.htm

You can also contact Mr. Jacob Russum, Director of Pupil Personnel Services at (516) 434-2620 for additional information.

ISLAND PARK UNION FREE SCHOOL DISTRICT
FRANCIS X. HEGARTY ELEMENTARY SCHOOL
Island Park, New York

KINDERGARTEN REGISTRATION

Child's Name: _____ Date: _____

Parent's Name(s): _____ _____

Questions asked during Kindergarten registration regarding nursery school/pre-k attendance.

1. Did your child attend nursery school/pre-k?

2. What nursery school/pre-k program did he/she attend?

3. How many days a week did your child go to nursery school/pre-k? How many hours each day?

   As 2 yr-old _____

   As 3 yr-old _____

   As 4 yr-old _____

4. How many months/years did he/she attend nursery school each year?

   As 2 yr-old _____

   As 3 yr-old _____

   As 4 yr-old _____

ISLAND PARK UNION FREE SCHOOL DISTRICT

SCHOOL CENSUS

We are required to conduct a census of all children under the age of 22 who reside in our school district and who have not yet graduated from high school. According to Section 3241 of Education Law, this census must include the name, residence, birth date, parent's names and "such further information as the Board of Education shall require." In the past, we have conducted this census by a house-to-house canvass of our community. We have converted to a census-by-mail procedure which will be less expensive and, with your cooperation, more accurate.

It is extremely important that you fill out this census form completely and accurately. This will assist us as we project school enrollment for the next *few years*. You can save the district postage if you would drop this form off in any of our schools main offices. Thank you.

Please Print

1. **FATHER OR GUARDIAN**_____ / **MOTHER OR GUARDIAN** _____

   Last Name, First *Last Name, First*

2. **ADDRESS:** _____

   Apt. No. *House No.* *Street* *City* *State* *Zip Code*

3. **HOME PHONE:** _____ More Than One Family at Your Address? **YES** ( ) **NO** ( )

4. **KINDLY PRINT THE NAMES OF ALL CHILDREN LIVING AT HOME, FROM BIRTH TO 22 YEARS OF AGE:**

LAST NAME , FIRST	**SEX M-F**	**BIRTHDAY MM/DD/YYYY**	**GRADE** **In September**	**SCHOOL** **Attending in September**

5. **IF A CHILD HAS A DISABILITY OR A SERIOUS PHYSICAL PROBLEM, PLEASE DESCRIBE BRIEFLY:**

   _____

   _____

6. **LANGUAGE SPOKEN AT HOME OTHER THAN ENGLISH:** _____

THANK YOU FOR YOUR ASSISTANCE _____ _____

Date *Signature*

NEW YORK STATE MIGRANT EDUCATION PROGRAM

IDENTIFICATION & RECRUITMENT OFFICE

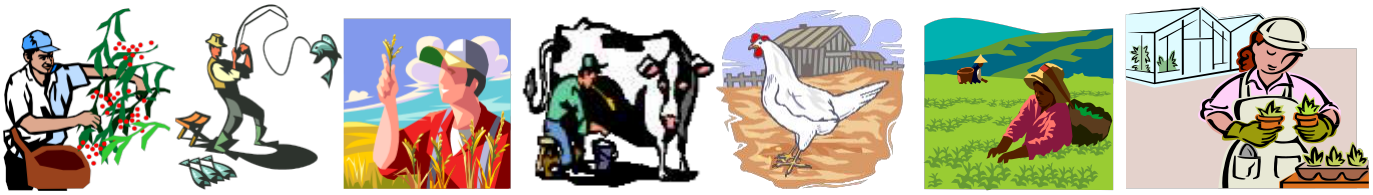
PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). 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 school 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.

Has anyone in your family worked, or looked for work at the following occupations during the past 3 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: _____

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 607-436-3606, or by mail to NYS Migrant Education Program-Identification and Recruitment Office: 100 Saratoga Village Blvd, Suite 41, Ballston Spa, NY 12020.

Date Withdrew_____

Attachment Va F ____R _____D_____

Application for Free and Reduced Price School Meals/Milk

To apply for free and reduced price meals for your children, read the instructions on the back, complete **only one** form for your household, sign your name and **return it to the address listed below.** Call (*516)434-2622,* if you need help. Additional names may be listed on a separate paper.

Return Completed Applications to: **Island Park Schools, Lunch Program**
150 Trafalgar Blvd.
Island Park, NY 11558

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	Homeless Migrant, Runaway
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAP/TANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. **Skip to Part 4, and sign the application.**

Name: _____ CASE #: _____

3. Report all income for ALL Household Members (Skip this step if you answered 'yes' to step 2)
All Household Members (including yourself and all children that have income).
List all Household members not listed in Step 1 (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total income for each source in whole dollars only. If they do not receive income from any other source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of household member	Earnings from work before deductions ***Amount / How Often***	Child Support, Alimony ***Amount / How Often***	Pensions, Retirement Payments ***Amount / How Often***	Other Income, Social Security ***Amount / How Often***	No Income
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐
	$ _____ / _____	$ _____ / _____	$ _____ / _____	$ _____ / _____	☐

Total Household Members (Children and Adults) ☐☐

*__Last Four Digits of Social Security Number:__ XXX-XX- __ __ __ __

I do not have a SS# ☐

*When completing section 3, an adult household member must provide the last four digits of their Social Security Number (SS#), or mark the "I do not have a SS# box" before the application can be approved.

4. Signature: An adult household member must sign this application before it can be approved.
I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school will get federal funds; the school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.
Signature: _____ **Date:** _____
Email Address: _____

Home Phone: _____ Work Phone: _____ Home Address: _____

5. Ethnicity and Race are optional; responding to this section does not affect your children's eligibility for free or reduced price meals.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Island ☐White

DO NOT WRITE BELOW THIS LINE – FOR SCHOOL USE ONLY

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

☐ SNAP/TANF/Foster
☐ Income Household: Total Household Income/How Often: _____/_____ Household Size: _____
☐ Free Meals ☐ Reduced Price Meals ☐ Denied/Paid

Signature of Reviewing Official _____ **Date Notice Sent:** _____

APPLICATION INSTRUCTIONS

To apply for free and reduced price meals, complete only one application for your household using the instructions below. Sign the application and return the application to Dena DeBari, Food Service, 150 Trafalgar Blvd., Island Park, NY 11558
If you have a foster child in your household, you may include them on your application. A separate application is not needed. Call the school if you need help: (516) 434-2622. Ensure that all information is provided. Failure to do so may result in denial of benefits for your child or unnecessary delay in approving your application.

PART 1 ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE APPLICATION FOR YOUR HOUSEHOLD.

(1) Print the names of the children, including foster children, for whom you are applying on one application.
(2) List their grade and school.
(3) Check the box to indicate a foster child living in your household, or if you believe any child meets the description for homeless, migrant, runaway (a school staff will confirm this eligibility).

PART 2 HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

(1) List a current SNAP, TANF or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. The case number is provided on your benefit letter.
(2) An adult household member must sign the application in PART 4. SKIP PART 3. Do not list names of household members or income if you list a SNAP case number, TANF or FDPIR number.

PART 3 ALL OTHER HOUSEHOLDS MUST COMPLETE THESE PARTS AND ALL OF PART 4.

(1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are applying for, all other children, your spouse, grandparents, and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly. If no income, check the box.** The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should **not** be considered as income for this program.
(3) Enter the total number of household members in the box provided. This number should include all adults and children in the household and should reflect the members listed in PART 1 and PART 3.
(4) The application must include the last four digits only of the social security number of the adult who signs **PART 4** if Part 3 is completed. If the adult does not have a social security number, check the box. **If you listed a SNAP, TANF or FDPIR number, a social security number is not needed.**
(5) An adult household member must sign the application in PART 4.

OTHER BENEFITS: Your child may be eligible for benefits such as Medicaid or Children's Health Insurance Program (CHIP). To determine if your child is eligible, program officials need information from your free and reduced price meal application. Your written consent is required before any information may be released. Please refer to the attached parent Disclosure Letter and Consent Statement for information about other benefits.

USE OF INFORMATION STATEMENT

Use of Information Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not submit all needed information, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the primary wage earner or other adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs.
We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

DISCRIMINATION COMPLAINTS

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.