Hicksville Public Schools
200 Division Avenue - Hicksville, NY 11801
Registration: 516-733-2168 - CPSE: 516-733-2160 - Fax: 516-733-6683
WEBSITE: HICKSVILLEPUBLICSCHOOLS.ORG

CPSE REGISTRATION PACKET

Please complete this registration packet and place it in a sealed envelope and drop off at the Administration building located at **200 Division Avenue** between the hours of 7:30 am and 3:00 pm. Or if after hours place through the mail slot located on the lower right side on the front of the building above the steps or the black mail box located on the left side of the front of the building above the steps.

Please note that this registration packet is only for the Committee on Preschool Special Education (CPSE) registration.

You will need to register for Kindergarten as your child ages out of the CPSE program. Please see the Hicksville Public School Website for more information on how to register for Kindergarten. Registration for children who expect to enter Kindergarten in September will begin in the Winter prior to September. The child must be 5 years of age on or before December 1 of the school year in which the child enters Kindergarten.

NASSAU COUNTY DEPARTMENT OJ? HEALTH

PRESCHOOL SPECIAL EDUCATION PROGRAM

GLOSSARY

Revised August 2018

The Preschool Special Education Program Training Committee has developed this Glossary to assist the Preschool commun ity in understanding the terms and language specific to the population we serve.

Nassau County Department of Health
Preschool Special Education Program
Training Committee Members
June 2013

Kris Anderson, Educational Specialist, Nassau County DOH

Shannon Jauck, Supervisor of the Preschool Special Education Program, Nassau County DOH

Joy Connolly, Director of Education Program Services, Child Care Council of Nassau, Inc.

Janice Friedman, Chairperson, CEO, Variety Child Learning Center

Carolyn Gammerman, Director, Long Island Early Childhood Direction Center

Desiree Metz, Program Direct or, Achieve Beyond

Amity Howard Reiss, CPSE Chairperson, Port Washington School District

Stacey Ratner, Director of Quality Assurance & Training, Variety Child Learning Center

Wendy Sciub ba, Supervisor of Preschool Program , The Hagedorn Little Village School

Lydia Wieselthier , Supervisor of On-Going Service s, Marion K Salomon & Associates

PWD (Preschool Student with a Disability)	A preschool student as defined in section 4410(1)(i) of Education Law who is eligible to receive preschool programs and services, is not entitled to attend the public schools of the school district of residence pursuant to section 3202 of the Education Law and who, because of mental, physical, or emotional reasons, has been identified as having a disability and can receive appropriate educational opportunities from special programs and services approved by the department. Eligibility as a preschool student with a disability shall be based on the results of an individual evaluation which is provided in the student's native language, not dependent on a single procedure, and administered by a multidisciplinary team in accordance with all other requirements as described in section 200.4 (b)(l) through (S) of Part 200 Regulations.

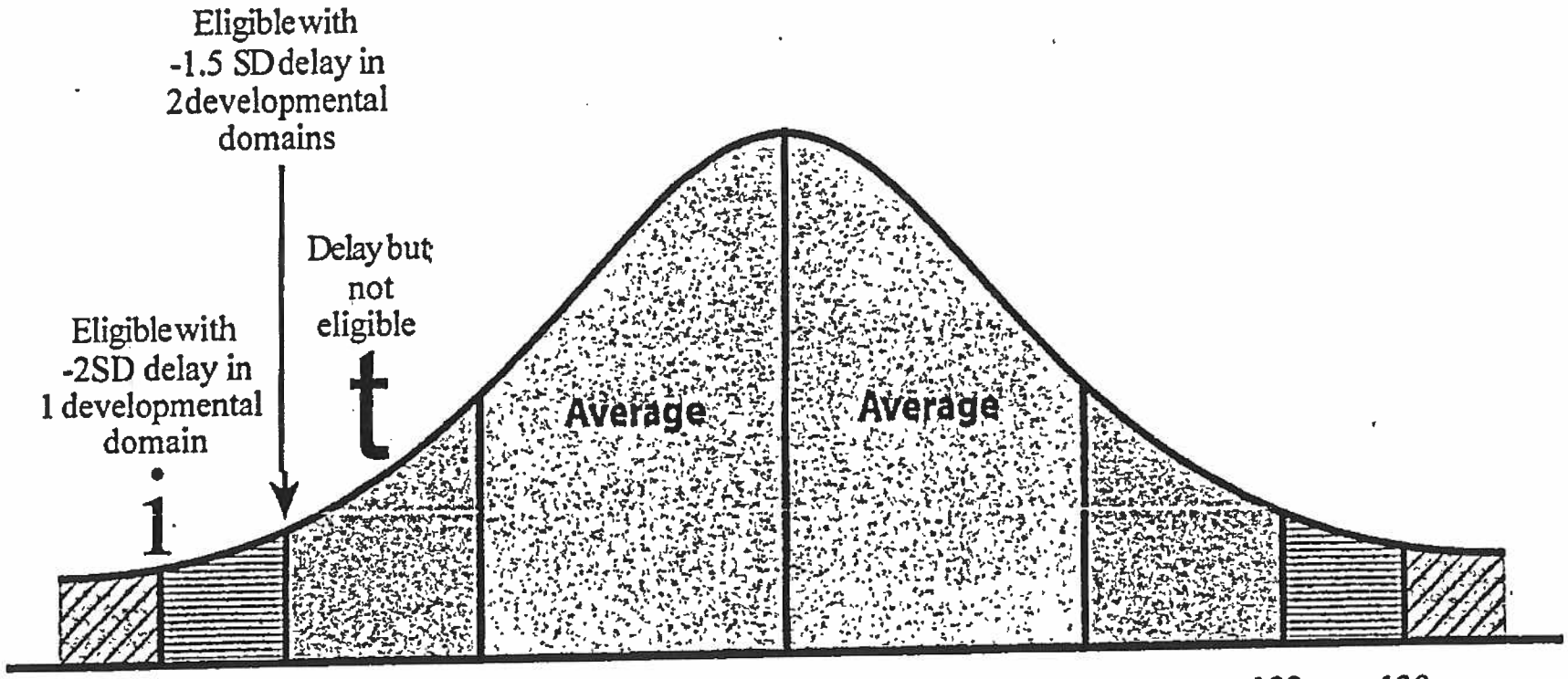
Assessment	The use of various tools and strategies to collect data for use in determining how a child's development is proceeding in each of the five domains of development: •*Cognitive:* refers to the mental processes of comprehension, memory, judgment and reasoning. •*Adaptive/Self-Help:* refers to the ability to display age appropriate self-care and to adapt to different circumstances. • *Physical:* refers to a child's gross and fine motor development. •*Communication/Speech and Language:* refers to the processes of expressing thoughts and feelings and to understand vocal, non-verbal, signed or other communication of others. •*Social/Emotional:* refers to the ability of a child to understand their own feelings and those of others and to respond to both with socially acceptable behavior . Also includes behavior achild exhibits during play.

Bell Curve	The normal distribution of test scores which when graphed forms a bell shaped curve.

Initial Evaluation	Refers to a multi-disciplinary assessment of a child's skills, strengths and needs to determine current level of functioning and how best to plan for the child. The evaluation consists of gathering information through observation, family interviews and standardized testing. The evaluation includes testing in all areas of developm ent : Motor, Cognition, Speech/language, Adaptive, Social/Emotional and Physical General Health. Evaluations should give a clear picture about how a child functions in all areas of development. Under New York State Education Department regulations, an initial evaluation includes a Psychological, Social History, observation of the child in a natural setting and a medical. Supplementary evaluations including speech/language,education, Occupational Therapy or Physical Therapy may be added as requested and approved by the child's school district.

ELIGIBILITY CRITERIA ON THE NORMATIVE CURVE

(For NYS Funded & County Funded Programs)



Standard Score	70	77.	85	100	115	122.	130
Percentile	2.1	5	16	SO	84	S	97.86
e Z-Score	4	7	-1	0	+1.	94	+2.0
. T-Score	-2.0	-1.5	40	SO	0	+1.5	70
	30	35			60	65	

NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100, Uniondale, New York 11553-3683

Physician Prescription for Evaluations

Based on a review of the child's records, I am referring this child for the following evaluation(s):

Student's Name: _____ DOB: _____

Agency/School _____ District: **HICKSVILLE**
(Agency, Center Based School or Individual Provider)

Type Of Evaluation (Please check any that apply)				
☐ Audiological	☐ Neurological	☐ Orthopedic	☒ Psychological	☐ Psychiatric
☐ Occupational Therapy	☐ Physical Therapy	☒ Speech	☐ Other _____	

Note: Please provide an ICD-10 code for each evaluation selected

*REQUIRED Reason for Evaluation (ICD-10 Code or Presenting Problem)	

Physician/Physician's Assistant/Nurse Practitioner Information

(Please print or use stamp):

Name:	
Address:	
Phone Number:	
License # (REQUIRED)	
NPI # (REQUIRED)	
Medicaid Provider # (REQUIRED)	

_____ _____
Signature of Physician/Physician's Assistant/Nurse Practitioner Date

Must be original signature: STAMPED SIGNATURE WILL NOT BE ACCEPTED

A FACSIMILE OR PHOTOCOPY OF THIS RX IS ACCEPTABLE.

January 2020

Hicksville UFSD
Committee on Preschool Special Education
200 Division Avenue
Hicksville, New York 11801
(516) 733-2160

NYSED Required Student Information Repository System Data

Check one of the two options below:

☐ My Child Does not attend a Preschool/Nursery School or Daycare

☐ My Child attends a Preschool/Nursery School or Daycare. If this option is indicated complete the below information (program name, days and hours of attendance).

The name of the program(s): _____.

My child typically attends the program(s) as indicated below:

	Monday	Tuesday	Wednesday	Thursday	Friday	Total Minutes for the Week:
Days In attendance						
Times attending						

_____
Student Name

_____
Student Date of Birth

_____ _____
Parent/Guardian Signature Date

APPENDIX A

Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

HOME LANGUAGE SURVEY

Child's Name: _____

Child's DOB: _____

1. What is your relationship to the child: Check one: ☐ Mother ☐ Father ☐ Guardian

2. English is the only language my child is exposed to: ☐ YES ☐ NO

School District instructions:
If parent checks "NO" then fax form to evaluator along with consent and referral so a bilingual evaluation can be arranged.

3. What language did your child learn when he/she first began to talk? _____

4. What language(s) does your family speak in your home? _____

5. In what language(s) does the mother speak to her child? _____

6. In what language(s) does the father speak to his child? _____

7. In what language does the caretaker speak to your child? _____ How often? _____

8. What language(s) does your child seem to respond to most readily? _____

9. In what language does your child speak to his/her brothers and sisters? _____

10. If born outside the continental United States, where was your child born? _____

11. How long has your child been exposed to English? _____

School District instructions:
If answer to # 11 is less than three months, suggest a three month waiting period.

12. Did the child spend time in a: ☐ Foster Home ☐ Orphanage

_____ _____
Parent's signature Date

_____ _____
School official completing form Title

BRUCE A. BLAKEMAN
NASSAU COUNTY EXECUTIVE

Irina Gelman, DPM, MPH, PhD
Commissioner of Health

NASSAU COUNTY DEPARTMENT OF HEALTH

PARENT CONSENT FORM FOR ACCESSING A PARENT OR STUDENT'S MEDICAID INSURANCE TO PAY FOR CERTAIN SPECIAL EDUCATION SERVICES IN A STUDENT'S INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

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

I, _____ as the parent/guardian of _____
(PRINT Parent Name) **(PRINT Child Name)**

DOB_____ **Medicaid CIN #: _____**

have received a written notification from the county/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 county or 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 county/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 (such as records or information about services your child receives)	
IEP, Written Order/Referral/Scripts	Special Transportation Log and Program Attendance
Evaluation Reports/Session Notes	Other Personally Identifiable Information
"Under the Direction Of" Logs and Certifications	Any other specific records pertaining to the child's services or program

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 Name and Signature:

SIGN

_____ _____ **Date:** _____
Parent/Guardian Name (Please Print) **Parent/Guardian Signature**

HICKSVILLE PUBLIC SCHOOLS

Office of the Registrar
Administration Building
200 Division Ave.
Hicksville, NY 11801
(516)-733-2168

NEW ENTRANT APPLICATION PROCESS

Required Forms for Registration and Documentation needed:

- Enrollment Form – Residency Questionnaire
- Migrant Education Program - Work Survey
- Affidavit of Residency
- New Entrant Registration Required Documentation
- NYS Public Health Law Immunization Requirements
- Affidavit of Landlord
- New Entrant Application
- Health History Form
- Immunization Form
- Health Examination Form
- Prior Special Education Services Form – optional
- Student Identification Form
- Transfer of Records Form

Instructions:

1. Print legibly to complete all forms in ink.
2. Collect the required documentation. Required documentation is listed on the following page.
3. Call the Registrar for an appointment at **(516)-733-2168**
4. Packet will be reviewed by Registrar.

PLEASE MAKE SURE TO INCLUDE YOUR E-MAIL ADDRESS ON THE NEW ENTRANT APPLICATION

HICKSVILLE PUBLIC SCHOOLS
Office of the Registrar
NEW ENTRANT REGISTRATION REQUIRED DOCUMENTATION

Parental Photo ID ____

Proof of Birth (1 Original Form)
___ Birth Certificate or ___ Baptismal Certificate or ___ Passport

Proofs of Parental Relationship:
___ Birth Certificate ___ Baptismal Certificate ___ Court Guardianship Papers ___ Court Custody Papers ___ Divorce Decree ___ Adoption Papers
___ Affidavits of Residential Custodial and Non-Residential Custodial Parents
___ Affidavits of Emancipation

Immunizations: New York State Public Health Law, Requirements, Sections 2164

Proof of Prior Schooling:
___ Transfer Card/Request ___ Reports Card(s) ___ Special Education Records (as appropriate).

Proof of Residency:

HOMEOWNER

ONE (1) PROOF FROM BELOW:
House Title or Deed
Real Estate Closing Statement
Recent Mortgage Statement
Recent Nassau County School Tax Receipt
Recent Nassau County General Tax Receipt
Current Home Insurance Declaration Page

In addition: ONE (1) of the following RECENT original Proofs in the Homeowner's Name from below:
Utility Bill
Bank Statement
Telephone Bill
Cell Phone Bill
Cable/Satellite Bill
Security System Bill
Credit Card Bill

NON-HOMEOWNER/RENTER

Notarized Landlord Affidavit and/or valid executed Lease from Homeowner

In addition:
TWO (2) of the following RECENT original proofs in the Renter's Name from below:
Utility Bill
Bank Statement
Telephone Bill
Cell Phone Bill
Cable/Satellite Bill
Security System Bill
Credit Card Bill

HICKSVILLE PUBLIC SCHOOLS
NEW ENTRANT APPLICATION
(please print)

Name of Pupil _____ Sex __M __F Date of Birth____/____/____
Last Name First Name M.I.

Address _____ Telephone No. _____
No. Street Town/State Zip Code

Homeless? ___ YES ___ NO Cell No. _____

Place of Birth _____ Date of Entry to US_____ Foster Child: _____ YES _____ NO
Town/State/Country

e-mail address: _____

PREVIOUS ADDRESSES (LAST 3 YEARS)	DATES FROM / TO	SCHOOL DISTRICT

Last School Attended _____ Grade Completed _____

School Address _____ Retained in Grade(s) _____

Has child attended school in Hicksville before? ____Y ____ N If yes, School _____

Father's Name _____ **Address** _____
(If different than student(s)

Employed by _____ Business Telephone _____ Cell Phone _____ Occupation _____

Mother's Name _____ **Address** _____
(If different than student(s)

Employed by _____ Business Telephone _____ Cell Phone _____ Occupation _____

Family Physician _____ _____ _____
name address telephone no.

Emergency Contact _____ _____ _____
(Other than parent) name address telephone no.
Relationship_____

Ethnicity:
American Indian or Alaskan Native _____ Asian or Pacific Islander _____ Multiracial _____

Black _____ Primary Language: _____

White _____ Language(s) spoken in Home _____

Hispanic _____ Corresponding Language: _____

LIST NAMES OF OTHER CHILDREN IN FAMILY

NAME	ADDRESS	DATE OF BIRTH	SCHOOL ATTENDING	GRADE

Natural Parent ___ Y ____ N
Custodial Parent ____ Y ____ N
Guardian ____ Y ____ N

_____
Parent / Guardian Signature Date

OFFICE USE ONLY

Census Form Completed: ____ Y ____ N Records Requested _____ Rec'd _____
(date) (date)

Registered by:_____ Date_____ School _____ Grade _____ Transport _____

3/10

REGISTRAR

NOTE TO SCHOOLS/LEAS: Please assist students and families filling out this form. The form should be included at 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 packet.

HOUSING QUESTIONNAIRE

Name of LEA: _____

Name of School: _____

Name of Student: _____
Last First Middle

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

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, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

Rev. 11/15/16

HICKSVILLE PUBLIC SCHOOLS

Theodore Fulton, Ed.D.
Superintendent of Schools

Inna Mishiev
Executive Director of Special Education &PPS

The Migrant Education Program (MEP) provides supplemental education and support services to eligible children through national funding. The purpose of the program is to ensure that all migrant students reach the academic standards and graduate with a high school diploma (or complete GED/HSE).

WORK SURVEY

Thank you for answering the following questions. If your child is eligible for the Migrant Education Program, they may receive additional educational support. This information is strictly confidential.

Student's Name _____ Parent's Name: _____

Address: _____ City: _____ Telephone: (____) _____

Date: _____ Parent Signature: _____

1. Within the last 3 years, have your children moved for any reason? YES _____ NO _____
2. Has anyone in your household moved from one school district to another within the United States to look for season or temporary work in agriculture? Yes _____ NO _____
   If you answered NO to either of these questions, please stop. 

If you answered **YES**, please continue.

3. When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States? Month _____ + ____ Year _____
4. Please check any of the agricultural activities listed below that you have looked for or worked in:

____ Plant or harvest vegetables or fruits
____ Detassel Corn
____ Tobacco Farm
____ Poultry and/or Egg Farm
____ Duck, Turkey, Chicken, Pork or Beef Processing Plant
____ Aquaculture/Fish Hatcheries
____ Canning vegetables or fruits
____ Sod Farm
____ Planting pruning or cutting trees
____ Dairy Farm
____ Flora Culture/Gladiola Farm
____ Greenhouse or Plant Nursery

Please list the names of all of the children in the household under 22 years of age.

CHILD'S NAME	DATE OF BIRTH (DOB)
1.	
2.	
3.	
4.	
5.	
6.	

200 Division Avenue, Hicksville New York 11801
PH: (516) 733-2168 FAX: (516) 733-6683

HICKSVILLE PUBLIC SCHOOLS
Department of Special Education and
Pupil Personnel Services
Administration Building, 200 Division Avenue
Hicksville, New York 11801
Phone: (516) 733-2160 **Fax: (516) 733-6683**

AFFIDAVIT OF RESIDENCY
(to be signed and notarized by Parent/Guardian)

State of New York)
)ss:
County of)

_____
Student Name

_____ being duly sworn, disposes and says:

1. I reside at _____ within the Hicksville Public School District which is my actual and only place of residence.

2. I agree to advise the Hicksville Public School District immediately in the event that I change my residence.

3. I understand that in order for my child/children to attend the Hicksville Public Schools, I must be a resident of the Hicksville Public School District. Therefore, I certify that I have actually taken up residency and domiciled at the above address. I further understand that if this certification is found to be false, my child/children will be withdrawn from the Hicksville School District and I will be liable for payment of tuition from their date of enrollment through their date of termination, and that I will be subject to the penalties for perjury, a Class A misdemeanor. I attest that all information provided by me on this document is true.

_____
(Signature)

PLEASE BE AWARE THAT THE DISTRICT MAINTAINS THE RIGHT TO VERIFY RESIDENCY THROUGH THE UTILIZATION OF A HOME VISIT. NEW REGISTRANTS AND/OR RESIDENTS MAY EXPECT TO BE CONTACTED BY OUR REPRESENTATIVES TO ARRANGE FOR SUCH A VISIT.

Sworn to before me this _____
Day of _____, 20____

DATED: _____

_____
Notary Public

HICKSVILLE PUBLIC SCHOOLS
Health Services

Dear Parent/Guardian:

Please complete this health history form and return it with your signature.

Student's Name: _____ Sex: _____

DOB: _____ Place of Birth: _____

Address: _____ Phone Number: _____

Mother: _____ Father _____ Guardian: _____

Family Physician: _____

Address: _____ Phone Number: _____

IF PARENT/GUARDIAN NOT AVAILABLE IN CASE OF EMERGENCY CALL:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

HEALTH HISTORY

Please explain any significant illness, operation or injuries:

_____

_____

_____

Does your child have any of the following: (Please explain any yes answer(s) below)

1. **Asthma**	Yes___ No___	7.	**Chronic Illness**	Yes___ No___
2. **Allergies**	Yes___ No___	8.	**Ear/Hearing Problem**	Yes___ No___
3. **Diabetes**	Yes___ No___	9.	**Eye/Vision Problem**	Yes___ No___
4. **Heart Condition**	Yes___ No___	10.	**Eyeglasses/Contacts**	Yes___ No___
5. **Seizures/Epilepsy**	Yes___ No___	11.	**Takes Medication Daily**	Yes___ No___
6. **Orthopedic Condition**	Yes___ No___	12.	**Skin/Rash Condition**	Yes___ No___

Explanation of "Yes" answers:

_____

_____

_____

Any items in bold (numbered items 1-7) that have a "Yes" answer, please fill out the back of this form.

Date: _____ Parent/Guardian Signature: _____

This form must be completed if you answered "Yes" to any item 1-7 on reverse side. Please note: a signed physician's prescription must accompany this form for any special medical considerations.

Physician(s) Clinic treating student: _____

Address: _____ Telephone No.: _____

Diagnosis: _____ Date of Onset: _____

Number of hospitalizations, reasons, outcomes, dates: _____

What were the signs and symptoms of the condition: _____

_____

_____

What specific treatments, interventions, approaches are used:

_____

_____

Does your child require use of any emergency medication (i.e. Epi-Pen, Benadryl, Glucagon, Valium, etc):

_____

_____

What are the special care needs in school (diet, treatments, equipment, prosthesis, braces, supplies, etc.):

_____

_____

What specific medications will your child need to take during school hours and when:

_____

_____

_____

_____

What special consideration do you have related to your child's condition while at school (i.e. educational, behavioral, physical education precautions, sports precautions, recess precautions, field trips):

_____

_____

How does the condition affect the degree of physical activity the student can do:

_____

_____

If your child has a problem at school related to his/her condition, what plan of action would you and your physician prefer the school personnel to take:

_____

_____

Please indicate if you have any concerns about having the above information shared with the Classroom teacher(s), bus driver and other appropriate school personnel: Yes*_____ No _____
(*school nurse will contact you to discuss your concerns).

Parent/Guardian Signature: _____

Hicksville Public Schools
Prior Special Education Programs/Services

Student's Name _____ DOB:

Street Address _____ Phone:_____

School Attended _____ District:_____

Address Phone#:_____

Last Grade Completed_____Teacher/Counselor's Name:_____

Did student **receive any special education services?** ☐ **No** ☐**Yes (indicate below):**

If you responded "YES" to the above, please complete:

Type of Special Education Program Attended:

☐ Resource Room ☐ Special Class ☐ Consultant Teacher ☐ Related Services
☐ BOCES Special Education: School Name: _____
☐ Other (Specify type of program or name of school) _____

Related Services Provided in Most Recent Placement: check all that apply

☐ Speech/Language ☐ Counseling ☐ Occupational Therapy
☐ Physical Therapy ☐ Hearing Services ☐ Vision Services

Classification (if known)

☐ Learning Disability
☐ Intellectual Disability
☐ Deaf-Blindness
☐ Autism
☐ Deafness
☐ Emotional Disturbance
☐ Hearing Impairment
☐ Multiple Disabilities
☐ Orthopedic Impairment
☐ Other Health Impairment
☐ Speech or Language Impairment
☐ Traumatic Brain Injury
☐ Vision Impairment

Do you have a copy of your child's most recent IEP: ☐ No ☐ Yes (please attach)

Name of CSE Chairperson/Special Education Director _____

Address of CSE Office_____ Phone#_____

Release of Records/Information to the Hicksville Public Schools

I authorize the school and CSE indicated above to release academic, psychological, psychiatric, medical and any other evaluations; IEPs, and records to the Hicksville schools. I am aware that all records will be kept confidential and access limited to school personnel who work with my child. I understand I may review all records. I also consent to having school district personnel who work with my child principal, psychologist, social worker, regular or special education teachers, related service providers, guidance counselor and/or CSE Chairperson) speak with individuals from the school and CSE office indicated above, I am aware my consent is voluntary and can be **WITHDRAWN** at any time.

_____ _____
Signature of Parent/Person in Parental Relationship Date

FOR OFFICE USE ONLY: Please Forward Copies of All Evaluations and Records to:
Committee on Special Education
Hicksville School District
200 Division Avenue
Hicksville, NY 11801
(516) 733-2160 Fax: (516) 733-6683

HICKSVILLE PUBLIC SCHOOLS
STUDENT RACIAL AND ETHNIC IDENTIFICATION

All students between 5 and 21 years of age have the right to a free and public education. Children may not be refused admission because of race, color, creed or national origin, sex, citizenship, handicapping condition or immigration status.

Name of School:	
Student Name: Last, First, Middle:	Grade Level:
School District Student Identification Number:	Date of Birth (Month/Day/Year): / /

DIRECTIONS TO PARENT/GUARDIAN
PLEASE ANSWER ALL QUESTIONS (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND. [For question (1) Check (✓) the box that best describes your child.] Check (✓) only ONE box.

1. **Is the student Hispanic, Latino, or of Spanish Origin?** Hispanic, Latino, or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.
   - ☐ **Yes, Hispanic**
   - ☐ **No, not Hispanic**

2. **Select one or more races from the following five racial groups** [For question (2) Check (✓) all groups that apply to your child; check (✓) at least ONE box]:
   - ☐ **AMERICAN INDIAN OR ALASKA NATIVE:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
   - ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
   - ☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
   - ☐ **BLACK OR AFRICAN AMERICAN:** A person having origins in any of the Black racial groups of Africa.
   - ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Signature of Parent/Guardian/Other _____ Date _____

Relationship to Student (please check one box below)

☐ Mother ☐ Father ☐ Guardian ☐ Other (Specify): _____

See reverse for important message to Parents/Guardians and confidentiality Procedures and Regulations.

HICKSVILLE PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL EDUCATION AND PUPIL PERSONNEL SERVICES
REGISTRATION OFFICE

200 Division Avenue
Hicksville, New York 11801
Telephone (516) 733-2168 Fax (516) 733-6683

PARENTAL REQUEST FOR TRANSFER OF RECORDS FORM

PARENT/GUARDIAN PRINT LEGIBLY AND PROVIDE SIGNATURE TO AUTHORIZE RELEASE OF SCHOOL RECORDS:

DATE OF REQUEST: _____ **DATE FIRST ENTERED HICKSVILLE:** _____

STUDENT: _____ **DOB:** _____ **GRADE:** _____

FORMER SCHOOL: _____

FORMER SCHOOL PHONE NUMBER: _____ **FAX NUMBER:** _____

FORMER HOME ADDRESS: _____

PARENTAL NAME AND SIGNATURE: _____

PARENTAL E-MAIL ADDRESS: _____

FORMER DISTRICT PLEASE SEND ALL PERTINENT EDUCATIONAL RECORDS TO:

__ Burns Avenue School, 40 Burns Avenue, Hicksville, NY 11801; Phone (516) 733-2311 Fax 733-6694

__ Dutch Lane School, 50 Stewart Avenue, NY 11801; Phone (516) 733-2361 Fax 733-3520

__ East Street School, 50 East Street, Hicksville, NY 11801; Phone (516) 733-2321 Fax 733-3533

__ Fork Lane School, 4 Fork Lane, Hicksville, NY 11801; Phone (516) 733-2341 Fax 733-3521

__ Lee Avenue School, 1 Seventh Street, Hicksville, NY 11801; Phone (516) 733-2351 Fax 733-3522

__ Old Country Road School, 49 Rhodes Lane, Hicksville, NY 11801; Phone (516) 733-2301 Fax 733-3523

__ Woodland School, 85 Ketcham Road, Hicksville, NY 11801; Phone (516) 733-2331 Fax 733-3524

__ Middle School, 215 Jerusalem Avenue, Hicksville, NY 11801; Phone (516) 733-2272 Fax 733-6528
ATTENTION GUIDANCE DEPARTMENT

__ High School, 180 Division Avenue, Hicksville, NY 11801; Phone (516) 733-2221 Fax 733-1194
ATTENTION GUIDANCE DEPARTMENT

PLEASE SEND ALL SPECIAL EDUCATION IEP'S or 504 PLAN AS APPLICABLE TO BE SENT TO:

__Director of PPS & Special Education, Hicksville Public Schools, 200 Division Avenue, Hicksville, NY 11801, Phone (516) 733-2160; Fax (516) 733-6683

This is a legal document. The information provided by you will be used by the Board of Education to determine whether a pupil is entitled to a free education in this school district. **Every question must be answered or the Affidavit will not be considered.**

HICKSVILLE PUBLIC SCHOOLS
AFFIDAVIT OF LANDLORD

STATE OF NEW YORK)
COUNTY OF NASSAU) SS:

I,_____, of full age, being duly sworn upon his or her oath, according to law, deposes and says:

1. I am the owner of the property located at_____ in the Hicksville School District

2. _____is a tenant and has been a tenant at the above premises since _____ _____, 20____. A true and complete copy of this tenant's lease, if in written form, is attached hereto. In the event that the tenant does not have a written lease, the pertinent terms of said lease are as follows:

   A. Circle one of the following: month to month / year to year

   B. Rental Amount: $_____per_____.

   C. The names of the permissible tenants are as follows:

   1._____ 4._____

   2._____ 5._____

   3._____ 6._____

3. I am making this affidavit knowing that the Hicksville Board of Education will rely on same in determining whether _____ will be considered a pupil who is entitled to an education free of charge.

4. I ___do_____do not believe that _____has been a tenant at the above premises

1. I understand and agree that if any of the statements made by me are willfully false that I may be subject to potential civil as well as criminal prosecution.

_____
(Landlord)

Sworn and subscribed before
Me this _____day of _____, 20____.

_____
(Notary Public)

Exhibit 1

HICKSVILLE PUBLIC SCHOOLS
Office of the Registrar
NEW ENTRANT REGISTRATION REQUIRED DOCUMENTATION

Immunizations: New York State Public Health Law, Requirements, Sections 2164

As of July 1, 2015, no child shall be admitted to school, or in the case of students entering from outside New York, be allowed to attend school, in excess of 14 days without satisfactory written evidence that the student has been immunized. Below is a summary of the changes to **School Immunization Requirements for the 2019-2020 School Year** based on NYSDOH amended regulations:

- MMR (grades K-12) 2 doses; (Pre-K) 1 dose
- Tdap (grades 6-12) 1dose
- DTap (grades Pre-K-6) 4-5 doses – if the 4th dose is received after age 4 then only 4 doses required; (grades 6-12) 3 doses.
- Polio (grades K-5 and 6-11) 4 doses – if the 3rd dose was received after 4, then 3 doses required; (grades Pre-K – 5, 11 and 12) 3 doses required.
- Varicella (grades K-5, 6-11) 2 doses (grades Pre-K and 12) 1 dose
- Hepatitis B (grades Pre-K-12) 3 doses
- Meningococcal (grades 7, 8, 9, & 10) 1 dose; (grade 12) 2 doses – 1 dose acceptable if given after age 16
- Haemophilus Influeznae Type B (HIB) (Pre-K) 1-4 doses
- Pneumococcal Conjugate Vaccine (PVC) (Pre-K) 1-4 doses

Any student who does not meet the above-stated criteria is in violation of New York State Public Health Law, Section 2164, and **will not be admitted to school** until the student presents satisfactory written evidence of compliance. Doses must meet proper intervals established by ACIP.

MEDICAL EXEMPTION
Medical exemption must be renewed annually; it must contain information to identify medical contraindications to specific immunization, must specify the length of time immunization contraindicated and must be written by a physician licensed to practice in the state of New York.

For the 2020-2021 School Year the following amendments to the above requirements will be in effect:

- Polio (Grades K-12) will now require 4 doses
- Varicella (Grades K-12) will now require 2 doses
- Meningitis (Grades 7-11) will now require 1 dose & (Grade 12) will now require 2 doses

HICKSVILLE PUBLIC SCHOOLS

CERTIFICATE OF IMMUNIZATIONS

This is to certify that _____ _____

(first name) (last name)

GRADE_____ SCHOOL_____ DATE OF BIRTH_____

Received the following immunizations (indicate full date: month, day, year)

Measles_____ _____ Disease date_____ Titer_____

Mumps_____ _____ Disease date_____ Titer_____

Rubella_____ _____Disease date_____ Titer_____

MMR _____ _____

HIB_____ _____ _____ _____

PCV _____ _____ _____ _____

Polio_____ _____ _____ _____ _____ _____

DPT/dtap _____ _____ _____ _____ _____ _____

DT/TD _____ _____ _____ _____ _____

Tdap _____ _____ _____ _____

Meningococcal_____ _____ _____ _____

Hepatitis B _____ _____ _____ _____

Hepatitis A _____ _____ _____

Varicella_____ _____ _____ Disease Date _____

Lead screening _____ _____

PPD _____ CXR _____

Medical Exemption_____ Serology attached_____

PHYSICIAN STAMP

DATE_____ PHYSICIAN SIGNATURE_____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

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

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	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: ☐ 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	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

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

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

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ 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 Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: 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	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed** – required for Dominick Murray Sudden Cardiac Arrest Prevention Act

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

If Restrictions Apply – Complete the information below

☐ **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 ONLY 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

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

NOTORIZED CUSTODIAL AFFIDAVITS

THE FOLLOWING APPLIES TO PARENTS/GUARDIANS WHO...

SUBMIT A PASSPORT INSTEAD OF A BIRTH CERTIFICATE FOR THEIR CHILD'S REGISTRATION:

- If parents have elected to submit a child's passport instead of a birth certificate, each parent must complete and have signed in front of a notary the attached Custodial Affidavit-Resident to prove custody. If you choose to submit a birth certificate, then disregard having these affidavits completed and skip this step.

PARENTS LIVING IN SEPARATE HOUSEHOLDS:

- If the child's father and the child's mother live in separate households, the parent registering the child who lives within Hicksville Public Schools, must complete a Custodial Affidavit-resident and sign it in front of a notary.

- If the other parent also lives in Hicksville, then they, too, would complete a Custodial Affidavit-resident and sign it in front of a notary. If the other parent lives outside of Hicksville, then that parent must, instead, complete a Custodial Affidavit-non-resident and sign it in front of a notary.

- If there are court papers outlining the custody arrangements, naturally, that can be submitted instead of these affidavits.

GUARDIAN(S) WHO ARE NOT LISTED ON THE CHILD'S BIRTH CERTIFICATE:

- If a guardian(s) is registering a child, then that child's guardian(s) must complete a Custodial Affidavit-resident and sign it in front of a notary. If there are court papers or special power of transfer outlining the custody arrangements, naturally, that can be submitted instead of these affidavits. Both sets of documentation may be required depending on the circumstances.

IF ANY OF THE ABOVE APPLIES, PLEASE INCLUDE THESE COMPLETED DOCUMENTS ALONG WITH THE CHILD'S REGISTRATION PACKET.

IF THE ABOVE CIRCUMSTANCES DO NOT APPLY TO YOUR HOUSEHOLD, THEN PLEASE DISREGARD AND SKIP THIS STEP.

This is a legal document. The information provided by you will be used by the Board of Education to determine whether a pupil is entitled to a free education in this school district.

HICKSVILLE PUBLIC SCHOOLS
AFFIDAVIT OF HICKSVILLE RESIDENT IN CUSTODIAL RELATIONSHIP

STATE OF NEW YORK)
COUNTY OF NASSAU) SS:

I,_____, of full age, being duly sworn upon his or her oath, according to law, deposes and says:

1. I reside at _____, in the Hicksville School District, in the County of Nassau in the State of New York.

2. I attest that _____, who is _____years old, resides with me on a full time, year round basis at _____, in the Hicksville School District.

3. The above child has resided with me since_____, 20____, and it is my intention that the above child will reside with me until_____.

4. The above child cannot reside with his/her parent/guardian for the following reason(s):
_____
_____

5. I state herein that I will/I will not (circle one) claim the above named child as a dependent for the current tax year.

6a. I support the above named child entirely and without charge.
OR
6b. I receive $_____ toward the support of the above named child per week/month/year (circle one) from _____.

7. I hereby accept full responsibility for ALL aspects of the above child's care including, but not limited to, authorization to consent to any and all educational programs, as well as to consent to, and provide for, any and all health, medical and safety need of the above child.

8. I am making this affidavit knowing that the Hicksville Board of Education will rely on same in determining whether _____ will be considered a pupil who is entitled to an education free of charge.

9. I understand and agree that if any of the statements made by me are willfully false that I may be subject to potential civil as well as criminal prosecution.

Sworn and subscribed before
me this _____day of _____, 20____.

_____
(Hicksville Resident in Custodial Relationship)

_____
(Notary Public)

Exhibit 4

This is a legal document. The information provided by you will be used by the Board of Education to determine whether a pupil is entitled to a free education in this school district.

HICKSVILLE PUBLIC SCHOOLS
AFFIDAVIT OF NON-RESIDENT CUSTODIAL PARENT OR LEGAL GUARDIAN

STATE OF NEW YORK)
COUNTY OF NASSAU) SS:

I, _____, of full age, being duly sworn upon his or her oath, according to law, deposes and says:

1. I reside at _____, in the town (city) of _____, in the State of _____.

2. I am the legal custodian/guardian of _____, who is _____ years old, and who resides with _____, on a full time, year round basis at _____ _____, in the Hicksville School District.
(A COPY OF THE DULY EXECUTED CUSTODY/GUARDIANSHIP PAPERS MAY BE ATTACHED).

3. My child has resided with the above person since _____, 20____, and it is my intention that my child will reside with the above person until _____.

4. My child cannot reside with me for the following reason(s):_____
_____
_____

5. I state herein that I will/will not(circle one) claim the above named child as a dependent for the current tax year.

6a. _____, entirely supports my above named child without charge

OR

6b. I provide $_____toward the support of my above named child per week/month/year (circle one)

7. I hereby authorize _____, to have full responsibility for ALL aspects of my child's care including, but not limited to, authorization to consent to any and all educational programs, as well as to consent to, and provide for, any and all health, medical and safety needs of my child.

8. I am making this affidavit knowing that the Hicksville Board of Education will rely on same in determining whether _____ will be considered a pupil who is entitled to an education free of charge.

9. I understand and agree that if any of the statements made by me are willfully false that I may be subject to potential civil as well as criminal prosecution.

Sworn and subscribed before
me this _____day of _____, 20____

_____
(Parent/Guardian)

_____
(Notary Public)

Exhibit 2