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.

NOTE TO SCHOOL / LEAS: Please assist students and families filling out this form. 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.

ENROLLMENT FORM – RESIDENCY QUESIONNAIRE

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 permanet housing

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

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

_____
Date

If the student is NOT living in permanent housing, **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 ay other necessary documents or immunizations.

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

Hicksville Public Schools

Marianne Litzman
Superintendent of Schools

Claire Hocchieser
Director of Special Education

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 seasonal or temporary work in agriculture? **YES** ___ **NO** ___

   If you answered **NO** to either of these questions, please stop. 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	____ Canning vegetables or fruits
____ Detassel Corn	____ Sod farm
____ Tobacco Farm	____ Planting pruning or cutting trees
____ Poultry and/or Egg Farm	____ Dairy Farm
____ Duck, Turkey, Chicken Pork or Beef processing plant	____ Flora Culture/Gladiola Farm
____ Aquaculture/Fish Hatcheries	____ 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)733-2160 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
Office of the Registrar
NEW ENTRANT REGISTRATION REQUIRED DOCUMENTATION

Parental Photo ID ____

Proof of Birth (1 Original Form)
___ Original 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) ORIGINAL 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
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

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
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

Date of first entry into a U.S. School: _____

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

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

Certificate of Immunizations

This is to certify that _____ _____
(First Name) (Last Name)

Grade_____ School_____ Date of birth_____

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

Measles_____ _____ (Disease Date:_____) (Titer Done:_____)

Mumps_____ _____ (Disease Date:_____) (Titer Done:_____)

Rubella_____ _____ (Disease Date:_____) (Titer Done:_____)

MMR_____ _____

Hib:_____ _____

Polio: (IPV, OPV)_____ _____ _____ _____ _____ _____

DPT/D Tap:_____ _____ _____ _____ _____ _____

DT/TD:_____ _____ _____ _____ _____ _____

Tdap:_____ _____ _____

Meningococcal:_____ _____ _____ _____

Hep B:_____ _____ _____ _____

Varicella:_____ _____ (Disease Date:_____)

Lead Screening:_____ _____

PPD:_____ CXR:_____

( ) Religious or Medical Exemption ( ) Serological Report Attached

(Documentation attached)

Physician Stamp: **Date**_____ _____
Physician Signature

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE 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:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached

☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached

☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached

☐ Yes, indicate type ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	

Lead Level Required Grades Pre- K & K **Date**

☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL

Other Pertinent Medical Concerns

One Functioning: ☐ Eye ☐ Kidney ☐ Testicle

☐ Concussion – Last Occurrence: _____

☐ Mental Health: _____

☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ 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

Name: DOB:

SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	

Deviation Degree: Trunk Rotation Angle:

Recommendations:

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

- ☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
- ☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
- ☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

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

Explain: _____

MEDICATIONS

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

List medications taken at home:

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature: **Date:**

Provider Name: *(please print)* Stamp:

Provider Address:

Phone:

Fax:

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

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 Disabled □ Mentally Retarded □ Speech Impaired
□ Emotionally Disturbed □ Other Health Impaired □ Multiply Disabled □ Autistic
□ Deaf □ Orthopedically Impaired □ Hard of Hearing □ Deaf-Blind
□ Visually Impaired □ Traumatic Brain Injury

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 all 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.

HICKSVIILE PUBLIC SCHOOLS
STUDENT RACIAL AND ETHNIC IDENTIFICATION

To the Parent/Guardian: Hicksville Public Schools has adopted a policy which requires the collection and recording of the ethnic identity of students in Hicksville Public Schools in accordance with the federal categories and definitions. The information will be used to:

- Report information to the State and federal Education Departments.
- Plan educational programs and make sure that they are readily available to all students.
- Analyze differences in academic performance, attendance and completion of school.

We need your help in order to accomplish this task.. Please review the Racial/Ethnic definitions on the back of this page. Put a (✓) in the box for the category or categories which best describe your child. Hicksville Public Schools understand the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all Sate and federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records office from the school or district will be required to identify the group which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff: this form will be filed in the student's permanent record as confidential information

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable be either student name or student identification number

Please complete the form on the reverse side of this page

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