HICKSVILLE PUBLIC SCHOOLS
Office of the Registrar
Administration Building
200 Division Ave.
Hicksville, NY 11801
(516) 733-2160

NEW ENTRANT APPLICATION PROCESS

Required Forms for Registration:

- New Entrant Application
- Screening Program Form
- Health History Form
- Immunization Form
- Prior Special Education Services Form
- Home Language Form
- Census Form
- Affidavit
- Transfer of records
- Health Appraisal Form

Instructions:

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

Hicksville Public Schools

Administration Building
200 Division Avenue
Hicksville, NY 11801-4800

Phone: 516-733-2101 Fax: 516-733-6683

Dear Parents:

In line with the state Guidelines, Hicksville's Screening program has been designed to obtain preliminary information regarding a child's development in the following areas:

- physical development
- cognitive development
- receptive and expressive language development
- articulation skills
- motor development

On the reverse side of this letter is a Screening Program Registration Form. Please fill out this form at the time of registration. After testing is completed, you will be notified as soon as possible if your child receives a rating that is either very high or very low so that further testing and observation may be initiated with your consent and guidance.

Upon your request, an information booklet will be made available which describes that district's screening program for all new students.

Sincerely,

Hicksville Public Schools
Registration Office

HICKSVILLE PUBLIC SCHOOLS
Screening Program Registration Form

Child's Name: _____ DOB: _____

Address: _____ Telephone No. _____

Parent/Guardian Name: _____

Entering Grade Level: _____ Native Language spoke in the Home _____

Number of Children in Family: _____ Position in Family _____

List Other Children in Family from One Day to 18 Years of Age

Name	**Date of Birth**	**School Attending**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is child presently taking any medication? _____ Please list medication: _____

_____

1. **Has your child ever been hospitalized? _____ Date: _____**
   If so, reason:
   _____
   Any other serious illness or injury?
   _____
2. **Please list any allergies:**
   _____
3. **Please list any speech problems:**
   _____
4. **Please list any special problems:**
   _____
5. **Has your child been screened or evaluated for Special Education?**
   _____
   If "yes", what school district?
   _____
6. **Has your child ever received Special Education services in another district? _____**
   If "yes", from : _____ to _____ What school district? _____
7. **Nature of services: _____ Resource Room Program**
   _____ Special Class
   _____ Speech and Language Services
   _____ Other; please specify:

Additional Comments: _____
_____
_____

I understand that all reports and testing results will be treated confidentially.

Parent/Guardian Signature: _____ Date: _____

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: _____

*****PLEASE NOTE*****

Medical forms must have an original doctor's signature as well as the doctor's office stamp. If your Doctor wants to use his form, it must have an original signature and the Doctor's office stamp on it.

LIST OF COMMUNITY RESOURCES FOR MEDICAL CARE:

1. Westbury/New Cassel Community Health Center
   682 Union Ave.
   Westbury, NY
   571-9500

2. Dr. Karl Freidman, M.D.
   Split Rock Medical Building
   66 Split Rock Road
   Syosset, NY 11791
   921-3131

3. Doctors Immediate Care
   1610 Old Country Road
   Westbury, NY
   228-4900

4. Pediatric Ambulatory Care Center
   Nassau University Medical Center
   Hempstead Tpke.
   East Meadow, NY 11554
   572-6367

HICKSVILLE PUBLIC SCHOOLS
Certificate of Immunizations

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

_____ _____ _____
(Grade) (School) (Date of Birth)

Measles: _____ _____ (Disease date: _____) (Titer done: _____)

Mumps: _____ _____ (Disease date: _____) (Titer done: _____)

Rubella: _____ _____ (Disease date: _____) (Titer done: _____)

MMR: _____ _____ (Disease date: _____) (Titer done: _____)

Hib: _____ _____ _____ _____

Tetramune: (DPT + Hib) _____ _____ _____

Polio: (TOPV, OPV) _____ _____ _____ _____ _____ _____

(IPV, elPV) _____ _____ _____ _____ _____ _____

DPT: _____ _____ _____ _____ _____ _____

DtaP: (Tripedia) _____ _____ _____ _____ _____ _____

DT/TD: _____ _____ _____ _____ _____ _____

Tdap: _____

Comvax:
(Hep B + Hib) _____ _____ _____ _____ _____ _____

Hep B: (HBV) _____ _____ _____ _____ _____ _____

Varicella vaccine: _____ Disease date: _____)

Lead screening: _____ _____

[ ] Religious or Medical exemption [ ] Serological Report attached

(Documentation attached)

Physician's Stamp: _____
(Physician's signature)

Date: _____

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

The University of the State of New York The State Education Department Office of Bilingual Education
Albany, New York 12234

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You.

T0 BE COMPLETED BY SCHOOL PERSONNEL
DISTRICT *Please print or type clearly*
SCHOOL GRADE
STUDENT NAME
DATE OF BIRTH Month: Day: Year
STUDENT INDENTIFICATION NUMBER
COUNTRY OF BIRTH / ANCESTRY
NUMBER OF YRS ENROLLED IN SCHOOL OUT
NAME / POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION
DETERMINATION: □ Possible LEP □ English Proficient

1. What language(s) is spoken in the student's home or residence? □ English □ Other _____ *specify*
2. What language(s) are spoken most of the time to the student, in the home or residence? □ English □ Other _____ *specify*
3. What language(s) does the student understand? □ English □ Other _____ *specify*
4. What language(s) does the student speak? □ English □ Other _____ *specify*
5. What language(s) does the student read? □ English □ Other _____ *specify* □ Does Not Read
6. What language(s) does the student write? □ English □ Other _____ *specify* □ Does Not Write
7. In your opinion, how well does the student understand, speak, read and write English?

	Very Well	**Only a little**	**Not at all**
Understands English	□	□	□
Speaks English	□	□	□
Reads English	□	□	□
Writes English	□	□	□

Month: Day: Year:

_____ _____

Signature of Parent/Guardian/Other Date

Hicksville Union Free School District

Annual School Census

THE FAMILY RESIDING AT

____

____

____

Census information assists the Board of Education in school planning All information is held in strict confidence. Review all preprinted items for accuracy. Cross out any information with errors and print the corrected information directly below the line within each box.

If any resident's name is **not preprinted**, please enter his/her full name and complete **one box for each resident.**

You must complete **one box for each person** living at this address.

In each box, please check only one choice where indicated and print all other information requested in the spaces provided.

If all preprinted information is accurate, please check here _____

Upon completion fold the bottom flap up and this top flap down. Then seal with tape. Please return **within one week.**

If you have any questions, please call 733-6653.

Telephone Number:

(Check One) Homeowner ( ) Tenant ( ) **Are there more than one family living at this address? Yes ___ No ___**

Step #2 Fold this flap down.

Last Name, First Name	Status	Sex	Date of Birth	School Attending	Disabled
______________	( ) Parent ( ) Child ( ) Guardian ( ) Foster ( ) Adult	( ) Male ( ) Female	__________	______________ Grade ______	( ) Yes ( ) No

Last Name, First Name	Status	Sex	Date of Birth	School Attending	Disabled
______________	( ) Parent ( ) Child ( ) Guardian ( ) Foster ( ) Adult	( ) Male ( ) Female	__________	______________ Grade ______	( ) Yes ( ) No

Last Name, First Name	Status	Sex	Date of Birth	School Attending	Disabled
______________	( ) Parent ( ) Child ( ) Guardian ( ) Foster ( ) Adult	( ) Male ( ) Female	__________	______________ Grade ______	( ) Yes ( ) No

Last Name, First Name	Status	Sex	Date of Birth	School Attending	Disabled
______________	( ) Parent ( ) Child ( ) Guardian ( ) Foster ( ) Adult	( ) Male ( ) Female	__________	______________ Grade ______	( ) Yes ( ) No

Last Name, First Name	Status	Sex	Date of Birth	School Attending	Disabled
______________	( ) Parent ( ) Child ( ) Guardian ( ) Foster ( ) Adult	( ) Male ( ) Female	__________	______________ Grade ______	( ) Yes ( ) No

Last Name, First Name	Status	Sex	Date of Birth	School Attending	Disabled
______________	( ) Parent ( ) Child ( ) Guardian ( ) Foster ( ) Adult	( ) Male ( ) Female	__________	______________ Grade ______	( ) Yes ( ) No

Last Name, First Name	Status	Sex	Date of Birth	School Attending	Disabled
______________	( ) Parent ( ) Child ( ) Guardian ( ) Foster ( ) Adult	( ) Male ( ) Female	__________	______________ Grade ______	( ) Yes ( ) No

Grade Codes: 20 = Pre-School; 60 = Graduated; 80 = Ungraded;

Hicksville Public Schools
Administration Building
200 Division Avenue
Hicksville, NY 11801
Office of the Registrar
516-733-2168

TRANSFER OF RECORDS REQUEST

As per the parental signature documented below, please forward all pertinent school records for the following student directly to the appropriate Hicksville School indicated:

ELEMENTARY SCHOOLS

☐ **Burns Avenue**
40 Burns Avenue
(516) 733-2311
(516) 733-6694 (Fax)

☐ **Dutch Lane**
50 Stewart Avenue
(516) 733-2361
(516) 733-3520 (Fax)

☐ **East Street**
50 East Street
(516) 733-2321
(516) 733-3533 (Fax)

☐ **Fork Lane**
4 Fork Lane
(516) 733-2341
(516) 733-3521(Fax)

☐ **Lee Avenue**
1 Seventh Street
(516) 733-2351
(516) 733-3522 (Fax)

☐ **Old Country Road**
49 Rhodes Lane
(516) 733-2301
(516) 733-3523 (Fax)

☐ **Woodland**
85 Ketcham Road
(516) 733-2331
(516) 733-3524 (Fax)

SECONDARY SCHOOLS

☐ **Middle School**
215 Jerusalem Avenue
516-733-2272
516-733-6528 (Fax)
ATT: Guidance Dept.

☐ **High School**
180 Division Avenue
516-733-2221
516-733-1194 (Fax)
ATT: Guidance Dept.

***Please forward all Special Education IEPS, Evaluations and Records directly to:**

☐ **Committee on Special Education**
Hicksville Public Schools
200 Division Avenue
Hicksville, NY 11801
(516) 733-2160 Fax: (516) 733-6683

STUDENT NAME: _____ D.O.B. _____

Entered in Hicksville Union Free School District as of: _____

Formerly of (Last Address): _____

School Last Attended: _____

School Address: _____

School Phone Number: _____ School Fax Number: _____

Parental Signature: _____ DATE _____

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 ADDRESSESS (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** _____

Employed by _____ Business Telephone _____ Cell Phone _____ Occupation_____

Family Physician _____ _____ _____
Name address telephone no.

Emergency Contact _____ _____ _____
(Other than parent)
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 _____