

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
REQUIREMENTS FOR REGISTRATION

REGISTRATION HOURS ARE MONDAY - FRIDAY, 8 AM TO 4PM
JULY AND AUGUST, MONDAY - THURSDAY, 8 AM TO 4 PM
PHONE: (631) 285-8890

- Original **and** a photocopy of birth certificate
- **FAX number or e mail address to previous** school and Transfer or Withdrawal paper from previous school
- **Transcript for High School students**
- Two proofs of residence in the Middle Country Central School District:
- **Homeowner:**
 - Current utility bills (Electric, Gas, Fuel, Water, Cable or Satellite television)
And one of the following:
 - Current Mortgage Statement
 - Deed to your home
 - Latest property tax bill
- **New home purchase:**
 - Mortgage commitment (on existing residence only)
with homeowner insurance policy.
- **Renters:**
 - Current utility bills (Electric, Gas, Fuel, Water, Cable or Satellite television)
 - Current Renter's Insurance policy
 - Original lease from leasing management firm, such as
Fairfield Properties, Island View or Westfield Green
or
 - District Registration Affidavit signed and notarized by the homeowner with a copy of
the homeowner's property tax bill.

Driver license, insurance cards and bank or credit card statements are not acceptable proof of residence.

- Custody papers, if applicable.
- Immunization record: A signed or stamped certificate of immunization on physician's letterhead or a previous school's signed health record indicating specific dates of quantities. (See required student immunizations).
- Parent/Guardian must bring picture I.D. with you.
- Please let the Registrar know if you are active military.

**MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
STUDENT REGISTRATION FORM**

NEW STUDENT RE-ENTRY

STUDENT INFORMATION

| | | | | | |
|-----------------------|--|--------------------|----------------------------------|-------------------------------|----------------------|
| STUDENT ID # | Last Name | First Name | Middle Name | Sex | Date of Birth |
| | Birthplace City | State | Country | | |
| BUILDING | CHILD'S ETHNIC AND RACE INFORMATION | | | | |
| | Please answer the two part question | | Is the child Hispanic or Latino? | YES | NO |
| GRADE | Please indicate any race group that applies, select one or more. | | | B - Black or African American | |
| | P - Native Hawaiian/Other Pacific Islander | | | W - White | |
| ENL | I - American Indian or Alaskan Native | | | A - Asian | |
| SPED | PREVIOUS SCHOOL INFORMATION | | | | |
| | Last School Attended | Grade Level | Name of District | | |
| ATTACHED | Address | | | | |
| Immunizations | Does your child receive any Special Education Services? | | | | Yes No |
| Custody Papers | COMPLETE IF STUDENT IS RE-ENTERING THE MIDDLE COUNTRY SCHOOL DISTRICT | | | | |
| | Last Date and School Attended | | | | |

PARENT/GUARDIAN INFORMATION (where child resides)

| | | | | |
|---|--|---------------------------|---|--------------------------------------|
| FAMILY ID # | Last Name - Mother or Guardian | First Name | Relationship to child | |
| Proof of Residence <input type="checkbox"/> House Deed or Closing Papers <input type="checkbox"/> Property Tax Bill <input type="checkbox"/> Mortgage Statement <input type="checkbox"/> Homeowners Insurance Policy <input type="checkbox"/> Landlord Affidavit <input type="checkbox"/> Utility Bill (2) <input type="checkbox"/> Apartment Complex Lease | Cell Number () | Work Number () | <input type="checkbox"/> Birth/Adopted Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Custodial Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Step Parent | |
| | Last Name - Father or Guardian | First Name | Relationship to child <input type="checkbox"/> Birth/Adopted Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Custodial Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Step Parent | |
| | Cell Number () | Work Number () | | |
| | Resident Address | | | |
| | STREET | TOWN | STATE | ZIP |
| | Mailing Address (if different) | | | Home Telephone () |
| | Is a second language spoken in the home? | Yes | No | If yes, what is the language? () |
| | Is enrollment related to Homelessness? | | | Yes No |
| | IF APPLICABLE PROVIDE NAME, ADDRESS AND PHONE NUMBERS OF PARENT NOT LIVING WITH CHILD | | | |
| | NAME | | | Home Number () |
| | STREET | TOWN | STATE | ZIP |
| | | | | Cell Number () |
| | | | | Work Number () |
| | SHOULD THIS PARENT RECEIVE SCHOOL MAILINGS? | | | Yes No |

SIBLING INFORMATION - Please list all other children in family including infants.

| Last Name | First Name | Middle Name | Sex | Date of Birth | Grade (if any) |
|-----------|------------|-------------|-----|---------------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Should the need arise that any of the above children become eligible for Medicaid Services, I give permission to disclose information regarding the educational records of my child for the sole purposes of Medicaid reimbursement, for health related education services.

Parent/Guardian Signature _____ **Date:** _____

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

STATE OF NEW YORK
COUNTY OF SUFFOLK

REGISTRATION AFFIDAVIT

The following person(s) _____

Reside(s) at _____

which is within the boundaries of the Middle Country Central School District. In the event that the Middle Country Central School District determines that the above person(s) does not reside at this address or has moved out, I understand that I will be liable for tuition for each student that attended the Middle Country Central School District and at that time the student (s) will be dropped from the attendance register and will no longer be allowed to attend school within the Middle Country Central School District.

Your deponent understands that this affidavit is made under oath; that the statements are true; that the Middle Country Board of Education will rely thereon and, if the information provided in the affidavit is false, the student will not be permitted to attend the district. The district will then take legal action to recover tuition and a referral will be made to the Suffolk County District Attorney's office for fraudulent misrepresentation.

Signature of Deponent (Homeowner)

Print Name

Telephone Number

Document provided by Homeowner:
___ Property Tax Bill: must be presented to MCCSD
Central Registration Office

Taken and Sworn to before me this
_____ day of _____, 20 ____

Notary Public

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

ATTN: SCHOOL HEALTH OFFICE

DEAR PARENT;

WHEN YOUR CHILD ENTERS SCHOOL WE ESTABLISH A CUMULATIVE RECORD FILE ON HIM/HER TO ENABLE US TO HAVE A GREATER UNDERSTANDING OF YOUR CHILD'S NEEDS. ALL INFORMATION, OF COURSE, WILL BE KEPT STRICTLY CONFIDENTIAL, SO PLEASE ANSWER EVERY QUESTION, PLEASE PRINT NEATLY. THANK YOU FOR YOUR COOPERATION.

STUDENT'S NAME _____ SEX _____ DOB _____ SCHOOL _____

ADDRESS _____ PHONE NO. _____

FATHER/GUARDIAN NAME _____ CELL PHONE NO. _____

MOTHER/GUARDIAN NAME _____ CELL PHONE NO. _____

PARENT'S PLACE OF EMPLOYMENT FATHER/GUARDIAN _____ WORK NO. _____

MOTHER/GUARDIAN _____ WORK NO. _____

PHYSICIAN TO BE CALLED IN EMERGENCY (LOCAL) PHONE NO. _____

TRANSPORTATION OF AN ILL CHILD IS TO BE ARRANGED BY PARENT OR PERSONS NAMED ABOVE IT IS A PARENTAL RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF CHANGES IN THE ABOVE.

FOR OFFICE USE ONLY:
_____ IMMUNIZATION RECORD VERIFIED/ATTACHED
Initials of Central Registration staff member _____

TO BE COMPLETED BY PARENT. PLEASE INDICATE IF HISTORY AND DESCRIBE BELOW:

ANEMIA _____ ASTHMA _____ ALLERGIES _____ DIABETES _____ EPILEPSY _____
HEART DISEASE _____ KIDNEY DISEASE _____ TUBERCULOSIS OR CONTACT WITH TB _____
SERIOUS ILLNESS, INJURY, OPERATIONS _____
EXPLANATION OF ABOVE AS CHECKED: _____

IS MEDICATION GIVEN ON A REGULAR BASIS? NO _____ YES _____
WILL MEDICATION BE GIVEN DURING SCHOOL? NO _____ YES _____

NEW YORK STATE LAW REQUIRES THE PARENT TO SUBMIT A WRITTEN REQUEST TO THE SCHOOL, AND IT MUST BE ACCOMPANIED BY A WRITTEN REQUEST FROM THE PHYSICIAN, IN WHICH HE INDICATES THE FREQUENCY AND THE DOSAGE OF THE PRESCRIBED MEDICATION. THIS MEDICATION MUST BE BROUGHT IN BY THE PARENT IN A PRESCRIPTION BOTTLE.

ANY VISION PROBLEMS: NO _____ YES _____ PLEASE SPECIFY _____
GLASSES WORN NO _____ YES _____ DATE OF EXAMINATION _____
DR./EXAMINER'S NAME/ADDRESS _____
HEARING DIFFICULTIES NO _____ YES _____ HEARING AID WORN NO _____ YES _____
PLEASE SPECIFY: _____

DATE OF LAST EXAMINATION _____
DOCTOR'S NAME _____
ADDRESS _____

IF ANY MODIFICATION IN THE SCHOOL'S PROGRAM IS REQUIRED, PLEASE SUBMIT A DOCTOR'S WRITTEN RECOMMENDATION.

SIGNATURE OF PARENT/GUARDIAN _____

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

ATTN: HEALTH OFFICE

ESTIMADOS PADRES O TUTORES:

CUANDO SU HIJO/A INGRESA A LA ESCUELA, ESTABLECEMOS UN ARCHIVO DE REGISTRO ACUMULATIVO QUE NOS PERMITE COMPRENDER MEJOR SUS NECESIDADES. DE MÁS ESTÁ DECIR QUE TODA LA INFORMACIÓN SE MANTENDRÁ ESTRICTAMENTE CONFIDENCIAL, POR LO QUE LE PEDIMOS QUE RESPONDA TODAS LAS PREGUNTAS EN LETRA IMPRENTA Y DE MANERA PROLIJA. GRACIAS POR SU COOPERACIÓN.

NOMBRE _____ SEXO _____ FECHA DE NACIMIENTO _____ ESCUELA _____

DIRECCIÓN _____ N.º DE TEL. DEL HOGAR _____

NOMBRE DEL PADRE/TUTOR _____ N.º DE CELULAR _____

NOMBRE DE LA MADRE/TUTORA _____ N.º DE CELULAR _____

LUGAR DE EMPLEO DE LOS PADRES

PADRE/TUTOR _____ N.º DE TEL. DEL TRABAJO _____

MADRE/TUTORA _____ N.º DE TEL. DEL TRABAJO _____

MÉDICO AL QUE SE DEBE LLAMAR EN CASO DE EMERGENCIA _____ N.º DE TELÉFONO _____

EL TRANSPORTE DE UN NIÑO ENFERMO QUEDARÁ A CARGO DE LOS PADRES O DE LAS PERSONAS MENCIONADAS ANTERIORMENTE SI HUBIERA ALGUNA MODIFICACIÓN EN LA INFORMACIÓN MENCIONADA ANTERIORMENTE. LOS PADRES SERÁN LOS RESPONSABLES DE NOTIFICAR A LA ENFERMERA DE LA ESCUELA.

FOR OFFICE USE ONLY:

_____ IMMUNIZATION RECORD VERIFIED/ATTACHED

Initials of Central Registration staff member _____

INDIQUE SI SU HIJO/A TIENE ALGUNO DE ESTOS ANTECEDENTES Y DESCRIBA A CONTINUACIÓN:

ANEMIA _____ ASMA _____ ALERGIAS _____ DIABETES _____ EPILEPSIA _____

ENFERMEDAD CARDÍACA _____ ENFERMEDAD RENAL _____ TUBERCULOSIS O CONTACTO CON TB _____

ENFERMEDADES GRAVES, LESIONES, OPERACIONES _____

EXPLICACIÓN DE LO MENCIONADO ANTERIORMENTE: _____

¿TOMA ALGÚN MEDICAMENTO REGULARMENTE? NO _____ SÍ _____

¿SE LE ADMINISTRARÁN MEDICAMENTOS DURANTE EL HORARIO ESCOLAR? NO _____ SÍ _____

LA LEY DEL ESTADO DE NUEVA YORK REQUIERE QUE LOS PADRES PRESENTEN UNA SOLICITUD POR ESCRITO A LA ESCUELA, LA CUAL DEBE ESTAR ACOMPAÑADA POR UNA SOLICITUD POR ESCRITO DE PARTE DEL MÉDICO, EN LA QUE SE INDIQUE LA FRECUENCIA Y LA DOSIS DEL MEDICAMENTO RECETADO. LOS PADRES DEBEN TRAER ESTE MEDICAMENTO EN UN FRASCO PARA MEDICAMENTOS.

PROBLEMAS DE LA VISTA: NO _____ SÍ _____ ESPECIFIQUE _____
 USA ANTEOJOS NO _____ SÍ _____ FECHA DEL EXAMEN _____
 NOMBRE DEL DR./DIRECCIÓN _____

PROBLEMAS AUDITIVOS NO _____ SÍ _____ USA AUDÍFONOS NO _____ SÍ _____
 ESPECIFIQUE: _____

FECHA DEL ÚLTIMO EXAMEN _____
 NOMBRE DEL MÉDICO _____
 DIRECCIÓN _____

SI REQUIERE ALGUNA MODIFICACIÓN EN EL PROGRAMA ESCOLAR, DEBE PRESENTAR LA RECOMENDACIÓN ESCRITA DEL MÉDICO.
 FIRMA DEL PADRE, MADRE O TUTOR _____

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT AT CENTEREACH

Central Registration 25 N Bicycle Path, Selden, NY 11784 Ph: 631-285-8890

Roberta A. Gerold, Ed. D. Superintendent of Schools

PREVIOUS SCHOOL FAX# or E MAIL _____

My Child _____ formerly a student in
Grade _____ of your school has been registered in Middle Country Central School District,
Centereach, NY. Please send the following information to the SCHOOL INDICATED BELOW:

Cumulative Records

A copy of the Permanent Record

All pertinent psychological and testing information which will be of value in placing this student.

Current Report Card.

All science labs, if applicable.

All ENL related testing scores, including, NYSELAT and NYSITELL

Thank you for your cooperation.

Parent/Guardian's Signature

Date

CENTEREACH HS fax:

A-F 631-285-8195

G-N 631-285-8225

O-Z 631-285-8139

Ph: 631-285-8120

EUGENE AUER MEMEORIAL ELEMENTARY

17 WING ST

LAKE GROVE NY 11755

Ph: 631-285-8500 fax: **631-285-8501**

OXHEAD ROAD ELEMENTARY

144 OXHEAD RD

CENTEREACH NY 11720

Ph: 631-285-8700 fax: **631-285-8701**

NEWFIELD HS

GUIDANCE DEPT

145 MARSHALL DR

SELDEN NY 11784

Ph: 631-285-8330 fax: **631-285-8336**

HAWKINS PATH ELEMENTARY

485 HAWKINS RD

SELDEN NY 11784

Ph: 631-285-8530 fax: **631-285-8531**

STAGECOACH ELEMENTARY

205 DARE RD

SELDEN NY 11784

Ph: 631-285-8730 fax: **631-285-8731**

DAWNWOOD MS

GUIDANCE DEPT

10 43RD STREET

CENTEREACH NY 11720

Ph: 631-285-8210 fax: **631-285-8201**

HOLBROOK ROAD ELEMENTARY

170 HOLBROOK AVE

CENTEREACH NY 11720

Ph: 631-285-8560 fax: 631-285-8561

UNITY DRIVE KDG CENTER

11 UNITY DR

CENTEREACH NY 11720

Ph: 631-285-8760 fax: **631-285-8761**

SELDEN MS

GUIDANCE DEPT

22 JEFFERSON AVE

CENTEREACH NY 11720

Ph: 631-285-8410 fax: **631-285-8401**

JERICHO ELEMENTARY SCHOOL

34 N COLEMAN RD

CENTEREACH NY 11720

Ph: 631-285-8600 fax: 631-285-8601

BICYCLE PATH KDG CENTER

27 N BICYCLE PATH

SELDEN NY 11784

Ph: 631-285-8800 fax: **631-285-8801**

CENTRAL REGISTRATION

25 N BICYCLE PATH

SELDEN NY 11784

fax: 631-285-8806

NEW LANE MEMORIAL ELEMENTARY

15 NEW LANE

SELDEN NY 11784

Ph: 631-285-8900 fax: 631-285-8901

SPECIAL EDUCATION/PUPIL PERSONNEL

25 N BICYCLE PATH STE. A

SELDEN NY 11784

Ph: 631-285-8850 fax: **631-285-8851**

NORTH COLEMAN ROAD ELEMENTARY

197 NORTH COLEMAN RD

CENTEREACH NY 11720

Ph: 631-285-8660 fax: **631-285-8661**

The mission of the MCCSD is to empower and inspire all students to apply the knowledge, skills, and attitudes necessary to be creative problem solvers, to achieve personal success, and to contribute responsibly in a diverse and dynamic world.



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

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or 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 in English, as well as prior school and personal history. Please complete the sections below entitled *Language Background and Educational History*. Your assistance in answering these questions is greatly appreciated. Thank you.

| Please write clearly when completing this section. | | |
|--|------------|---------------------------------|
| STUDENT NAME: | | |
| First | Middle | Last |
| DATE OF BIRTH: | | GENDER: |
| Month | Day | Year |
| | | <input type="checkbox"/> Male |
| | | <input type="checkbox"/> Female |
| PARENT/PERSON IN PARENTAL RELATION INFO: | | |
| Last Name | First Name | Relation to Student |

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

| | | | |
|--|--------------------------------------|---------------------------------|--|
| 1. What language(s) is(are) spoken in the student's home or residence? | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ specify |
| 2. What was the first language your child learned? | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ specify |
| 3. What is the Home Language of each parent/guardian? | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | _____ specify |
| | <input type="checkbox"/> Guardian(s) | | _____ specify |
| 4. What language(s) does your child understand? | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ specify |
| 5. What language(s) does your child speak? | <input type="checkbox"/> English | <input type="checkbox"/> Other | <input type="checkbox"/> Does not speak _____ specify |
| 6. What language(s) does your child read? | <input type="checkbox"/> English | <input type="checkbox"/> Other | <input type="checkbox"/> Does not read _____ specify |
| 7. What language(s) does your child write? | <input type="checkbox"/> English | <input type="checkbox"/> Other | <input type="checkbox"/> Does not write _____ specify |

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

Yes* No Not sure *If yes, please explain: _____

How severe do you think these difficulties are? Minor Somewhat severe Very severe

10a. Has your child ever been referred for a special education evaluation in the past? No Yes* *Please complete 10b below

10b. *If referred for an evaluation, has your child ever received any special education services in the past?
 No Yes – Type of services received: _____

Age at which services received (Please check all that apply):
 Birth to 3 years (Early Intervention) 3 to 5 years (Special Education) 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? No Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

12. In what language(s) would you like to receive information from the school? _____

Month: _____ Day: _____ Year: _____

 Date

Signature of Parent or of Person in Parental Relation _____

Relationship to student: Mother Father Other: _____

| | |
|--|---|
| OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ | |
| NAME: _____ | POSITION: _____ |
| IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____ | |
| NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW | |
| NAME: _____ | POSITION: _____ |
| ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| **DATE OF INDIVIDUAL INTERVIEW: _____ Mo. DAY YR. | OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM |
| NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL | |
| NAME: _____ | POSITION: _____ |
| DATE OF NYSITELL ADMINISTRATION: _____ MO. DAY YR. | PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING |
| FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____ | |