MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
REQUIREMENTS FOR REGISTRATION

25 N BICYCLE PATH SELDEN NY 11784 PHONE: 631-285-8890

REGISTRATION HOURS ARE MONDAY – FRIDAY **7:00 AM - 4:00PM**

- 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 or Island View

      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 <u>signed or stamped</u> certificate of immunization on physician's letterhead or a previous school's signed health record indicating <u>specific dates of quantities.</u> (See required student immunizations).

- Parent/Guardian must bring picture I.D. with you.

Registration Forms and Change of Address Forms can be printed from the district website:

WWW.MCCSD.NET

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

GRADE	
ENL	SPED

CHILD'S ETHNIC AND RACE INFORMATION

Please answer the two part question	Is the child Hispanic or Latino?	YES	NO
Please indicate any race group that applies, select one or more.		B – Black or African American	
P – Native Hawaiian/Other Pacific Islander		W – White	
I – American Indian or Alaskan Native		A – Asian	

PREVIOUS SCHOOL INFORMATION

Last School Attended	Grade Level	Name of District

Address

Does your child receive any Special Education Services? Yes No

COMPLETE IF STUDENT IS RE-ENTERING THE MIDDLE COUNTRY SCHOOL DISTRICT

Last Date and School Attended

ATTACHED	
Immunizations	
Custody Papers	

PARENT/GUARDIAN INFORMATION (where child resides)

FAMILY ID #

Proof of Residence
- ☐ House Deed or Closing Papers
- ☐ Property Tax Bill
- ☐ Mortgage Statement
- ☐ Homeowners Insurance Policy
- ☐ Landlord Affidavit
- ☐ Utility Bill (2)
- ☐ Apartment Complex Lease

Last Name - Mother or Guardian	First Name	Relationship to child
		___ Birth/Adopted Parent ___ Legal Guardian ___ Custodial Care ___ Foster Care ___ Step Parent
Cell Number ( )	**Work Number** ( )	
Last Name - Father or Guardian	**First Name**	**Relationship to child** ___ Birth/Adopted Parent ___ Legal Guardian ___ Custodial Care ___ Foster Care ___ 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

STREET TOWN STATE ZIP

Home Number ( )
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 ACCOMPANID 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.° DE TEL. DEL HOGAR _____

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

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

LUGAR DE EMPLEO DE LOS PADRES

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

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

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

NEWFIELD HS
GUIDANCE DEPT
145 MARSHALL DR
SELDEN NY 11784
Ph: 631-285-8330 **fax: 631-285-8336**

DAWNWOOD MS
GUIDANCE DEPT
10 43RD STREET
CENTEREACH NY 11720
Ph: 631-285-8210 **fax: 631-285-8201**

SELDEN MS
GUIDANCE DEPT
22 JEFFERSON AVE
CENTEREACH NY 11720
Ph: 631-285-8410 **fax: 631-285-8401**

CENTRAL REGISTRATION
25 N BICYCLE PATH
SELDEN NY 11784
fax: 631-285-8806

EUGENE AUER MEMEORIAL ELEMENTARY
17 WING ST
LAKE GROVE NY 11755
Ph: 631-285-8500 **fax: 631-285-8501**

HAWKINS PATH ELEMENTARY
485 HAWKINS RD
SELDEN NY 11784
Ph: 631-285-8530 **fax: 631-285-8531**

HOLBROOK ROAD ELEMENTARY
170 HOLBROOK AVE
CENTEREACH NY 11720
Ph: 631-285-8560 fax: 631-285-8561

JERICHO ELEMENTARY SCHOOL
34 N COLEMAN RD
CENTEREACH NY 11720
Ph: 631-285-8600 fax: 631-285-8601

NEW LANE MEMORIAL ELEMENTARY
15 NEW LANE
SELDEN NY 11784
Ph: 631-285-8900 fax: 631-285-8901

NORTH COLEMAN ROAD ELEMENTARY
197 NORTH COLEMAN RD
CENTEREACH NY 11720
Ph: 631-285-8660 **fax: 631-285-8661**

OXHEAD ROAD ELEMENTARY
144 OXHEAD RD
CENTEREACH NY 11720
Ph: 631-285-8700 **fax: 631-285-8701**

STAGECOACH ELEMENTARY
205 DARE RD
SELDEN NY 11784
Ph: 631-285-8730 **fax: 631-285-8731**

UNITY DRIVE KDG CENTER
11 UNITY DR
CENTEREACH NY 11720
Ph:631-285-8760 **fax: 631-285-8761**

BICYCLE PATH KDG CENTER
27 N BICYCLE PATH
SELDEN NY 1 1784
Ph:631-285-8800 **fax: 631-285-8801**

SPECIAL EDUCATION/PUPIL PERSONNEL
25 N BICYCLE PATH STE. A
SELDEN NY 11784
Ph: 631-285-8850 **fax: 631-285-8851**

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:

Month *Day* *Year*

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

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

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

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

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

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

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

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

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

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

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

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

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

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ☐ **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: ☐ NO ☐ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

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