

Deer Park School District

REGISTRATION



Attached you will find a packet of information required for registration. In order to facilitate the registration process and minimize your time, it is necessary to complete all enclosed documents. In addition to this packet, the following documentation will be required at the time of registration:

Photo Identification of parent/guardian

Proof of Residence: see attached

Birth Certificate

Immunization Record

Social Security Number

School records

REGISTRATION IS NOT COMPLETE UNTIL ALL NECESSARY
INFORMATION AND
DOCUMENTATION IS PROVIDED



Deer Park School District
Office of Central Registration
Washington School

220 Washington Avenue, Deer Park New York 11729

Phone: (631) 274-4372 Fax: (631) 274-8867

The following requirements **must** be met in order to enroll a student into the Deer Park School District:

- The student must be registered by the parent or legal guardian (Proof of legal guardianship and/or court papers are required)
- The student must be present at the registration intake appointment
- Photo Identification (ID) is required of the student's parent/legal guardian.
- Original Birth Certificate
- Student's social security card
- District's Health Appraisal form (see attached) & Immunization form (see attached) signed and stamped by physician
- Current report card and secondary transcript if available
- Withdrawal card/Discharge documentation from previous school
- Proof of Residency: **(ALL OF THE FOLLOWING MUST BE PROVIDED)**

Homeowner: Current property tax statement
Current utility bill

Renter: Landlord Affidavit (See Attached) **must** be notarized
Current property tax statement of homeowner
Current utility in renter's name

Under penalties of perjury, the statements contained in this application are true. Statements in this application are subject to verification by the Deer Park School District and false statements are subject to financial liability where applicable. It is the applicant's responsibility to notify the school district of any changes or circumstances affecting this application. **ANY FALSE STATEMENTS MADE IN THIS APPLICATION ARE ALSO PUNISHABLE AS A CLASS 'A' MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.**

REGISTRATION FORM

PRIMARY DATA

FIRST NAME _____
LAST NAME _____
MIDDLE NAME _____ GRADE _____
ETHNICITY _____ SEX _____
SOCIAL SECURITY NUMBER _____
DATE OF BIRTH _____
DISTRICT ID # _____
SECURITY ALERT _____
VERIFICATION _____
BIRTH CITY _____
BIRTH STATE _____
BIRTH COUNTRY _____
PRIMARY LANGUAGE _____
SECONDARY LANGUAGE _____

DATA 1

DATE REGISTERED _____
PROOF OF RESIDENCE _____
PREVIOUS ADDRESS: _____
CITY _____ STATE _____ ZIP _____
PREVIOUS PHONE: _____
PREVIOUS SCHOOL NAME: _____
ADDRESS: _____
CITY _____ STATE _____ ZIP _____
Did student previously attend Deer Park Schools?
school _____ grade _____ date _____
ALL IMMUNIZATIONS (CIRCLE ONE) YES OR NO
HOME: OWN or RENT
Date student entered the U.S. ____ / ____ / ____
1st school attended in the U.S. _____
city _____ state _____

DATA 2

SIBLINGS _____
BIRTH DATE _____
SIBLINGS _____
BIRTH DATE _____
SIBLINGS _____
BIRTH DATE _____
SIBLINGS _____
BIRTH DATE _____

ADDITIONAL PEOPLE LIVING IN YOUR HOME

ADULT NAME _____, _____
Name Relationship
ADULT NAME _____, _____
CHILD'S NAME _____, _____
Name Date of Birth
CHILD'S NAME _____, _____
CHILD'S NAME _____, _____

PHONES AND ADDRESSES

PHONES AND ADDRESSES

FATHER NAME _____
FATHER HOME ADDRESS _____

MOTHER NAME _____
MOTHER HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____
HOME PHONE () _____

CITY _____ STATE _____ ZIP _____
HOME PHONE () _____

BUSINESS PHONE () _____
CELL PHONE () _____
EMPLOYER _____

BUSINESS PHONE () _____
CELL PHONE () _____
EMPLOYER _____

CHECK APPROPRIATE BOXES:

- ok to pick up legal custody
 lives with student receives mailing

CHECK APPROPRIATE BOXES:

- ok to pick up legal custody
 lives with student receives mailing

MALE GUARDIAN

Step-Father Foster Father Other _____
Relationship

Name _____

Address _____

CITY _____ STATE _____ ZIP _____

HOME PHONE () _____

BUSINESS PHONE () _____

CELL PHONE () _____

FEMALE GUARDIAN

Step-Mother Foster Mother Other _____
Relationship

Name _____

Address _____

CITY _____ STATE _____ ZIP _____

HOME PHONE () _____

BUSINESS PHONE () _____

CELL PHONE _____

FAMILY PHYSICIAN _____

PHONE NUMBER _____

X _____

PARENT SIGNATURE

regform

EMERGENCY CONTACT

NAME _____

PHONE NUMBER () _____

I understand that the statements in this application are subject to verification by the School District and that false statements could subject me to financial liability where applicable.

DEER PARK PUBLIC SCHOOLS
1881 Deer Park Avenue
Deer Park, New York 11729

HEALTH INFORMATION FORM

Child's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Place of Birth: _____ Birth Weight: _____

Full Term or Premature: _____ Type of Delivery: _____

Father's Name: _____ Business Phone: _____

Mother's Name: _____ Business Phone: _____

Local physician to be called in case of emergency and parent cannot be reached:

Name of Doctor: _____ Phone: _____

Has child had any of the following? Please state dates.

Chicken Pox _____	Diabetes _____	Serious injuries _____
Measles _____	Pneumonia _____	_____
German Measles _____	Rheumatic Fever _____	Tonsillectomy _____
Roseola _____	Heart Disease _____	Surgery _____
Mumps _____	Poliomyelitis _____	_____
Scarlet Fever _____	Tuberculosis _____	_____
Scarlatina _____	Epilepsy _____	Allergies _____
Whooping Cough _____	Ear conditions _____	Asthma _____
Hepatitis B _____		

Does your child have any eye difficulties? If so, describe:

Name of specialist treating eye condition: _____

Does your child have any speech problems, (lisp, baby talk, etc.) If so, describe:

Is there any history in mother or father's family of Diabetes, Epilepsy, Heart Disease or Tuberculosis? If so, name relationship and diagnosis:

Please state the approximate age of your child when he/she sat up, _____, walked, _____, talked, _____.

Please list other children in family and their birth dates:

Parent Signature

Date

DEER PARK PUBLIC SCHOOLS
Deer Park, New York

STUDENT: _____
DATE: _____

SCHOOL: _____
GRADE: _____

Dear Parent/Guardian,

New York State Immunization Law requires children enrolling in school for the first time or new to the Deer Park Schools, must have a certificate from his/her physician for the following immunizations. Month, day and year must be indicated.

1. Polio (OPV) #1 _____ #2 _____ #3 _____ #4 _____
Polio (IPV) #1 _____ #2 _____ #3 _____ #4 _____

2. DTAP #1 _____ #2 _____ #3 _____ #4 _____

TD Booster(adult type) _____

Tdap #1 _____ required for students entering 6th grade and who are 11yrs of age or older

** 3. Measles Vaccine
Mumps Vaccine (M-M-R) #1 _____ #2 _____
Rubella

** 4. Measles Vaccine #1 _____ OR - ↓
#2 _____

5. Mumps Vaccine #1 _____

6. Rubella Vaccine #1 _____

7. _____ Titer Date done _____ Results _____

** 8. Haemophilus Influenzae
(Type B) (Hib) #1 _____ #2 _____ #3 _____ #4 _____

* 9. Tuberculosis Test Type _____ Date _____ Results _____

10. Lead Level Screening(strongly recommended)Date _____ Results _____ $\frac{MCG}{DL}$ (Pre-K or K)

11. Hepatitis B #1 _____ #2 _____ #3 _____

12. Varicella(chicken pox) _____ Is required for Pre-K & K born on or after 1/1/98
All students entering 6,7,8th grade in Sept born on or after 1/1/94

Please Note: ** For children 18 months to 5 years in Day Care or any Pre-School Program.
* Required by Deer Park School District

Physician's Signature _____ Physician's Address _____ Physician's Telephone _____	PHYSICIAN'S STAMP
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Please have your private physician complete this report and return it to the school nurse by SEPTEMBER 30th for currently enrolled students and within 15 days for a new entrant. Incoming Pre-K & Kindergarten student entering school in September must have a physical no more than 12 months prior to their school entrance.

IF THIS FORM IS NOT RETURNED COMPLETED IN FULL YOUR CHILD WILL NEED TO HAVE A MEDICAL SCREENING BY OUR SCHOOL PHYSICIAN.

HEALTH CERTIFICATE / APPRAISAL FORM

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached
 No immunizations given today
 Immunizations given since last Health Appraisal mcg/dl _____

Sickle Cell Screen: Positive Negative Not done Date: _____
 PPD: Positive Negative Not done Date: _____
 Elevated Lead: Yes No Not done Date: _____
 Dental Referral Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Allergies: LIFE THREATENING Food: _____ Insect: _____ Other: _____
 Seasonal Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____ Urine: _____ Date of Exam: _____

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th <input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Vision - without glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td style="text-align: center;">Referral</td> </tr> <tr> <td style="text-align: center;">Vision - with glasses/contact lenses</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Vision - Near Point</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> <tr> <td style="text-align: center;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="text-align: center;">R</td> <td style="text-align: center;">L</td> <td></td> </tr> </table>	Vision - without glasses/contact lenses	R	L	Referral	Vision - with glasses/contact lenses	R	L		Vision - Near Point	R	L		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	
Vision - without glasses/contact lenses	R	L	Referral														
Vision - with glasses/contact lenses	R	L															
Vision - Near Point	R	L															
Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L															

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed Yes No Student may self carry and self administer medication Yes No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, play ground, work & school activities OR only as checked:

____ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

____ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: _____ None

Known or suspected disability: _____ Please monitor

Restrictions: _____ Please monitor

Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear other: _____

OPTIONAL INFORMATION, if known

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Provider's Signature: _____ Phone: _____ (Stamp below)

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

DEER PARK SCHOOL DISTRICT
OFFICE OF PUPIL PERSONNEL SERVICES
1881 Deer Park Avenue
Deer Park, New York 11729



Dear Parent or Guardian:

As a part of your child's medical requirements for school, a physical examination has been required for students in Prekindergarten, Kindergarten in Grades 2, 4, 7 and 10 and all new entrants. A law was recently enacted that expands health screenings to include the **dental health** of students in New York State.

Effective September 1, 2008, it is now mandated that your child have the required dental examination for school attendance. A completed dental certificate must be submitted to the school district as required by the New York State Department of Health.

On the reverse side of this letter is a district dental certificate available for you to take to your child's dentist to be completed. Once the dental screening has been completed; please return this form to the health office in your child's school. The school nurse will place this screening certificate on file with your child's Cumulative Health Record.

Please call the school's Health Office if you have any questions or concerns.

Thank you.

DEER PARK SCHOOL DISTRICT

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, Pre K, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Sex: Male Female Will this be your child's first visit to a dentist? Yes No
Month Day Year

School: Name Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? Yes No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

- Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.
 No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

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Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

- Yes No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].
- Yes No **Untreated Caries** – Does this child have an open cavity? [At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].
- Yes No **Dental Sealants Present**

Other problems (Specify): _____

III. Treatment Needs (check all that apply)

- No obvious problem. Routine dental care is recommended. Visit your dentist regularly.
- May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.
- Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

CUSTODIAL STIPULATION FORM

Please answer **all** the questions indicated below:

Student Name _____ Date Of Birth _____

Current Address _____ Home Phone Number _____

Mother's Name _____ Legal Custody
Last Name _____ First Name _____ Yes or No

Father's Name _____ Legal Custody
Last Name _____ First Name _____ Yes or No

Legal Guardian's Name (If Applicable) _____ Legal Custody
Last Name _____ First Name _____ Yes or No

① Who does the child reside with in the Deer Park School District?

Please indicate:

Mother Only Other Relationship _____

Father Only Briefly Explain: _____

Mother and Father _____

② Is there a custody agreement in effect ?

YES If yes, briefly describe your situation and attach a copy of the custody document, divorce decree, guardianship papers etc...

NO If no, please sign to verify the following statement:

I attest to the fact that a custody agreement does not exist or pertain to my child as indicated in this registration process.

X _____

Signature

NEW YORK STATE EDUCATION LAW STIPULATES THAT PARENTS HAVE THE RIGHT TO ACCESS THEIR CHILD'S SCHOOL RECORDS AND REPORT CARDS, UNLESS OTHERWISE INDICATED IN A COURT ORDER.

③ Is there a request for dual mailing to the non-custodial parent?

Yes If yes, please furnish the following :

_____, _____, _____
Last Name First Name Relationship

_____, _____, _____
Address State Zip Code

NO If No , please sign to decline X _____

Signature

④ Is the non-custodial parent permitted to pick the student up from school for illness, appointments, etc..?

YES Ok to pick up student NO Not permitted to pick up student

NOTE: THE ONLY PERSON PERMITTED TO SIGN YOUR CHILD OUT OF THE BUILDING FOR ANY REASON IS THE PARENT/LEGAL GUARDIAN AND/OR DESIGNEE AS INDICATED ON THIS DOCUMENT AND EMERGENCY CARD.

I understand and agree that the above information identified in this document is true. I further understand that if any statements made by me are willfully false my child's registration and attendance in the Deer Park School District may be subject to review by the Board of Education. Knowingly withholding information that is relevant with relation to custodial concerns may result in legal action.

X _____
Signature

Today's Date

DEER PARK UNION FREE SCHOOL DISTRICT

1881 Deer Park Avenue
Deer Park, NY 11729
(631) 274-4001 * Fax (631) 242-6762

Elizabeth Marino
Superintendent of Schools

Frank Caliguiri
Asst. Superintendent

Eva Demyen
Deputy Superintendent

Marguerite Jimenez
Asst. Superintendent

Dear Parents,

According to New York State Commissioner of Education Regulations, public schools must conduct a new entrant screening for all new students to the Deer Park Schools by December 1st of the incoming school year, or if entry takes place after December 1st of the school year, within 15 days of entry.

This screening is a method of identifying children who may possibly have an educationally disabling condition or who may possibly be gifted.

The State screening program is designed to obtain information regarding each student's development in the following areas:

- Physical
- Cognitive
- Receptive and Expressive Language
- Articulation Skills
- Motor

The building Learning Support Team, (LST), in your child's school will conduct the new entrant screening. Included on this team is the school nurse, the school psychologist, the speech/language therapist, the reading teacher at the elementary level and a guidance counselor if your child is entering the middle school or high school, and a physical education teacher.

After completion of the screening, a member of the LST or your child's classroom teacher will include a review of the results during the scheduled parent conference in December if your child is in an elementary grade, or through the first quarter report card mailing if your child is at the secondary level. If, as a result of the initial screening procedure, additional intervention is indicated, this will be discussed with you shortly after the actual screening takes place.

We look forward to your assistance and participation joining with the professional staff to make your child's school years a rewarding and fulfilling experience.

Sincerely,



Frank Caliguiri
Assistant Superintendent
Pupil Personnel Services

I have read and understand the contents of this letter.

DEER PARK UNION FREE SCHOOL DISTRICT

1881 Deer Park Avenue
Deer Park, NY 11729
(631) 274-4001 * Fax (631) 242-6762

Elizabeth Marino
Superintendent of Schools

Frank Caliguiri
Asst. Superintendent

Eva Demyen
Deputy Superintendent

Marguerite Jimenez
Asst. Superintendent

Dear Parent/Guardian:

Your child will be attending the Deer Park School District for the upcoming school year. When you registered your child, you were required to present a record of your child's immunization history, signed and stamped by your child's doctor.

In accordance with New York State Immunization Laws, children enrolling in school for the first time or new to the Deer Park Schools will have their immunization history reviewed by our school nurses.

Required immunizations are as follows:

Polio	3 doses
DT or Dtap	3 doses
M.M.R.	1 dose (Measles, Mumps, Rubella)
Measles	2 nd dose (M.M.R. preferred) required for K and older
H.I.B. - Vaccine	Pre-K 3 doses or 1 dose on or after 15 mos of age
Tuberculosis Test	test must be within the last year
Lead Level Screening	strongly recommended Pre-K & K
Hepatitis B	3 doses
Varicella (chicken pox)	All students entering Pre-K & K All students entering 6 th , 7 th , 8 th grade in Sept. born on or after 1/1/94
Tdap Booster	All students entering 6 th grade 11 yrs. or older
Proof of physical	Within 1 year of school entrance

Please be aware that your child may be excluded from school if any of the above required immunizations are incomplete. If you should have any questions regarding this matter, please call your child's school nurse as listed below:

John Quincy Adams School	274-4430
May Moore School	274-4480
John F. Kennedy School	274-4330
Robert Frost Middle School	274-4230
Deer Park High School	274-4130
Abraham Lincoln School	274-4370
St.Cyril & Methodious School	667-6229

We appreciate your assistance in this matter and hope to make your child's school year a rewarding and fulfilling experience.

X _____
I have read and understand the contents of this letter



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

TO BE COMPLETED BY SCHOOL PERSONNEL			
DISTRICT <small>Please print or type clearly</small>			
SCHOOL		GRADE	
STUDENT NAME			
DATE OF BIRTH			
Month:		Day:	Year:
STUDENT IDENTIFICATION NUMBER			
COUNTRY OF BIRTH / ANCESTRY			
NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.			
NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION			
DETERMINATION:			
		<input type="checkbox"/> Possible LEP	
		<input type="checkbox"/> English Proficient	

(✓ boxes that apply)

- What language(s) is spoken in the student's home or residence? English Other _____ specify
- What language(s) are spoken most of the time to the student, in the home or residence? English Other _____ specify
- What language(s) does the student understand? English Other _____ specify
- What language(s) does the student speak? English Other _____ specify
- What language(s) does the student read? English Other _____ specify Does Not Read
- 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaks English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reads English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writes English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Parent/Guardian/Other

Month: Day: Year: Date

**DEER PARK SCHOOL DISTRICT
OFFICE OF CENTRAL REGISTRATION
PRIOR SPECIAL EDUCATION SERVICES**

Student's Name: _____ Date Of Birth: _____
Current Address: _____ Phone number: _____

Last School Attended: _____ School District: _____
Address: _____ Phone number: _____
Last Grade Completed: _____ Teacher or Guidance Counselor's Name : _____

Did student receive any special education services? NO YES (indicate below):

IF YOU RESPONDED "YES" TO THE ABOVE, PLEASE COMPLETE THE FOLLOWING:

Type of Special Education Program Attended:

- Special Education Class Resource Room
 Inclusion Program Related Services Only
 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 Vision Services
 Physical Therapy Hearing Services

Classification If known

- Don't Know 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 copy)

Name of CSE Chairperson/ Special Education Director _____
Address of CSE Office _____ Phone # _____

Release of Records / Information to the Deer Park School District

I authorize the school and CSE indicated above to release academic, psychological, psychiatric, medical and all other evaluations, IEPs and records to the Deer Park 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 services 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

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.

DEER PARK PUBLIC SCHOOLS
AFFIDAVIT OF LANDLORD

STATE OF NEW YORK}
COUNTY OF SUFFOLK} 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 Deer Park Union Free School District.

2. _____ is a tenant and has been a tenant at the above premises since _____, 20____. A true and complete copy of the 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 Deer Park 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.

5. I understand and agree that if any of the statements made by me are willfully false that:

A. I will accept full financial responsibility for any and all tuition charges as determined solely by the discretion of the Deer Park Public Schools; and that

B. I may be subject to potential civil as well as criminal prosecution.

Sworn and subscribed before me
this ___ day of _____, 20____

Notary Public

Landlord

Address

Phone Number

Health Clinics

MARTIN LUTHER KING HEALTH CENTER

1556 Straight Path

Wyandanch, NY 11798

(631) 854-1700

BRENTWOOD FAMILY HEALTH CENTER

1869 Brentwood Road

Brentwood, NY 11717

(631) 853-3400

By Appointment Only

*Inquire About Reduced Rates

**Long Island Dental Providers who provide
Dental Examinations for a Free or Reduced Fee**

Suffolk County:

Adults and Children w/LDD, Inc.
1428 Fifth Avenue
Bay Shore, NY 11706
(631) 665-1900

UCP Association of Greater Suffolk
159 Carleton Avenue
Central Islip, NY 11722
(631) 543-5105

SUNY @ Stony Brook School of Dentistry
Nichols Road- South Campus
Sullivan Building
Stony Brook, NY 11794
(631) 632-8974

St. Charles Hospital
200 Belle Terre Road
Port Jefferson, NY 11777
(631) 474-6324 or (631) 474-6300

Suffolk County Dept of Health Clinic Services
County Center
Riverhead, NY 11901
(631) 852- 691

Nassau County:

Catholic Charities Health AADC
333 North Main Street
Freeport, NY 11520
(516) 623-7400 X 143

Long Island Jewish Medical Center
270-05 76th Avenue
New Hyde Park, NY 11040
(718) 470-7000

Nassau University Medical Center (NUMC)
2201 Hempstead Turnpike
East Meadow, NY 11554
(516) 572-6139

New York State Immunization Requirements for School Entrance/Attendance¹

Vaccines	Pre-kindergarten (Day Care, Nursery, Head Start, or Pre-K) ²	School (K-12)
Diphtheria Toxoid-Containing Vaccine	3 doses (New York City Schools – 4 doses) ³	3 doses (New York City schools – 4 doses – required for kindergarten only)
Tetanus Toxoid-Containing Vaccine and Pertussis Vaccine (DTaP, DTP) ⁴	3 doses if born on or after 1/1/2005	Not applicable until student born on or after 1/1/2005 enrolls in school
Tetanus, Diphtheria, and Pertussis Booster (Tdap)	Not applicable	Born on or after 1/1/94 and enrolling in grades 6 through 8 for the 2009-2010 school year ⁵ 1 dose
Polio (IPV or OPV)	3 doses	3 doses
Measles, Mumps and Rubella (MMR) ⁶	1 dose	2 doses of measles-containing vaccine and 1 dose each of mumps and rubella (preferably as MMR)
Hepatitis B	3 doses	3 doses ⁷
Haemophilus influenzae type b (Hib)	3 doses if less than 15 months of age or 1 dose administered on or after 15 months of age ⁸	Not applicable
Pneumococcal Conjugate Vaccine (PCV)	Born on or after 1/1/08 4 doses by 15 months of age, given at age-appropriate times and intervals ⁹	Not applicable
Varicella (Chickenpox) ¹⁰	Born on or after 1/1/2000	Born on or after 1/1/98 or born on or after 1/1/94 and enrolling in grades 6 through 10 for the 2009-2010 school year ¹⁰ 1 dose

- 1 Demonstrated serologic evidence of either measles, mumps, rubella, hepatitis B or varicella antibodies is acceptable proof of immunity to these diseases. Diagnosis by a physician, physician assistant or nurse practitioner that a child/student has had measles, mumps, or varicella diseases is acceptable proof of immunity to those diseases.
- 2 Children in a Pre-kindergarten setting should be age appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP).
- 3 Please note at this time that New York State requires 3 doses of diphtheria toxoid-containing vaccine (New York City requires 4 doses for pre-kindergarten and kindergarten only) and three doses of polio vaccine for entry into kindergarten and for any student entering a school in New York State for the first time. However, ACIP recommends 4 doses of diphtheria toxoid-containing vaccine by age 18 months and 5 doses by age 4-6 years of age. Children 4-6 years of age should receive 4 doses of polio vaccine unless the 3rd dose is given after 4 years of age.
- 4 DTaP is the vaccine currently recommended for diphtheria, tetanus and pertussis.
- 5 Students enrolling in grades 6 through 8 includes students who are entering, repeating or transferring into grades 6 through 8 and students who are enrolling in gradeless classes and are the age equivalent of grades 6 through 8. Ten-year-olds entering grades 6 through 8 do not need to have a Tdap vaccine. They will need to receive a Tdap once they turn 11. Students who receive a Td vaccine within 2 years prior to entering grades 6 through 8 should not receive (with rare exceptions) the booster dose of Tdap until 2 years has elapsed. It is required that those students who are not eligible on this basis be flagged, tracked, and immunized at the appropriate time.
- 6 The New York State Department of Health Immunization Program concurs with the ACIP which recommends that vaccine doses administered up to 4 days before the minimum interval or 12 months of age for measles, mumps, rubella and varicella be counted as valid.
- 7 Hepatitis B – For students in grades 7-12, 3 doses of Recombivax HB or Engerix-B is required, except for those students who received 2 doses of adult hepatitis B vaccine (Recombivax) which is recommended for children 11-15 years old.
- 8 Four doses of Haemophilus influenzae type b (Hib) is recommended by 15 months or more of age, however only 3 doses are required for day-care entry. If a child enters a day care on or after 15 months of age, and has not received 3 doses of Hib vaccine, only one dose on or after 15 months of age is required.
- 9 Unvaccinated children 7-11 months of age should receive 2 doses, at least 4 weeks apart, followed by a 3rd dose at age 12-15 months. Unvaccinated children 12-23 months of age should receive 2 doses of vaccine at least 8 weeks apart. Previously unvaccinated children 24-59 months of age should receive only 1 dose.
- 10 Students enrolling in grades 6 through 10 includes students who are entering, repeating or transferring into grades 6 through 10 and students who are enrolling in gradeless classes and are the age equivalent of grades 6 through 10. Two (2) doses of varicella vaccine are recommended for all students, but not required for school entry.

For further information contact: **New York State Department of Health, Bureau of Immunization,**
Room 649, Corning Tower ESP, Albany, NY 12237, (518) 473-4437.
New York City Department of Health and Mental Hygiene, Bureau of Immunization, Program Support Unit,
P.O. Box 21, 18th Floor/Mailroom, 2 Lafayette St., New York, NY 10007, (212) 676-2301.

Requisitos del Estado de Nueva York en cuanto a vacunas para ingresar y asistir a la escuela¹

Vacunas	Pre-kinder (guardería infantil, casa-cuna, Head Start o pre-kinder) ²	Escuela (k-12)
Vacuna con toxoide contra la difteria	3 dosis (Escuelas de la Ciudad de Nueva York - 4 dosis) ³	3 dosis (En las escuelas de la Ciudad de Nueva York se requieren 4 dosis para kinder solamente)
Vacuna con toxoide contra el tétano y Vacuna contra la tos ferina (DTap, DTP) ⁴	3 dosis si nació el 1º de enero de 2005 o después	No corresponde hasta que el alumno nacido el 1º de enero de 2005 o después se inscriba en la escuela
Refuerzo contra tétano, difteria y los ferina (Tdap)	No corresponde	Nacido el 1/1/94 o después y se inscribe en los grados 6 hasta 8 para el año escolar 2009-2010 ⁵ 1 dosis
Polio (IPV u OPV)	3 dosis	3 dosis
Sarampión, paperas y rubéola (MMR) ⁶	1 dosis	2 dosis de una vacuna que contenga sarampión y 1 dosis de paperas y de rubéola (preferiblemente como MMR)
Hepatitis B	3 dosis	3 dosis ⁷
Haemophilus influenzae tipo b (Hib)	3 dosis si es menor de 15 meses de edad o 1 dosis administrada cuando cumpla los 15 meses de edad o después ⁸	No corresponde
Vacuna con conjugado neumocócico (PCV)	Nacido el 1º de enero de 2008 o después 4 dosis a los 15 meses de edad, administradas a edades e intervalos adecuados ⁹	No corresponde
Varicela ⁴	Nacido el 1º de enero de 2000 o después	Nacido el 1/1/98, o nacido el 1/1/94 o después y se inscribe en los grados 6 a 10 para el año escolar 2009-2010 ¹⁰ 1 dosis

- ¹ La evidencia serológica demostrada de anticuerpos contra sarampión, paperas, rubéola, hepatitis B o varicela se acepta como prueba de inmunidad contra estas enfermedades. El diagnóstico de un médico, asistente médico o enfermero(a) practicante que indique que el niño/alumno ha padecido sarampión, paperas o varicela, es prueba suficiente de inmunidad contra dichas enfermedades.
- ² Los niños en pre-kinder deben vacunarse a las edades adecuadas. La cantidad de dosis depende del programa recomendado por el Comité consultivo sobre prácticas de vacunación (ACIP por sus siglas en inglés).
- ³ Se debe tener en cuenta que, en la actualidad, el Estado de Nueva York requiere 3 dosis de vacuna con toxoide contra la difteria (la Ciudad de Nueva York exige 4 dosis para pre-kinder y kinder únicamente) y tres dosis de vacuna contra el polio para entrar a kinder y para todo alumno que entre por primera vez a una de las escuelas del Estado de Nueva York. Sin embargo, el ACIP recomienda 4 dosis de vacuna con toxoide contra la difteria antes de los 18 meses y 5 dosis antes de los 4 a 6 años de edad. Los niños entre los 4 y 6 años de edad deben recibir 4 dosis de vacuna contra el polio a menos que la tercera dosis se administre después de los cuatro años de edad.
- ⁴ La DTaP es la vacuna contra la difteria, tétano y tos ferina que se recomienda en la actualidad.
- ⁵ Los alumnos que se inscriben en los grados 6 a 8 incluyen estudiantes que ingresen, repitan o se trasladen a estos grados, y los alumnos que se inscriben en clases sin grado y que tienen una edad equivalente a los grados 6 a 8. No se requiere que los niños de diez años que empiezan los grados 6 a 8 estén vacunados con la vacuna Tdap. Deben recibir una Tdap cuando cumplan los 11. Los alumnos que reciban la vacuna Td en un período de dos años antes de entrar a los grados 6 a 8 no deben recibir (con raras excepciones) la dosis de refuerzo de Tdap hasta que hayan pasado dos años. Se exige que aquellos alumnos que no reúnan los requisitos debido a estas circunstancias se marquen, reciban seguimiento y se vacunen en el momento adecuado.
- ⁶ El Programa de vacunación del Departamento de Salud del Estado de Nueva York está de acuerdo con el ACIP, que recomienda administrar las vacunas hasta 4 días antes del lapso de tiempo mínimo o 12 meses de edad, para que las vacunas contra el sarampión, paperas, rubéola o varicela se puedan considerar válidas.
- ⁷ Hepatitis B – para alumnos en los grados 7 a 12, se exigen 3 dosis de Recombivax HB o Engerix-B, con la excepción de aquellos que hayan recibido 2 dosis de la vacuna contra la hepatitis B (Recombivax) para adultos, la cual se recomienda para niños entre los 11 y 15 años de edad.
- ⁸ Se recomiendan 4 dosis de Haemophilus influenzae tipo b (Hib) antes de los 15 meses o más de edad; no obstante, sólo se exigen 3 dosis para entrar a la guardería infantil. Si un niño entra a la guardería infantil al cumplir los 15 meses de edad o después y no ha recibido 3 dosis de la vacuna Hib, se requiere solamente una dosis al cumplir los 15 meses de edad o después.
- ⁹ Los niños sin vacunas entre los 7 y 11 meses de edad deben recibir 2 dosis en un intervalo de por lo menos 4 semanas, seguidas de una tercera dosis entre los 12 y 15 meses. Los niños sin vacunas entre los 12 y 23 meses de edad deben recibir 2 dosis de vacunas a un intervalo de por lo menos 8 semanas. Los niños sin vacunas entre los 24 y 59 meses de edad deben recibir solamente 1 dosis.
- ¹⁰ Estudiantes que se inscriban en los grados 6 a 10 que ingresen, repitan o se trasladen a estos grados, y estudiantes que se inscriben en clases sin grado y que tienen una edad equivalente a los grados 6 a 10. Al entrar a la escuela se recomienda, pero no se exige, que todos los alumnos hayan recibido 2 dosis de la vacuna contra la varicela.

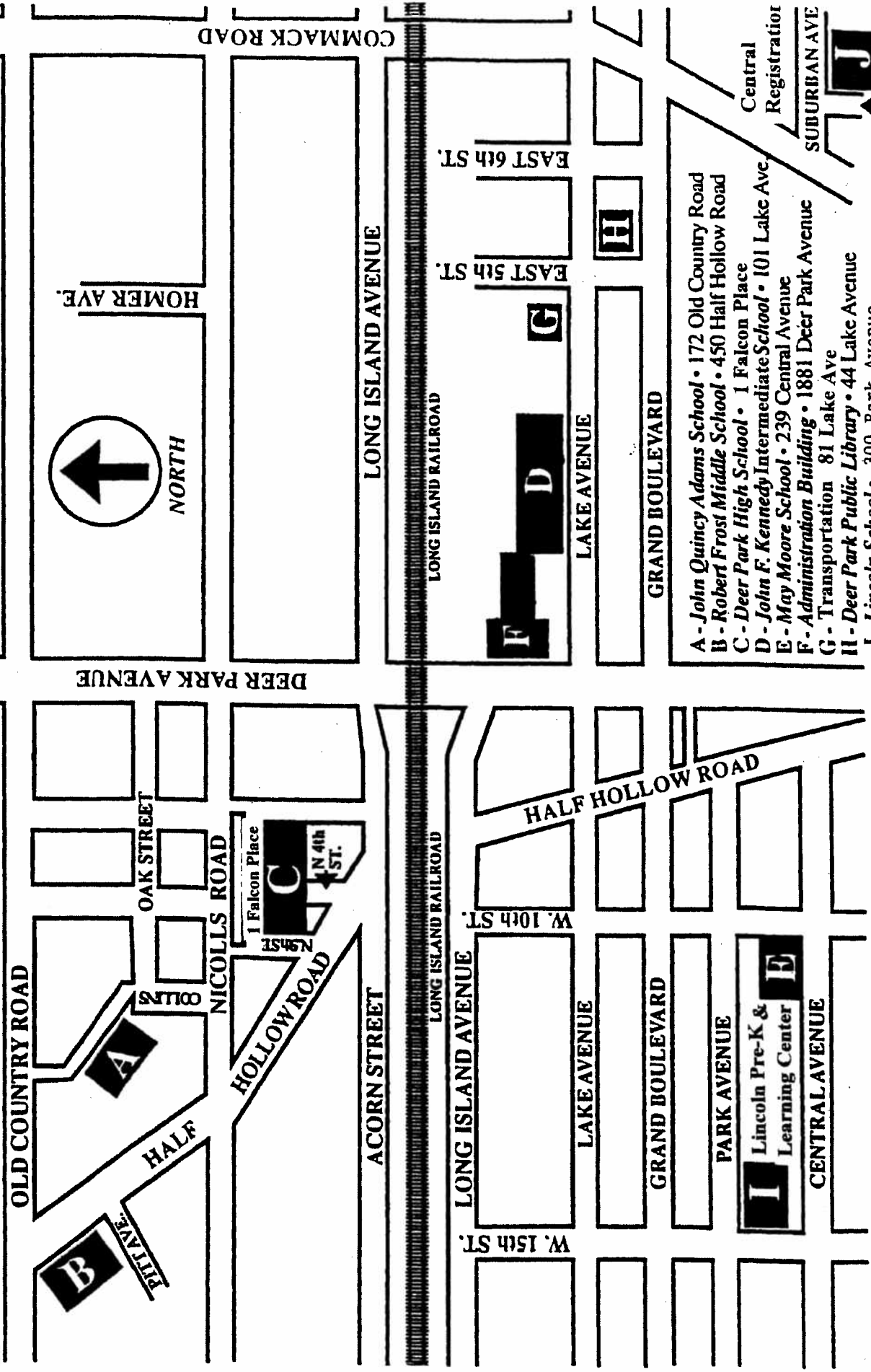
Si desea más información, comuníquese con: **New York State Department of Health, Bureau of Immunization,**
Rm 649 Corning Tower ESP, Albany, NY 12237 (518) 473-4437.
New York City Department of Health and Mental Hygiene, Bureau of Immunization, Program Support Unit,
P.O. Box 21, 18th Floor/Mailroom, 2 Lafayette St., New York, NY 10007 (212) 676-2301.

DEER PARKS SCHOOL DISTRICT



NORTH TO JERICHO TURNPIKE
NORTH TO NORTHERN STATE PKWY - EXIT 42

NORTH TO LONG ISLAND EXP'WY - EXIT 51



- A - John Quincy Adams School • 172 Old Country Road
- B - Robert Frost Middle School • 450 Half Hollow Road
- C - Deer Park High School • 1 Falcon Place
- D - John F. Kennedy Intermediate School • 101 Lake Ave.
- E - May Moore School • 239 Central Avenue
- F - Administration Building • 1881 Deer Park Avenue
- G - Transportation • 81 Lake Ave
- H - Deer Park Public Library • 44 Lake Avenue
- I - Lincoln School • 300 Park Avenue
- J - Washington School • 220 Washington Ave

SOUTH TO SOUTHERN STATE PARKWAY - EXIT 39

Deer Park Schools – Household Verification Form

Please print

2009 - 2010

Student's Name (Last, First M) _____ School _____ Teacher _____

Date of Birth _____ Grade _____ Gender _____ Race/Ethnicity* _____

Primary Household Name _____ Primary Household Phone _____

Primary Household Address _____ Town _____ Zip _____

Secondary Household Name (if applicable) _____ Secondary Household Phone _____

Secondary Household Address _____ Town _____ Zip _____

Other Siblings in the Primary Household

Name of Child	Date of Birth	School Attending	Grade	Gender	Race/Ethnicity*

* Race/Ethnicity - list all that apply:

A: Asian, B: Black, H: Hispanic, I: American Indian or Alaska Native, P: Pacific Islander or Native Hawaiian W: White

Parent or Guardian Information

Parent/Guardian:

Name Last, First	Gender	Address	Home Phone	Work Phone	Cell Phone	Email Address
Relationship to child	<input type="checkbox"/> OK to pick up student <input type="checkbox"/> Legal custody <input type="checkbox"/> Live with student <input type="checkbox"/> Receives mailings					

Parent/Guardian:

Name Last, First	Gender	Address	Home Phone	Work Phone	Cell Phone	Email Address
Relationship to child	<input type="checkbox"/> OK to pick up student <input type="checkbox"/> Legal custody <input type="checkbox"/> Live with student <input type="checkbox"/> Receives mailings					

If you are making a guardian, name, and/or address change, please include legal documentation with this form.

**** Please fill out both sides completely, and provide signature.****

Other Persons who lives in Primary Household (example Step Parent, Grandparent, Aunt, Uncle)

Name Last, First	Gender	Relationship to children	Work Phone	Cell Phone	
					<input type="checkbox"/> OK to pick up student
					<input type="checkbox"/> OK to pick up student
					<input type="checkbox"/> OK to pick up student

Other Contacts

	Name Last, First	Gender	Home Phone	Work Phone	Cell Phone
Emergency Contact 1					
Emergency Contact 2					
Emergency Contact 3					
Doctor					
Dentist					

Check here if your child has had any allergies, illness or injuries in the past year or has taken any medication on a daily basis. Please list medications on this card. Also, include anything the school should know in order to give your child special care. To protect my child's health and safety in school, I consent to the sharing of pertinent health information with involved school staff.

Allergies _____
 Illness _____
 Injuries _____
 Medications _____
 Other _____

- In case of an illness or injury and no authorized adult (listed on this card) can be reached, please transport my child to the nearest hospital emergency room by ambulance if necessary.
- I realize that the school district cannot assume responsibility for medical fees or expenses incurred.
- I hereby give permission to share health information with teachers for safety reasons.

Check this box if you are a new registrant

Check this box if information is accurate and no changes are required

Return form to your child's school or mail to: IT Department, 220 Washington Avenue, Deer Park, NY 11729

Parent/Guardian (Print name) _____ Signature _____ Date _____