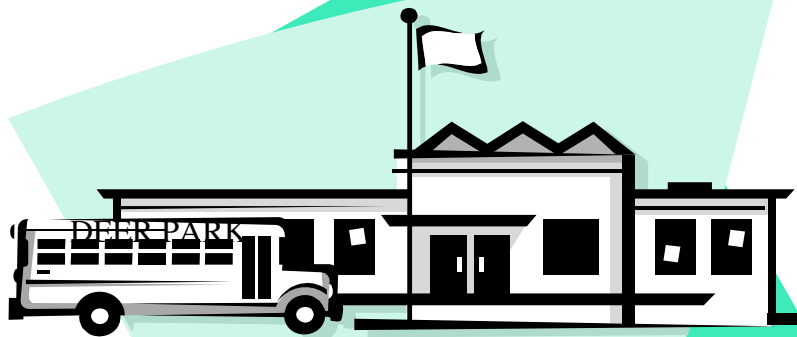


# DEER PARK SCHOOL DISTRICT

## REGISTRATION APPLICATION



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:

**Proof of Residence: see attached residence requirements**

**Birth Certificate**

**Immunization Record**

**Parent/Guardian Photo ID**

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
- 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 \_\_\_\_\_  
DISTRICT ID NUMBER \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
BIRTH CITY \_\_\_\_\_ STATE \_\_\_\_\_  
BIRTH COUNTRY \_\_\_\_\_  
PRIMARY LANGUAGE \_\_\_\_\_  
SECONDARY LANGUAGE \_\_\_\_\_

## DATA 2

SIBLINGS \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_  
SIBLINGS \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_  
SIBLINGS \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_  
SIBLINGS \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE ( ) \_\_\_\_\_

BUSINESS PHONE ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

EMPLOYER \_\_\_\_\_

### CHECK APPROPRIATE BOXES:

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

### MALE GUARDIAN

Step-Father    Foster Father    Other \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_

BUSINESS PHONE ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

X \_\_\_\_\_

PARENT SIGNATURE

## DATA 1

DATE REGISTERED \_\_\_\_\_  
PROOF OF RESIDENCE \_\_\_\_\_

PREVIOUS ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PREVIOUS PHONE: \_\_\_\_\_

PREVIOUS SCHOOL : \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ zip \_\_\_\_\_

DID STUDENT PREVIOUSLY ATTEND DEER PARK SCHOOL?

school \_\_\_\_\_ grade \_\_\_\_\_ date \_\_\_\_\_

Date student entered the U.S. \_\_\_\_\_

1<sup>st</sup> school attended in U.S. \_\_\_\_\_

city \_\_\_\_\_

state \_\_\_\_\_

## OTHERS LIVING IN HOME

ADULT NAME \_\_\_\_\_, \_\_\_\_\_  
Name Relationship

ADULT NAME \_\_\_\_\_, \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_, \_\_\_\_\_  
Name Date of Birth

CHILD'S NAME \_\_\_\_\_, \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_, \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE ( ) \_\_\_\_\_

BUSINESS PHONE ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

EMPLOYER \_\_\_\_\_

### CHECK APPROPRIATE BOXES:

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

### FEMALE GUARDIAN

Step-Mother    Foster Mother    Other \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_

BUSINESS PHONE ( ) \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

Birth Weight: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Type of Delivery: \_\_\_\_\_

Full Term or Premature: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

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 \_\_\_\_\_

Tonsillectomy \_\_\_\_\_

German Measles \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_

Surgery \_\_\_\_\_

Roseola \_\_\_\_\_

Heart Disease \_\_\_\_\_

Allergies \_\_\_\_\_

Mumps \_\_\_\_\_

Poliomyelitis \_\_\_\_\_

Asthma \_\_\_\_\_

Scarlet Fever \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Scarlatina \_\_\_\_\_

Epilepsy \_\_\_\_\_

Whooping Cough \_\_\_\_\_

Ear conditions \_\_\_\_\_

Does your child have any eye difficulties? If so, describe including the 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: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

Date: \_\_\_\_\_

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 (1PV) #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

2. DTAP #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ #4 \_\_\_\_\_

TD Booster (adult type) \_\_\_\_\_

Tdap #1 \_\_\_\_\_ required for students entering 6<sup>th</sup> grade and who are 11yrs. of age or older

\*\* 3. Measles Vaccine

Mumps Vaccine (M-M-R) #1 \_\_\_\_\_ #2 \_\_\_\_\_

Rubella

OR

\*\* 4. Measles Vaccine #1 \_\_\_\_\_ #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 01/01/98

All students entering 6,7,8<sup>th</sup> grade in Sept. born on or after 01/01/94

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 _____  Address _____  Telephone _____	PHYSICIAN'S STAMP
---	-------------------

Please have your private physician complete this report and return it to the school nurse by SEPTEMBER 30<sup>th</sup> 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: \_\_\_\_\_

*Referral*

Body Mass Index: _____ Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Vision - without glasses/contact lenses	R	L	
	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: \_\_\_\_\_

# 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

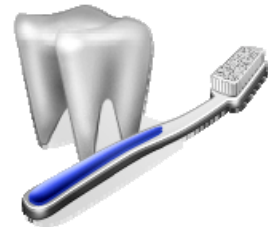
### **Nassau County:**

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

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

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

*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

--	--

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 ½ 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.

## **ACCEPTABLE USE POLICY**

Networked resources, including Internet access, are available to students and staff in the school. All users are required to follow the conditions laid down in the policy. Any breach of these conditions may lead to withdrawal of the user's access, monitoring and or retrospective investigation of the users use of services, and in some instances could lead to criminal prosecution. Any breach of the conditions will also be considered a disciplinary matter.

These networked resources are intended for educational purposes, and may only be used for legal activities consistent with the rules of the school. Any expression of a personal view about Deer Park UFSD matters in any electronic form of communication must be endorsed to that effect. Any use of the network that would bring the name of the District into disrepute is not allowed.

The District expects that staff will use new technologies as appropriate within the curriculum and that staff will provide guidance and instruction to pupils in the use of such resources. All computer systems will be regularly monitored to ensure that they are being used in a responsible fashion.

## **CONDITIONS OF USE**

### **Personal Responsibility**

Access to the networked resources is a privilege, not a right. Users are responsible for their behaviour and communications. Staff and pupils will be expected to use the resources for the purposes for which they are made available. Users are to take due care with the physical security of hardware they are using. Users will accept personal responsibility for reporting any misuse of the network to the District Administrator of Instructional Technology.

### **Acceptable Use**

Users are expected to utilize the network systems in a responsible manner. It is not possible to set hard and fast rules about what is and what is not acceptable but the following list provides some guidelines on the matter:

## **NETWORK ETIQUETTE AND PRIVACY**

Users are expected to abide by the rules of network etiquette. These rules include, but are not limited to, the following:

1. Be polite – never send or encourage others to send abusive messages.
2. Use appropriate language – users should remember that they are representatives of the school on a global public system. Illegal activities of any kind are strictly forbidden.
3. Do not use language that could be calculated to incite hatred against any minority group.

4. Privacy – do not reveal any personal information (e.g. home address, telephone number) about yourself or other users. Do not trespass into other user's files or folders.
5. Password – do not reveal your password to anyone. If you think someone has learned your password then contact the District Administrator of Instructional Technology.
6. Electronic mail – Is not guaranteed to be private. Messages relating to or in support of illegal activities will be reported to the authorities. Do not send anonymous messages.
7. Disruptions – do not use the network in any way that would disrupt use of the network by others.
8. Pupils will not be allowed access to unsupervised and/or unauthorised chat rooms and should not attempt to gain access to them.
9. As part of our erate and CIPA compliance, the District uses a filtering system to block inappropriate content from being accessed on the network. Staff or students finding unsuitable websites through the school network should report the web address to the District Administrator of Instructional Technology. In the event that an educational site is blocked, please fill out the appropriate form and send it to the Instructional Technology Department.
10. Do not introduce any laptops, disks or usb drives into the network without having them checked for viruses. Any personal laptop must be registered with the Instructional Technology Department prior to accessing the wireless network. The form can be downloaded from the Instructional Technology eBoard.
11. Do not attempt to visit websites that might be considered inappropriate. (Such sites would include those relating to illegal activity. All sites visited leave evidence in the network and on the computer. Downloading some material is illegal and the police or other authorities may be called to investigate such use.
12. Unapproved system utilities and executable files will not be allowed in pupils' work areas or attached to e-mail.
13. Files held on the school's network will be regularly checked by the Instructional Technology Department.
14. Other than eBoards and curriculum/course related blogs or webpages, social interactions between teachers and students are prohibited.
15. It is the responsibility of the User (where appropriate) to take all reasonable steps to ensure compliance with the conditions set out in this Policy document, and to ensure that unacceptable use of the Internet/Intranet does not occur.

**UNACCEPTABLE USE**

Examples of unacceptable use include but are not limited to the following:

- Users must login with their own user ID and password, where applicable, and must not share this information with other users. They must also log off after their session has finished.
- Users finding machines logged on under other users username should log off the machine whether they intend to use it or not.
- Accessing or creating, transmitting, displaying or publishing any material (e.g. images, sounds or data) that is likely to cause offense, inconvenience or needless anxiety.
- Accessing or creating, transmitting or publishing any defamatory material.
- Receiving, sending or publishing material that violates copyright law.
- Receiving, sending or publishing material that violates the rules of confidentiality and/or education law.
- Transmitting unsolicited material to other users (including those on other networks).
- Adding additional password protection to any computer device owned by the District is prohibited.
- Unauthorized access to data and resources on the school network system or other systems.
- User action that would cause corruption or destruction of other users' data, or violate the privacy of other users, or intentionally waste time or resources on the network or elsewhere.

**Additional Guidelines**

- Users must comply with the acceptable use policy of any other networks that they access.
- Users must not download software without approval from the Instructional Technology Department.

**SERVICES**

There will be no warranties of any kind, whether expressed or implied, for the network service offered by the school. The school will not be responsible for any damages suffered while on the system. These damages include loss of data as a result of delays, non-deliveries, or service interruptions caused by the system or your errors or omissions. Use of any information obtained via the network is at your own risk.

**NETWORK SECURITY**

Users are expected to inform the District Administrator of Instructional Technology immediately if a security breach is identified. Do not demonstrate this problem to other users. Users must login with their own user id and password, where applicable, and must not share this information with other users. Users identified as a security risk will be denied access to the network.

**PHYSICAL SECURITY**

Staff users are expected to ensure that portable equipment such as laptops, digital cameras and video cameras are securely locked away when they are not being used.

**WILLFUL DAMAGE**

Any malicious attempt to harm or destroy any equipment or data of another user or network connected to the school system will result in loss of access, disciplinary action and, if appropriate, legal referral. This includes the creation or uploading of computer viruses. The use of software from unauthorized sources is prohibited.

**MEDIA PUBLICATIONS**

For the safety of our students, District employees should follow these guidelines when posting student-related information to the District's Web site, sites that link from the District Web site, and District eBoards:

- Documents/pictures may not include student last names.
- Family information (address, telephone number, e-mail address, etc.) may not be posted.
- Student location information (schedule, after-school activity participation, bus stop, etc.) may not be posted.

Publishing includes, but is not limited to:

- the school website/eBoards/blogs/wikis
- web broadcasting
- online newspapers

First Reading: August 25, 2009  
Second Reading: September 22, 2009  
Adoption Date: September 22, 2009

**DEER PARK UFSD STUDENT USER AGREEMENT FORM**

After reading the Deer Park UFSD Acceptable Use Policy, please complete this form to indicate that you agree with the terms and conditions outlined in the above AUP document and agree to compliance with needed future revisions. **Your signature is required before access may be granted to the Deer Park UFSD network.**

As a student of Deer Park UFSD and a user of the computer network, I have read and hereby agree to comply with the Deer Park UFSD Acceptable Use Policy.

Student Name (Please Print): \_\_\_\_\_

Student's School: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

As parent/legal guardian of the student signing above, I grant permission for my child to access networked computer services such as electronic mail and Internet. I have read and agree to the Deer Park UFSD Acceptable Use Policy, and I understand that I may be held responsible for violations by my child. I understand that some materials on the Internet may be objectionable; therefore I agree to accept responsibility for guiding my child, and conveying to her/him appropriate standards for selecting, sharing, and/or exploring information and media.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# CUSTODIAL STIPULATION FORM

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

Student Name \_\_\_\_\_

Date Of Birth \_\_\_\_\_

Current Address \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Mother's Name \_\_\_\_\_  
Last Name

First Name \_\_\_\_\_

Legal Custody  
 Yes or  No

Father's Name \_\_\_\_\_  
Last Name

First Name \_\_\_\_\_

Legal Custody  
 Yes or  No

Legal Guardian's Name (If Applicable) \_\_\_\_\_  
Last Name

First Name \_\_\_\_\_

Legal Custody  
 Yes or  No

① Who does the child reside within 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 date

**Deer Park Union Free School District**  
**Office of Central Registration**  
**Washington School**  
220 Washington Avenue  
Deer Park, New York 11729  
(631) 274-4372/Fax (631) 274-8867

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:**

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

## TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT \_\_\_\_\_ *Please print or type clearly*

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:  Possible LEP  
 English Proficient

*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*

(✓ 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 \_\_\_\_\_  Does Not Read *specify*
- What language(s) does the student write?  English  Other \_\_\_\_\_  Does Not Write *specify*
- In your opinion, how well does the student understand, speak, read and write English?

	<i>Very well</i>	<i>Only a little</i>	<i>Not at all</i>
<b>Understands English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Speaks English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Reads English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Writes English</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
*Signature of Parent/Guardian/Other*

\_\_\_\_\_  
*Date*

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

**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 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\_\_

\_\_\_\_\_

Landlord

\_\_\_\_\_

Address

\_\_\_\_\_

Notary Public

\_\_\_\_\_

Phone Number

# New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

Vaccines	Pre-kindergarten (Day Care, Nursery, Head Start, or Pre-K) <sup>2</sup>	School (k-12)
Diphtheria Toxoid-Containing Vaccine	3 doses (New York City Schools – 4 doses) <sup>3</sup>	3 doses (New York City schools – 4 doses – required for kindergarten only)
Tetanus Toxoid-Containing Vaccine and Pertussis Vaccine (DTaP, DTP) <sup>4</sup>	3 doses if born on or after 1/1/2005	3 doses if born on or after 1/1/2005
Tetanus, Diphtheria, and Pertussis Booster (Tdap)	Not applicable	Born on or after 1/1/1994 and enrolling in grades 6 through 10 for the 2011-2012 school year <sup>5</sup> 1 dose
Polio (IPV or OPV)	3 doses	3 doses
Measles, Mumps and Rubella (MMR) <sup>6</sup>	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 <sup>7</sup>
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 <sup>8</sup>	Not applicable
Pneumococcal Conjugate Vaccine (PCV)	Born on or after 1/1/2008 4 doses by 15 months of age, given at age-appropriate times and intervals <sup>9</sup>	Not applicable
Varicella (Chickenpox) <sup>6</sup>	Born on or after 1/1/2000	Born on or after 1/1/1998 or born on or after 1/1/1994 and enrolling in grades 6 through 12 for the 2011-2012 school year <sup>10</sup> 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 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. Children ages 7-10 who have not been adequately vaccinated with DTP/DTaP, and for whom no contraindications exist, should receive a single dose of Tdap.
- 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. PCV13 is the preferred vaccine for use in healthy unvaccinated/partially vaccinated children 2-71 months of age. A single supplemental dose of PCV13 is recommended for children 14-59 months who have already completed the age appropriate series of PCV7.
- 10 Students enrolling in grades 6 through 12 includes students who are entering, repeating or transferring into grades 6 through 12 and students who are enrolling in gradeless classes and are the age equivalent of grades 6 through 12. 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,**  
253 Broadway, 7th Floor, Room 703, New York, NY 10007, (212) 341-9522.

# Requisitos del Estado de Nueva York en cuanto a vacunas para ingresar y asistir a la escuela <sup>1</sup>

Vacunas		Pre-kindergarten (guardería infantil, casa-cuna, Head Start o pre-kindergarten) <sup>2</sup>	Escuela (K-12)
Vacuna con toxoide contra la difteria	3 dosis (Escuelas de la Ciudad de Nueva York - 4 dosis) <sup>3</sup>	3 dosis (En las escuelas de la Ciudad de Nueva York se requieren 4 dosis para kinder solamente)	3 dosis
Vacuna con toxoide contra el tétano y Vacuna contra la tos ferina (DTaP, DTP) <sup>4</sup>	3 dosis si nació el 1 <sup>er</sup> de enero de 2005 o después	3 dosis si nació el 1 <sup>er</sup> de enero de 2005 o después	3 dosis si nació el 1/1/94 o después y se inscribe en los grados 6 hasta 9 para el año escolar 2010-2011 <sup>5</sup> 1 dosis
Refuerzo contra tétano, difteria y tos ferina (Tdap)	No corresponde		Nacido el 1/1/94 o después y se inscribe en los grados 6 hasta 9 para el año escolar 2010-2011 <sup>5</sup> 1 dosis
Polio (IPV u OPV)	3 dosis		3 dosis
Sarampión, paperas y rubéola (MMR) <sup>6</sup>	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 <sup>7</sup>
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 <sup>8</sup>		No corresponde
Vacuna con conjugado neumocócico (PCV)	Nacido el 1 <sup>er</sup> de enero de 2008 o después 4 dosis a los 15 meses de edad, administradas a edades e intervalos adecuados <sup>9</sup>		No corresponde
Varicela <sup>6</sup>	Nacido el 1 <sup>er</sup> 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 11 para el año escolar 2010-2011 <sup>10</sup> 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 9 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 9. No se requiere que los niños de diez años que empiezan los grados 6 a 9 estén vacunados con la vacuna Tdap. Deben recibir una Tdap cuando cumplan los 11. Los alumnos que reciben la vacuna Td en un período de dos años antes de entrar a los grados 6 a 9 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 11 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 11. 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 Park Schools – Household Verification Form

*Please print*

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

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_ Race/Ethnicity\*  A  B  I  P  W

Is the student Hispanic, Latino, or of Spanish origin?  Yes  No

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*
					<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> W
					<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> W
					<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> W
					<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> W
					<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> I <input type="checkbox"/> P <input type="checkbox"/> W

\* Race/Ethnicity - Check all that apply:

A: Asian, B: Black, 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 of card completely, and provide signature.\*\*

**Other People who live in the 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

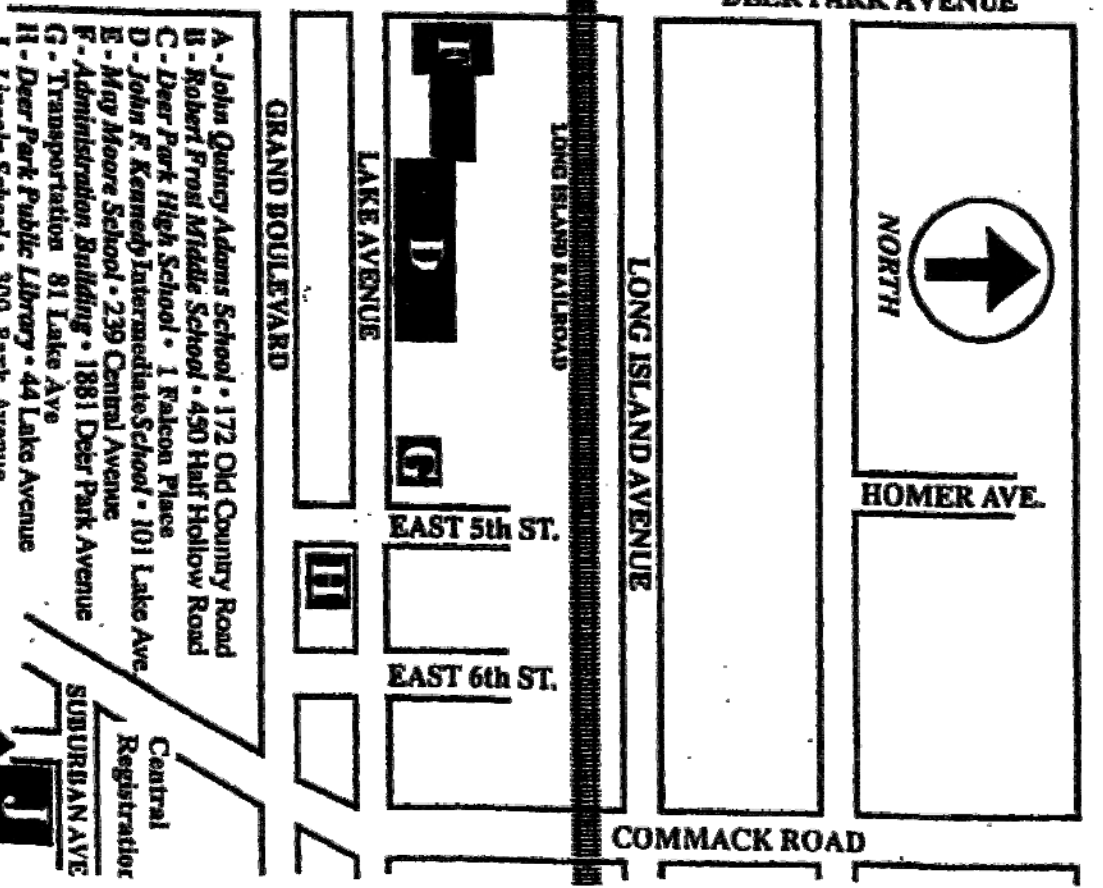
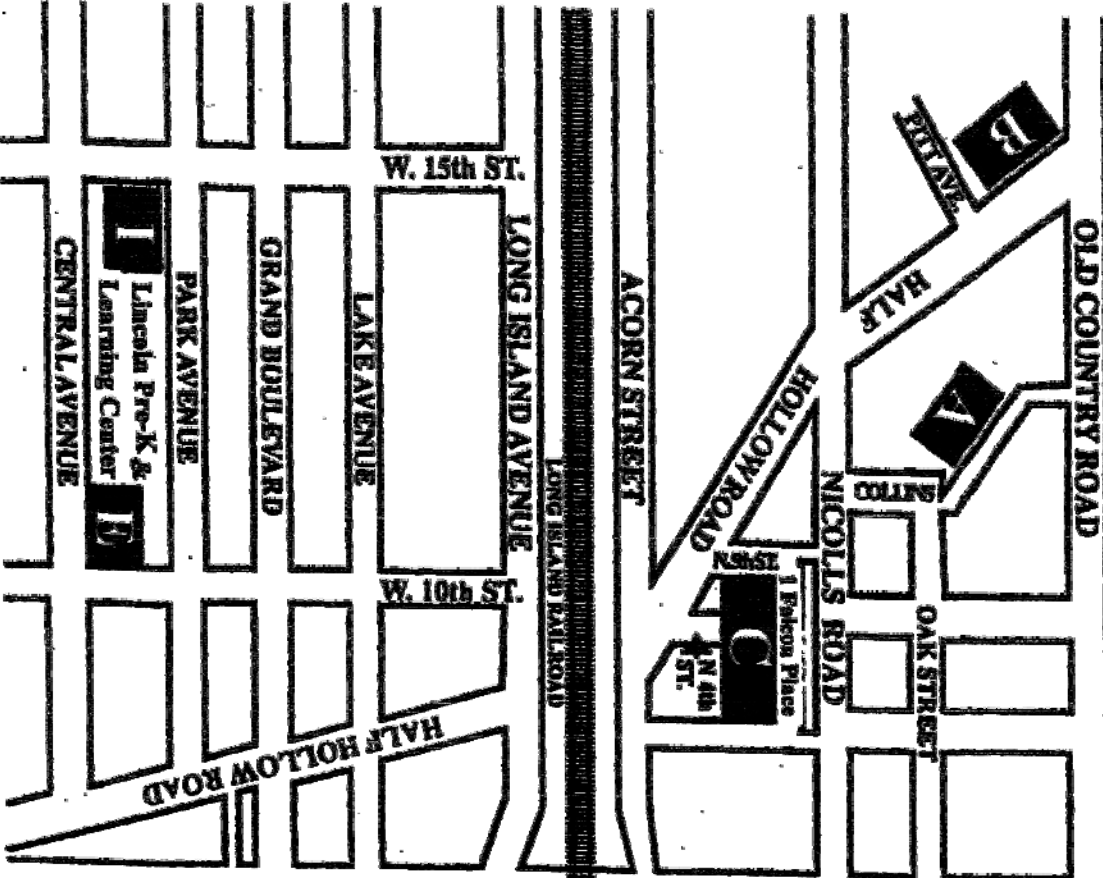
Parent/Guardian (Print name) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

# DEER PARK SCHOOL DISTRICT



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

NORTH TO LONG ISLAND EXPWY - EXIT 51



SOUTH TO SOUTHERN STATE PARKWAY - EXIT 39

- 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

Central Registrar  
SUBURBAN AVE

Washington School