

HICKSVILLE PUBLIC SCHOOLS

Office of the Registrar
Administration Building
200 Division Ave.
Hicksville, NY 11801
(516) 733-2168

NEW ENTRANT APPLICATION PROCESS

Required Forms for Registration:

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

Instructions:

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

**HICKSVILLE PUBLIC SCHOOLS
Office of the Registrar**

NEW ENTRANT REGISTRATION REQUIRED DOCUMENTATION

Parental Photo ID ___

Proof of Birth (1 Original Form)

___ Original Birth Certificate or ___ Baptismal Certificate or ___ Passport

Proofs of Parental Relationship:

___ Birth Certificate ___ Baptismal Certificate ___ Court Guardianship Papers ___ Court Custody Papers ___ Divorce Decree ___ Adoption Papers
 ___ Affidavits of Residential Custodial and Non-Resident Custodial Parents
 ___ Affidavits of Emancipation

Immunization:

Three Polio (OPV and/or IPV)
 Three DPT/DTap or TD/DT
 Two MMR or Two Measles, One Mumps, One Rubella-Measles first vaccine must be after one year of age
 One Varicella
 Three Hepatitis B—older students may have two doses adult vaccine (Recombivax)
 One Pertussis (Tdap)—for older students entering Grade 6 in 2007 and for future students born on or after 1/1/94
 One Pertussis (usually DTap or DTP)—for younger students born on or after 1/1/05

Proof of Prior Schooling:

___ Transfer Card/Request ___ Report Card(s) ___ Special Education Records (as appropriate)

HOMEOWNER	NON-HOMEOWNER/RENTER	FAMILY LIVING WITH ANOTHER FAMILY
<p>THREE (3) original proofs as indicated below: TWO (2) ORIGINAL PROOFS FROM BELOW: House Title or Deed House Contract Real Estate Closing Statement Notarized Affidavit from the Homeowner Recent Nassau County Tax Bill Receipt from Homeowner Recent Mortgage Statement or Home Insurance Bill from Homeowner</p> <p>In addition, ONE (1) of the following RECENT original proofs in the Homeowner's Name from below: Recent Electric Bill Recent Water Bill Recent Cell Phone Bill Recent Oil Bill Recent Telephone Bill Recent Gas Bill Recent Cable/Satellite Bill Recent Security System Bill Recent Credit Card Bill</p>	<p>THREE (3) original proofs as indicated below: Notarized Affidavit from the Homeowner or Lease Recent Nassau County Tax Bill Receipt from Homeowner Recent Mortgage Statement from Homeowner Home Insurance Bill from Homeowner</p> <p>In addition to the above, THREE (3) of the following original proofs in the Renter's Name: Recent Bank Statement Recent Electric Bill Recent Cell Phone Bill Recent Oil Bill Recent Telephone Bill Recent Gas Bill Recent Cable/Satellite Bill Recent Security System Bill Recent Credit Card Bill</p>	<p>THREE (3) original proofs as indicated below: Notarized Affidavit from the Homeowner or Lease Recent Nassau County Tax Bill Receipt from Homeowner Recent Mortgage Statement from Homeowner Home Insurance Bill from Homeowner</p> <p>In addition to the above, THREE (3) of the following original proofs in the name of the Family living with the homeowner: Recent Bank Statement Recent Electric Bill Recent Cell Phone Bill Recent Oil Bill Recent Telephone Bill Recent Gas Bill Recent Cable/Satellite Bill Recent Security System Bill Recent Credit Card Bill</p>

**HICKSVILLE PUBLIC SCHOOLS
NEW ENTRANT APPLICATION
(please print)**

Name of Pupil _____ Sex M F Date of Birth____/____/____

Last Name First Name M.I.

Address _____ Telephone No. _____

No. Street Town/State Zip Code

Homeless? YES NO Cell No. _____

Place of Birth _____ Date of Entry to US _____ Foster Child: YES NO
Town/State/Country

Date of First entry into a U.S. School: _____

PREVIOUS ADDRESSES (LAST 3 YEARS)	DATES FROM / TO	SCHOOL DISTRICT

Last School Attended _____ Grade Completed _____

School Address _____ Retained in Grade(s) _____

Has child attended school in Hicksville before? Y N If yes, School _____

Father's Name _____ **Address** _____
(if different than student(s))

Employed by _____ Business Telephone _____ Cell Phone _____ Occupation _____

Mother's Name _____ **Address** _____

Employed by _____ Business Telephone _____ Cell Phone _____ Occupation _____

Family Physician _____
Name address telephone no.

Emergency Contact _____
(Other than parent) Relationship _____

Ethnicity:

American Indian or Alaskan Native _____ Asian or Pacific Islander _____ Multiracial _____

Black _____ Primary Language : _____

White _____ Language(s) spoken in Home: _____

Hispanic _____ Corresponding Language: _____

LIST NAMES OF OTHER CHILDREN IN FAMILY				
NAME	ADDRESS	DATE OF BIRTH	SCHOOL ATTENDING	GRADE

Natural Parent Y N

Custodial Parent Y N

Guardian Y N

Parent/Guardian Signature Date

OFFICE USE ONLY

Census Form Completed: Y N Records Requested _____ Rec'd _____
(date) (date)

Registered by: _____ Date _____ School _____ Grade _____ Transport _____

Hicksville Public Schools

Administration Building
200 Division Avenue
Hicksville, NY 11801-4800

Phone: 516-733-2168

Fax: 516-733-6683

Maureen K Bright
Superintendent of Schools

Ann Cappello
District Clerk

Dear Parents:

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

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

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

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

Sincerely,

Hicksville Public Schools
Registration Office

HICKSVILLE PUBLIC SCHOOLS
Screening Program Registration Form

Child's Name: _____ DOB: _____

Address: _____ Telephone No. _____

Parent/Guardian Name: _____

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

Number of Children in Family: _____ Position in Family _____

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

<u>Name</u>	<u>Date of Birth</u>	<u>School Attending</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

1. Has your child ever been hospitalized? _____ Date: _____
If so, reason: _____

Any other serious illness or injury?

2. Please list any allergies: _____

3. Please list any speech problems: _____

4. Please list any special problems: _____

5. Has your child been screened or evaluated for Special Education?

If "yes", what school district?

6. Has your child ever received Special Education services in another district? _____
If "yes", from : _____ to _____ What school district? _____

7. Nature of services: _____ Resource Room Program
_____ Special Class
_____ Speech and Language Services
_____ Other; please specify: _____

Additional Comments: _____

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

Parent/Guardian Signature: _____ Date: _____

HICKSVILLE PUBLIC SCHOOLS
Health Services

Dear Parent/Guardian:

Please complete this health history form and return it with your signature.

Student's Name: _____ Sex: _____

DOB: _____ Place of Birth: _____

Address: _____ Phone Number: _____

Mother: _____ Father _____ Guardian: _____

Family Physician: _____

Address: _____ Phone Number: _____

IF PARENT/GUARDIAN NOT AVAILABLE IN CASE OF EMERGENCY CALL:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

HEALTH HISTORY

Please explain any significant illness, operation or injuries:

Does your child have any of the following: (Please explain any yes answer(s) below)

- | | | | |
|--------------------------------|----------------|-----------------------------------|----------------|
| 1. Asthma | Yes ___ No ___ | 7. Chronic Illness | Yes ___ No ___ |
| 2. Allergies | Yes ___ No ___ | 8. Ear/Hearing Problem | Yes ___ No ___ |
| 3. Diabetes | Yes ___ No ___ | 9. Eye/Vision Problem | Yes ___ No ___ |
| 4. Heart Condition | Yes ___ No ___ | 10. Eyeglasses/Contacts | Yes ___ No ___ |
| 5. Seizures/Epilepsy | Yes ___ No ___ | 11. Takes Medication Daily | Yes ___ No ___ |
| 6. Orthopedic Condition | Yes ___ No ___ | 12. Skin/Rash Condition | Yes ___ No ___ |

Explanation of "Yes" answers:

Any items in bold (numbered items 1-7) that have a "Yes" answer, please fill out the back of this form.

Date: _____ Parent/Guardian Signature: _____

This form must be completed if you answered "Yes to any item 1-7 on reverse side. Please note: a signed physician's prescription must accompany this form for any special medical considerations.

Physician(s) Clinic treating student: _____

Address: _____ Telephone No.: _____

Diagnosis: _____ Date of Onset: _____

Number of hospitalizations, reasons, outcomes, dates: _____

What were the signs and symptoms of the condition: _____

What specific treatments, interventions, approaches are used:

Does your child require use of any emergency medication (i.e. Epi-Pen, Benadryl, Glucagon, Valium, etc.):

What are the special care needs in school (diet, treatments, equipment, prosthesis, braces, supplies, etc.):

What specific medications will your child need to take during school hours and when:

What special consideration do you have related to your child's condition while at school (i.e. educational, behavioral, physical education precautions, sports precautions, recess precautions, field trips):

How does the condition affect the degree of physical activity the student can do:

If your child has a problem at school related to his/her condition, what plan of action would you and your physician prefer the school personnel to take:

Please indicate if you have any concerns about having the above information shared with the Classroom teacher(s), bus driver and other appropriate school personnel: Yes* _____ No _____
(*school nurse will contact you to discuss your concerns).

Parent/Guardian Signature: _____

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

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

LIST OF COMMUNITY RESOURCES FOR MEDICAL CARE:

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

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

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

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

HICKSVILLE PUBLIC SCHOOLS
Certificate of Immunizations

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

(Grade) (School) (Date of Birth)

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

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

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

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

Hib: _____

Tetramune: (DPT + Hib) _____

Polio: (TOPV, OPV) _____

(IPV, eIPV) _____

DPT: _____

DtaP: (Tripedia) _____

DT/TD: _____

Tdap: _____

Comvax:
(Hep B + Hib) _____

Hep B: (HBV) _____

Varicella vaccine: _____ (Disease date: _____)

Lead screening: _____

Religious or Medical exemption

Serological Report attached

(Documentation attached)

Physician's Stamp:

(Physician's signature)

Date: _____

Hicksville Public Schools
Prior Special Education Programs/Services

Student's Name _____ DOB: _____

Street Address _____ Phone: _____

School Attended _____ District: _____

Address _____ Phone #: _____

Last Grade Completed _____ Teacher/Counselor's Name: _____

Did student receive any special education services? No Yes (indicate below):

If you responded "YES" to the above, please complete:

Type of Special Education Program Attended:

- Resource Room Special Class Consultant Teacher Related Services
 BOCES Special Education: School Name _____
 Other (Specify type of program or name of school _____)

Related Services Provided in Most Recent Placement: check all that apply

- Speech/Language Counseling Occupational Therapy
 Physical Therapy Hearing Services Vision Services

Classification (if known)

- Learning Disabled Mentally Retarded Speech Impaired
 Emotionally Disturbed Other Health Impaired Multiply Disabled Autistic
 Deaf Orthopedically Impaired Hard of Hearing Deaf-Blind
 Visually Impaired Traumatic Brain Injury

Do you have a copy of your child's most recent IEP: No Yes (please attach)

Name of CSE Chairperson/Special Education Director _____

Address of CSE Office _____ Phone # _____

Release of Records/Information to the Hicksville Public Schools

I authorize the school and CSE indicated above to release academic, psychological, psychiatric, medical and all other evaluations, IEPs, and records to the Hicksville schools. I am aware that all records will be kept confidential and access limited to school personnel who work with my child. I understand I may review all records. I also consent to having school district personnel who work with my child principal, psychologist, social worker, regular or special education teachers, related service providers, guidance counselor and/or CSE Chairperson) speak with individuals from the school and CSE office indicated above. I am aware my consent is voluntary and can be withdrawn at any time.

Signature of Parent/Person in Parental Relationship

Date

FOR OFFICE USE ONLY: Please forward copies of all evaluations and records to:

Committee on Special Education
Hicksville School District
200 Division Avenue
Hicksville, NY 11801
(516) 733-2160 Fax: (516) 733-6683

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	<i>Please print or type clearly</i>
SCHOOL	GRADE
STUDENT NAME	
DATE OF BIRTH Month: Day: Year	
STUDENT IDENTIFICATION NUMBER	
COUNTRY OF BIRTH / ANCESTRY	
NUMBER OF YRS ENROLLED IN SCHOOL OUT	
NAME / POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION	
DETERMINATION: <input type="checkbox"/> Possible LEP <input type="checkbox"/> English Proficient	

- | | | | |
|---|----------------------------------|--------------------------------|--|
| 1. What language(s) is spoken in the student's home or residence? | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ <i>specify</i> |
| 2. What language(s) are spoken most of the time to the student, in the home or residence? | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ <i>specify</i> |
| 3. What language(s) does the student understand? | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ <i>specify</i> |
| 4. What language(s) does the student speak? | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ <i>specify</i> |
| 5. What language(s) does the student read?
Not Read | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ <input type="checkbox"/> Does <i>specify</i> |
| 6. What language(s) does the student write?
Not Write | <input type="checkbox"/> English | <input type="checkbox"/> Other | _____ <input type="checkbox"/> Does <i>specify</i> |
| 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"/>

Month: Day: Year:

Signature of Parent/Guardian/Other

Date

Hicksville Union Free School District



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

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

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

Annual School Census

THE FAMILY RESIDING AT

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

If all preprinted information is accurate, please check here _____

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

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

Telephone Number:

(Check One) Homeowner () Tenant ()

Are there more than one family living at this address? Yes ___ No ___

Step #2 Fold this flap down.

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

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

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

TRANSFER OF RECORDS REQUEST

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

ELEMENTARY SCHOOLS

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Burns Avenue
40 Burns Avenue
(516) 733-2311
(516) 733-6694 (Fax) | <input type="checkbox"/> Dutch Lane
50 Stewart Avenue
(516) 733-2361
(516) 733-3520 (Fax) | <input type="checkbox"/> East Street
50 East Street
(516) 733-2321
(516) 733-3533 (Fax) | <input type="checkbox"/> Fork Lane
4 Fork Lane
(516) 733-2341
(516) 733-3521(Fax) |
| <input type="checkbox"/> Lee Avenue
1 Seventh Street
(516) 733-2351
(516) 733-3522 (Fax) | <input type="checkbox"/> Old Country Road
49 Rhodes Lane
(516) 733-2301
(516) 733-3523 (Fax) | <input type="checkbox"/> Woodland
85 Ketcham Road
(516) 733-2331
(516) 733-3524 (Fax) | |

SECONDARY SCHOOLS

- | | |
|---|--|
| <input type="checkbox"/> Middle School
215 Jerusalem Avenue
516-733-2272
516-733-6528 (Fax)
ATT: Guidance Dept. | <input type="checkbox"/> High School
180 Division Avenue
516-733-2221
516-733-1194 (Fax)
ATT: Guidance Dept. |
|---|--|

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

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

STUDENT NAME: _____ D.O.B. _____

Entered in Hicksville Union Free School District as of: _____

Formerly of (Last Address): _____

School Last Attended: _____

School Address: _____

School Phone Number: _____ School Fax Number: _____

Parental Signature: _____ DATE: _____

Hicksville Union Free School District

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

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

ANNUAL SCHOOL CENSUS

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

THE FAMILY RESIDING AT

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

If all preprinted information is accurate, please check here ____

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

If you have any questions, please call 733-2168.

Telephone Number:

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

Step #2 Fold this flap down

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

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

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

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

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

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

GRADE CODES: 20 = Pre-School; 60 = Graduated; 80 = Ungraded