

CONNETQUOT CENTRAL SCHOOL DISTRICT OF ISLIP
Central Registration · Arthur E. Premm Building
1200 Montauk Hwy
Oakdale, NY 11769
(631) 244-2215 ext. 3938

UNIVERSAL PRE-KINDERGARTEN APPLICATION PACKET

Connetquot Central School District anticipates receipt of a New York State grant to administer a Universal Pre-Kindergarten Program. This grant will allow a limited number of children who will be four (4) years of age on or before December 1, 2020 to attend a half day Pre-K program during the 2020-21 school year. Kindly note the program highlights below:

- Applications must be received by **Friday, March 20, 2020.**
- Applicants will be selected by **lottery** on **Monday, April 13, 2020.**
- Please note: this selection is not a first come, first served process.
- Transportation is not provided.

Application Requirements:

*Complete ALL forms entirely.
 Print clearly.
 All documentation presented must be **ORGINIAL AND CURRENT.**
 Sign where signature is required.
 Submit to Central Registration at above address.*

Documents for the Student:

- Original Birth Certificate
- Physical within one year
- Proof of Immunizations

If applicable:

- Proof of Custody/Guardianship

Documents for Proof of Residency

Homeowners	Renters
Submit ONE : - Deed - Mortgage Statement - Current Tax Bill	Submit ONE : - Yearly Apartment Complex Lease - Notarized Yearly Lease, <i>if private home must be submitted with the homeowner's deed, current tax bill or mortgage statement</i> - Notarized Affidavit of Residence <i>must be submitted with the homeowner's deed, current tax bill or mortgage statement</i>
Submit TWO : - Current Utility Bills <i>no cell phone bills accepted</i>	Submit TWO : - Current Utility Bills <i>if utilities are included in your rental agreement, then two other bills must be submitted, no cell phone bills accepted</i>
Submit ONE : - Valid NYS Driver's License <i>with current district address</i> - NYS Non-Driver's Photo ID <i>with current district address</i>	Submit ONE : - Valid NYS Driver's License <i>with current district address</i> - NYS Non-Driver's Photo ID <i>with current district address</i>

It is the responsibility of the parent/guardian to provide residential proof, as well as proof of birth, health records, educational records and custody/guardianship documents at the time of registration. Please note we cannot make any exceptions. Please be aware that it is a crime to fraudulently register a child in a school district other than the district in which the parent/guardian reside. The Connetquot Central School District is committed to the prevention of any such activity.

CONNETQUOT CENTRAL SCHOOL DISTRICT OF ISLIP

2020-2021 Universal Pre-Kindergarten Program Application

Date _____ Application Number _____ Student ID _____ Program Location _____

STUDENT INFORMATION			
First Name:		Middle Name:	Last Name: Grade: UPK
Date of Birth:	Select: Male _____ Female _____	Age:	Place of Birth (City, State, Country):
Is the student Hispanic or Latino? Yes _____ No _____	Please indicate all race groups that apply: American Indian or Alaskan Native _____ White _____ Asian _____ Native Hawaiian or Pacific Islander _____ Black or African American _____		Office Use Only: Proof of Birth: _____
Previously applied for services from Connetquot CSD: Yes _____ No _____ Date _____	Siblings registered in Connetquot CSD: Yes _____ No _____ School _____		Office Use Only: Household Name: _____
Second language spoken at home: Yes _____ No _____ Language _____		Previous preschool/daycare provider: _____	Office Use Only: _____
Receiving Special Education or Related Services, <i>please check</i> : IEP _____ Resource Room _____ Special Class _____ Speech _____ Counseling _____ Other _____			
HOUSEHOLD INFORMATION			
Residence Type: Own _____ Rent _____	Office Use Only: Mortgage/Deed/Tax Bill _____ Yearly Complex Lease _____ Notarized Affidavit _____ Yearly Notarized Lease _____ Photo ID _____ Utility Bill _____ Other Bill _____ Sale Contract _____ Supervisor Approval _____		Office Use Only: Home School _____
Home Address: _____ Street Apt. # Town State Zip Code			Mailing Address: P.O. Box _____ _____
Student Resides with: Both Mother & Father _____ Mother _____ Father _____ Stepparent _____ Foster Parent _____ Guardian _____ <i>relationship</i> , _____	Marital Status of Parents: Married _____ Separated _____ Divorced _____ Never Married _____	Court Order, Divorce or Separation Agreement: Yes _____ No _____ Stipulations: _____ Order of Protection End Date _____ Residential Parent: _____ Non-Residential Parent: _____ Non-Residential Parent Address: _____	
CONTACT INFORMATION			
Parent/Guardian	Mother		Father
Name			
Home Phone			
Cell Phone			
Work Phone			
Email			
Occupation			
Employer's Name & Address			
PERSONS TO BE CALLED IN THE EVENT PARENT CANNOT BE REACHED			
Emergency Contact			
Relationship to Student			
Home Phone			
Cell Phone			
Address			
MEDICAL CONTACT			
	Physician		Dentist (Optional)
Name			
Phone Number			
Address			

Parents have the responsibility of presenting to the District a certified copy of any order, decree of legally binding instrument affecting custody or other parental rights and, without one, school officials will assume that both parents may see the child and both parents will have access to school records.

I grant permission for the Connetquot Central School District to request all school records from any school previously attended.

Signature or Parent/Guardian _____ Print Name _____ Date _____

CONNETQUOT CENTRAL SCHOOL DISTRICT OF ISLIP

2020-2021 Universal Pre-Kindergarten Program Application

Student Name _____

Location Preference Selection

The following are the proposed agencies for the 2020-2021 Universal Pre-K Program:

- EARLY DISCOVERIES CENTER* · 2210 Smithtown Ave., Ronkonkoma · 631-585-2020
- SCOPE located at E. J. Bosti Elementary School · 50 Bourne Blvd., Bohemia · 631-360-0800 x 133
- SCOPE located at Idle Hour Elementary School · 334 Idle Hour Blvd., Oakdale · 631-360-0800 x 133
- SCOPE located at Slocum Elementary School · 2460 Sycamore Ave., Ronkonkoma · 631-360-0800 x 133
- EARLY CHILDHOOD LEARNING CENTER/DDI · 90 Airpark Drive, Ronkonkoma · 631-580-4001

Please number ALL site/sessions in order of preference by indicating 1, 2, 3 etc.

AM SESSIONS

PM SESSIONS

- | | |
|--|--|
| _____ 8:30-11:00 Early Discoveries* | _____ 12:30-3:00 Early Discoveries* |
| _____ 8:30-11:00 SCOPE at E.J. Bosti ES | _____ 11:45-2:15 SCOPE at E.J. Bosti ES |
| _____ 8:30-11:00 SCOPE at Idle Hour ES | _____ 11:45-2:15 SCOPE at Slocum ES |
| _____ 8:30-11:00 SCOPE at Slocum ES | _____ 12:30-3:00 Early Childhood Learning Center/DDI |
| _____ 9:00-11:30 Early Childhood Learning Center/DDI | |

*Extended care is available at this location for a fee as follows:

AM session: 8:00am - 8:30am and 11:00am-11:30am

PM session: 3:00pm - 4:00pm

Please indicate if interested: Yes _____ No _____ Time _____

YOUR SELECTION DOES NOT GUARANTEE CHOICE OF SITE/SESSION

Affidavit Statement

Your Deponent understands that the facts contained in this registration packet are made under oath; that the statements contained are true; that the Connetquot Board of Education will rely thereon, and that in the event there are misstatements of fact in this packet, such misstatements entitle the Board of Education to levy charges of perjury, a crime, as well as holding the Parent/Guardian responsible for the tuition for such a student.

SIGNATURE of Parent/Guardian

Signed before me on _____

PRINT Parent/Guardian Name

School Personnel

CONNETQUOT CENTRAL SCHOOL DISTRICT OF ISLIP

Health History Form

STUDENT'S NAME _____ DATE OF BIRTH _____
ADDRESS _____ CONTACT NUMBER _____
CITY/STATE/ZIP _____ PARENT NAME _____
PHYSICIAN NAME _____ PHYSICIAN PHONE _____

- | 1. Has the student had: | Y/N | <i>If so, when?</i> | | Y/N | <i>If so, when?</i> |
|---------------------------|-------|---------------------|---------------------|-------|---------------------|
| Anemia | _____ | _____ | Mumps | _____ | _____ |
| Arthritis | _____ | _____ | Operations | _____ | _____ |
| Asthma | _____ | _____ | Orthopedic Disorder | _____ | _____ |
| Cardiac Disorder | _____ | _____ | Pneumonia | _____ | _____ |
| Chicken Pox | _____ | _____ | Rheumatic Fever | _____ | _____ |
| Diabetes | _____ | _____ | Rubella | _____ | _____ |
| Ear Disorder | _____ | _____ | Scarlet Fever | _____ | _____ |
| Elevated Cholesterol | _____ | _____ | Seizure Disorder | _____ | _____ |
| Head Injury or Concussion | _____ | _____ | Serious Injuries | _____ | _____ |
| High/Low Blood Pressure | _____ | _____ | Sore Throats | _____ | _____ |
| Hives or Eczema | _____ | _____ | TB Test | _____ | _____ |
| Measles | _____ | _____ | Tuberculosis | _____ | _____ |
| Meningitis | _____ | _____ | Urinary Disorder | _____ | _____ |
| Migraines | _____ | _____ | Other | _____ | _____ |

2. Allergies, please specify:
Bee Sting _____ Food _____ Medication _____ Other _____

3. Has the student ever had an insect bite followed by a rash? Yes ___ No ___

4. Has the student ever complained about any joint pain? Yes ___ No ___

5. Has the student ever been hospitalized? Yes ___ No ___

If yes, please explain and provide date of service: _____

6. May the student participate in a regular unlimited Physical Education Program? Yes ___ No ___

If no, please explain and provide a physician's note stating limitation(s) and reason for limitation(s):

7. Does the student have a vision problem? Yes ___ No ___

Please specify: _____ Do they wear glasses/contacts? Yes ___ No ___

If yes, please provide: Name of eye doctor: _____ Telephone: _____

8. Does the student have a hearing loss? Yes ___ No ___

Please specify: _____ Do they wear hearing aids? Yes ___ No ___

If yes, please provide: Name of ear doctor: _____ Telephone: _____

9. Has the student ever been examined by a psychologist or psychiatrist (circle one)? Yes ___ No ___

If yes, please provide: Name of doctor _____ Telephone: _____

10. Please provide any additional information concerning the student's physical or emotional health:

11. Is the student taking any medication? Yes ___ No ___

If yes, please provide the reason for and the name of medication:

12. Will the student be taking this medication in school? Yes* ___ No ___

*If yes, you must complete the **Medication in School Authorization Form*** as part of the registration process.*

Under New York State's Health Law 2164, students may not attend school unless proof of immunization compliance is submitted at time of registration. New York State Education Law requires that a child entering the school district must have a physical examination. Proof of examination must be provided to the school nurse within 30 days of registering your child to the Connetquot Central School District.

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Anaphylaxis Care Plan Attached <input type="checkbox"/> Environmental
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Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
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Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
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Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
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Risk Factors for Diabetes or Pre-Diabetes:
 Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI _____ kg/m2 **Percentile (Weight Status Category):** <5th 5th-49th 50th-84th 85th-94th 95th-98th 99th and >

Hyperlipidemia: No Yes **Hypertension:** No Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name:	DOB:
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SCREENINGS

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis	Negative	Positive	Referral	
Required for boys grade 9 And girls grades 5 & 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			

Recommendations:
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

Full Activity without restrictions including Physical Education and Athletics.

Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications

No Contact Sports **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

No Non-Contact Sports **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY
 Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports
 Student is at **Tanner Stage:** I II III IV V

Accommodations: Use additional space below to explain

<input type="checkbox"/> Brace*/Orthotic	<input type="checkbox"/> Colostomy Appliance*	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Insulin Pump/Insulin Sensor*	<input type="checkbox"/> Medical/Prosthetic Device*	<input type="checkbox"/> Pacemaker/Defibrillator*
<input type="checkbox"/> Protective Equipment	<input type="checkbox"/> Sport Safety Goggles	<input type="checkbox"/> Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

Order Form for Medication(s) Needed at School attached

List medications taken at home:		

IMMUNIZATIONS

Record Attached Reported in NYSIIS Received Today: Yes No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: <i>(please print)</i>	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child’s School When Entirely Completed.

CONNETQUOT CENTRAL SCHOOL DISTRICT OF ISLIP

MEDICATION IN SCHOOL AUTHORIZATION FORM

The following procedures must be followed in order for the student to be administered medication during the school day:

1. The medication **MUST** be brought to the school health office by a parent or responsible adult. It should **NEVER** be carried to school by the student.
2. For all prescription drugs and/or non-prescription drugs, the school must have on file a written request from the doctor indicating the reason for the medication and the frequency and amount of dosage.
3. For all types of medication, the school must have on file a written request from the parent to administer it.
4. All written requests should be provided utilizing this **Medication in School Authorization Form**.

If you have any questions concerning this procedure, please contact your school nurse.

To be completed by the Parent/Guardian:

I, _____, request that my child _____, grade _____; receive the medications as prescribed below by our licensed healthcare prescriber. The medications will be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medications.

Signature _____ Date _____ Phone _____
Address _____ Cell _____

To be completed by the Licensed Healthcare Prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Patient: _____ Date of Birth: _____

Diagnosis: _____ Medicine: _____

Prescribed Dosage, Frequency and Route of Administration:

Prescribed Time Taken During School Hours: _____

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions, if any:

Other Recommendation:

Name of Licensed Prescriber and Title: _____

Prescriber's Signature: _____ Date: _____ Phone: _____

Address: _____ Fax: _____

AFFIDAVIT OF RESIDENCE

FOR RENTERS USE ONLY WHEN NO COMPLEX OR NOTARIZED LEASE IS AVAILABLE

**THIS FORM MUST BE SUBMITTED WITH THE PROPERTY OWNER’S DEED,
MORTGAGE STATEMENT OR CURRENT TAX BILL**

Parent/Guardian Statement

_____ being duly sworn deposes and says: I am the parent/legal guardian of
_____ ; that my residence is _____
_____ : which is within the boundaries of the Connetquot Central School District.

Your deponent understands that this affidavit is made under oath; that the statements contained in this disclosure are true and complete; that the Connetquot Board of Education is relying on this disclosure; that any misstatements made could result in tuition reimbursement and/or criminal charges being brought against the person whose signature appears hereon, and that the Connetquot Central School District reserves all rights under law concerning any inaccuracies made herein regardless of when disclosed.

Parent/Guardian _____
Signature of Deponent

Sworn to before me this _____
day of _____ 20 ____.

Notary Public

Owner/Landlord Statement

_____ being duly sworn deposes and says: I am the owner/landlord of the premises located at: _____ which premises are located within the Connetquot Central School District. This property is identified on the Suffolk County Tax Map as: District _____ Section _____ Block _____ Lot _____, and I certify that _____ resides at _____, as heretofore disclosed.
Parent Name Address

Your deponent understands that this affidavit is made under oath; that the statements contained in this disclosure are true and complete; that the Connetquot Board of Education is relying on this disclosure; that any misstatements made could result in criminal charges being brought against the person whose signature appears hereon, and that the Connetquot Central School District reserves all rights under the law concerning any inaccuracies made herein regardless of when disclosed.

Owner/Landlord _____ Home Phone _____ Cell Phone _____
Print Name

Owner/Landlord _____
Signature of Deponent

Sworn to before me this _____
day of _____ 20 ____.

Notary Public