

**Connetquot Central School District of Islip
Central Registration**

ALL REGISTRATIONS MUST COMPLETE AND SIGN THIS FORM

If a student qualifies as residing in temporary housing, the student is not required to submit proof of residency and other required documents that may be part of the registration packet.

HOUSING QUESTIONNAIRE

Name of LEA: Connetquot Central School District of Islip

Name of School: _____

Name of Student: _____
Last First Middle

Gender: Male Female Date of Birth: ____/____/____ Grade: ____ ID#: ____
Month Day Year (preschool-12) (optional)

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check one box.)

- In a shelter
- With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): _____
- In permanent housing

X _____
Print name of Parent, Guardian, or
Student (for unaccompanied homeless youth)

X _____
Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Date

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

McKinney-Vento Liaison Signature

Date

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

In response to the Covid-19 crisis, we have altered our application procedure for electronic submission only. To apply for the 2021-2022 Universal Pre-K, complete ALL forms and submit with the required documents via email to registration@ccsdli.org. Your application is not complete until all documents are received and reviewed by Central Registration.

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, 2021 (and, as per grant guidelines, cannot be age eligible for enrollment in Kindergarten) to attend a full day Pre-K program during the 2021-22 school year. The program will be provided exclusively through SCOPE between the hours of 8:30 am and 1:30 pm within District buildings yet to be determined. Due to Covid-19, it is unknown at this time if this will be a fully in-person or hybrid program. Kindly note the program highlights below:

- Applications must be received by **Friday, June 4, 2021**.
- Applicants will be selected by **lottery**. Notification of acceptance/location will be sent early-July. Every attempt will be made to place the child in the home school, or if not available, by school building closest to child's home. *Please note: this selection is not a first come, first served process.*
- Transportation is not provided.

Application Requirements:

- **Complete and sign all Application Forms Please print clearly.**
- **Email Forms WITH the required documents listed below to: registration@ccsdli.org**

Documents for the Student:

- Original Birth Certificate
- Physical within one year
- Proof of Immunizations
- Proof of Custody/Guardianship *(If applicable)*

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

2021-22 UNIVERSAL PRE-KINDERGARTEN APPLICATION

PLEASE PRINT CLEARLY Application Number _____ Date _____ Program Location _____

| STUDENT INFORMATION | | | | | | | | | | |
|---|--|--|---|---|----------------------|--|---------------------------------|---|---|--|
| First Name: | | | Middle Name: | | | Last Name: | | | Grade: UPK | |
| Date of Birth: | | Male _____ Female _____ | Age: | Place of Birth: <small>City, Town State or Country</small> | | Is the student Hispanic or Latino? Yes _____ No _____ | | Office Use Only: Proof of Birth: _____ | Re-entry: _____ Cohort Year: _____ | |
| Please indicate all race groups that apply: American Indian _____ Native Hawaiian or Pacific Islander _____ or Native Alaskan _____ White _____ Asian _____ African American or Black _____ | | | | | Date Applied: N/A | Start Date: N/A | Student ID# _____ | | | |
| Previously applied for services from Connetquot CSD: Yes _____ No _____ Siblings registered in Connetquot CSD: Yes _____ No _____ School _____ | | | Previous preschool/daycare provider: _____ | | | Office Use Only: | | | | |
| Second language spoken at home: Yes _____ No _____ Language _____ | | | Receiving Special Education or Related Services, please check: IEP _____ Resource Room _____ Special Class _____ Speech _____ Other _____ | | | | | HH Name: _____ | | |
| Is the parent/guardian a member of the Armed Forces AND on active duty? Yes _____ No _____ Entered date _____ Exit Date _____ | | | | | | | | | | |
| HOUSEHOLD INFORMATION | | | | | | | | | | |
| Residence Type: Own _____ Rent _____ Other _____ | | Office Use Only: Mortgage/Deed/Tax Bill _____ Yearly Complex Lease _____ Notarized Affidavit _____ Yearly Notarized Lease _____ Photo ID _____ Utility Bill _____ Other Bill _____ Contract of Sale _____ Supervisor Approval _____ | | | | | | Home School _____ | | |
| Home Address: _____, _____, _____, _____, _____ <small>Street Apt. # Town State Zip Code</small> | | | | | | | Mailing Address: P.O. BOX _____ | | | |
| Student Resides with: Both Mother & Father _____ Mother _____ Father _____ Stepparent _____ Foster Parent _____ Guardian _____ | | Marital Status of Parents: Married _____ Separated _____ Divorced _____ Never Married _____ | | Court Order, Divorce or Separation Agreement: Yes _____ No _____ Stipulations: _____ Residential Parent: _____ Non-Residential Parent: _____ Address: _____ Order of Protection: _____ | | | | | | |
| CONTACT INFORMATION | | | | | | | | | | |
| | | | MOTHER | | | FATHER | | | 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>I grant permission for the Connetquot Central School District to request all school records from any school previously attended.</i> X _____ Parent/Guardian Signature Date | |
| Name | | | | | | | | | | |
| Home Phone | | | | | | | | | | |
| Cell Phone | | | | | | | | | | |
| Work Phone | | | | | | | | | | |
| Email | | | | | | | | | | |
| Occupation | | | | | | | | | | |
| Employer's Name & Address | | | | | | | | | | |
| EMERGENCY CONTACTS | | | | | | | | | | |
| Relation to Student | | | | | | | Physician | | Dentist (optional) | |
| Name | | | | | | | | | | |
| Home Phone | | | | | | | | | | |
| Cell Phone | | | | | | | | | | |
| Address | | | | | | | | | | |

PARENT/GUARDIAN 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.

X _____
Parent/Guardian Signature

_____ Date School Personnel

CONNETQUOT CENTRAL SCHOOL DISTRICT OF ISLIP

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled *Language Background and Educational History*. Your assistance in answering these questions is greatly appreciated. Thank you.

| | | |
|--|--------|-------------------------|
| STUDENT NAME: | | |
| First | Middle | Last |
| DATE OF BIRTH: | | GENDER: |
| Month | Day | Year |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| PARENT/GUARDIAN NAME: | | |
| First | Last | Relationship to Student |

Language Background

1. What language(s) is(are) spoken in the student's home residence? English Other _____
specify
2. What was the first language your child learned? English Other _____
specify
3. What is the Home Language of each parent/guardian? Mother _____ Father _____ Guardian _____
specify specify specify
4. What language(s) does your child understand? English Other _____
specify
5. What language(s) does your child speak? English Other _____ Does not speak
specify
6. What language(s) does your child read? English Other _____ Does not read
specify
7. What language(s) does your child write? English Other _____ Does not write
specify

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____.
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? Yes* No Not sure *If yes, please explain: _____
How severe do you think these difficulties are? Minor Somewhat severe Severe
- 10a. Has your child ever been referred for a special education evaluation in the past? Yes* No *If yes, please complete 10b below
- 10b. *If referred for an evaluation, has your child ever received any special education services in the past? Yes No
Type of services received: _____ Age at which services received: Birth to 3 years 3 to 5 years 6 years or older
- 10c. Does your child have an Individualized Education Program (IEP)? Yes No
11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

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

Answers to these questions, ESL screening and/or prior ESL services may affect the student's school placement.

Signature of Parent/Guardian

Date

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 | If so, when? | Y/N | Y/N | If so, when? |
|---------------------------|-------|--------------|---------------------|-------|--------------|
| 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 BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE**

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 | Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached |
| Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type | <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached |
| Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type | Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: |
| Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type | Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached |

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 Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

| | | | | |
|---|--------------------------|--------------------------|---------------|--|
| Height: | Weight: | BP: | Pulse: | Respirations: |
| Laboratory Testing | Positive | Negative | Date | List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ) |
| TB- PRN | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Sickle Cell Screen-PRN | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Lead Level Required Grades Pre- K & K | | | Date | |
| <input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 5 \mu\text{g/dL}$ | | | | |

System Review and Abnormal Findings Listed Below

| | | | | |
|---------------------------------|---|--|---------------------------------------|---|
| <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 |

Assessment/Abnormalities Noted/Recommendations: _____ Diagnoses/Problems (list) _____ ICD-10 Code* _____

Additional Information Attached

*Required only for students with an IEP receiving Medicaid

| | | | | | |
|--|--|--|---|--|--------------------------|
| Name: | | | | DOB: | |
| SCREENINGS | | | | | |
| Vision (w/correction if prescribed) | | Right | Left | Referral | Not Done |
| Distance Acuity | | 20/ | 20/ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
| Near Vision Acuity | | 20/ | 20/ | | <input type="checkbox"/> |
| Color Perception Screening | | <input type="checkbox"/> Pass <input type="checkbox"/> Fail | | | <input type="checkbox"/> |
| Notes | | | | | |
| Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz. | | | | | Not Done |
| Pure Tone Screening | | Right <input type="checkbox"/> Pass <input type="checkbox"/> Fail | Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail | Referral <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
| Notes | | | | | |
| Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7 | | Negative | Positive | Referral | Not Done |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> |
| RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK | | | | | |
| <input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> Other Restrictions: | | | | | |
| Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level OR Grades 9-12 who wish to play at the modified interscholastic sports level. Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____ | | | | | |
| <input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions. | | | | | |
| MEDICATIONS | | | | | |
| <input type="checkbox"/> Order Form for Medication(s) Needed at School Attached | | | | | |
| IMMUNIZATIONS | | | | | |
| <input type="checkbox"/> Record Attached | | <input type="checkbox"/> Reported in NYSIS | | | |
| HEALTH CARE PROVIDER | | | | | |
| Medical Provider Signature: | | | | | |
| Provider Name: <i>(please print)</i> | | | | | |
| Provider Address: | | | | | |
| Phone: | | | Fax: | | |
| Please Return This Form To Your Child's School When 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