Connetquot Central School District of Islip
Central Registration

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

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

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

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, *if private home must be submitted with the homeowner's deed, current tax bill or mortgage statement* - Notarized Affidavit of Residence *must be submitted with the homeowner's deed, current tax bill or mortgage statement*
Submit ***TWO***: - Current Utility Bills *no cell phone bills accepted*	Submit ***TWO***: - Current Utility Bills *if utilities are included in your rental agreement, then two other bills must be submitted, no cell phone bills accepted*
Submit ***ONE***: - Valid NYS Driver's License *with current district address* - NYS Non-Driver's Photo ID *with current district address*	Submit ***ONE***: - Valid NYS Driver's License *with current district address* - NYS Non-Driver's Photo ID *with current district address*

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

2019-2020 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, *please check:* 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____ *relationship,*	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 _____
PHYSICAN NAME _____ PHYSICAN PHONE _____

1. Has the student had:

	Y/N	*If so*, when?		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 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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

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

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list)	ICD-10 Code
_____	_____
_____	_____
_____	_____
_____	_____

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ 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

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ 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: *(please print)*	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