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: ____/____/____ *Month Day Year* Grade: ____ *(preschool-12)* ID#: _____ *(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 to include electronic submission. To apply for the 2022-2023 Universal Pre-K, complete ALL forms and submit with the required documents via email to registration@ccsdli.org; fax to 631-244-2294 or mail to above address. 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, 2022 (and, as per grant guidelines, cannot be age eligible for enrollment in Kindergarten) to attend a full day Pre-K program during the 2022-23 school year. The program will be provided exclusively through SCOPE within some, but not all, District elementary buildings. The time of the program will be 9:30 am to 2:30 pm at all available buildings with the exception that E. J. Bosti will be from 8:30 am to 1:30 pm. Kindly note the program highlights below:

- Applications must be received by **Friday, February 18, 2022.**
- Applicants will be selected by **lottery**. Notification of acceptance/location will be sent mid-April. *Please note: this selection is not a first come, first served process.*
- Transportation is **not** provided and is the responsibility of the parent.

Application Requirements:

- ***Complete and sign all Application Forms Please print clearly.***
- ***Submit Forms WITH the required documents listed below to:***
  Email: registration@ccsdli.org,
  Fax: 631- 244-2294, or
  Mail to above address.

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, *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

2022-23 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: _____ City, Town _____ State or Country	Is the student Hispanic or Latino? Yes____ No____	Office Use Only: Proof of Birth:	Re-entry: N/A	Cohort Year: N/A

Please indicate all race groups that apply:
American Indian or Native Alaskan____ White_____ Asian_____ Native Hawaiian or Pacific Islander_____ 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: _____ Street, _____ Apt. #, _____ Town, _____ State, _____ Zip Code

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
Name		
Home Phone		
Cell Phone		
Work Phone		
Email		
Occupation		
Employer's Name & 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.

X_____ _____
Parent/Guardian Signature **Date**

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

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.

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: _____

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: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ 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
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ 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*

*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/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
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** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

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

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY 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: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, 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

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

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

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

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		❑ Male ❑ 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 _____ specify ❑ Father _____ specify ❑ Guardian _____ specify
4. **What language(s) does your child understand?** ❑ English ❑ Other _____ specify
5. **What language(s) does your child speak?** ❑ English ❑ Other _____ specify ❑ Does not speak
6. **What language(s) does your child read?** ❑ English ❑ Other _____ specify ❑ Does not read
7. **What language(s) does your child write?** ❑ English ❑ Other _____ specify ❑ Does not write

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
10. **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***