FRANKLIN SQUARE UNION FREE SCHOOL DISTRICT
DISTRICT OFFICES: Washington Street School
760 Washington Street, Franklin Square, NY 11010-3898

FAX: (516) 505-6972

Patrick J. Manley
Superintendent of Schools
(516) 505-6975

FOUNDATION
for SUCCESS

Dear Parent or Guardian:

Welcome to Franklin Square! We are pleased that you have expressed an interest in registering your child for our schools. As you work with our Central Registrar, please know that we are anxious to complete the necessary paperwork as quickly as possible. If you'll pay careful attention to these requirements, I am certain we will be able to successfully register your child quickly. To register, please call the Central Registration Office at 481-4100 ext. 3311 for an appointment.

Enclosed with this letter is a registration packet for you to complete. Included in this packet is a *"Physician's Medical Form"* which you may bring at the time of registration. Please note that the physical exam must be dated from September 2018 or any date thereafter. Your child will be excluded from all physical activity until the *"Physician's Medical Form"* is completed and returned to the Central Registration Office. The School Medical Doctor will examine any child who is not seen by his/her own physician. Also included in the packet is a *"Record of Immunization"* form for your physician to complete. Please bring this form with you to the registration. Your child may **not** begin school until a completed *"Record of Immunization"* form is presented to the Central Registration Office.

In order to register your child for school, please be sure to provide the following:

1. **Original** birth certificate

2. Proof of immunization with **physician's original signature**
   (See attached sheet indicating New York State required immunizations.)

3. Proof of residency (original documents). **Current documentation must be provided.**

Students will not be registered unless proofs of residence are submitted. Since the cost to educate a child in this District is approximately $16,451 per year, we must be certain that every child is a legal resident. The District requires proofs of residence in order to protect the taxpayers from the costs of educating non-resident students. We recognize that presenting these proofs may be somewhat bothersome, but we hope you understand the requirement is for your benefit as a new member of this community.

Warning: This District will take legal action to collect tuition charges if the student is illegally registered. Any person or persons, in addition to parents or guardians, who provide false evidence of residence will also be prosecuted. The District may investigate a student's residence by visits and other means.

You must submit one proof from each category:
(PLEASE SUBMIT ORIGINAL DOCUMENTS)

CHILD'S BIRTH – PART A
_____Birth Certificate (original)

PARENT/GUARDIAN'S IDENTITY – PART B
_____Driver's License
_____Photo Identification Card
_____Visa
_____Valid Passport
_____Other Photo Identification Issued by a Government Agency

PROOF OF RESIDENCY – PART C
_____Deed

If you are a renter, you must provide one of the following:
_____Lease – Include a copy of Landlord Deed, Tax Bill or Mortgage Statement
_____Notarized Affidavits from Owner and Parent/Guardian
Include a copy of Landlord Deed, Tax Bill or Mortgage Statement

PROOF OF RESIDENCY – PART D
Current Documentation Must Be Provided
_____Nassau County Tax Bill
_____Mortgage Statement/Mortgage Commitment
_____Payroll Check
_____Utility Bill_____Fuel Bill _____DDS ID
_____Any Utility Hook-up Agreement

PROOF OF PARENTAL RELATIONSHIPS AND FAMILY INFORMATION - PART E
_____Birth Certificate or Adoption Order
_____Court Order Establishing Custody
_____Foster Parent Placement Order (DSS-2999)
_____Guardianship Documents or Court Order

Your child will not be able to attend school without receipt of all the required documents. Should you have any questions, please contact the Central Registrar's office at 516-481-4100 ext. 3311.

Again, I welcome you to our schools. We are very proud of all that this district represents and look forward to making you and your child a part of our educational community.

Sincerely yours,

Patrick J. Manley

Patrick J. Manley
Superintendent of Schools

PJM:cm

Pre-K Registration

Type or Print

PUPIL'S NAME _____
(LAST) (FIRST) (MIDDLE INITIAL)

ELEMENTARY SCHOOL _____ FRANKLIN SQUARE SCHOOL DISTRICT

HOME ADDRESS _____

_____
(City) (State) (Zip)

TELEPHONE 1._____ 2._____ 3._____
(Home #) (Cell #)

DATE OF BIRTH: _____ MALE _____ FEMALE _____
(MONTH) (DAY) (YEAR)

BIRTHPLACE _____
(VILLAGE, TOWN OR CITY) (STATE) (COUNTY)

PROOF OF BIRTH _____ ENTRANCE DATE _____

SCHOOL LAST ATTENDED _____ **Preference for Pre-K (NOT Guaranteed) AM or PM** **ENTERING GRADE** _____

ETHNICITY (Choose One): ☐ Hispanic/Latino ☐ Non Hispanic/Latino

RACE: (Choose one or more)
☐ White ☐ Black or African American ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

COUNTRY OF ORIGIN: _____ DATE ENTERED U.S. _____

YEARS IN U.S. SCHOOLS _____

HOMELESS: Yes ☐ No ☐

LIVING ARRANGEMENT: ☐ Shelter ☐ Relatives ☐ Hotel
☐ Other _____

FAMILY INFORMATION

	BIRTHPLACE	U.S. CITIZEN	OCCUPATION	BUSINESS ADDRESS	BUSINESS TELEPHONE
MOTHER					
FATHER					

Mother's Email: _____ **Father's Email:** _____

PUPIL LIVING WITH _____ _____
(NAME of Parent/Guardian) (RELATIONSHIP)

LANGUAGES SPOKEN IN HOME _____

Other Children in Family including Foster, etc. (give name and birth date)

1. _____ D.O.B._____ 3. _____ D.O.B._____

2. _____ D.O.B._____ 4. _____ D.O.B._____

Adults (other than parents) living in home — Relationship to Student

1. _____ _____

2. _____ _____

UNUSUAL HOME CONDITIONS AFFECTING PUPIL
i.e., Death, Divorce, Separation, Step Parent, Parental Handicaps (deaf, blind, etc.), One Parent Home, etc.

DATE REGISTERED _____
Entered on E-School _____

_____

_____

WITHDRAWAL DATA:
DATE: _____ REASON: _____

FRANKLIN SQUARE SCHOOL DISTRICT
PROOF OF RESIDENCY

STUDENTS WILL BE REGISTERED AND ADMITTED TO SCHOOL UPON THE DISTRICT'S RECEIPT OF PROOF OF THE CHILD'S BIRTH, PROOF OF THE PARENTS' IDENTITY, AND PROOF OF RESIDENCY.
The District's Registrar will determine any need for additional proofs.

The Franklin Square School District must determine that every child is a **LEGAL** resident. The District requires proofs from the following categories in order to protect the taxpayers from the costs of educating illegal registrants.

WARNING: The District will take legal action against anyone who participates in falsely providing information to register a child illegally. The District will investigate all residency claims that are suspect by visits or other means.

YOU MUST SUBMIT ONE PROOF FROM EACH CATEGORY
(PLEASE SUBMIT **ORIGINAL** DOCUMENTS)

CHILD'S BIRTH:
____Birth Certificate (original)

PROOF OF RESIDENCY:
If you are the Homeowner you **must** provide one of the following:
_____Deed

If you are a Renter you **must** provide one of the following:
_____Lease (Include a copy of Landlord Deed, Tax Bill or Mortgage Statement)
_____Notarized Affidavits from Owner **and** Parent/Guardian
(Include a copy of Landlord Deed, Tax Bill or Mortgage Statement)

PARENT/GUARDIAN'S IDENTITY:
_____Driver's License
_____DMV Photo Identification Card
_____Visa
_____Valid Passport
_____Other Photo Identification Issued by Government Agency

PROOF OF RESIDENCY:
Current Documentation Must Be Provided
_____Nassau County Tax Bill
_____Mortgage Statement/Mortgage Commitment
_____Payroll Check
_____Utility Bill _____Fuel Bill _____DDS ID
_____Any Utility Hook-up Agreement

PROOF OF PARENTIAL RELATIONSHIPS AND FAMILY INFORMATION:
_____Birth Certification or Adoption Order
_____Court Order establishing custody
_____Foster Parent Placement Order (DSS-2999)
_____Guardianship documents or Court Order

I submit that the above documents have been presented and represent true information.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Revised 3/2016

FRANKLIN SQUARE SCHOOL DISTRICT

PARENT/GUARDIAN AFFIDAVIT IN LIEU OF LEASE

1. I/We _____

   and my/our child(ren) _____

   _____

   _____

   _____

   are residing at the residence of:

   _____
   Name of Owner/Landlord

   _____
   Street Address

   _____
   Town County Zip

2. I/We understand that this statement is being made under the penalties of perjury in order that the above name(s) child(ren) may be admitted to the Franklin Square School District. I/We further understand that if the child(ren) is/are found not be a legitimate resident that I/we will be legally responsible for and will be billed for the school district's annual tuition rate of approximately **$16,451** per year, per child retroactive to the first day of admission. I/We also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application may make me/us liable to criminal prosecution. I/We have been informed that the school district will make unannounced home visits for purposes of residency and information verification.

_____
Parent/Guardian Signature

Sworn before me this _____ day of

_____ 20_____

_____
Notary Public

FRANKLIN SQUARE SCHOOL DISTRICT

LANDLORD AFFIDAVIT IN LIEU OF LEASE

Please include a copy of Landlord Deed, Tax Bill or Mortgage Statement

1. I/We _____ am/are the owner(s)/landlord of the following premises:

   _____
   Street

   _____
   Town County Zip

2. Name(s) of Parent(s) or Guardian(s) residing full time at above address:

   _____, _____

   and child(ren) _____, _____

   _____, _____

3. I/We understand that this statement is being made under the penalties of perjury in order that the above name(s) child(ren) may be admitted to the Franklin Square School District. I/We further understand that if the child(ren) is/are found not be a legitimate resident that I/we will be legally responsible for and will be billed for the school district's annual tuition rate of approximately **$16,451** per year, per child retroactive to the first day of admission. I/We also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application may make me/us liable to criminal prosecution. I/We have been informed that the school district will make unannounced home visits for purposes of residency and information verification.

_____
Signature of Landlord

_____
Landlord's Name (Print)

_____
Landlord's Address of Residence

_____
Town Zip

_____
Landlord's Phone Number

Sworn before me this _____day

of_____20_____

_____
Notary Public

7/2014

2018-19 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades pre-k through 10, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: intervals between doses of polio vaccine DO NOT need to be reviewed for grades 5, 11 and 12.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 11 and 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

Dose requirements MUST be read with the footnotes of this schedule.

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older		**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)[3]	**Not applicable**			**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older	**3 doses**
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**			
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses** of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years			
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**	**1 dose**	**2 doses**	**1 dose**
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**			**Grades 7, 8 and 9: 1 dose**	**Grade 12: 2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**			
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**			

NEW YORK STATE | Department of Health

Record of Immunization

NAME _____

Date of Birth _____

Hib Vaccine _____

Prevnar Vaccine _____

DTaP Vaccine _____

DT _____

Tdap _____

Oral Polio Vaccine (OPV) _____
(IPV) _____

MMR #1 _____ Measles _____
MMR #2 _____ Mumps _____
Rubella _____

MCV4 #1_____ **#2**_____

Hep B: # 1_____ **# 2**_____ **# 3**_____

Varicella Vaccine: (1) _____(2)_____Varicella Disease _____

TB-Mantoux _____ TB PPD _____

Lead test date _____ Results _____

Other_____

Physician's Signature_____Date_____

Revised 12/3/15

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 ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

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

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

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type ☐ 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.

Health History
(To be completed by Parent/Guardian)

Name: _____ **DOB** _____ **Grade:** _____

Allergies

Food Type:_____ (Ingestion_____ Touch _____ Airborne _____)

Insect _____ Seasonal _____ Medication_____ Other _____

Symptoms to look for: _____

Are these allergies: Self-dignosed or MD dignosed (circle one)

Uses an Epi-Pen _____

Student's Medical History: Please note date if possible

Anemia _____	Diabetes_____	Mumps _____	Seizure _____	Eczema_____
Asthma _____	German Measles ____	Mononucleosis _____	Epilepsy _____	
Chickenpox _____	Hepatitis _____	Pneumonia _____	Heart Disease/Murmur_____	
Cystic Fibrosis _____	Measles _____	Scarlet Fever _____	Rheumatic Fever _____	
Tuberculosis _____	Ear Conditions_____	Frequent Cold/Sore Throats _____		

Other Relevant Medical Information: _____

Past Surgical History: _____

Present Health:

Skin: Rashes, Bruises, Unexplained Lumps: _____

Eyes: Normal Vision _____ Amblyopia _____ Wears Glasses _____

Respiratory Illnesses: _____

Cardiovascular: Known Murmur _____ Shortness of breath _____ Limits to physical activity_____

Ever evaluated by a Cardiologist _____

Gastrointestinal: Frequent stomach aches _____ Frequent diarrhea _____ Frequent constipation _____

Urinary Problems _____ Skeletal/Neuromuscular Disorders _____

Developmental History:

When did your child reach the following milestones? (Month/Year)

Sit Alone_____ Walk Alone _____ Say single words _____ Use two word sentences _____ Toilet Trained _____

Psychosocial History:

Family: Intact Family _____ Divorced _____ Separated _____ Adopted _____ Guardianship _____ Other _____

Does your child receive outside services (tutoring, speech therapy, physical therapy, counseling): _____

Specify _____

Medication:

Does your child take any medication on a daily basis? _____ Specify _____

Other Comments:

_____

Parent/Guardian Signature _____ **Date** _____

revised 9/17/14

SAMPLE

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

PRIOR SPECIAL EDUCATION SERVICES

NAME _____ **GRADE** _____ **DOB** _____
(Print First and Last Name)

SECTION I: PRE-KINDERGARTEN STUDENTS ONLY

1. Has your child (age 3 to 5) ever received Special Education service through Committee on Preschool Special Education (CPSE) in the Franklin Square School District? **Yes** ____ **No** _____ (Check One) If "No" proceed to Section II
   - Dates of CPSE Service: **From** _____ **To** _____
   - Was a Transition Meeting held? **Yes** _____ **No** _____ **Not Sure** _____
     (Check One) If "No" or "Not Sure" please go to the Special Education Office after registration
2. I am registering my child for the Franklin Square Pre-K program. **Yes** _____ **No** _____
   (Check One) If "No" discontinue registration and go to the Special Education Office. (See Carolyn Mione)

SECTION II:

1. Has your child (age 5 & older) ever received Special Education service through Committee on Special Education (CSE)? **Yes** _____ **No** _____ (Check One) If "No" discontinue

---

SECTION III:

SCHOOL DISTRICT IN WHICH YOUR CHILD WAS PRESENTED TO CSE:

_____
District City State

PLEASE CHECK THE HANDICAPPING CONDITION DETERMINED BY THE LAST CSE:

☐ Autism	☐ Deafness	☐ Orthopedically Impairment
☐ Emotionally Disturbance	☐ Hearing Impairment	☐ Other Health-Impairment
☐ Learning Disability	☐ Speech/Language Impairment	☐ Multiple Disabilities
☐ Intellectually Impairment	☐ Visually Impairment/Blindness	☐ Deaf-Blindness

LAST SPECIAL EDUCATION SERVICE RECEIVED IN:

_____
School City State Date

Name & phone number of Contact Person: _____

CHECK TYPE OF SERVICE BELOW:

☐ Resource Room	☐ Day School / Integrated	☐ Hospital Placement
☐ Integrated Class	☐ Residential School	☐ Court Placement
☐ Self-Contained Class	☐ Itinerant Service	
☐ BOCES / Special School	☐ Special Home Instruction	

I, _____ (Print Your Full Name) authorize the release of information to the Franklin Square School District in order to obtain all special education data to assist in seeking the most appropriate placement for my son/daughter _____ (Print Childs Full Name).

_____
Signature of Parent/Guardian Date

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colon-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

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.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:
☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or 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(s) _____ *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

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

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? If yes, please describe them.

*Yes** ☐ *No* ☐ *Not sure* ☐ *If yes, please explain: _____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ No ☐ Yes* **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
☐ No ☐ Yes – Type of services received: _____

Age at which services received *(Please check all that apply)*:
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

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? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ☐ Mother ☐ Father ☐ Other: _____

Official Entry Only - Name/Position of Qualified Personnel Administering HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

Name/Position of Qualified Personnel Reviewing HLQ and Conducting Individual Interview

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ No ☐ Yes

**DATE OF INDIVIDUAL INTERVIEW: _____ (Mo / Day / Yr.)

OUTCOME OF INDIVIDUAL INTERVIEW:
☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

Name/Position of Qualified Personnel Administering NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (Mo. / Day / Yr.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

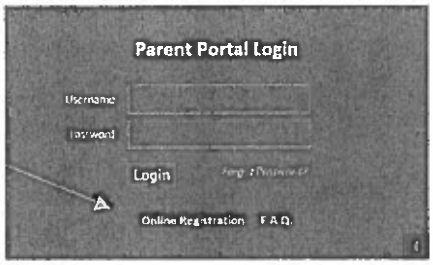
DIRECTIONS TO SET UP PARENT PORTAL

Welcome to the Franklin Square School District. Below are directions and screenshots for the registration process. Please fill in the information requested.

*****You must call the main office of your child's school to obtain the Student ID number 3 days after registration is complete.***

Step 1: Proceed to the district website and click on the Parent Portal quick-link on the bottom right side of the page. (http://franklinsquare.k12.ny.us)

Step 2: Click on "Online Registration"



Step 3: There are 3 short parts to fill out.

A: Account Information

B: Personal Parent Information

C: Student Information (need student ID number to complete) Please contact your child's school 3 days after registration to obtain ID number.

***Please note that H. Frank Carey High School and Franklin Square School District (elementary schools) are two separate school districts. Even if you have an older child in the high school, you will need a separate parent portal account for your younger child.

If you need support, please email Michelle at the email shown below.

mbalsdon@franklinsquare.k12.ny.us