Great Neck Public Schools
Phipps Administration Building
Office of Registration
345 Lakeville Road, Great Neck, NY 11020 (516) 441-4080

Welcome to the Great Neck School District

You **must** reside in the District in order to register your child for school. **Registration is a three step process. Step one move in. The second step** is to complete and submit the Online Registration Application. After the application is submitted our staff will review the application within 1-3 business days. All applications are reviewed in the order they are received. **Step three**-You will then receive an email either letting you know your child is registered or what additional documents may still be needed.

For the Online Registration link and direction go to: https://www.greatneck.k12.ny.us Administration>Registration

Before you begin the online registration, please gather the following documents and scan them to your computer so you can upload them during the registration process.

The following documents are required for registration and can be uploaded into the Online Registration System. In the event the family is not able to present the required documentation, an appointment may be requested with the supervisor to determine what other documents will be acceptable to register the student in school.

Acceptable Proof of Residence: All of these will be uploaded while filling out the Online Application.
If homeowner, please provide one of the following: Deed, Current Town or North Hempstead Tax Bill (If you need a copy call (516) 869-7800), Closing statement, Proprietary lease (for Co-op).
If renting, please provide the following: Lease (all pages with complete landlord contact information), Rental Agreement (all pages with complete landlord contact information)
** Both Lease and Rental agreement to be accompanied with the local village/town official rental permit for that property (should be supplied to the tenant by the landlord).

Notarized Residency Affidavits for Tenant and Owner Affidavits are provided by the district. In addition to the Owner/Renter Affidavits, the property owner's full contact information, Deed, Current Town or North Hempstead Tax Bill (If you need a copy call (516) 869-7800), landlords Proprietary lease (for Co-op)

3 Pieces of Current Official Mail (i.e. bank statements, credit card statements, insurance bills, cell phone bills, and utility bills, etc.) dated current or past month only).
Additional Documentation:
Student Records The following student records are also required:
▪ **Proof of Age (Original Birth Certificate).** If not in English an Official Notarized Translation is required. **(All students)**
▪ **Up-to-Date Immunization Record** signed and stamped by a doctor. **Public School only**
▪ **Physical** (by a New York State Doctor within 30 days of starting school, the physical must have been performed within the last 12 months. **Public School only**
▪ School Records (i.e. report card, official transcript, course schedule. **Public School only**
▪ If a student is receiving special education services, a copy of the **IEP is required.**
Proof of Guardianship/Parental Relationship. (Not required if parent is listed on birth certificate)
If parents divorced, Family Court or Divorce Agreement naming registering parent as custodial parent or having residential custody, or signed and notarized affidavits obtained from our office.
Note: In the event of Divorce or Separation, both parents have equal access to their children and student records, unless legal documentation is submitted at Registration limiting this.

Great Neck Public Schools, Office of Registration and Attendance
345 Lakeville Road, Great Neck, NY 11020
residency@greatneck.k12.ny.us (516) 441-4080

Name:_____ Application #:_____ Date:_____

Public School Registration Checklist

******Please include the application number in all correspondence******

____ Deed, Closing Statement, or Current School/Village Tax Bill
Or
____ Proprietary Lease (Co-op)
Or
____ Lease (all pages with complete landlord contact information)
Rental Agreement (all pages with complete landlord contact information)
**** Both Lease and Rental agreement to be accompanied with the local village/town official rental permit for that property (should be supplied to the tenant by the landlord).**

____ Current Mail 3 Different Pieces of Official Mail, utility bills work best-shipping labels are unacceptable, must be stamped within the past 30 days.

____ Certification of Residency (notarized)

____ Parent/Guardian Photo ID: You are Required to add all Parents listed on the Birth Certificate, to the Online Application in the Parent Section.

____ Custody Agreement or Notarized Affidavits if applicable. A secondary mailing will be set up for all non-household parents

____ Original Birth Certificate (Original and an official, notarized translation to English, if necessary)

____ Immunization Record (stamped by a physician) * REQUIRED to Complete Registration.**

____ Physical, performed and stamped within the last 12 months by a New York State Doctor.
***** REQUIRED to Complete Registration.**

____ Home Language Questionnaire (one form for EACH student)

____ Dental Form – Elementary Only (one form for EACH student)

____ Report Card/Transcript. Important for placement: *Prior School Information* needs to be entered before submitting the application. For Kindergarten enrollment please list the current Pre-School or Daycare Program, if applicable.

____ Please make sure you SUBMIT the application. An email from 'Parentsupport' will be sent as soon as you Submit the application letting you know it has been submitted. Check your email and make sure you receive this verification. All applications are reviewed in the order they are received. Please allow 1-3 business days for our staff to review your application.

If the application is complete and all documents are uploaded are correct, you will receive an email letting you know your application is 'APPROVED AND POSTED'.

If any of the documents are missing or information is incomplete, your application will be placed on HOLD, and you will receive an email letting you know what is missing. Incomplete application or document will delay the processing.

GREAT NECK PUBLIC SCHOOLS
REGISTRATION OFFICE
345 LAKEVILLE ROAD
GREAT NECK, NY 11020

CERTIFICATION OF RESIDENCY

(Affidavit is valid for one year from date of notary signature)

This is to certify that I, _____

understand that this statement is being made UNDER THE PENALTIES OF PERJURY, so that my child/children may be admitted to the schools of the Great Neck Public Schools.

I am currently residing at _____
(Address)
_____

as my legal residence. I further certify that I **do not** maintain another residence outside the boundaries of the Great Neck School District. **I further certify I will be living with my children while they are attending Great Neck School.**

I understand that if I or the above mention child(ren) is (are) found not to be a legitimate residents of the Great Neck Union Free School District, **that I WILL BE LEGALLY RESPONSIBLE FOR AND WILL PAY THE SCHOOL DISTRICT'S ANNUAL TUITION RATE PER CHILD (Minimum range is $16,548.00 - $24,941.00), RETROACTIVE TO THE FIRST DAY OF ADMISSION, ALONG WITH ANY COSTS ASSOCIATED WITH ENROLLING YOUR CHILD" and MY CHILD/CHILDREN WILL BE DISENROLLED**. I 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 will make me liable to criminal prosecution. I understand that the school district will make an announced home visit for purposes of residency verification. In addition, the district may make an unannounced home visit for the purpose of residency verification.

I further understand that if I move out of the home listed above, I will immediately notify the school district.
By signing below, I admit to having read and understood the above conditions.

_____ _____
Signature of Parent/Person in Parental Relation Date

Sworn to before me
This _____ day of _____, 20_____

_____
NOTARY PUBLIC

I have read and understood the above and am certifying the resident understands the statement they are signing. Please attach copy of ID.

_____ _____ _____
Signature of Translator Relationship Phone

Sworn to before me
This _____ day of _____, 20_____

_____
Notary Public

(rev. 03/2022)

2022-23 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). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. 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, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 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 adolescent 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		
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**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**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

1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
   d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6, 7 and 8: 10 years; minimum age for grades 9 through 12: 7 years)
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
   b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 through 12.
   c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.

4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
   c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
   d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.

5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
   a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: At least one dose is required for all grades (prekindergarten through 12).

6. Hepatitis B vaccine
   a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
   b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.

7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
   a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
   b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.

8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks).
   a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
   b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
   c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.

9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
   c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
   d. If dose 1 was received at 15 months or older, only 1 dose is required.
   e. Hib vaccine is not required for children 5 years or older.

10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
   a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
   b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
   c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
   d. If one dose of vaccine was received at 24 months or older, no further doses are required.
   e. PCV is not required for children 5 years or older.
   f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: www.health.ny.gov/prevention/immunization/schools

For further information, contact:

New York State Department of Health
Bureau of Immunization
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437

New York City Department of Health and Mental Hygiene
Program Support Unit, Bureau of Immunization,
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433

GREAT NECK PUBLIC SCHOOLS
Health Services
Immunization Record

NAME_____ DOB_____ SCHOOL_____

ADDRESS_____ PHONE_____ GRADE_____ TEACHER_____

Under section 2164 of the New York State Public Health Law, all children attending school,... or any preschool program must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, Varicella, Meningococcal, Haemophilus Influenza b & Prevnar. Children who attend a preschool...must also show evidence of lead screening.
Please have your Health Care Provider fill in **Month, Day & Year of ALL Immunizations. ALL DATES ARE REQUIRED.**

Your child <u>may not</u> attend school without this information.

PLEASE CHECK WITH YOUR DOCTOR FOR THE REQUIRED DOSES FOR YOUR CHILD ACCORDING TO ACIP GUIDELINES*

- **DTaP → <u>3-5 Doses Required</u>** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___
- **Tdap→ <u>1 Dose Required</u>** {Mandatory Grades 6th -12th}
  1. ___/___/___
- **IPV → <u>3-5 Doses Required</u>** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___
- **HBV (HEPATITIS B)→ <u>3 Doses Required</u>**
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ Additional Doses: ___/___/___ ___/___/___ ___/___/___
- **MMR→ <u>2 Doses Required</u>** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kindergarten.}

  MMR: 1. ___/___/___ 2. ___/___/___

  Or MEASLES: 1. ___/___/___ 2. ___/___/___ MUMPS 1. ___/___/___ 2. ___/___/___ RUBELLA 1. ___/___/___ 2. ___/___/___
- **VARICELLA VACCINE (CHICKEN POX)→ <u>2 Doses Required</u>** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kind., 1st, 2nd, 3rd, 4th, 6th, 7th, 8th, 9th, 10th & 11th Grade}
  1. ___/___/___ 2. ___/___/___ <u>Or proof of Disease from Health Care Provider</u>→ DATE: 1. ___/___/___
- **MenACWY / Menactra / MCV4 / Menveo VACCINE→ <u>1-2 Doses Required</u>** {1st Dose Required for 7th, 8th, 9th, 10th & 11th Grade. 2nd Dose Required on or After Age 16, &/or Entering 12th Grade.}
  1. ___/___/___ 2. ___/___/___

<u>For children entering Preschool program</u>

- **Hib (HAEMOPHILUS INFLUENZA b)→ <u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
- **PREVNAR (PCV) → <u>1-4 Doses Required</u>** {Depending on Age & Grade}
  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
- **LEAD SCREENING →<u>Required for Preschool</u> →** ___/___/___ → _____

<u>Optional Vaccines</u>

- **HEPATITIS A Vaccine (HAV)→** 1. ___/___/___ 2. ___/___/___
- **HUMAN PAPILLOMAVIRUS (HPV)→** 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
- **PPV (Pneumococcal Polysaccharide Vaccine) →** 1. ___/___/___ 2. ___/___/___
- **ROTATEQ→** 1. ___/___/___ 2. ___/___/___ 3. ___/___/___
- **OTHER VACCINES: _____→** 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

➢ PPD/TB TEST→ ___/___/___ Read ___/___/___ → _____ mm → Result: N___ P___

Children who have not been immunized may be admitted <u>with 1 Dose of **each required vaccine series</u> & has **WRITTEN** age appropriate appointments to complete the series according to the ACIP guidelines.**

<u>**PHYSICIAN'S SIGNATURE**</u>, <u>**STAMP**</u>, ADDRESS, PHONE NUMBER

_____

DATE: ___/___/___ _____

_____

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.

GREAT NECK PUBLIC SCHOOLS
HEALTH SERVICES

DENTAL HEALTH REPORT
(ELEMENTARY SCHOOLS ONLY)

Student's Name: _____ Date: _____

School: _____ Grade: _____

This is to certify that the student named above:

Is under my care for dental treatment: _____

Has completed dental treatment: _____

Name of Dentist: _____

Signature of Dentist: _____

Address: _____

_____

This report should be returned to the school.

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

Lissette Colón-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:		GENDER:
Month	*Day*	*Year*
		❑ 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:		STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
District Name (Number) & School	*Address*	

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 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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: