

Glen Cove School District Registration of New Students

To enter pre-kindergarten, children must be four years old on or before December 1 of the school year.

To enter kindergarten, child must be five years old on or before December 1 of the school year.

Parents/Guardians must bring the following information with them at the time of registration:

1. Proof of your child's age.

Ways to show a child's age

- * Certified Birth Certificate (from any country)
- * Baptismal record (from any country)
- * A Passport (from any country)

If you don't have a Birth Certificate, baptismal record or passport, you can use other documents if you've had them for at least two years, such as:

- * Driver's license
- * State or governmental ID
- * School photo ID with date of birth
- * Consulate ID Card
- * Hospital or health records
- * Military dependent ID card
- * Other documents from federal/state/local agencies (examples: Department of Social Services, Office of Refugee Resettlement)
- * Court Orders
- * Native American tribal document
- * Records from international aid agencies or voluntary agencies

2. Your own Photo ID such as a driver's license or passport.

3. A record from physician with all inoculations listed with a doctor's signature so stamp.

For current immunization requirements, please select this link: <http://www.health.ny.gov/publications/2370.pdf>)

4. Proof of residency.

Ways you can show residency:

- * Lease or deed
- * Affidavit from the person you pay rent to, saying you live there
- * Affidavit from a third party saying you live there
- * A letter from the person you pay rent to saying you live there
- * A letter from another person saying you live at your address

If you don't have any of the above, you may use the following:

- * Pay stub showing your address
- * Income tax form that shows your address
- * Utility bill or other bill in your name
- * Membership documents based on residency, such as a local library card
- * Voter registration card
- * Driver's license, or permit, or non-driver ID
- * State or other government issue ID
- * Documents from government agencies such as a social service agency or the federal Office of Refugee Resettlement
- * Custody or guardianship papers

5. Proof of custody or guardianship

or

an affidavit (Parent or Guardian) saying that you have "total and permanent custody and control" over the child

or

other proof such as documentation that the child has been placed with a sponsor by a federal agency

GLEN COVE CITY SCHOOL DISTRICT
Dosoris Lane
Glen Cove, New York 11542

Today, _____, I am requesting permission to have the following child admitted to Glen Cove City School District.
(Date)

DS

LS

GS

CS

MS

HS

Student's Name: _____ M ____ F ____ Grade _____
(Last, First, Middle)

Date of Birth _____
month day year

Mother/Guardian/Other _____

Last Name _____ First Name _____ Middle Initial _____

Address _____

Phone #: Home () _____ Work () _____ Cell () _____

Date of Birth _____ Email _____

Name of Employer _____

Father/Guardian/Other _____

Last Name _____ First Name _____ Middle Initial _____

Address _____

Phone #: Home () _____ Work () _____ Cell () _____

Date of Birth _____ Email _____

Name of Employer _____

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed, or national origin, sex, citizenship, handicapping condition, or immigration status.

ETHNICITY (must select one):

- ☐ Hispanic, Latino or Spanish
☐ Not Hispanic, Latino or Spanish

Race (must select at least one):

- ☐ African American
☐ American Indian/Alaskan Native
☐ Asian
☐ Native Hawaiian/Pacific Islander
☐ White

Residency/Housing

- | | |
|--|--|
| <input type="checkbox"/> Other Situation | <input type="checkbox"/> Train/Bus Station |
| <input type="checkbox"/> Abandoned Apartment | <input type="checkbox"/> With Relative |
| <input type="checkbox"/> In a Mote/Hotel | <input type="checkbox"/> Permanent Housing |
| <input type="checkbox"/> In a Shelter | <input type="checkbox"/> Train/Bus/Car |
| <input type="checkbox"/> Temporary Housing | <input type="checkbox"/> Park/Campsite |

Please be aware of your right to the referral and evaluation of your child for the purposes of special education services or programs. For more information, you may contact our Special Education department at 516-801-7051 and/or refer to the New York State website

<http://www.p12.nysed.gov/specialed/publications/policy/parentsguide.pdf> for *A Parent's Guide to Special Education*.

EMERGENCY CONTACT INFORMATION

In an emergency, if I (we) cannot be reached at any of the numbers listed above, you may call the following. They are authorized to pick up my child for illness, accident or early dismissal purposes. Should anyone else be so requested, I further understand that it is my responsibility to notify the school in writing.

Name _____ Relationship _____

Address _____

Phone #: Home () _____ Work () _____ Cell () _____

Name _____ Relationship _____

Address _____

Phone #: Home () _____ Work () _____ Cell () _____

If you do not wish to have your child released to an individual, please notify this office in writing. For legal reasons (ie, divorce or separation) a court order must be on file in the office.

Under **PENALTIES OF PERJURY**, the statements contained in this application are true. I understand that the statements in this application are subject to verification by the School District and that false statements could subject me to transportation and/or tuition charges where applicable. I also understand that it is my responsibility to notify the school of any changes or circumstances affecting this application. **ANY FALSE STATEMENTS MADE IN THIS APPLICATION ARE ALSO PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW**

To be signed at registration

Date

Date

PRINT Name of Mother/Guardian

PRINT Name of Father/Guardian

Signature Mother/Guardian

Signature Father/Guardian

Registrars Signature and Date

At the request of the parent/guardian, this registration packet has was completed with assistance of an interpreter. The registration packet was presented to the parent/guardian in their native language of

_____.

This packet was completed by:

Print Name (Interpreter)

Sign Name (Interpreter)

Pre-K Eligibility Verification

Student Name: _____

Financial Information:

Income After Taxes (Annual Net Income)

Father _____

Mother _____

Do you receive any social services benefits?

Yes ☐

No ☐

If yes, Please present proof of benefits.

List all family members living in household:

Name:

Relationship:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Income verified by Registrar _____

Date _____

W-2 2020 _____

Previous year income tax 2019P _____

Verificación de Elegibilidad para Pre-Kinder

Nombre del estudiante: _____

Información Financiera:

Ingresos después de impuestos (Ingreso Neto Anual)

Padre _____

Madre _____

¿Recibe algún beneficio de servicios sociales? Si ☐ No ☐

Si la respuesta es afirmativa, por favor presentar prueba de beneficios.

Enumere todos los miembros de la familia que viven en el hogar:

Nombre:

Relación:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Ingreso verificado por la Registradora _____

Fecha _____

W-2 2020 _____

Impuestos del año interior 2019 P _____



150 Dosoris Lane, Glen Cove, New York 11542 · (516) 801-7010 · Fax: (516) 801-7019

TO: Parent/Guardian of _____

RE: Special Education/Special Services

Was your Child in any special education program or in need of any special services?

Yes ☐

No ☐

Parent/Guardian Signature _____



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

Lisette 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:

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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> 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* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>*Please complete 10b below</i>	
10b. <i>*If referred for an evaluation</i> , has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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? _____	

Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____
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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> MO. DAY YR. </div>	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <div style="display: flex; justify-content: space-between; font-size: small;"> MO. DAY YR. </div>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING </div>
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	



154 Dosoris Lane, Glen Cove, New York 11542 · (516) 801-7010 · Fax: (516) 801-7019

**GLEN COVE CITY SCHOOL DISTRICT
IMMUNIZATION ACKNOWLEDGEMENT**

Dear Parent/Guardian:

New York State Education Law and the Regulations of the Commissioner of Education require a physical examination of all children who enter a school district for the first time. It must be completed no more than 12 months prior to, or 30 days after entering school.

New York State Public Health Law, Section 2164, mandates that schools cannot permit a child to be admitted unless the parent provides the school with a certificate of immunization or proof from a physician that the child is in the process of receiving required immunizations.

Attached are school forms for your convenience. According to law, these must be completed with 14 days of the child's entry to school. Please complete and sign the enclosed health forms, as well as the acknowledgement below.

If you have any questions or specific health concerns, please feel free to call the appropriate school.

PARENT/GUARDIAN ACKNOWLEDGEMENT

Student Name: _____ Grade: _____

Phone: _____

Pursuant to Public Health Law 2164, I/we the undersigned acknowledge that we have fourteen (14) days [30 days for records from out of New York state] to provide the Glen Cove School District with our son's/daughter's immunization records. Furthermore, we understand that failure to comply within the allotted time may result in my child's exclusion from school.

Parent/Guardian Signature

Date

GLEN COVE CITY SCHOOL DISTRICT*(to be completed by school health official and signed by parent/guardian)***New Entrant Confidential Information****Health Form**

Date _____
 Transferred from _____
 School _____
 Grade _____ Age _____
 ID# _____

Last name _____ First Name _____

Date of Birth _____ Sex _____

Address _____ Phone _____

Mother/Guardian _____ Work Phone _____ Cell _____

Father/Guardian _____ Work Phone _____ Cell _____

Physician _____ Address _____ Phone _____

Please supply the name of a local person to be contacted in an emergency if the parents cannot be reached:

Name _____ Home/work Phone _____ Cell _____

Name _____ Home/work phone _____ Cell _____

Note: *The school does not have facilities to care for sick children in school or to transport children home.
 Please notify the school immediately of any changes in emergency information.*

STUDENT HEALTH & DISEASE HISTORY

	Date		Date		Date		Date
Anemia		Heart Disease		Rheumatic Fever		Asthma/Allergies	
Chicken Pox		Measles*		Scarlet Fever		Ear Conditions	
Diabetes		Mumps*		Tuberculosis		Frequent colds/sore throats	
Epilepsy		Nephritis		Contact w/TBC		Operations	
German Measles		Pneumonia		Whooping Cough		Serious Injuries	

**Doctor's proof required*

Any serious illness or physical disability other than above _____

Is he/she able to participate in all activities and sports _____

Is he/she under medical care on a regular basis ____ If yes, please list details and physician's name _____

Has your child ever been hospitalized, please give reason and approximate dates _____

Is he/she presently taking medication _____ Type _____ Dosage _____ Time _____

Does he/she have a hearing problem _____ Physician _____ Speech problem _____

Does he/she have a vision problem _____ Physician _____ Wear glasses _____

Does he/she have a balance or coordination problem _____ Scoliosis _____

Has he/she had a prolonged high fever _____ Convulsions _____ Details _____

Has he/she ever had an EEG _____ Neurological exam _____ Details _____

Has he/she ever swallowed a poisonous substance _____ Details _____

Start of Menses (if applicable) _____ Difficulties _____

Is there any additional information that you feel the school nurse should be made aware of ____

This parent/guardian signature authorizes the nurse to share this information with school staff on a "need-to-know" basis.

Nurse Signature _____ Parent/Guardian Signature _____

Interpreter Signature _____

GLEN COVE CITY SCHOOL DISTRICT*(to be completed by school health official and signed by parent/guardian)***New Entrant Confidential Information****Social History Form**

Date _____

Language spoken at home _____

Last name _____ First Name _____

Prenatal History:

- Age of mother at child's birth _____
- Check those conditions which the mother had during pregnancy:

Virus infection _____	German Measles _____	Diabetes _____
Bleeding _____	Anemia _____	RH _____
High blood pressure _____	Kidney/bladder infection _____	Phlebitis _____
Prolonged vomiting _____	Accident/injury _____	Convulsions _____
		X-ray _____
- Check those medications taken during pregnancy:

Water _____	Nausea _____	Pain _____	Sleeping _____	Alcohol _____	Other drugs _____
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Birth History:

- Birth weight: pounds _____ ounces _____
- Full term _____ Premature(month) _____ Incubator _____
- Type of birth:

Prolonged labor _____	Induced _____	Forceps used _____
Anesthesia: local _____	General _____	Spinal _____
		None _____
		Can't remember _____
Presentation: Head first _____	Breech _____	Cord around neck _____
		Caesarian _____
- Condition at birth: Normal _____

Breathing difficulties _____	Cyanosis (blue) _____
Transfusion _____	Jaundice (yellow) _____
Feeding difficulties _____	Sleeping difficulties _____
Convulsions _____	Paralysis _____
Physical defects (specify) _____	

Developmental History: (Physical):

- Did he/she ever have a feeding problem _____ When _____

Colic _____	Allergy _____	Undereating _____	Overeating _____
-------------	---------------	-------------------	------------------
- At what age did he/she sit _____ walk _____ talk _____
- At what age was he/she toilet trained _____
- Is his/her speech difficult to understand _____

Stutter _____	Lisp _____	Speech errors _____	Delayed _____
---------------	------------	---------------------	---------------
- Is he/she right _____ or left-handed _____ or uses both hands _____

(Social/Emotional):

- Has he/she had any nervous tendencies _____ Please explain _____

Thumbsucking _____	Nailbiting _____	Fear of the dark _____	Nightmares _____	Bedwetting _____
Tics _____	Headaches _____	Frequent stomachaches _____	Vomiting _____	
Excessive storytelling (lie or fantasy) _____		Refuse to speak _____		
- Are you concerned about his/her behavior _____ Please explain _____

Stubborn _____	Easily angered _____	Temper tantrums _____	Resists authority _____
Short attention span _____	Restless _____	Hyperactive _____	Overanxious _____
Fearful of making mistakes _____	Depressed _____	Has few friends _____	Loner _____

(Learning):

- Has he/she experienced difficulties with: Reading _____ Spelling _____ Handwriting _____

Math _____	Learning Disabilities _____	Please explain _____
------------	-----------------------------	----------------------
- Has any member of the family experienced any of these difficulties, (i.e. Parents, grandparents, brothers, sisters) _____

This parent/guardian signature authorizes the nurse to share this information with school staff on a "need-to-know" basis.

Nurse Signature _____ Parent/Guardian Signature _____

Interpreter Signature _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR IF AN AREA IS NOT ASSESSED INDICATE NOT DONE					
Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).					
STUDENT INFORMATION					
Name				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
School:				DOB:	
				Grade:	
				Exam Date:	
HEALTH HISTORY					
Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached			
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached			
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> Medication/Treatment Order Attached		Date of last seizure: <input type="checkbox"/> Seizure Care Plan Attached	
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type		Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached			
Risk Factors for Diabetes or Pre-Diabetes: <i>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.</i>					
BMI _____ kg/m2					
Percentile (Weight Status Category): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and>					
Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done			Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not Done		
PHYSICAL EXAMINATION/ASSESSMENT					
Height:		Weight:		BP:	
				Pulse:	
				Respirations:	
Laboratory Testing		Positive Negative		Date	
TB- PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Sickle Cell Screen-PRN		<input type="checkbox"/>		<input type="checkbox"/>	
Lead Level Required Grades Pre- K & K				Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$					
<input type="checkbox"/> System Review and Abnormal Findings Listed Below					
<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes		<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Dental		<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> Back/Spine	
<input type="checkbox"/> Neck		<input type="checkbox"/> Lungs		<input type="checkbox"/> Genitourinary	
				<input type="checkbox"/> Extremities	
				<input type="checkbox"/> Skin	
				<input type="checkbox"/> Neurological	
				<input type="checkbox"/> Speech	
				<input type="checkbox"/> Social Emotional	
				<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:				Diagnoses/Problems (list) ICD-10 Code*	
<input type="checkbox"/> Additional Information Attached				*Required only for students with an IEP receiving Medicaid	

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

GLEN COVE CITY SCHOOL DISTRICT
Glen Cove, New York 11542
YOUR CHILD'S TEETH – IMPORTANT FACTS

Dear Parent:

More than 95 percent of all decay takes place or begins between the ages of 5 and 18 (the school years). Not all tooth decay has to happen though. Now, while they are young, children should be taught the need for developing good dental health habits, habits that will do much to guard against tooth decay – children's greatest dental problem. Some simple rules may help...they are easy to follow. They may help your child enjoy a lifetime of bright, perfect smiles and spare him or her from needless discomfort and pre-mature loss of teeth. Start your child off now on this program:

1. Visit your dentist regularly. By correcting little flaws before they become big problems, he will save your child from serious dental troubles in the future.
2. Eat a well-balanced diet of wholesome foods – lean meat, fish, poultry, cereals and dairy products. Fresh fruits and vegetables are good for dental health and also make tasty snacks.
3. Brush immediately after meals, if possible, because all decay begins within just minutes after eating. Brush in the direction the teeth grow – down on the upper teeth, up on the lower teeth. If brushing is not possible, rinsing the mouth with water will help.

Remember, no child can do his best work in school if he is bothered by dental problems. And nothing adds more to his or her pleasing appearance and happy personality than a healthy mouth and sparkling teeth. Thank you for your cooperation.

Superintendent of Schools

Please detach and return

ANNUAL DENTAL REPORT

NAME _____

HOME ROOM _____

INSPECTED ON _____

TREATMENT NOT NECESSARY _____

TREATMENT IN PROGRESS _____

TREATMENT COMPLETED ON _____

SIGNATURE OF DENTIST

IF NOT UNDER TREATMENT, PLEASE GIVE REASON

DATE

SIGNATURE OF PARENT

06/05

LANDLORD AFFIDAVIT

STATE OF NEW YORK)

)ss.

COUNTY OF _____)

Date: _____

To Whom it May Concern:

I, _____, certify that
(Name of Landlord)

_____ and
(Name of Parent/Guardian)

_____ reside at:
(Name of Children Seeking to Enroll)

(address)

(City, State, Zip)

Landlords Signature

Sworn to before me on this _____ day of _____, 20

Notary Public

THIRD PARTY AFFIDAVIT

STATE OF NEW YORK)

)ss.

COUNTY OF _____)

Date: _____

To Whom it May Concern:

I, _____, certify that
(Name of Third Party)

_____ and
(Name of Parent/Guardian)

_____ reside at:
(Name of Children Seeking to Enroll)

(address)

(City, State, Zip)

Third Party Signature

Sworn to before me on this _____ day of _____, 20

Notary Public

Community Eligibility Provision (CEP)/Provision 2 non-base year Household Income Eligibility Form

Glen Cove City School District elementary Schools is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and federal program benefits that your child(ren) may qualify for. Read the instructions on the back, complete **only one** form for your household, sign your name and return it to the school named above. Call the school if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade/Teacher	Foster Child	No Income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

2. SNAP/TANF/FDPIR Benefits:

If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE # here. Skip to Part 5, and sign the application.

Name: _____ CASE # _____

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions Amount / How Often	Child Support, Alimony Amount / How Often	Pensions, Retirement Payments Amount / How Often	Other Income, Social Security Amount / How Often	No Income
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>
	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	\$ ____ / ____	<input type="checkbox"/>

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is being reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I may be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE - FOR SCHOOL USE ONLY

Email Address:

Home Phone

Work Phone

Home Address

Annual Income Conversion (Only convert when multiple income frequencies are reported on application)

Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

Snap/TANF/Foster

Income Total Household Income/How Often:

Free Eligibility

Reduced Eligibility

Denied Eligibility

Household Size:

Signature of Reviewing Official

CE/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART 1

ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE THAN ONE FORM FOR YOUR HOUSEHOLD.

- (1) Print the names of the children, including foster children, for whom you are applying on one form.
- (2) List their grade and school.
- (3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.

PART 2

HOUSEHOLDS GETTING SNAP, TANF OR FDIPIR SHOULD COMPLETE PART 2 AND SIGN PART 4.

- (1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDIPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter.
- (2) An adult household member must sign the form in PART 4. **SKIP PART 3** - Do not list names of household members or income if you list a SNAP, TANF or FDIPIR number.

PARTS 3 & 4

ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4.

- (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space.
- (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. If the current income was more or less than usual, write that person's usual income. **Specify how often this income amount is received: weekly, every other week (bi-weekly), 2 x per month, monthly.** If no income, check the box. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should not be considered as income for this program.

PRIVACY ACT STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

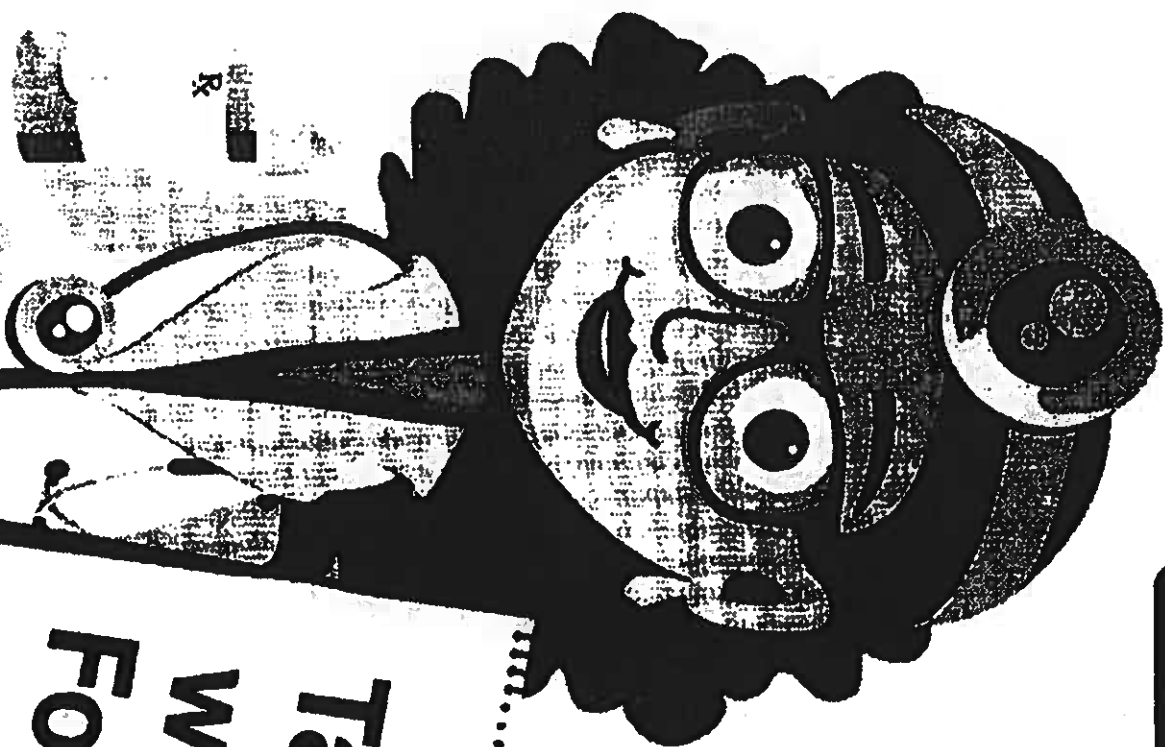
To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW Washington, D.C. 20250-9410;
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

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What is SNAP?

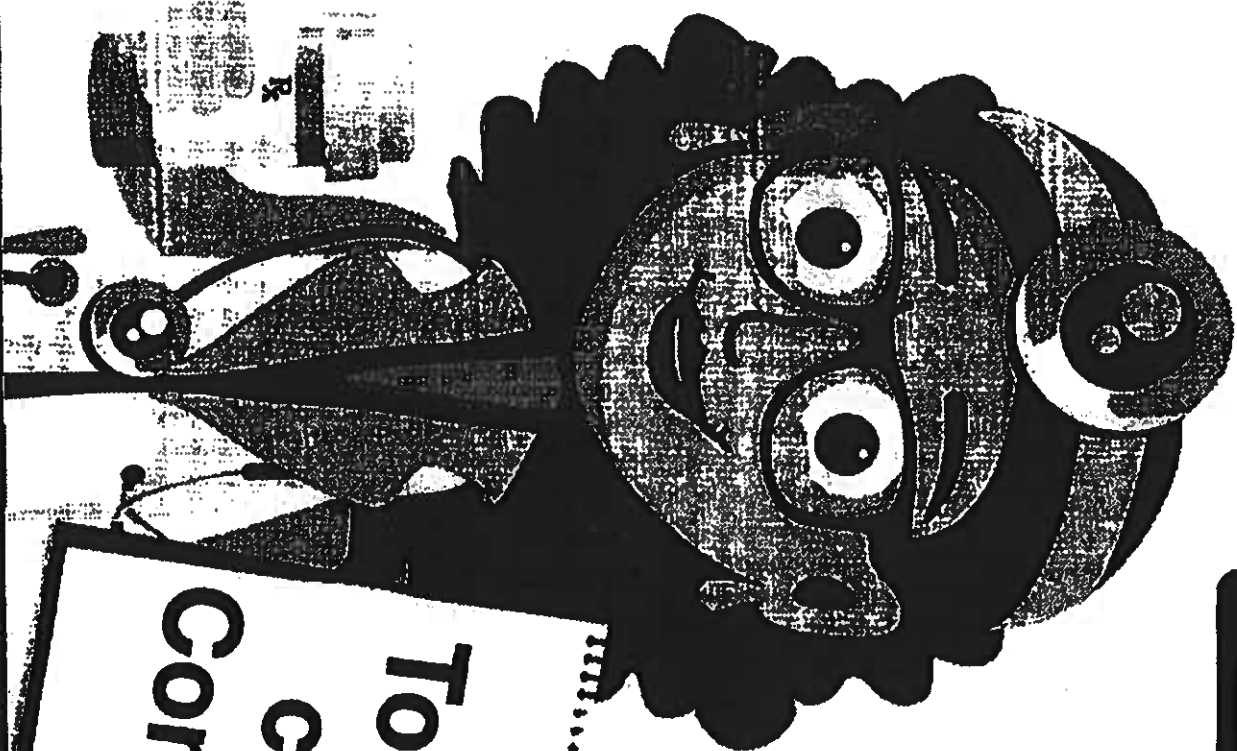
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snap@islandharvest.org**



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Comida**



¿Qué es SNAP?

Anteriormente conocido como estampillas de comida. Puedes obtener mas dinero para alimentos saludables que necesitas

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a conseguir mas
dinero para comida**

Llamalo ahora al

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