



7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-9892

Miller Place Union Free School District

REGISTRATION CHECKLIST

Welcome to the Miller Place Union Free School District!

A complete Registration Packet is required for all students. Re-enrolling and Pre-school students are required to follow the same instructions. Enclosed in this packet are the registration forms to be completed and signed by the parent or guardian enrolling the student(s). Along with the registration forms, supporting documentation is necessary to finalize enrollment. In order to avoid any delay in the registration process, please have all of the completed forms and documents ready and available at the time of your appointment. [Registration is by appointment only.](#)

Registration Forms and Supporting Documentation:

Registration Packet:

- Student Registration Form (RF-02)
- Residency Questionnaire (RF-12)
- Home Language Questionnaire (RF-03)
- Language Preference Form (RF-15)
- Health Information Form (RF-04)
- Health Examination Form (RF-04B) –*to be completed and signed by health professional*
- Dental Hygiene Form (RF-04C) –*to be completed and signed by health professional*
- Request for Records (RF-06)
- Transportation Form (RF-07)
- Student Information Form (RF-09)
- Family Information Supplemental Form (RF-05)
- Custodial Affidavit (*if applicable*)

Supporting Documentation-Required at the time of Registration

- Student's Birth Certificate with raised seal or other alternative official document
- Student's Immunization Records prepared by physician
- All applicable custodial agreements (*official copies*) **Required if parents are single, divorced, or separated**
- Proof of Residence **Three Items are required to prove residence**

One (1) of the following current items: Lease Deed Recent Mortgage Statement Landlord's Affidavit of Occupancy (<i>if applicable</i>) Other Affidavits or documents (<i>if applicable</i>)	Two (2) of the following current items: Electric Bill Gas Bill Water Bill Fuel Delivery Bill Cable Bill Landline Phone Bill Driver's License/Non-Driver ID Card Car Insurance/Car Registration Bank Statement (<i>first page only black out account number</i>) Other document(s) (<i>new residents are allotted 45 days to submit documents</i>)
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Student Name: _____

Student Registration Information: REQUIRED

The following registration forms are needed for each student:

- ☐ Student Registration Form (RF-02)
- ☐ Residency Questionnaire (RF-12)
- ☐ Home Language Questionnaire (RF-03)
- ☐ Language Preference Form (RF-15)
- ☐ Health Information Form (RF-04)
- ☐ Health Examination Form (RF-04B)
- ☐ Dental Hygiene Form (RF-04C)
- ☐ Request for Records (RF-06)
- ☐ Transportation Form (RF-07)
- ☐ Student Information Form (RF-09)
- ☐ Student's Birth Certificate with raised seal or other alternative official document
- ☐ Student's Immunization Records prepared by physician

Please provide the following information:

- ☐ Family Information Supplemental Form (RF-05)
- ☐ All applicable custodial agreements (official copies)
- ☐ Foster Children – DSS 2999 Form (if applicable)

Family Residency Information:

One (1) of the following current items:

- ☐ Lease
- ☐ Deed
- ☐ Recent Mortgage Statement
- ☐ Landlord's Affidavit of Occupancy (if applicable)
- ☐ Other Affidavits or documents (if applicable)

Two (2) of the following current items: (30 days from date of registration)

- ☐ Electric Bill
- ☐ Gas Bill
- ☐ Water Bill
- ☐ Fuel Delivery Bill
- ☐ Cable Bill
- ☐ Landline Phone Bill
- ☐ Drivers License/Non-Driver ID Card
- ☐ Car Insurance/Car Registration
- ☐ Bank Statement (first page only black out account number)
- ☐ Other document(s)



Miller Place Union Free School District

STUDENT REGISTRATION FORM

(Please Print All Information)

7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-0686

Registration Date: _____ Enrollment Date: _____ Grade Registering: _____ ID#: _____

Student Information					
Student's Legal Last Name		Student's Legal First Name		Middle Name	Suffix (Jr./III,IV)
Nickname	Gender (Circle) <i>Male or Female</i>	Date of Birth ____/____/____		Age	
Ethnicity Is the student Hispanic or Latino – (Circle One) <i>Yes or No</i>		Birth Country		Proof of Birth <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Alien Card <input type="checkbox"/> Passport <input type="checkbox"/> Other	
Race – (Check one or more that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White		Birth City	US Citizen(Circle) <i>Yes or No</i> (to be answered after enrollment)		
If not born in the United States, Date Entered (optional):		Birth State	Home Language		
Guardian Information					
Marital Status of Parents <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Official Custody Papers					
Father's Name		Employer	Work Phone #	Cell Phone #	
Father's E-mail Address					
Mother's Name		Employer	Work Phone #	Cell Phone #	
Mother's E-mail Address					
Household Information					
Family Surname		Home Phone Number	Homeless (Circle) <i>Yes or No</i>	Residency Verified	
Residence Street Address			Mailing Address (if different)		
Residence City, State, Zip Code			Mailing City, State, Zip Code (if different)		

Student Information			
Student's Legal Last Name		Student's Legal First Name	Middle Name
			Suffix (Jr./III,IV)
Household Information Continued			
OTHERS IN HOUSEHOLD	Name	Gender (Circle) <i>Male or Female</i>	Date of Birth ____/____/____
	Relationship		
	Name	Gender (Circle) <i>Male or Female</i>	Date of Birth ____/____/____
	Relationship		
	Name	Gender (Circle) <i>Male or Female</i>	Date of Birth ____/____/____
	Relationship		
Name	Gender (Circle) <i>Male or Female</i>	Date of Birth ____/____/____	Relationship
Name	Gender (Circle) <i>Male or Female</i>	Date of Birth ____/____/____	Relationship
Previous Educational Information (if applicable)			
Has the student attended a Miller Place UFSD school in the past?			<i>Yes or No</i>
School Transferred from:			Telephone #:
Previous School Address:			Principal:
Foster Care Information			
Is the student a Foster Child? (Form DSS-2999 must be provided)			<i>Yes or No</i>
Foster Agency:			Telephone #:
Foster Agency Address:			Case Worker:
Special Education Information			
Is the student receiving special education services? (Provide a copy of the most recent IEP).			<i>Yes or No</i>
<input type="checkbox"/> Speech <input type="checkbox"/> OT/PT <input type="checkbox"/> Resource Room <input type="checkbox"/> Self-Contained Classroom <input type="checkbox"/> 504 Accommodation Plan			
Special Education Service Provider or School District Providing Services:			Contact:
Emergency Contact Information			
Please list those who will be responsible in case of an emergency if the parents cannot be reached (the student will not be released to anyone not listed):			
Name	Phone Number	Cell Phone Number	Relationship
Name	Phone Number	Cell Phone Number	Relationship
Name	Phone Number	Cell Phone Number	Relationship

Signature of Parent/Guardian

Date



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:

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 ☐ Father

specify

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

☐ Does not speak

specify

6. What language(s) does your child read?

☐ English ☐ Other

☐ Does not read

specify

7. What language(s) does your child write?

☐ English ☐ Other

☐ Does not write

specify

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

<i>Educational History</i>	
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. <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 30%;"> Yes* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> </div> <div style="width: 65%;"> *If yes, please explain: _____ </div> </div>	
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. If referred for an evaluation , 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-around; font-size: small;"> MO. DAY YR. </div>	OUTCOME OF INDIVIDUAL INTERVIEW: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM </div> <div style="width: 50%;"></div> </div>
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <div style="display: flex; justify-content: space-around; font-size: small;"> MO. DAY YR. </div>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 70%;"> <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING </div> <div style="width: 30%; text-align: center;"> <input type="checkbox"/> COMMANDING </div> </div>
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO GSE RECOMMENDATION: _____ _____ _____	



Miller Place Union Free School District

LANGUAGE PREFERENCE FORM

(Please Print All Information)

7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-0686

Student Name:		ID #:	
Parent /Guardian Name:			

We would like to know your language preference when receiving important information from the school. Though it is quite difficult to provide translation and interpretation services in every language, your assistance in answering the questions below is greatly appreciated.

1. In what language would you like to receive written information from the school?

☐ English
☐ Arabic
☐ Bengali
☐ Chinese
☐ Haitian Creole
☐ Korean
☐ Portuguese
☐ Russian
☐ Spanish
☐ Urdu
☐ Other Language _____

2. In what language would you prefer to communicate orally with school staff?

☐ English
☐ Arabic
☐ Bengali
☐ Chinese
☐ Haitian Creole
☐ Korean
☐ Portuguese
☐ Russian
☐ Spanish
☐ Urdu
☐ Other Language _____

Signature of Parent/Guardian

Date



Miller Place Union Free School District

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Phone: (631) 474-2700
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STUDENT INFORMATION (Please Print All Information)

The information requested in this form will be used to determine if the Miller Place School District is eligible for supplemental funding for the education of immigrant students. An annual count must be submitted to the New York State Education Department (NYSED). You are not required to complete the information in this form. If you choose not to complete the form, the school district may not be eligible for supplemental funding for the education of immigrant students. The school district administrators and NYSED have access to this information.

Student Identification Information

Student's Last Name: _____ First Name: _____

Date of Birth: ____/____/____ Grade Level: ____

Please respond to the questions below by checking the appropriate box

1. Is your child between the ages of 3 to 21? ☐ Yes ☐ No
2. Was your child born outside the fifty United States? ☐ Yes ☐ No
3. Has your child attended public and non-public school(s)
in the United States for **less than** three full academic years? ☐ Yes ☐ No

Parent/Guardian Verification of Information

I hereby verify that the above information is true and correct to the best of my knowledge and belief.

Name (please print)

Signature of Parent/Guardian

Date



Miller Place Union Free School District

7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
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RESIDENCY QUESTIONNAIRE (Please Print All Information)

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ Grade: ____ ID#: ____
Month Day Year (preschool-12) (optional)

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check one box.)

- ☐ In permanent housing
- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____

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

Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)

Date



Miller Place Union Free School District

HEALTH INFORMATION FORM

(Please Print All Information)

7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-0686

Student Information

Student's Legal Last Name	Student's Legal First Name	Middle Name	Grade/School
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1. Allergies – Environmental	Yes or No
2. Allergies -- Food	Yes or No
3. Allergies -- Medicine	Yes or No
4. Asthma	Yes or No
5. Chicken pox	Yes or No
6. Contact with TB	Yes or No
7. Diabetes	Yes or No
8. Diphtheria	Yes or No
9. Ear Condition	Yes or No
10. Eye Glasses/Contact Lenses	Yes or No
11. Fractures	Yes or No
12. Frequent Colds	Yes or No
13. Frequent Headaches	Yes or No
14. Frequent Sore Throats	Yes or No
15. German Measles	Yes or No

16. Hearing Aid	Yes or No
17. Heart Disease	Yes or No
18. Measles	Yes or No
19. Mumps	Yes or No
20. Operations	Yes or No
21. Orthopedic Defect	Yes or No
22. Pneumonia	Yes or No
23. Rheumatic Fever	Yes or No
24. Scarlet Fever	Yes or No
25. Seizure Disorder	Yes or No
26. Serious Injuries	Yes or No
27. Speech Difficulties	Yes or No
28. Tuberculosis	Yes or No
29. Whooping Cough	Yes or No

If answered yes to any of the above, please provide necessary explanation and detail (such as dates).

Is your child receiving any medication on a continuing basis at the present time? Please be as specific as possible.	Yes or No
Any modification in activity requested by your doctor at the present time?	Yes or No
Family Physician:	Physician Phone #:
Family Dentist:	Dentist Phone #:

Signature of Parent/Guardian

Date

Miller Place Union Free School District Health Examination Form

**Miller Place
High School**

15 Memorial Drive
Miller Place, NY 11764
Health Office: 631-474-2481
Fax: 631-331-4093

**North Country Road
Middle School**

191 North Country Rd
Miller Place, NY 11764
Health Office: 631-474-7258
Fax: 631-474-0362

**Laddie A. Decker
Sound Beach School**

197 North Country Rd
Miller Place, NY 11764
Health Office: 631-474-2721
Fax: 631-331-4342

**Andrew Muller
Primary School**

65 Lower Rocky Point Road
Miller Place, NY 11764
Health Office: 631-474-2717
Fax: 631-474-4738

Dear Parents/Guardians,

New York State law requires a health examination for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th, and 11th grade.**

The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time. The school will provide you with a list of dentists and registered dental hygienists who offer dental services on a free or reduced cost basis if you ask for it.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school, and when your child starts K, 1st, 3rd, 5th, 7th, 9th, & 11th grades. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.

We suggest you make copies of the completed forms for your own records before sending them to the school health office.

Sincerely,
The Miller Place School Nurses

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

<input type="checkbox"/> Allergies	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Asthma	<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
<input type="checkbox"/> Seizures	Type: Date of last seizure: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Diabetes	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: 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: ☐ Yes ☐ Not Done

Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:	
Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$	
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>			

☐ System Review Within Normal Limits

☐ Abnormal Findings – List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine/Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations: Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:		Affirmed Name (if applicable):		DOB:	
SCREENINGS					
Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11					
Vision Screening	With Correction <input type="checkbox"/> Yes <input type="checkbox"/> No	Right	Left	Referral	Not Done
Distance Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Near Vision Acuity		20/	20/	<input type="checkbox"/> Yes	<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail					<input type="checkbox"/>
Notes					
Hearing Screening: 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"/>
Notes					
Scoliosis Screening: Boys grade 9, Girls grades 5 & 7		Negative	Positive	Referral	Not Done
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/>
FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK					
<input type="checkbox"/> *Family cardiac history reviewed – required for Dominick Murray Sudden Cardiac Arrest Prevention Act					
<input type="checkbox"/> Student may participate in all activities without restrictions.					
If Restrictions Apply – Complete the information below					
<input type="checkbox"/> Student is restricted from participation in:					
<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:					
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					
<input type="checkbox"/> Other Accommodations*: Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):					
<small>*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.</small>					
MEDICATIONS					
<input type="checkbox"/> Order Form for medication(s) needed at school attached					
COMMUNICABLE DISEASE			IMMUNIZATIONS		
<input type="checkbox"/> Confirmed free of communicable disease during exam			<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS		
HEALTHCARE PROVIDER					
Healthcare Provider Signature:					
Provider Name: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

2022-23 School Year

New York State Immunization Requirements for School Entrance/Attendance¹

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		

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**

2370

New York State Department of Health/Bureau of Immunization
health.ny.gov/immunization

4/22

MILLER PLACE UNION FREE SCHOOL DISTRICT

DENTAL HYGIENE FORM

Student Name: _____

School: _____ **Grade** _____

Dental care is an essential part of the total health program for your child. The school district urges you to have your child visit the dentist for an examination at a minimum of once yearly. Please have your family dentist check the appropriate box and return the form to the Health Office.

_____ Dental attention is being received.
Treatment to be completed on _____ (Date)

_____ Dental attention completed on _____ (Date)

_____ Under Orthodontic Treatment.

Special Notations:

Dentist Signature: _____

Date: _____



Miller Place Union Free School District

7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-0686

TRANSPORTATION FORM

(Please Print All Information)

Student Name:			Student ID #:	
School:		Grade:		
Parent/Guardian Name:		Phone Number:		
Street Address:	<hr/> <hr/>			
Home Schooled:	YES or NO <i>(please circle option)</i>			
For Office Use Only:				
Registration Date:		Start Date:		
Bus Stop Location:	Bus In to School (AM):	Bus Letter or Number	Approximate Time	
	Bus Home from School (PM):	Bus Letter or Number	Approximate Time	
Special Needs or Other Comments:	<p align="center">Minibus - Yes or No</p> <hr/>			

MILLER PLACE UNION FREE SCHOOL DISTRICT

Special Education Department

7 Memorial Drive

Miller Place, NY 11764-2036

Telephone (631) 474-2700 x799

Fax (631) 474-9890

Seth A. Lipshie
Superintendent

Sandra Wojnowski
Executive Director for Educational Services

Dear Parents/Guardians,

The District provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. Any parent or person in parental relation who suspects that his/her child has a disability may refer the child for an evaluation by the District's Committee on Special Education (CSE) for eligibility for special education services and programs. More detailed information on this process is available in "*A Parent's Guide to Special Education*", which is published on the New York State Education Department's website in English and Spanish:

<http://www.p12.nysed.gov/specialed/parentpubs.htm>.

Additional information can also be found on the Pupil Personnel Services/Special Education page through the District website:

<https://www.millerplace.k12.ny.us/Page/5593>.

Parents and persons in parental relation should contact Mrs. Wojnowski or Mr. Koch at the District's Office of Pupil Personnel Services if they suspect that his/her child has a disability.

Sandra Wojnowski
Executive Director for Educational Services
7 Memorial Drive
Miller Place, NY 11764
631-474-2700 x 799

Jeremy Koch
Administrator for Special Education
7 Memorial Drive
Miller Place, NY 11764
631-474-2700 x 799

SW



Miller Place Union Free School District

REQUEST FOR RECORDS

(Please Print All Information)

Date of Request: _____

Name of School: _____

Address of School: _____

To Whom It May Concern:

Name of Student: _____ **Grade:** _____ **Date of Birth:** _____

The above student, was formerly registered in your district, and is now registered at the Miller Place Union Free School District. Please forward the records requested to the school building indicated at the end of this letter:

Records Requested: Academic Records – transcript, report cards, science labs including latest grades

Achievement and Intelligence Scores, and SAT, ACT, AP scores if applicable

Attendance Records

Discipline Records

Learning Disability Testing

Psychological / Psychiatric Records

Health Records

Physicals

Immunizations

Social History

Any and all other information available including ALL Special Education records.

Thank you for your assistance with this request.

I, _____ hereby give permission for you to release the above listed records to the Miller Place Union Free School District.

Signature of Parent or Guardian: _____

Relationship: _____

Address: _____

Telephone: _____

Witness Signature: _____ **Witness Name:** _____

*****PLEASE SEND RECORDS TO THE SCHOOL ADDRESS INDICATED BELOW*****

☐ Andrew Muller Primary School
65 Lower Rocky Point Road
Miller Place, NY 11764
Phone: (631) 474-2715
Fax: (631) 474-4738

☐ Laddie A. Decker Sound Beach School
197 North Country Road
Miller Place, NY 11764
Phone: (631) 474-2719
Fax: (631) 474-2497

☐ Miller Place UFSD
Special Education Office
7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-9890

☐ North Country Road Middle School
191 North Country Road
Miller Place, NY 11764
Phone: (631) 474-2710
Fax: (631) 474-5178

☐ Miller Place High School
Attn: Guidance
15 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2723
Fax: (631) 474-2734



Miller Place Union Free School District

7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-0686

FAMILY INFORMATION SUPPLEMENTAL FORM (Please Print All Information)

☐ Not applicable (please sign below)

Parents have the responsibility of presenting an official copy of any legally binding instrument effecting custody or other parental rights, and, without one, the school will assume that both parents have equal access to school records and student information.

Student Information			
Student's Legal Last Name	Student's Legal First Name	Middle Name	Grade/School

Custodial Parent Information				
Last Name	First Name	Employer		
Street Address	City	State	Zip Code	
Home Phone #	Work Phone #	Cell Phone #		
E-mail Address			Receive Mailings? <i>Yes or No</i>	

Non-Custodial Parent Information				
Last Name	First Name	Employer		
Street Address	City	State	Zip Code	
Home Phone #	Work Phone #	Cell Phone #		
E-mail Address			Receive Mailings? <i>Yes or No</i>	

Step Parent Information (if applicable)				
Last Name	First Name	Employer		
Street Address	City	State	Zip Code	
Home Phone #	Work Phone #	Cell Phone #		
E-mail Address			Receive Mailings? <i>Yes or No</i>	

Legal Guardian (if other)				
Last Name	First Name	Employer		
Street Address	City	State	Zip Code	
Home Phone #	Work Phone #	Cell Phone #		
E-mail Address			Receive Mailings? <i>Yes or No</i>	

Signature of Parent/Guardian

Date

WHAT IF...

the youth is not living with a parent?
the parents are separated or divorced?



For more information:



To enroll in school:

You (the parent, guardian, or caregiver) have to show that the youth is living with you and that you have total and permanent custody and control. To do this, you can show the school district:

- proof of custody or guardianship
OR
- an affidavit (written statement signed under oath) 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.

There are different requirements for youth in temporary housing (this may include, for example, youth who have run away or been kicked out of their homes).

For more information about temporary housing and enrollment, call NYS-TEACHS at 800-388-2014.

Enrollment requirements:

NYS Education Department
Office of Student Support Services
(518) 486-6090

Enrollment of immigrant children and youth:

NYS Education Department
Office of Bilingual Education &
World Languages
(718) 722-2445

Enrollment of children and youth in temporary housing:

NYS Technical and Education Assistance
Center for Homeless Students
(NYS-TEACHS)
(800) 388-2014

NYS Education Department
State Coordinator for Homeless Education
(518) 473-0295

This pamphlet is a summary of the applicable regulatory provisions and is intended for informational purposes only. For further information on the applicable regulatory requirements, please consult an attorney or see 8 NYCRR section 100.2(x) and 100.2(y), as amended effective July 1, 2015,

August 2015

A GUIDE TO understanding THE NEW RULES FOR SCHOOL REGISTRATION



New York State
EDUCATION DEPARTMENT
Knowledge > Skill > Opportunity

To enroll in school, you have to show:

- that you live and intend to remain in the school district. This is called showing you are a “resident.”
- AND
- your child’s age.



Do you know how to show that you live in the district where you are enrolling your children?



Do you know how to prove your children’s ages?

Did you know:

- Your child must be enrolled within one day of your request.
- Children and youth can get a free public education, even if they are undocumented or are not citizens.
- Schools **cannot** ask you for your social security card or social security number at the time of or as a condition of enrollment.
- Schools **cannot** ask about immigration status at the time of or as a condition of enrollment (but after enrollment they may ask about which country your child was born in).
- There are many different ways to show residency. Schools must give you choices and **cannot** only ask for a lease or a deed.
- Your child can be enrolled in school even if you don’t have his or her birth certificate.
- Youth may enroll in school under certain circumstances even if they are not living with their parents.

Children and youth in temporary housing can enroll in school without the documents normally needed to enroll. Children and youth are temporarily housed or homeless if they lack a fixed, regular, and adequate nighttime residence which includes, for example:

- living in a shelter or,
- sharing the home of a relative or a friend because they lost their home or were evicted.

Ways you can show residency:

- Lease or deed
- Affidavit (a written statement signed under oath) from the person you pay rent to, 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
- Other documentation, such as:
 - 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 issued ID
 - Documents from government agencies such as a social service agency or the federal Office of Refugee Resettlement
 - Custody or guardianship papers

If the school district decides your child can’t go to school in the district because he or she is not a resident, the district must give you a letter within two business days explaining its decision and how to appeal the decision.

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

CUSTODIAL AFFIDAVIT*

7. Statement establishing who provides the child with food, clothing, and all other necessities.

8. Custodial statement assuming full responsibility for all matters relating to the child's education and medical care.

9. Statement of any other relevant facts. _____

Notary:

Signature of Custodian

Sworn to me this _____ day of _____.

Notary Public

* Where applicable, this affidavit must be executed individually by each custodian.



7 Memorial Drive
Miller Place, NY 11764
Phone: (631) 474-2700
Fax: (631) 474-0686

Miller Place Union Free School District

LANDLORD'S AFFIDAVIT OF OCCUPANCY

(In lieu of Deed, Rental Agreement, or Lease)

State of New York)

)ss:

County of Suffolk)

I, _____ being duly sworn depose and say:
Full Legal Name – Please Type or Print Legibly

That I am the landlord for:

Full Address – Please Type or Print Legibly

and that said premises are being occupied by _____,
Full Legal Name of Parent/Guardian/Occupant– Please Type or Print Legibly

the parent, and _____, the children of
Full Legal Name(s) of School-Age Children Residing At Premises Listed Above

said parent. To my knowledge, the above parties occupy the premises as their actual, only, and legal residence address.

Further, I understand that this affidavit is a public record, that knowingly falsifying same is offering a false instrument for filing, and that such an act is punishable under the Criminal Laws governing fraud. I understand and agree that if false information is knowingly filed, and the school district is unable to recover tuition and collection costs for the children granted admission on the basis of this affidavit, said filing shall be grounds for a civil action against me for any moneys due to the school district.

Further, I swear that I have supplied the information in this affidavit, that to my knowledge the same is complete, accurate, and true, and that I have read and understood the pre-printed provisions of this affidavit.

Signature of Deponent*

Title if Real Estate Agency or Corporation – Please Type or Print Legibly

Street Address

State

Zip Code

Notary:

Sworn to before me this _____ day of _____, 20____. _____
Notary Public

* Signature to be witnessed by a Notary Public if Landlord occupies the same premises and is not an employee or official of a realty company or corporation. Signature of individual property owners not occupying the premises may be witnessed by other than a Notary Public. Company or corporation official's signature over title and company name need not be witnessed.