

Check One
() Original
() Amendment
() Rescind

SUFFOLK COUNTY DEPT. OF HEALTH SERVICES
D.S.C.S.N. – 50 LASER COURT
HAUPPAUGE, NY 11788-3620

Check One
() summer
() fall
() Summer/Fall

School Year _____
C.P.S.E. Meeting Date: _____

PRESCHOOL ENROLLMENT FORM

Child's Legal Name: Last _____ First _____ M.I. ___ M ___ F ___ DOB _____
Legal Address _____ Town _____ Zip Code _____
School District _____ Race/Ethnic _____
Parent/Guardian _____ Home # _____ Business # _____ Cell# _____
Or Foster Parent _____
PARENT/GUARDIAN NAME
_____ Home # _____ Business # _____ Cell # _____
PARTNER/SPOUSE NAME

SEIT AND/OR RELATED SERVICE
SUMMMER SERVICES _____ FALL SERVICES _____
Summer Start Date _____ End Date _____ Fall Start date _____ End Date _____

SUMMER	FALL
CENTER BASED PROVIDER _____	CENTER BASED PROVIDER _____
SUMMER LOCATION _____	FALL LOCATION _____
SUMMER START _____ END DATE _____	FALL START _____ END DATE _____
M T W TH F (circle) R.C. _____ OPTION # _____	M T W TH F (circle) R.C. _____ OPTION # _____
SESSION TIMES: From _____ to _____	SESSION TIMES: From _____ to _____

*In accordance with The State Education Department, Office of Vocational and Educational Services for Individuals with Disabilities, Regulations of the Commissioner of Education, Pursuant to § 207, §3214, §4403, § 4404, §4410 of the Education Law, PART 200 Students with Disabilities § 200.16 (e) (5): In developing its recommendation for a preschool student with disability, to receive programs and services, the committee must identify transportation options for the student and **encourage parents to transport their child** at public expense where cost effective.*

Check One

- I choose to transport my child at my own expense and do not want Parental Mileage Reimbursement or bus transportation. **(Sign Below)**

- I choose to transport my child to and from school and choose to accept Parental Mileage Reimbursement (PMR).
I _____ the parent/guardian/foster parent
*Of the above named child, request reimbursement for my mileage in the transportation of my child to and from services provided pursuant to section 4410 of the New York State Education Law. A **VENDOR CONTROL NUMBER WILL BE CREATED BY THE COUNTY IN ORDER FOR ALL REIMBURSEMENT CLAIMS TO BE PAID TO AUTHORIZED PARENT/GUARDIAN** .In consideration for such reimbursement for said transportation, I hereby indemnify and hold harmless the County of Suffolk, its employees, agents and designated representatives, from and against all claims, cost, and judgments, liens, encumbrances and expenses, including attorneys' fees, arising out of my acts, omissions or negligence in connection with the services described in this statement. I must immediately initiate a new parent transportation statement when a change of any one of the following occurs: legal residence, provider agency, provider site or annual review*

- The Suffolk County Department of Health Preschool Special Education Program requires the attestation of the parent **FOR A DETAILED EXPLANATION** to explain why there is no responsible adult to drive their child to school. *(Explanation)*

_____. **(Sign below, Fill out page 2)**

I will notify the school district in writing prior to changing my address. If the address change results in my child becoming a resident of a different school district and/or municipality, I will also register my child with the new school district and notify the new school district's CPSE Chair in writing prior to this change taking effect.

Parent/Legal Guardian Name _____ Signature: _____
(Circle one) (Print):

CPSE Chair Name: _____ CPSE Chair Signature: _____ Date: _____

TRANSPORTATION COORDINATOR SIGNATURE DATE

Check One
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[] Amendment
[] Rescind

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Check One
[] summer
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PRESCHOOL BUS TRANSPORTATION
AUTHORIZATION FORM

SCHOOL YEAR: _____ CPSE DATE: ____/____/____

Section Id

Child's Legal Last Name _____ First _____ M.I. _____ M _____ F _____ DOB _____
Legal Address _____ Town _____ Zip Code _____
School District _____ Race/Ethnic _____
Parent/Guardian _____ Home Phone: (631) _____ Business # _____ Cell # _____
Or Foster Parent _____ Parents Name _____
_____ Home Phone: (631) _____ Business # _____ Cell # _____
Partner/Spouse Name _____

Section II

Summer Provider _____ Fall Provider _____
Location _____ Session Times _____ Location _____ Session Times _____
Start date _____ End Date _____ Start Date _____ End Date _____
PICK UP: [] Legal Address M T W TH F DROP OFF: [] Legal Address M T W TH F
[] Other Address M T W TH F [] Other Address M T W TH F
Circle Days Circle Days
[] PARENTS WILL TRANSPORT UNTIL BUSING BEGINS

PARENTS / GUARDIANS ACKNOWLEDGE CHILD MAY BE ON THE BUS FOR UP TO 90 MINUTES EACH WAY, INITIAL HERE (_____)

Table with 2 columns: PICK UP - IF OTHER THAN LEGAL ADDRESS and DROP OFF - IF OTHER THAN LEGAL ADDRESS. Fields include NAME, ADDRESS, CITY, PHONE (631) _____ - _____ CELL _____.

Section III

Table with 2 columns: SPECIAL NEEDS AUTHORIZED IN IEP and PERSONS AUTHORIZED TO RECEIVE CHILD: (MUST SHOW ID). Fields include Car Seat Type, Child's Weight, Wheelchair Type, Air Cond., Medical Needs or Other Concerns, NAME, RELATIONSHIP.

* ALL MOBILITY DEVICES MUST BE APPROVED BEFORE TRANSPORTATION CAN BEGIN

Section IV

LOCAL EMERGENCY DROP OFF (Must list two in Suffolk County, in close proximity of school to home)

Table with 2 columns: EMERGENCY DROP OFF #1 and EMERGENCY DROP OFF #2. Fields include NAME, RELATIONSHIP, ADDRESS, CITY, PHONE (631) _____ - _____ CELL _____.

Review all information before signing

SIGNATURE OF SCHOOL DISTRICT REPRESENTATIVE _____ DATE ____/____/____

PARENT/GUARDIAN/SURROGATE SIGNATURE _____ DATE ____/____/____

*EACH SUFFOLK COUNTY PRESCHOOL VEHICLE HAS A DRIVER ASSISTANT