The Hyde Park Central School District empowers our community to strive for excellence and embrace the opportunities of our globally connected world.

Hyde Park Central School District · Administration Offices · PO Box 2033, Hyde Park, NY 12538

Phone: (845)229-4000 · Fax: (845) 229-4056 · www.hpcsd.org

Dr. Pedro Roman
Superintendent of Schools

Dr. Gregory S. Brown
Deputy Superintendent

Melissa Lawson
Asst. Superintendent for Pupil Services

Linda Steinberg
Asst. Superintendent for Finance & Operations

Dear Families,

Children that live in the Hyde Park Central School District's attendance zone (https://www.hpcsd.org/domain/14) and are 4 years old by December 1, 2024 may apply for enrollment in the Universal Pre-Kindergarten program starting in September, 2024. There is no cost for this full day program. Registration for Hyde Park UPK will begin on February 12, 2024.

The program is offered at two locations -

- Hyde Park Elementary School Building
- Holy Trinity Annex (formerly St. Peters' School)

Please be aware that there are a limited number of spaces available for this program. If the enrollments exceed the 147 available seats, a randomized lottery will take place on May 3, 2024. Acceptance letters will be mailed on or around May 16, 2024 to all selected families. After May 3, 2024, a wait-list will be created and seats will then be filled on a first come, first served basis.

The next page of this packet has a list of forms to be filled out and documents that need to be provided in order to complete the application process.

Appointments are required to submit your application.

Please call the Student Registration Department at (845)229-4000 ext. 1606 or ext. 1607 to make your appointment. You may also schedule your appointment online at https://calendar.app.google/yToTPdsDnWxMpcAA7 or visit our website at www.hpcsd.org.

Sincerely,

Melissa Lawson

Melissa Lawson
Assistant Superintendent for Pupil Services

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HYDE PARK CENTRAL SCHOOL DISTRICT
STUDENT REGISTRATION

11 Boice Road, P.O. Box 2033, Hyde Park, NY 12538
Telephone (845)229-4000 Ext. 1606 Fax (845)229-4056
Email: hpcsdregistrar@hpcsd.org

REGISTRATION CHECKLIST for UPK APPLICATION

Student's Name: _____ Registration Date: ____/____/____

Name of Person Registering Student: _____

Relationship to Student: _____ Phone #: _____

DOCUMENTS TO BE PROVIDED BY PARENT/GUARDIAN TO COMPLETE REGISTRATION:	STAFF INITIALS
PROOF OF RESIDENCY: ***Homeowner:*** The most recent school or property tax bill ***AND*** one current, recurring bill with your name & address for services you receive at this address (ie. electric, cable, telephone bill, etc.) ***Renting in an apartment complex:*** Your current signed lease ***AND*** one current, recurring bill with your name & address for services you receive at this address (ie. electric, cable, telephone bill, etc.) ***Renting from a private owner:*** Your current lease ***AND*** the owner's school or property tax bill ***AND*** one current, recurring bill with your name & address for services you receive at this address (ie. electric, cable, telephone bill, etc.) If you do not have a formal lease, your landlord will need to complete the attached Residency Affidavit. This affidavit **must** be notarized. If the utilities are included in your lease, you will need to provide an additional form of proof of residency.	
Proof of Birth: Original Birth Certificate ***OR*** Passport ***OR*** New York State ID Card	
Photo ID of Parent/Guardian registering student, which may include: Driver's License ***OR*** Passport (must be current) ***OR*** NY State Identification Card	
Proof of Immunizations	
Physical Exam Report (must be within 1 year of start date in school)	
Current IEP or 504 Plan, if applicable - please provide a copy when you register	
DS2999 form (foster care children), if applicable	
Court Documents: such as Custody Order, Order of Protection, Guardianship, etc., if applicable	
STAC 202 - if applicable	

ATTACHED FORMS TO BE COMPLETED:	
Registration Form	
Enrollment/Residency Questionnaire	
FERPA	
Home Language Questionnaire (HLQ)	
Emergency Contact Information Form	
Food Service Form	
Residency Affidavit - ONLY if needed for proof of residency	
Medicaid Form - complete ONLY if your child receives Special Education Services	
Transportation Form	
Kindergarten - Health Form ☐ HMS - Music/Language Form ☐ FDR - Health Form ☐ Athletic Form ☐	

FOR OFFICE USE ONLY

Home School: ☐ NES ☐ NPE ☐ RRS ☐ VAS ☐ HMS ☐ FDR Attending School: ☐ NES ☐ NPE ☐ RRS ☐ VAS ☐ HMS ☐ FDR ☐ HPE ☐ HTA

Reason not attending home school: ☐ ENL ☐ Special Ed ☐ At capacity ☐ Other: _____

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PUPIL REGISTRATION FORM

PLEASE PRINT ALL INFORMATION

THIS BOX IS FOR DISTRICT STAFF ONLY

Child's Name: _____
Last First MI

Child's Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Household Phone # _____ ☐Home ☐Cell

Sex: ☐F ☐M | **Grade:** _____ | **Date of Birth:** ____/____/____

City of Birth: _____ | **State of Birth:** _____

REGISTRATION TYPE:
☐New Enrollee ☐Re-Enrollee
☐Change of Address ☐Change of Guardian
☐CPSE Eval ☐CPSE Transfer ☐CSE Eval

Pupil ID#: _____

Home School: _____

Attending School: _____

Registration Date: _____/_____/_____

How many years has the child attended school in the US? _____ outside the US? _____

Has your child ever been enrolled in HPCSD? ☐No ☐Yes

ETHNIC ORIGIN: ☐YES, Hispanic ☐NO, not Hispanic

RACE (NYS Required, please check all that apply):
☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Black ☐White

CHILD'S LEGAL GUARDIAN: ☐Mother ☐Father ☐Foster Parent ☐Other: _____

CHILD LIVES WITH: ☐Mother ☐Father ☐Foster Parent ☐Other: _____

Is there a custody order for the child? ☐Yes ☐No Is there an Order of Protection? ☐Yes ☐No

Parent/Guardian #1

*This will be the **FIRST** parent/guardian contacted*

Name: _____ Relationship to Student: _____

Email: _____ Residential Address: _____

Mailing Address: _____

Phone Contact #1 for Guardian #1: _____ ☐Home ☐Cell ☐Work

Phone Contact #2 for Guardian #1: _____ ☐Home ☐Cell ☐Work

Phone Contact #3 for Guardian #1: _____ ☐Home ☐Cell ☐Work

Does parent/guardian need accommodations for hearing impairment? ☐Yes ☐No Type: _____

Is this parent/guardian in Active Military Service: ☐Yes ☐No Entry date: ___/___/___ Exit date: ___/___/___

Parent/Guardian #2

*This will be the **SECOND** parent/guardian contacted*

Name: _____ Relationship to Student: _____

Email: _____ Residential Address: _____

Mailing Address: _____

Phone Contact #1 for Guardian #2: _____ ☐Home ☐Cell ☐Work

Phone Contact #2 for Guardian #2: _____ ☐Home ☐Cell ☐Work

Phone Contact #3 for Guardian #2: _____ ☐Home ☐Cell ☐Work

Does parent/guardian need accommodations for hearing impairment? ☐Yes ☐No Type: _____

Is this parent/guardian in Active Military Service: ☐Yes ☐No Entry date: ___/___/___ Exit date: ___/___/___

PUPIL REGISTRATION FORM (Page 2)

If your child received Special Education services prior to enrolling in this district, complete the following:

Name of School District Attended: _____ Phone #: _____

Services were provided by: _____

CHECK ALL SUPPORTS SERVICES THAT YOUR CHILD CURRENTLY RECEIVES
☐ READING ☐ MATH ☐ SPEECH ☐ OCCUPATIONAL THERAPY ☐ PHYSICAL THERAPY ☐ COUNSELING
☐ SPECIAL EDUCATION PROGRAM ☐ ENGLISH AS A NEW LANGUAGE

CENSUS INFORMATION

THE FOLLOWING INFORMATION IS NECESSARY TO KEEP THE SCHOOL CENSUS UP TO DATE.
PLEASE INCLUDE **ALL** CHILDREN FROM BIRTH TO 18 YEARS OLD, INCLUDING REGISTRANT.

Name Of Child	Place of Birth	Date of Birth	Grade	School
		___/___/___		
		___/___/___		
		___/___/___		
		___/___/___		
		___/___/___		

I understand the requirements for enrollment and request that my child(ren) be admitted to schools in the Hyde Park Central School District. This is my actual and only permanent address.

I am the legal guardian of the above listed child(ren). This/these child(ren) reside with me at this address.

I certify that the information provided on this form is true and correct and that the statements made herein are being made under penalty of perjury, knowing that the Hyde Park CSD will rely upon them in determining whether the above child(ren) will be admitted to its schools.

I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the district may commence legal proceedings against me to collect the annual tuition rate, determined by the New York State Education Department, retroactive to the first date of admission for each child, and may seek criminal action against me for filing a false document.

I understand that the district reserves the right to investigate any student's residency by any legal means available, including but not limited to, public records, site visits and any other lawful methods of investigation.

I understand that any false statements made herein are punishable as a Class A misdemeanor pursuant to Section 210.45 of the penal law of the State of New York and may be referred to the office of the District Attorney.

_____ _____/_____/_____

Parent/Guardian Signature **Date**

Hyde Park Central School District
P.O. Box 2033
Hyde Park, NY 12538
Phone: (845)229-4000

ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE

Name of LEA: **HYDE PARK CENTRAL SCHOOL DISTRICT**

Student's Last Name: _____ First Name: _____ M.I.: ___

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ Current Grade: _____
Month Day Year (preschool - 12)

Address: _____ Phone: _____

City: _____ Zip Code: _____

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? (Check ***one*** box)

☐ 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): _____
☐ In permanent housing

_____ _____ ____/____/____
Print name of Parent/Guardian OR Student if unaccompanied homeless youth ***Signature of Parent/Guardian OR Student if unaccompanied homeless youth*** ***Date***

FOR OFFICE USE ONLY

☐ New to District ☐ Re-entry ☐ New Address ☐ Change of Guardian

School (check one): ☐ FDR ☐ HMS ☐ NES ☐ NPE ☐ RRS ☐ VAS ☐ CPSE ☐ UPK ☐ Homeschooled
☐ Private/Parochial School: _____

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FERPA RELEASE OF INFORMATION

The purpose of the Family Educational Rights and Privacy Act (FERPA) is to protect the privacy of information concerning individual students by placing certain restrictions on the disclosure of "non-directory information" contained in a student's educational records. I understand that I have the right not to consent to the release of my educational records and I have the right to receive a copy of such records upon request.

Name of Student:_____ DOB:_____/_____/_____

(Please Print)

I, the undersigned, hereby authorize the Hyde Park Central School District ("District") to request the following:

	Education Records		Health Records		IEP (please fax & transfer on IEP Direct)
	Psych. Evals. & Related Service Reports (any additional evals)		Transcript, Last Report Card & Exit Grades		Discipline Records
	Science Labs		Other:		

From the following Person and/or Agency:

NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

I understand that this authorization will remain in effect from today until I send a written request to the District to revoke the authorization. I also understand that revoking the authorization shall not affect disclosures previously made by the District prior to the receipt of any such authorization.

Signature of Parent/Guardian and/or Eligible Student: _____ Date: ___/___/___

FOR OFFICE USE ONLY:

	Netherwood Elem. - Ph 845-229-4055 - Fax 845-229-2797		North Park Elem. - Ph 845-229-4040 - Fax 845-229-5655
	Ralph R. Smith Elem. - Ph 845-229-4060 - Fax 845-229-2828		Violet Avenue Elem - Ph 845-486-4499 - Fax 845-486-7796
	Haviland Middle School - Ph 845-229-4030 - Fax 845-229-4038		Special Ed. Dept. - Ph 845-229-4050 - Fax 845-229-2933
	FDR High School Guidance Dept. - Fax 845-229-2181 - Email: Jillfuller@hpcsd.org		

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HYDE PARK CENTRAL SCHOOL DISTRICT

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 print clearly when completing this section

STUDENT NAME: _____ _____ _____
First Middle Last

DATE OF BIRTH: _____/_____/_____ GENDER: ____ Male ____ Female

PARENT/GUARDIAN INFO: *RELATIONSHIP TO STUDENT:* _____

LAST NAME: _____ FIRST: _____

HOME LANGUAGE CODE: _____

LANGUAGE BACKGROUND:			
1. What language(s) is (are) spoken in the student's home or residence?	0 English	0 Other _____ *specify*	
2. What was the first language your child learned?	0 English	0 Other _____ *specify*	
3. What is the home language of each parent/guardian?	0 Mother _____ *specify* 0 Father _____ *specify* 0 Guardian(s) _____ *specify*		
4. What language(s) does your child understand?	0 English	0 Other _____ *specify*	
5. What language(s) does your child speak?	0 English	0 Other _____ *specify*	0 Does not speak
6. What language(s) does your child read?	0 English	0 Other _____ *specify*	0 Does not read
7. What language(s) does your child write?	0 English	0 Other _____ *specify*	0 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:
HydePark Central School District, PO Box 2033, Hyde Park, NY 12538 District Name (Number) & School Address	

HOME LANGUAGE QUESTIONNAIRE (HLQ) - PAGE 2

EDUCATION 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 their ability to understand, speak, read or write in English or any other language? If yes, please describe them.

O Yes O No O Not sure If Yes, please explain: _____

How severe do you think these difficulties are? O Minor O Somewhat severe O Severe

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

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

Age at which services were received (please check all that apply)
O Birth to 3 years (Early Intervention) O 3 to 5 years (Special Education) O 6 years or older (Special Education)

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

11. Is there anything else you think is important for the school to know about your child? (e.g. special talents, health conditions, etc.)
_____

12. In what language would you like to receive information from the school?
O English O Spanish O Other (Please specify) _____

_____ **Date:** ___/___/___

Signature of Parent or Guardian

Relationship to Student: O Mother O Father O Other - please specify _____

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 CONDUCTION INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

Oral Interview Necessary O No O Yes

Date of Individual Interview: _____/_____/_____
Outcome of Individual Interview: O Administer NYSITELL O English Proficient O Refer to Language Proficiency Team

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: ___/___/___	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: O Entering O Emerging O Transitioning O Expanding O Commanding

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

EMERGENCY CONTACT INFORMATION

STUDENT'S NAME: _____ D.O.B.: ____/____/____

ADDRESS: _____

School: _____ Teacher: _____ Grade: _____ Bus Rte: _____ (issued by Transportation)

PARENT/GUARDIAN INFORMATION:

Student Resides With (Check all that apply): ◯ Mother ◯ Father ◯ Other: _____

Parent/Guardian #1 (FIRST parent/guardian to be contacted)

Name: _____ Relationship to Student: _____

Address: _____

Phone # to be called 1st: _____ ◯ Home ◯ Work ◯ Cell

Phone # to be called 2nd: _____ ◯ Home ◯ Work ◯ Cell

Phone # to be called 3rd: _____ ◯ Home ◯ Work ◯ Cell

E-Mail: _____ ◯ Home ◯ Work

Parent/Guardian #2 (SECOND parent/guardian to be contacted)

Name: _____ Relationship to Student: _____

Address: _____

Phone # to be called 1st: _____ ◯ Home ◯ Work ◯ Cell

Phone # to be called 2nd: _____ ◯ Home ◯ Work ◯ Cell

Phone # to be called 3rd: _____ ◯ Home ◯ Work ◯ Cell

E-Mail: _____ ◯ Home ◯ Work

PERSONS TO CALL IF PARENT/GUARDIAN IS NOT AVAILABLE:

1. **NAME:** _____ Relationship to Student: _____

   Is this person permitted to pick student up from school? ◯ Yes ◯ No

   CELL PH. #: _____ OTHER PH. #: _____ ◯ HM ◯ WK

2. **NAME:** _____ Relationship to Student: _____

   Is this person permitted to pick student up from school? ◯ Yes ◯ No

   CELL PH. #: _____ OTHER PH. #: _____ ◯ HM ◯ WK

EMERGENCY CONTACT INFORMATION - Page 2

MEDICAL INFORMATION:

Physician's Name: _____ Phone: _____

Hospital Preference: _____

Any Special Health Issues (i.e., allergies, etc.)? ◯ Yes ◯ No

If Yes, please explain: _____

List current medications:

1. _____
2. _____
3. _____
4. _____

EMERGENCY DISMISSAL:

In the event of an emergency dismissal during the school day, where should your child be transported?

◯ HOME ◯ ALTERNATE LOCATION - *NOTE: The alternate location **must** be within your school's attendance zone.*

ALTERNATE LOCATION INFORMATION:

Name: _____ Phone: _____

Address: _____

PRINT PARENT/GUARDIAN NAME: _____

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**

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School Meal Price Benefit History

Student Name: _____

Previous District: _____

Previous School: _____

Were you receiving meal price benefits? (Please mark one option)

- ☐ **YES, FREE MEALS** (You did not pay for any school meals)
- ☐ **YES, REDUCED PRICED MEALS** (You paid $0.25 for all school meals)
- ☐ **NO, FULL PRICED MEALS** (You paid the full price for all meals)
- ☐ **DOES NOT APPLY**

THIS INFORMATION IS NECESSARY TO HELP THE FOOD SERVICE DEPARTMENT ESTABLISH A 30 DAY GRACE PERIOD OF CONTINUED BENEFITS THAT YOU RECEIVED IN YOUR PREVIOUS SCHOOL.

DURING THESE 30 DAYS YOU WILL CONTINUE TO RECEIVE YOUR EXISTING BENEFITS WHILE WE CONFIRM IF YOUR BENEFITS CAN BE RECERTIFIED FOR THE ENTIRE SCHOOL YEAR.

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RESIDENCY AFFIDAVIT

Note: This affidavit is to be completed by the home owner or leaseholder when a person is renting an apartment or room(s) within a privately owned home or apartment, including their own home, or is sharing a house or apartment with another family where there is no formal lease.

Please PRINT all information:

My name is _____, and I am the legal owner or leaseholder of this address: _____.

Please attach a copy of your school or property tax bill, deed, mortgage statement or lease.

What part of your home do these tenants occupy? (Example: basement apt., 1st floor, apartment #, number of rooms in the home, etc.): _____

The terms and conditions of tenancy are as follows:

Lease start date: ____/____/____ Lease End date: ____/____/____ **OR,** Month to month start date:____/____/____ **OR,** Temporarily residing in my home/apartment due to loss of housing as of ____/____/____.

I understand the requirements for enrollment and request that the following child/children be admitted to the schools of the Hyde Park Central School District as a district resident:

_____ _____

_____ _____

To the best of my knowledge, the above mentioned property is the current and only legal residence of _____(Name of Parent/Guardian) and the child(ren)/ward(s) named above.

The following is a list of the names of **ALL** persons residing at this address:

_____ _____
_____ _____
_____ _____

I certify that the information provided on this form is true and correct and that the statements made herein are being made under penalty of perjury, knowing that the Hyde Park Central School District will rely upon them in determining whether the above named child/children will be admitted to its schools. I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the district may commence legal proceedings against me to collect the annual tuition rate retroactive to the first day of admission for such child/children and/or seek criminal action against me for filing a false document.

The most recent annual tuition rates, as determined by the New York State Department of Education are as follows: ***(please note these rates are estimated and adjusted annually)***

Grades K-6 = $11,350 ***Grades 7-12 = $14,261***

NOTE: The following statement, signature requirement and notarization requirement apply to all sections of this form, and must be met for application to be accepted.

As the property owner/andlordeaseholder, I certify that I will notify the Hyde Park Central School District Central Registration Office, PO Box 2033, Hyde Park, NY 12538, within 30 days of termination of this living arrangement.

_____ ____/____/____

Signature of Property Owner/Landlord/Leaseholder **Date**

_____

_____

Print Owner/Landlord/Leaseholder Name **Owner/Landlord/ Leaseholder Phone Number**

Owner/Landlord/Leaseholder Address: _____

_____

E-Mail: _____

Sworn to before me this

_____

Day of

_____,

20___

Notary Public

Hyde Park Central School District
Committee on Special Education
P.O. Box 2033
Hyde Park, NY 12538
(845)229-4050 x 1611

Medicaid Consent

Dear Parent/Guardian:

Child's Date of Birth: _____
Client Identification Number (CIN): _____

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's individualized education program (IEP) and to ask you to give us your child's Client Identification Number (CIN) or allow us to obtain the CIN if you do not know it.

This consent allows the school district/county to bill Medicaid for covered health-related services and to release information to the school district's/county's Medicaid Billing Agent for that purpose.

I, _____ as the parent/guardian of _____, have received a written notification from the school district/county that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the school district/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child.

I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district/county must give me annual written notification of my rights regarding this consent.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records will be shared:

Records to be shared (e.g. records or information about services your child receives, student demographic information):	
IEP	Medication Administration Report
Written Order/Referral	Special Transportation Log
Evaluation Reports	Other Personally Identifiable Information
Session Notes	Any Other Specific Records Pertaining to the Student's Services or Program

Student's CIN, if known: _____

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

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HYDE PARK CENTRAL SCHOOL DISTRICT

UNIVERSAL PRE-KINDERGARTEN TRANSPORTATION FORM

CHILDS LAST NAME:_____ FIRST NAME:_____

DATE OF BIRTH:___/___/___ GRADE: UNIVERSAL PRE-KINDERGARTEN

HOME ADDRESS:_____

PARENT NAME:_____ CELL PHONE #:_____ HOME #:_____

PARENT NAME:_____ CELL PHONE #:_____ HOME #:_____

SCHOOL ATTENDING:_____ SCHOOL YEAR_____

DOES YOUR CHILD REQUIRE TRANSPORTATION TO & FROM SCHOOL? ☐ YES ☐ NO

MY CHILD WILL BE PICKED UP AT: _____HOME _____DAYCARE _____ALTERNATE LOCATION

IF YOUR CHILD IS BEING PICKED UP AT A LOCATION OTHER THAN HOME, COMPLETE BELOW:

NAME OF ADULT AT OTHER LOCATION:_____

PHONE NUMBER:_____

ADDRESS:_____

CIRCLE DAYS TO BE PICKED UP AT THIS LOCATION:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY AS NEEDED

MY CHILD WILL BE DROPPED OFF AT: _____HOME _____DAYCARE _____ALTERNATE LOCATION

IF YOUR CHILD IS BEING DROPPED OFF AT A LOCATION OTHER THAN HOME, COMPLETE BELOW:

NAME OF ADULT AT OTHER LOCATION:_____

PHONE NUMBER:_____

ADDRESS:_____

CIRCLE DAYS TO BE PICKED UP AT THIS LOCATION:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY AS NEEDED

PARENT SIGNATURE:_____ DATE:___/___/___

NOTE: CHANGES REQUIRE AN UPDATED FORM - ASSIGNED ROUTE WILL BE DETERMINED BY TRANSPORTATION

Revised January 2022 Pick Up Route:_____ Drop Off Route:_____

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Dr. Pedro Roman
Superintendent of Schools

Dr. Gregory S. Brown
Deputy Superintendent

Melissa Lawson
Asst. Superintendent for Pupil Services

Linda Steinberg
Asst. Superintendent for Finance & Operations

Parental Rights to Referral and Evaluation for Special Education Services or Programs

The Hyde Park Central School District offers supports for students in general education such as psychological services, curriculum and instructional modifications and Academic Intervention Services (AIS). The Response to Intervention (RtI) team in your child's school may make a referral to the Committee on Special Education (CSE) if interventions have not been successful. In addition, parents and guardians have the right to refer their child to the Committee on Special Education (CSE).

A referral is a written statement asking that the school district evaluate your child to determine if he or she needs special education services. This written statement should be addressed to:

Joanna Murphy
Director of Special Education
P.O. Box 2033
Hyde Park, NY 12538

There is a requirement that the building principal offer to meet with you to discuss other ways to help your child. As a result, you may withdraw your referral, or ask that the referral process continue.

Additional information is available in English and Spanish in a document called, *A Parent's Guide to Special Education* at www.nysed.gov.

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2023-24 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

NOTES:
All children must be age-appropriately immunized to attend school in NYS. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine must be in accordance with the "ACIP-Recommended Child and Adolescent Immunization Schedule." 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 must 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	Pre-Kindergarten (Day Care, Head Start, Nursery or Pre-K)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)[2]	**4 doses**	**5 doses or 4 doses** if the 4th dose was received at 4 years or older or **3 doses** if 7 years or older and the series was started at 1 year or older	**3 doses**	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)[3]	**Not applicable**		**1 dose**	
Polio vaccine (IPV/OPV)[4]	**3 doses**	**4 doses or 3 doses** if the 3rd dose was received at 4 years or older		
Measles, Mumps and Rubella vaccine (MMR)[5]	**1 dose**	**2 doses**		
Hepatitis B vaccine[6]	**3 doses**	**3 doses or 2 doses of adult hepatitis B vaccine** (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years		
Varicella (Chickenpox) vaccine[7]	**1 dose**	**2 doses**		
Meningococcal conjugate vaccine (MenACWY)[8]	**Not applicable**		**Grades 7, 8, 9, 10 and 11: 1 dose**	**2 doses or 1 dose** if the dose was received at 16 years or older
Haemophilus influenzae type b conjugate vaccine (Hib)[9]	**1 to 4 doses**	**Not applicable**		
Pneumococcal Conjugate vaccine (PCV)[10]	**1 to 4 doses**	**Not applicable**		

NEW YORK STATE | Department of Health

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

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
   a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
   b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
   c. 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 through 9: 10 years; minimum age for grades 10, 11, and 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 2023-2024, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 9; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 10, 11, and 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, must 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 through 10: 10 years; minimum age for grades 11 and 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.
   f. For further information, refer to the CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

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 CDC Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age.

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