

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
REQUIREMENTS FOR REGISTRATION
25 N BICYCLE PATH SELDEN NY 11784 PHONE: 631-285-8890
CLOSED FRIDAYS IN JULY AND AUGUST

▪ **Original or a photocopy of proof of age document.**

Examples:

- Birth certificate
- Driver's license
- Passport
- Baptismal certificate
- State or other government issued identification
- School photo identification with date of birth
- Consulate identification card
- Hospital or health records
- Military dependent identification card
- Documents issued by federal, state or local agencies
- Native American tribal document
- Court orders or other court-issued documents

▪ **FAX number or email address to previous school and Transfer or Withdrawal paper from previous school**

▪ **Transcript for High School students**

▪ **Proof of residency in the Middle Country Central School District.**

Examples:

- Current utility bills (Electric, Gas, Fuel, Water, Cable or Satellite television)
- Current Mortgage Statement
- Deed to your home
- Post office change of address
- Mortgage commitment
- Current Renter's Insurance policy
- Voter Registration
- Original lease
- Income tax form
- Membership documents
- Official driver's license
- State or government issued identification
- Pay stub

▪ **Immunization record:** A signed or stamped certificate of immunization on physician's letterhead or a previous school's signed health record indicating specific dates of quantities. (See required student immunizations).

▪ **Parent/Guardian photo identification**

▪ **Custody paperwork if applicable**



**MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
STUDENT REGISTRATION FORM**

NEW STUDENT

RE-ENTRY

STUDENT INFORMATION

STUDENT ID #	Last Name		First Name		Middle Name		Sex	Date of Birth
	Birthplace City			State	Country			
BUILDING	CHILD'S ETHNIC AND RACE INFORMATION							
	Please answer the two-part question				Is the child Hispanic or Latino?		YES	NO
	Please indicate any race group that applies, select one or more.						B – Black or African American	
	P – Native Hawaiian/Other Pacific Islander				W – White			
GRADE	I – American Indian or Alaskan Native				A – Asian			
	PREVIOUS SCHOOL INFORMATION							
ESL	SPED	Last School Attended			Grade Level	Name of District		
Address								
Does your child receive any Special Education Services?							Yes	No
COMPLETE IF STUDENT IS RE-ENTERING THE MIDDLE COUNTRY SCHOOL DISTRICT								
Last Date and School Attended								

ATTACHED

Immunizations	
Custody Papers	

PARENT/GUARDIAN INFORMATION (where child resides)

Proof of Residence	Last Name – Parent 1 or Guardian 1		First Name		Relationship to child <input type="checkbox"/> Birth/Adopted Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Custodial Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Step Parent	
	Cell Number ()		Work Number ()			
	Email:					
	Last Name – Parent 2 or Guardian 2		First Name		Relationship to child <input type="checkbox"/> Birth/Adopted Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Custodial Care <input type="checkbox"/> Foster Care <input type="checkbox"/> Step Parent	
	Cell Number ()		Work Number ()			
	Email:					
	Resident Address					
	STREET		TOWN		STATE	ZIP
	Mailing Address (if different)					Home Telephone ()
	Is a second language spoken in the home?		Yes	No	If yes, what is the language?	
Is enrollment related to Homelessness?					Yes	No
IF APPLICABLE PROVIDE NAME, ADDRESS AND PHONE NUMBERS OF PARENT NOT LIVING WITH CHILD						
NAME					Home Number ()	
STREET		TOWN		STATE	ZIP	
					Cell Number ()	
					Work Number ()	
SHOULD THIS PARENT RECEIVE SCHOOL MAILINGS?					Yes	No
					Email	

Parent/Guardian Signature _____ Date: _____



HOUSING QUESTIONNAIRE

Name of LEA: Middle Country Central School District

Name of School: TBD

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 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 (for unaccompanied homeless youth)

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

Date

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT AT CENTEREACH

Central Registration 25 N Bicycle Path, Selden, NY 11784 Ph: 631-285-8890

Roberta A. Gerold, Ed. D. Superintendent of Schools

PREVIOUS SCHOOL FAX# or E MAIL _____

My Child _____ formerly a student in
Grade _____ of your school has been registered in Middle Country Central School District,
Centereach, NY. Please send the following information to the SCHOOL INDICATED BELOW:

Cumulative Records

A copy of the Permanent Record

All pertinent psychological and testing information which will be of value in placing this student.

Current Report Card.

All science labs, if applicable.

All ENL related testing scores, including, NYSESLAT and NYSITELL

Thank you for your cooperation.

Parent/Guardian's Signature

Date

CENTEREACH HS fax:
A-F 631-285-8195
G-N 631-285-8225
O-Z 631-285-8139

EUGENE AUER MEMORIAL ELEMENTARY
17 WING ST
LAKE GROVE NY 11755
Ph: 631-285-8500 fax: 631-285-8501

OXHEAD ROAD ELEMENTARY
144 OXHEAD RD
CENTEREACH NY 11720
Ph: 631-285-8700 fax: 631-285-8701

NEWFIELD HS
GUIDANCE DEPT
145 MARSHALL DR
SELDEN NY 11784
Ph: 631-285-8330 fax: 631-285-8336

HAWKINS PATH ELEMENTARY
485 HAWKINS RD
SELDEN NY 11784
Ph: 631-285-8530 fax: 631-285-8531

STAGECOACH ELEMENTARY
205 DARE RD
SELDEN NY 11784
Ph: 631-285-8730 fax: 631-285-8731

DAWNWOOD MS
GUIDANCE DEPT
10 43RD STREET
CENTEREACH NY 11720
Ph: 631-285-8210 fax: 631-285-8201
akostrna@mccsd.net

HOLBROOK ROAD ELEMENTARY
170 HOLBROOK AVE
CENTEREACH NY 11720
Ph: 631-285-8560 fax: 631-285-8561

UNITY DRIVE KDG CENTER
11 UNITY DR
CENTEREACH NY 11720
Ph: 631-285-8760 fax: 631-285-8761

JERICO ELEMENTARY SCHOOL
34 N COLEMAN RD
CENTEREACH NY 11720
Ph: 631-285-8600 fax: 631-285-8601

BICYCLE PATH KDG CENTER
27 N BICYCLE PATH
SELDEN NY 11784
Ph: 631-285-8805 fax: 631-285-8801

SELDEN MS
GUIDANCE DEPT
22 JEFFERSON AVE
CENTEREACH NY 11720
Ph: 631-285-8410 fax: 631-285-8423

NEW LANE MEMORIAL ELEMENTARY
15 NEW LANE
SELDEN NY 11784
NEW LANE MEMORIAL ELEMENTARY
Ph: 631-285-8900 fax: 631-285-8901

SPECIAL EDUCATION/PUPIL PERSONNEL
25 N BICYCLE PATH STE. A
SELDEN NY 11784
Ph: 631-285-8850 fax: 631-285-8851

CENTRAL REGISTRATION
centralreg@mccsd.net

NORTH COLEMAN RD ELEMENTARY
197 N COLEMAN RD
CENTEREACH NY 11720
Ph: 631-285-8660 fax: 631-285-8661

The mission of the MCCSD is to empower and inspire all students to apply the knowledge, skills, and attitudes necessary to be creative problem solvers, to achieve personal success, and to contribute responsibly in a diverse and dynamic world.

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

ATTN: SCHOOL HEALTH OFFICE

DEAR PARENT;

WHEN YOUR CHILD ENTERS SCHOOL WE ESTABLISH A CUMULATIVE RECORD FILE ON HIM/HER TO ENABLE US TO HAVE A GREATER UNDERSTANDING OF YOUR CHILD'S NEEDS. ALL INFORMATION, OF COURSE, WILL BE KEPT STRICTLY CONFIDENTIAL, SO PLEASE ANSWER EVERY QUESTION, PLEASE PRINT NEATLY. THANK YOU FOR YOUR COOPERATION.

STUDENT'S NAME _____ SEX _____ DOB _____ SCHOOL _____

ADDRESS _____ PHONE NO. _____

FATHER/GUARDIAN NAME _____ CELL PHONE NO. _____

MOTHER/GUARDIAN NAME _____ CELL PHONE NO. _____

PARENT'S PLACE OF EMPLOYMENT

FATHER/GUARDIAN _____ WORK NO. _____

MOTHER/GUARDIAN _____ WORK NO. _____

PHYSICIAN TO BE CALLED IN EMERGENCY (LOCAL) PHONE NO. _____

TRANSPORTATION OF AN ILL CHILD IS TO BE ARRANGED BY PARENT OR PERSONS NAMED ABOVE IT IS A PARENTAL RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF CHANGES IN THE ABOVE.

FOR OFFICE USE ONLY:

_____ IMMUNIZATION RECORD VERIFIED/ATTACHED

Initials of Central Registration staff member _____

TO BE COMPLETED BY PARENT. PLEASE INDICATE IF HISTORY AND DESCRIBE BELOW:

ANEMIA _____ ASTHMA _____ ALLERGIES _____ DIABETES _____ EPILEPSY _____

HEART DISEASE _____ KIDNEY DISEASE _____ TUBERCULOSIS OR CONTACT WITH TB _____

SERIOUS ILLNESS, INJURY, OPERATIONS _____

EXPLANATION OF ABOVE AS CHECKED: _____

IS MEDICATION GIVEN ON A REGULAR BASIS? NO _____ YES _____

WILL MEDICATION BE GIVEN DURING SCHOOL? NO _____ YES _____

NEW YORK STATE LAW REQUIRES THE PARENT TO SUBMIT A WRITTEN REQUEST TO THE SCHOOL, AND IT MUST BE ACCOMPANIED BY A WRITTEN REQUEST FROM THE PHYSICIAN, IN WHICH HE INDICATES THE FREQUENCY AND THE DOSAGE OF THE PRESCRIBED MEDICATION. THIS MEDICATION MUST BE BROUGHT IN BY THE PARENT IN A PRESCRIPTION BOTTLE.

ANY VISION PROBLEMS: NO _____ YES _____ PLEASE SPECIFY _____

GLASSES WORN NO _____ YES _____ DATE OF EXAMINATION _____

DR./EXAMINER'S NAME/ADDRESS _____

HEARING DIFFICULTIES NO _____ YES _____ HEARING AID WORN NO _____ YES _____

PLEASE SPECIFY: _____

DATE OF LAST EXAMINATION _____

DOCTOR'S NAME _____

ADDRESS _____

IF ANY MODIFICATION IN THE SCHOOL'S PROGRAM IS REQUIRED, PLEASE SUBMIT A DOCTOR'S WRITTEN RECOMMENDATION.

SIGNATURE OF PARENT/GUARDIAN _____



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
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____
			<i>specify</i>
	<input type="checkbox"/> Guardian(s)		_____
			<i>specify</i>
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____
			<i>specify</i>
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write
			<i>specify</i>

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

Home Language Questionnaire (HLQ)—Page Two

Educational History	
8. Indicate the total number of years that your child has been enrolled in school _____	
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. Yes* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> *If yes, please explain: _____	
How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below	
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? _____	

_____ Month: _____ Day: _____ Year: _____
Signature of Parent or of Person in Parental Relation **Date**

Relationship to student: Mother Father Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ Mo. DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ Mo. DAY YR.	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:	



SIBLING INFORMATION - Please list all other children in family including infants.

Last Name	First Name	Middle Name	Sex	Date of Birth	Grade (if any)

2024-25 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

All children must be age-appropriately immunized to attend school in New York State. 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

IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- Work related to logging, harvesting, or initial processing of trees.
- Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (_____) - _____ - _____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

To submit this referral please email to migranteducation@esboces.org, or fax to 631-240-8912, or by mail to Long-Island-METRO Migrant Education Program- 969 Roanoke House Avenue, Riverhead, NY. 11901.