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.**

OWNERS:

One (1) of the following items:
Mortgage statement, Deed, property tax bill, or title

Two (2) of the following current items:
Utility bill, income tax form, voter registration, insurance bill, bank statement, state or government issued identification, driver's license, learner's permit or non-driver identification, pay stub, telephone bill, oil bill, DSS declaration or other original documents evidencing residency.

RENTERS:

One (1) of the following items
Lease, sworn landlord affidavit (notarized), landlord statement (notarization optional) or unsworn third party statement, or a sworn residency affidavit (notarized).

One (1) of the following current items:
Utility bill, income tax form, voter registration, insurance bill, bank statement, state or government issued identification, driver's license, learner's permit or non-driver identification, pay stub, telephone bill, oil bill, DSS declaration or other original documents evidencing residency.

- **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**
- **Copy of IEP or 504 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		

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
	I – American Indian or Alaskan Native		A – Asian

PREVIOUS SCHOOL INFORMATION

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

BUILDING	
GRADE	
ESL	SPED

ATTACHED

Immunizations	
Custody Papers	

PARENT/GUARDIAN INFORMATION (where child resides)

Proof of Residence

Last Name – Parent 1 or Guardian 1	First Name
Cell Number ( )	Work Number ( )
Email:	

Relationship to child
____ Birth/Adopted Parent
____ Legal Guardian
____ Custodial Care
____ Foster Care
____ Step Parent

Last Name – Parent 2 or Guardian 2	First Name
Cell Number ( )	Work Number ( )
Email:	

Relationship to child
____ Birth/Adopted Parent
____ Legal Guardian
____ Custodial Care
____ Foster Care
____ Step Parent

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

STREET TOWN STATE ZIP

SHOULD THIS PARENT RECEIVE SCHOOL MAILINGS?	Yes	No

Home Number ( )
Cell Number ( )
Work Number ( )
Email

Parent/Guardian Signature ______________________________ Date: ______________

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

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

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: _____ /_____ /_____ (*Month Day Year*)

Grade: _____ (*preschool-12*)

ID#: ____________ (*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 **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 ACCOMPANID 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______________________

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2024-25 School Year
New York State Immunization Requirements for School Entrance/Attendance[1]

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**		

NEW YORK STATE | Department of Health

NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for Prekindergarten Students[i]

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father ☐ other ______________

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?
☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?
17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure If yes, in what language(s)? 17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure If yes, in what language(s)?
18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no If yes, in what language(s)?
19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no If so, what goals do they describe?
20. Please describe anything special you did to prepare your child to begin Prekindergarten.

[i] For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.

Eastern Suffolk BOCES
Educational Services That Transform Lives

NEW YORK STATE MIGRANT EDUCATION PROGRAM

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.

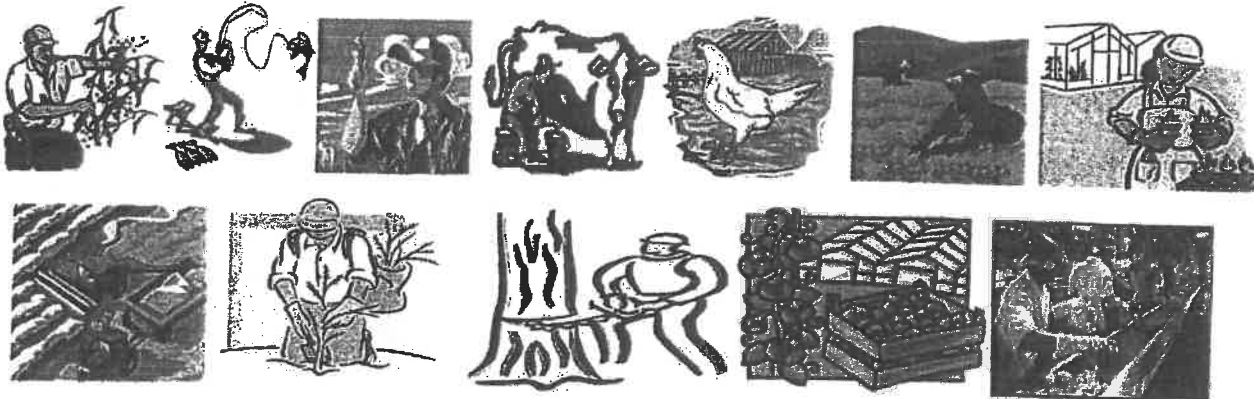
Please take a few minutes to complete this questionnaire.

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.