



SOUTH COUNTRY

CENTRAL SCHOOL DISTRICT

A tradition of quality... A future of excellence

CENTRAL REGISTRATION

189 Dunton Ave, East Patchogue, NY 11772

Phone: (631) 730-1617 Fax: (631) 286-0810

www.southcountry.org

REQUIREMENTS FOR REGISTRATION

In order to safeguard the health of your youngster, place your child in the most appropriate program, and to conform with New York State Law and district policy, we need appropriate information and records.

A. PLEASE COMPLETE THE ATTACHED FORMS IN THEIR ENTIRETY. →

B. PLEASE BRING THE FOLLOWING DOCUMENTS AT THE TIME OF REGISTRATION: ↓

1. PROOF OF RESIDENCY

ONE FORM OF PRIMARY <input type="checkbox"/>	TWO FORMS OF SECONDARY <input type="checkbox"/> *
<i>If you reside in your own home:</i>	<input type="checkbox"/> Utility Bill
<input type="checkbox"/> Deed of Ownership of Premises	<input type="checkbox"/> Cable/Satellite Statement
<input type="checkbox"/> House Insurance Statement	<input type="checkbox"/> Fuel Delivery Statement
<input type="checkbox"/> Mortgage Statement	<input type="checkbox"/> Bank Statement or Check
<input type="checkbox"/> Suffolk County/Town of Brookhaven Tax Statements	<input type="checkbox"/> Voter Registration Card
<i>If you are renting or leasing:</i>	<input type="checkbox"/> Current Driver's License
<input type="checkbox"/> Lease or Rental Agreement	<input type="checkbox"/> Department of Social Services Documentation
<input type="checkbox"/> Notarized Residency Affidavit Form	<input type="checkbox"/> Change of Address Confirmation Notice from USPS

* All secondary proof must be original documents, bear your name, and indicate your South Country address. Your child will not be enrolled until South Country Central School District receives and verifies the documents listed above.

2. BIRTH CERTIFICATE

A birth certificate with a raised seal must be provided for Pre-K and Kindergarten entrants. A photocopied birth certificate is acceptable for entrants in grades 1-12

3. HEALTH RECORDS

IMMUNIZATION RECORD

Certificate of immunization signed by a physician or by a representative of an official health clinic OR School health record signed by official

PHYSICAL EXAM FORM

Must be dated within the past year & signed by a physician.

If your child has a severe allergy or health alert, please contact the school nurse. Any forms that need to be completed by your pediatrician must be submitted by the first day of school or at time of registration to ensure your child receives proper care and treatment. Additional information is available on our district website under Health Services.

4. ACADEMIC RECORDS

Please provide the following based on grade level:

K-3: Most Recent Report Card

6-8: Most Recent Report Card & Class Schedule

4-5: State Test Scores & Most Recent Report Card

9-12: Unofficial Transcript, Class Schedule & Most Recent Report Card

5. PROOF OF CUSTODY OR GUARDIANSHIP (if applicable)

FOSTER PARENTS: Placement order from Department of Social Services 2999

GUARDIANSHIP: Appropriate Legal Documentation/Court Documentation

6. SPECIAL EDUCATION (if applicable)

Student Support Service Record Request Form

Please provide a copy of the child's current Individualized Education Program ("IEP")

Please note: your child's legal name must appear on all official school records. Requests to use an alternate name will not be honored. Arrangements may be made to have such names used in class and on unofficial records. Under New York State Law, Section 3202, a child must reside with one or both of his/her parents or guardians unless they are deceased, imprisoned or committed to an institution, or have deserted or abandoned the child, or reside outside of New York State. In such cases, only legally appointed guardians, foster parents, or custodians may assume custody and responsibility for the care of the child.

WARNING: ANY PERSON OR PERSONS WHO PROVIDE WILLFULLY FALSE INFORMATION REGARDING RESIDENCE WILL BE SUBJECT TO CRIMINAL PENALTIES. A FALSE STATEMENT REGARDING RESIDENCE OR ENTITLEMENT TO A TUITION FREE EDUCATION FROM THE DISTRICT IS PUNISHABLE AS A CLASS A MISDEMEANOR FOR PERJURY IN THE THIRD DEGREE AND/OR FILING A FALSE INSTRUMENT. IN ADDITION, IF IT IS DETERMINED THAT A REGISTRANT'S CHILD RESIDES OUTSIDE OF THE DISTRICT, THE DISTRICT MAY TAKE LEGAL ACTION TO COLLECT TUITION OR TRANSPORTATION CHARGES. TUITION CHARGES MAY EXCEED \$10,000 PER YEAR IF THE STUDENT IS NOT LEGALLY ENTITLED TO RECEIVE A TUITION FREE EDUCATION FROM THE DISTRICT. THE DISTRICT RESERVES THE RIGHT TO INVESTIGATE ANY STUDENT'S RESIDENCY BY ANY LEGAL MEANS AVAILABLE.

TEMPORARY HOUSING INFORMATION

This section is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

- 1. Is your current address a temporary living arrangement? Yes No
- 2. Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

If you answered YES to the above questions, please complete the remainder of this section.
If you answered NO, this section is complete.

TEMPORARY HOUSING QUESTIONNAIRE

1. Where is the student presently living? (Check one box)

- In a motel In a shelter With more than one family in a house or apartment
- Moving from place to place In a hospital Awaiting foster care
- In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

2. Please list the address that the student was last permanently housed at:

3. Name of School District where student was last permanently housed:

4. Date on which student began residing in temporary housing or temporary living arrangement?

5. Do you have children age 5 and under? Yes No If so, please provide their names, age, and any pre-school experience.

Unaccompanied Youth: a homeless child for whom no parent or person in parental relation is available or who is living in a residential facility for runaway and homeless youth.

-Is the student in physical custody of a parent/guardian? Yes No

NOTE: If you have been placed by the Department of Social Services in temporary housing outside of the school district, the Department of Social Services is responsible for your transportation.

****Children and youth in temporary housing are entitled to immediate enrollment in school and access to all District programs, activities, and services to the same extent as they are provided to residents even if they lack the records normally needed for enrollment, including, but not limited to, previous academic records, medical records, proof of residency and other documentation.**

FOR OFFICE USE ONLY Homeless Liaison Signature: _____ Date: _____

Family Received STAC Form: YES NO

Family Received Homeless Brochure and Information: YES NO

FOR OFFICE USE ONLY PRONOUN: he/him she/her they/them

Household Name: _____ Enrollment Date: _____

Student Name: _____ Ethnicity: _____

Student D.O.B.: _____ Re-Entrant: Yes No Temp Housing: Yes No

Gender: Male Female Foster Child: Yes No ESL: Yes No TBD

Student ID #: _____ IEP _____ 504 Plan _____

Home School: _____ Age: _____ Grade: _____ Health Alert: Yes No

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION PACKET

STUDENT NAME:

LAST: _____ FIRST: _____ M.I.: _____

HOUSEHOLD INFORMATION

HOUSEHOLD SURNAME: _____

REGISTER DATE: _____

HOUSEHOLD ADDRESS: _____

MAILING ADDRESS (if different from household): _____

CROSS STREET: _____

HOUSEHOLD PHONE: (_____) _____

RESIDENCE TYPE: OWN RENT LEASE OTHER: _____

MOVE IN DATE: _____ LEASE EXPIRATION DATE: _____

HOUSEHOLD LANGUAGE: _____ FOSTER CARE AGENCY: Yes No

NUMBER OF ADULTS IN HOUSEHOLD (21 & OVER): _____ NUMBER OF SENIORS IN HOUSEHOLD (62 & OVER): _____

PLEASE LIST ALL MEMBERS OF THE HOUSEHOLD (UNDER 21) AND THEIR RELATIONSHIP TO THE STUDENT:

NAME	DATE OF BIRTH	CURRENT GRADE	NAME OF SCHOOL	RELATIONSHIP TO STUDENT

PROOF OF RESIDENCY ATTACHED:

- PROPERTY TAX BILL
- MORTGAGE STATEMENT
-
- HOUSE DEED
- NOTARIZED LANDLORD AFFIDAVIT

- UTILITY BILL
- DRIVERS LICENSE
- DSS PAPERWORK
- CHANGE OF ADDRESS CONFIRMATION
- BANK STATEMENT OR CHECK

- LEASE AGREEMENT
- OTHER: _____

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION PACKET

STUDENT INFORMATION

FIRST NAME: _____ MIDDLE NAME: _____ LAST NAME: _____

GENDER: MALE FEMALE DATE OF BIRTH: _____ AGE: _____

ENTERING GRADE: _____ PRONOUN: he/him she/her they/them

IS THE STUDENT HISPANIC, LATINO OR OF SPANISH ORIGIN? YES NO

RACE(S): AMERICAN INDIAN/ALASKAN NATIVE ASIAN BLACK PACIFIC ISLANDER WHITE

DOMINANT LANGUAGE: _____ BIRTH CITY/STATE: _____

BIRTH COUNTRY: _____ DATE ENTERED USA (if applicable): _____

MULTIPLE BIRTH (if applicable): TWIN TRIPLET QUADRUPLET QUINTUPLET

CHILD LIVES WITH: NATURAL PARENT LEGAL GUARDIAN (COURT APPOINTED) FOSTER PARENT

OTHER PERSON IN PARENTAL RELATIONSHIP (PLEASE DESCRIBE RELATIONSHIP) _____

SCHOOL HISTORY

LAST SCHOOL ATTENDED: _____ LAST DATE OF ATTENDANCE: _____

SCHOOL ADDRESS: _____ SCHOOL PHONE #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. DOES THE STUDENT REQUIRE SPECIAL EDUCATION SERVICES? YES NO
IF YES, PLEASE PROVIDE A COPY OF THE CHILD'S CURRENT INDIVIDUALIZED EDUCATION PROGRAM. ("IEP")

2. DOES THIS STUDENT HAVE A 504 PLAN YES NO

3. WAS THE STUDENT EVER IN AN ENL OR ESL PROGRAM ? IS ENGLISH A NEW (ENL) LANGUAGE FOR YOUR STUDENT
 ESL ENL N/A

FOSTER CARE INFORMATION

IS THE STUDENT CURRENTLY A FOSTER CHILD? YES NO

FOSTER CARE AGENCY INFORMATION

AGENCY NAME: _____ ADDRESS: _____

CASE WORKER: _____ TELEPHONE: () _____

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION PACKET

PARENT/GUARDIAN INFORMATION

A parent guardian is defined as an individual who may or may not have custodial rights to a student and may or may not receive correspondence from the school, which will be determined at the time of registration. When completing the form, please indicate the individual's relationship to the child (ex. mother, father, aunt, grandparent, etc.) and indicate whether or not they will receive district correspondence. Also, please note any visitation restrictions that may exist please provide appropriate legal documentation.

1) FIRST: _____ MIDDLE: _____ LAST: _____

GENDER: MALE FEMALE

RESIDES IN HOUSEHOLD: YES NO MARITAL STATUS: _____

EDUCATION LEVEL: NONE HIGH SCHOOL BACHELOR DEGREE POST GRADUATE DEGREE

MAILING ADDRESS: _____ HOME PHONE: (____) _____
_____ WORK PHONE: (____) _____

E-MAIL ADDRESS: _____ CELL PHONE: (____) _____

EMPLOYER NAME: _____ EMPLOYER PHONE: (____) _____

WORK ADDRESS: _____

RELATIONSHIP TO STUDENT: _____

CUSTODIAL PARENT: YES NO RECEIVE CORRESPONDENCE FROM SCHOOL: YES NO

PARENT/GUARDIAN INFORMATION

2) FIRST: _____ MIDDLE: _____ LAST: _____

GENDER: MALE FEMALE

RESIDES IN HOUSEHOLD: YES NO MARITAL STATUS: _____

EDUCATION LEVEL: NONE HIGH SCHOOL BACHELOR DEGREE POST GRADUATE DEGREE

MAILING ADDRESS: _____ HOME PHONE: (____) _____
_____ WORK PHONE: (____) _____

E-MAIL ADDRESS: _____ CELL PHONE: (____) _____

EMPLOYER NAME: _____ EMPLOYER PHONE: (____) _____

WORK ADDRESS: _____

RELATIONSHIP TO STUDENT: _____

CUSTODIAL PARENT: YES NO RECEIVE CORRESPONDENCE FROM SCHOOL: YES NO

GUARDIAN INFORMATION ONLY (IF APPLICABLE)

DO YOU HAVE A COURT ORDER GRANTING CUSTODY TO YOU? YES NO COPY PROVIDED

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION PACKET

*OTHER THAN PARENT/GUARDIAN

EMERGENCY CONTACT INFORMATION

1) FIRST: _____ MIDDLE: _____ LAST: _____

GENDER: MALE FEMALE

RESIDES IN HOUSEHOLD: YES NO

MAILING ADDRESS: _____ HOME PHONE: (____) _____

_____ WORK PHONE: (____) _____

CELL PHONE: (____) _____

E-MAIL ADDRESS: _____

RELATIONSHIP TO STUDENT: _____

EMERGENCY CONTACT INFORMATION

2) FIRST: _____ MIDDLE: _____ LAST: _____

GENDER: MALE FEMALE

RESIDES IN HOUSEHOLD: YES NO

MAILING ADDRESS: _____ HOME PHONE: (____) _____

_____ WORK PHONE: (____) _____

CELL PHONE: (____) _____

E-MAIL ADDRESS: _____

RELATIONSHIP TO STUDENT: _____

EMERGENCY CONTACT INFORMATION

3) FIRST: _____ MIDDLE: _____ LAST: _____

GENDER: MALE FEMALE

RESIDES IN HOUSEHOLD: YES NO

MAILING ADDRESS: _____ HOME PHONE: (____) _____

_____ WORK PHONE: (____) _____

CELL PHONE: (____) _____

E-MAIL ADDRESS: _____

RELATIONSHIP TO STUDENT: _____

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION PACKET

STUDENT NAME: LAST: _____ FIRST: _____ M.I.: _____

TEMPORARY HOUSING INFORMATION

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- 1. Is your current address a temporary living arrangement? [] Yes [] No
2. Is this temporary living arrangement due to loss of housing or economic hardship? [] Yes [] No

If you answered YES to the above questions, please complete the remainder of this section.
If you answered NO, this section is complete.

TEMPORARY HOUSING QUESTIONNAIRE

1. Where is the student presently living? (Check one box)

- [] In a motel [] In a shelter [] With more than one family in a house or apartment
[] Moving from place to place [] In a hospital [] Awaiting foster care
[] In a place not designed for ordinary sleeping accommodations such as a car, park or campsite

2. Please list the address that the student was last permanently housed at:

3. Name of School District where student was last permanently housed:

4. Date on which student began residing in temporary housing or temporary living arrangement?

5. Do you have children age 5 and under? [] Yes [] No If so, please provide their names, age, and any pre-school experience.

Unaccompanied Youth: a homeless child for whom no parent or person in parental relation is available or who is living in a residential facility for runaway and homeless youth.

-Is the student in physical custody of a parent/guardian? [] Yes [] No

NOTE: If you have been placed by the Department of Social Services in temporary housing outside of the school district, the Department of Social Services is responsible for your transportation.

**Children and youth in temporary housing are entitled to immediate enrollment in school and access to all District programs, activities, and services to the same extent as they are provided to residents even if they lack the records normally needed for enrollment, including, but not limited to, previous academic records, medical records, proof of residency and other documentation.

FOR OFFICE USE ONLY Homeless Liaison Signature: _____ Date: _____

Family Received STAC Form: [] YES [] NO

Family Received Homeless Brochure and Information: [] YES [] NO

SOUTH COUNTRY CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION PACKET

STUDENT NAME: LAST: _____ FIRST: _____ M.I.: _____

EMERGENCY HEALTH INFORMATION

NOTE: In the final disposition of an emergency case, judgment of the school authorities will prevail.

Family Physician: _____ Phone: (____) _____

Address: _____

SPECIAL HEALTH PROBLEMS (Please include any medications):

Wears Glasses/Contact Lenses: YES NO

If at any time the above information must be changed, I will notify the school in writing.

Signature of Parent/Guardian _____ Date _____

ALLERGY SCREENING

If your child has an allergy (such as food, medication, or environmental) please answer the following questions:

1. Is your child allergic to anything? YES NO *Please include any food, medication or environmental allergies*

Please specify allergen and your child's reaction (i.e. hives, rash, shortness of breath, etc.): _____

2. Does your child have a prescribed EpiPen for this allergy? YES NO

3. Is your child at risk for a life-threatening allergic reaction? YES NO

4. Has your child's allergy been identified through allergy testing? YES NO

5. Please check circumstances which reaction could occur: Contact Ingestion Airborne

ASTHMA

If your child has asthma please answer the following questions:

1. Does your child have asthma? YES NO

2. Does your child use an inhaler or a nebulizer at home? YES NO

3. Will medication be required for use during school hours? YES NO

HEALTH HISTORY INFORMATION

1. Has your child ever had any of the following? Yes No If yes, please check and provide explanation:

- | | | |
|--|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> German measles | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Anemia or Sickle Cell | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Hernias |

Date of Illness: _____ Explanation: _____

2. Has your child ever had chest pain, murmurs, irregular beats, shortness of breath, or been treated for any other "heart problems"? If yes, please provide a note from your doctor stating whether or not your child may participate in all activities at school including Physical Education.

YES NO Explanation: _____

3. Has your child ever had a seizure? If yes, please provide a note from your doctor stating whether or not your child may participate in all school activities at school including Physical Education.

YES NO Explanation: _____

4. Has your child ever had high blood pressure?

YES NO Explanation: _____

5. Has your child ever had a fracture, serious injury, or illness requiring medical attention or surgery?

YES NO Area of Injury: _____

6. Does your child have any persistent swelling in his/her joints?

YES NO Explanation: _____

7. Does your child wear glasses, contact lenses, hearing aid or other prosthesis?

YES NO Explanation: _____

8. Does your child have a hearing loss in either ear?

YES NO Explanation: _____

9. Has your child ever had any serious eye injury or vision problem?

YES NO Explanation: _____

10. Is your child taking any medication? If so please list them.

YES NO Explanation: _____

11. Does your child have any medical condition or restrictions on activity that we should know about?

YES NO Explanation: _____

12. Is there a history of Tuberculosis in the family?

YES NO Explanation: _____

13. Has your child ever been hospitalized since birth?

YES NO Explanation: _____

14. Was your child born with a congenital defect?

YES NO Explanation: _____



SOUTH COUNTRY

CENTRAL SCHOOL DISTRICT

OFFICE OF CENTRAL REGISTRATION
189 Dunton Ave, East Patchogue, NY 11772
Phone: (631) 730-1617 Fax: (631) 286-3346
www.southcountry.org

AUTHORIZATION FOR RELEASE OF STUDENT RECORDS

Authorization is hereby granted by the undersigned for the release of student records, including but not limited to the most recent report card, academic transcripts, test records, special education records, medical records / immunizations and discipline records.

PARENT/GUARDIAN PERMISSION FOR RELEASE OF RECORDS:

I _____, give permission to
(Parent/Guardian Name – please print)

PREVIOUS SCHOOL

School Name

School Address

School Phone # School Fax #

to release all official records regarding _____
Student Name, Date of Birth

(Signature of Parent / Guardian) Date

PLEASE FORWARD ALL RELEVANT RECORDS TO THE SCHOOL CHECKED BELOW

- | | | |
|--|--|--|
| <input type="checkbox"/> Bellport High School
205 Beaver Dam Road
Brookhaven, NY 11719
Grades 9-12
Guidance Office
Phone: (631) 730-1607 or 1608
FAX: (631) 286-4025 | <input type="checkbox"/> Bellport Middle School
35 Kreamer St.
Bellport, NY 11713
Grades 6-8
Guidance Office
Phone: (631) 730-1768
FAX: (631) 286-4460 | <input type="checkbox"/> Frank P. Long Intermediate School
599 Brookhaven Ave
Bellport, NY 11713
(631) 731-1727
Grades 4-5
Phone: (631) 730-1726 or 1727
FAX: (631) 286-0276 |
| <input type="checkbox"/> Brookhaven Elementary School
101 Fireplace Neck Rd
Brookhaven, NY 11719
Universal Pre-K / Grades K-3
(631)730-1702 or 1718
FAX: (631) 286-6210 | <input type="checkbox"/> Kreamer St. Elementary School
37 Kreamer St.
Bellport, NY 11713
Grades K-3
(631) 730-1650
FAX: (631) 776-0903 | <input type="checkbox"/> Verne W. Critz Elementary School
185 Dunton Ave
E. Patchogue, NY 11772
Grades K-3
(631) 730-1676 or 1677
FAX: (631) 286-2918 |

**SOUTH COUNTRY CENTRAL SCHOOL DISTRICT
SCHOOL HISTORY**

Please provide a list of the schools that your child has attended.

STUDENT NAME _____

GRADE	SCHOOL	DISTRICT	STATE	DATE STARTED	DATE ENDED	COMPLETED GRADE
K						
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						



Lisette Colon-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
_____	_____	_____
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>	<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* No Not sure <input type="checkbox"/> <input type="checkbox"/> <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? _____

_____ <i>Signature of Parent or of Person in Parental Relation</i>	Month: _____	Day: _____	Year: _____ <i>Date</i>
Relationship to student: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____			

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

South Country Central School District
Student Support Services
105 Fireplace Neck Road
Brookhaven, NY 11719

631-730-1781

Fax: 631-286-4914

AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

I hereby give my permission for the exchange of the following information/evaluations:
This consent will remain in effect unless withdrawn in writing.

Special Education: Social History, Educational, Psychological, Psychiatric, Functional Behavior Assessment, Behavior Intervention Plan, Medical (including immunizations), Neurological, Occupational Therapy, Physical Therapy, Speech Therapy, Prior Written Notice/Consent and IEP for the following school years:

****PLEASE TRANSFER 2024-25 IEP VIA FRONTLINE/IEP DIRECT****

**Transcript for HS students – Please send current Special Education records
Psychological Evaluation
Educational Evaluation
Social History**

Other: _____

Between:

Kerry Carson Director
South Country CSD
Student Support Services
105 Fireplace Neck Road
Brookhaven, NY 11719
631-730-1781
fax: 631-286-4914

**Please scan records to:
Nancy Kujan
nkujan@southcountry.org**

and _____

Fax# _____

Phone# _____

Regarding my child
(print) _____

DOB: _____

Guardian's Signature _____

Guardian Print Name _____

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.

BOARD OF EDUCATION

Chris Picini, President
Joseph L. Barry, Vice-President
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SOUTH COUNTRY

CENTRAL SCHOOL DISTRICT



SUPERINTENDENT OF SCHOOLS

Mr. Antonio Santana

ADMINISTRATIVE OFFICES

189 Dunton Avenue
East Patchogue, NY 11772
(631) 730-1510
FAX: (631) 286-6394
www.southcountry.org

Student Chromebook Loan Agreement

MOBILE DEVICE ISSUANCE AGREEMENT 2024/2025

Student Name: _____

Student ID#: _____

Parent / Guardian Name: _____

Parent / Guardian Email: _____

The above is the equipment issued to the above Student. The student agrees to the acceptance of the equipment with their Parent /Guardian signature below. It is the student responsibility to report any problems with their equipment to include operation, damage of any kind, loss or theft. The Student and Parent are responsible for any damage and/or loss of the device. There will be a \$306.00 charge for a new device. The student also agrees to return above equipment upon request or withdrawal from the South Country Central School District.

SIGNATURE _____ DATE _____
(Parent / Guardian)

_____ For Official Use Only _____

Building(s): BHS / BMS / FPL / BES / KES / VWC

Device Type: CHROMEBOOK

Date of Receipt: _____

SCCSD Asset #: _____ (8 digit starts with year 20XX)

Equipment S/N: _____ (DELL Service Tag or Acer S/N)

SIGNATURE _____ DATE _____
(Technology)