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 #

BUILDING
GRADE
ESL / **SPED**

ATTACHED

Immunizations	
Custody Papers	

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

PARENT/GUARDIAN INFORMATION (where child resides)

Proof of Residence

Last Name – Parent 1 or Guardian 1	First Name	Relationship to child
		___ Birth/Adopted Parent ___ Legal Guardian ___ Custodial Care ___ Foster Care ___ Step Parent
Cell Number ( )	Work Number ( )	
Email:		

Last Name – Parent 2 or Guardian 2	First Name	Relationship to child
		___ Birth/Adopted Parent ___ Legal Guardian ___ Custodial Care ___ Foster Care ___ 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

STREET TOWN STATE ZIP

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

SHOULD THIS PARENT RECEIVE SCHOOL MAILINGS? Yes No

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 **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_____

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

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

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Elisa Alvarez, Associate 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 Person in Parental Relation:
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.

STUDENT NAME:		
First	*Middle*	*Last*
DATE OF BIRTH:		GENDER:
Month	*Day*	*Year* ☐ Male ☐ Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other	*specify*
2. What was the first language your child learned?	☐ English	☐ Other	*specify*
3. What is the Home Language of each parent/guardian?	☐ Parent 1 *specify*	☐ Parent 2 *specify*	☐ Guardian(s) *specify*
4. What language(s) does your child understand?	☐ English	☐ Other	*specify*
5. What language(s) does your child speak?	☐ English	☐ Other *specify*	☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other *specify*	☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other *specify*	☐ 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:
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*
❑ ❑ ❑ ***If yes,** please explain:_____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

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

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

Age at which services received *(Please check all that apply):*
❑ **Birth to 3 years (Early Intervention)** ❑ **3 to 5 years (Special Education)** ❑ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ❑ **No** ❑ **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: ❑ **Parent** ❑ **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: ❑ NO ❑ YES

**DATE OF INDIVIDUAL INTERVIEW: _____ MO DAY YR.	OUTCOME OF INDIVIDUAL INTERVIEW: ❑ ADMINISTER NYSITELL ❑ ENGLISH PROFICIENT ❑ 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: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

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

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
Discipline Record(s) if applicable

Thank you for your cooperation.

_____
Parent/Guardian's Signature

_____
Date

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

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

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

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

CENTRAL REGISTRATION
centralreg@mccsd.net

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

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

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

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

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

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

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

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

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

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

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

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.

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

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.

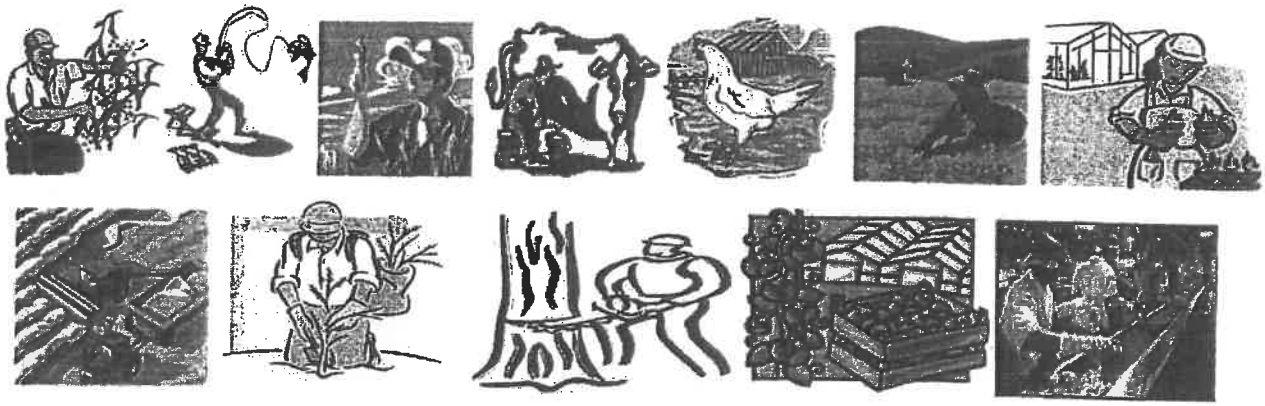
Please take a few minutes to complete this questionnaire.

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.