Great Neck Public Schools
Phipps Administration Building
Office of Registration
345 Lakeville Road, Great Neck, NY 11020 (516) 441-4080
residency@greatneck.k12.ny.us

Welcome to the Great Neck School District 2026-2027

Great Neck Public Schools can only register your children once your children are living full time and sleeping in a house or apartment inside our district boundaries.

Registration is a three-step process.

Step one-move in, if you are NOT living in Great Neck, you are not permitted to register for school.

Step two- complete and submit the **Online Registration Application**. www.greatneck.k12.ny.us Administration>Registration After the application is submitted our staff will review the application within 1-3 school business days. All applications are reviewed in the order they are received. **Applications missing documents will delay your registration.**

Step three-Once your application is fully approved and all documents are received, you will receive an email to call our office to make an in-person appointment to verify your original documents. When that appointment is completed, your student's enrollment will take place.

WE DO NOT ACCEPT UNSCHEDULED WALK-IN REGISTRATION APPLICATIONS

Before you begin the online registration, please gather the following documents and scan them to your computer so you can upload them during the registration process.

The following documents are required for registration and can be uploaded into the Online Registration System. In the event the family is not able to present the required documentation, an in-person appointment may be requested by our registration team to determine what other documents will be acceptable to register the student in school.

Acceptable Proof of Residence: All of these will be uploaded while filling out the Online Application.
Homeowners, please provide one of the following: Deed, Current Town or North Hempstead Tax Bill (If you need a copy call (516) 869-7800), Closing statement, Proprietary lease (for Co-op).
Renters, please provide the following: Lease (all pages with complete landlord contact information), Rental Agreement (all pages with complete landlord contact information)
** Both Lease and Rental Agreement must be accompanied with the local village/town official rental permit for that property (must be supplied to the tenant by the landlord).

3 Pieces of Current Official Mail (i.e. bank statements, credit card statements, insurance bills, cell phone bills, and utility bills, etc., dated current or past month only).

Additional Documentation:

Student Records The following student records are also required:

- **Proof of Age (Original Birth Certificate).** If not in English an Official Notarized Translation is required. **(All students)**
- **Up-to-Date Immunization Record** signed and stamped by a doctor. **Public School only**
- **Physical** (by a New York State Doctor within 30 days of starting school, the physical must have been performed within the last 12 months. **Public School only**
- School Records (i.e. report card, official transcript, course schedule. **Public School only**
- If a student is receiving special education services, a copy of the **IEP is required.**

Proof of Guardianship/Parental Relationship. (Not required if parent is listed on birth certificate)
If parents are divorced, documents indicating residential custody of the student are required.

Great Neck Public Schools, Office of Registration and Attendance
345 Lakeville Road, Great Neck, NY 11020
residency@greatneck.k12.ny.us (516) 441-4080

Name:_____ Date:_____ Application #:_____

Public School Registration Checklist 2026-27

******Please include the application number in all correspondence******

____ **Deed, Closing Statement, or Current School/Village Tax Bill**
Or
____ **Proprietary Lease (Co-op)**
Or
____ **Lease (all pages with complete landlord contact information)**
Rental Agreement (all pages with complete landlord contact information)
**** Both Lease and Rental agreement must be accompanied with the local village/town official rental permit for that property (should be supplied to the tenant by the landlord). Permit will be verified.**

____ **Current Mail 3 Different Pieces of Official Mail, utility bills work best-shipping labels are unacceptable, must be stamped within the past 30 days.**

____ **Certification of Residency (notarized)**

____ **Parent/Guardian Photo ID: You are Required to add all Parents listed on the Birth Certificate, to the Online Application in the Parent Section.**

____ **Custody Agreement or Notarized Affidavits if applicable. A secondary mailing will be set up for all non-household parents**

____ **Original Birth Certificate (Original and an official, notarized translation to English, if necessary)**

____ **Immunization Record (stamped by a physician) *** REQUIRED to Complete Registration.**

____ **Physical, performed and stamped within the last 12 months by a New York State Doctor.**
***** REQUIRED to Complete Registration.**

____ **Home Language Questionnaire (one form for EACH student)**

____ **Dental Form – Elementary Only (one form for EACH student)**

____ **Report Card/Transcript. Important for placement: *Prior School Information* needs to be entered before submitting the application. For Kindergarten enrollment please list the current Pre-School or Daycare Program, if applicable.**

____ **Please make sure you SUBMIT the application. An email from "Parentsupport" will be sent as soon as you Submit the application letting you know it has been submitted. Check your email and make sure you receive this verification. All applications are reviewed in the order they are received. Please allow 1-3 business days for our staff to review your application.**

If the application is complete and all documents are uploaded and are correct, you will receive an email to call our office to make an in-person appointment to verify your original documents. Once that appointment is complete your student's enrollment will take place. WE DO NOT ACCEPT UNSCHEDULED WALK-IN REGISTRATION APPLICATIONS**.**

If any of the documents are missing or information is incomplete, your application will be placed on HOLD, and you will receive an email letting you know what is missing.
Incomplete applications and/or missing documents will delay the processing.

GREAT NECK PUBLIC SCHOOLS
REGISTRATION OFFICE
345 LAKEVILLE ROAD GREAT NECK, NY 11020

CERTIFICATION OF RESIDENCY (required document)

(Affidavit is valid for one year from date of notary signature, one affidavit per application)

This is to certify that I (we), _____ _____
(parent (s) names listed above)
understand this statement is being made UNDER THE PENALTIES OF PERJURY, so that all my school aged child/children listed below

_____ , _____
, _____
(print child/all children's name above living at this address)
may be admitted to the schools of the Great Neck Public Schools.

I am currently residing (living) at _____
(Address)
_____

I attest that it is my legal residence. I further certify that I **do not** maintain another residence outside the boundaries of the Great Neck School District. **I further certify I will be living with my children while they are attending Great Neck School.**

I understand that if I or the above mention child(ren) is (are) found not to be a legitimate residents of the Great Neck Union Free School District, **that I WILL BE LEGALLY RESPONSIBLE FOR AND WILL PAY THE SCHOOL DISTRICT'S ANNUAL TUITION RATE PER CHILD (Minimum range is $21,084.00-30,915.00), RETROACTIVE TO THE FIRST DAY OF ADMISSION, ALONG WITH ANY COSTS ASSOCIATED WITH ENROLLING YOUR CHILD" and MY CHILD/CHILDREN WILL BE DISENROLLED**. I also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application will make me liable to criminal prosecution. I understand that the school district will make an announced home visit for purposes of residency verification. In addition, the district may make an unannounced home visit for the purpose of residency verification.

I further understand that if I move out of the home listed above, I will immediately notify the school district.
By signing below, I admit to having read and understood the above conditions.

_____ _____
Signature of Parent/Person in Parental Relation Date

Sworn to before me
This _____ day of _____, 20_____

_____
NOTARY PUBLIC

I have read and understood the above and am certifying the resident understands the statement they are signing. Please attach copy of ID.

_____ _____ _____
Signature of Translator Relationship Phone

Sworn to before me
This _____ day of _____, 20_____

_____
NOTARY PUBLIC

rev. 08/2026

GREAT NECK PUBLIC SCHOOLS

HEALTH SERVICES

DENTAL HEALTH REPORT (eff. 08/26)
(ELEMENTARY SCHOOLS ONLY)

Student's Name: _____ Date: _____

School: _____ Grade: _____

This is to certify that the student named above:

Is under my care for dental treatment: _____

Has completed dental treatment: _____

Name of Dentist: _____

Signature of Dentist: _____

Address: _____

_____

This report should be returned to the school.

2026-2027 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

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors:Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ < 5th ☐ 5th- 49th ☐ 50th- 84th ☐ 85th- 94th ☐ 95th- 98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list) ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/		☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

<u>If Restrictions Apply</u> – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process <u>ONLY</u> required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.

GREAT NECK PUBLIC SCHOOLS
Health Services
Immunization Record

NAME_____ DOB_____ SCHOOL_____

ADDRESS_____ PHONE_____ GRADE____ TEACHER_____

Under section 2164 of the New York State Public Health Law, all children attending school,… or any preschool program must be immunized against Diphtheria, Pertussis, Tetanus, Polio, Measles, Mumps, Rubella, Hepatitis B, Varicella, Meningococcal, Haemophilus Influenza b & Prevnar. Children who attend a preschool…must also show evidence of lead screening.
Please have your Health Care Provider fill in **Month, Day & Year of ALL Immunizations. ALL DATES ARE REQUIRED**.

Your child may not attend school without this information.

*****PLEASE CHECK WITH YOUR DOCTOR FOR THE REQUIRED DOSES FOR YOUR CHILD ACCORDING TO ACIP GUIDELINES*****

- **DTaP** → **3-5 Doses Required** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}

  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___

- **Tdap**→ **1 Dose Required** {Mandatory Grades 6th -12th}

  1. ___/___/___

- **IPV** → **3-5 Doses Required** {Must have 1 Dose given AFTER age 4, prior to Kindergarten}

  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___ 6. ___/___/___

- **HBV (HEPATITIS B)**→ **3 Doses Required**

  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ Additional Doses: ___/___/___ ___/___/___ ___/___/___

- **MMR**→ **2 Doses Required** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kindergarten.}

  MMR: 1. ___/___/___ 2. ___/___/___
  Or MEASLES: 1.___/___/___ 2. ___/___/___ MUMPS 1. ___/___/___ 2.___/___/___ RUBELLA 1. ___/___/___ 2.___/___/___

- **VARICELLA VACCINE (CHICKEN POX)**→ **2 Doses Required** {1st Dose Must be given on or After First Birthday. 2nd Dose Required for Kind., 1st, 2nd, 3rd, 4th, 6th, 7th, 8th, 9th, 10th & 11th Grade}

  1. ___/___/___ 2. ___/___/___ Or proof of Disease from Health Care Provider→ DATE: 1. ___/___/___

- **MenACWY / Menactra / MCV4 / Menveo VACCINE**→ **1-2 Doses Required** {1st Dose Required for 7th, 8th, 9th, 10th & 11th Grade. 2nd Dose Required on or After Age 16, &/or Entering 12th Grade.}

  1. ___/___/___ 2. ___/___/___

For children entering Preschool program

- **Hib (HAEMOPHILUS INFLUENZA b)**→ **1-4 Doses Required** {Depending on Age & Grade}

  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___

- **PREVNAR (PCV)** → **1-4 Doses Required** {Depending on Age & Grade}

  1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___

- **LEAD SCREENING** →**Required for Preschool** → ___/___/___ → _____

Optional Vaccines

- **HEPATITIS A Vaccine (HAV)**→ 1. ___/___/___ 2. ___/___/___
- **HUMAN PAPILLOMAVIRUS (HPV)**→ 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
- **PPV (Pneumococcal Polysaccharide Vaccine)** → 1. ___/___/___ 2. ___/___/___
- **ROTATEQ**→ 1. ___/___/___ 2. ___/___/___ 3. ___/___/___
- **OTHER VACCINES:** _____→ 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

➢ PPD/TB TEST→ ___/___/___ Read ___/___/___ → _____ mm → Result: N___ P___

Children who have not been immunized may be admitted with 1 Dose of **each required vaccine series & has **WRITTEN** age appropriate appointments to complete the series according to the ACIP guidelines.**

PHYSICIAN'S SIGNATURE, **STAMP**, ADDRESS, PHONE NUMBER

_____

DATE: ___/___/___ _____

_____

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* ❑ Guardian(s) _____ *specify*	❑ Parent 2 _____ *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: