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 and 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

AND
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: (not a homeowner)
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).

AND
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

BUILDING
GRADE

ESL	SPED

ATTACHED

Immunizations	
Custody Papers	

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:** _____

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

ATTN: HEALTH OFFICE

DEAR PARENT/GUARDIAN;

WHEN YOUR CHILD ENTERS SCHOOL, WE ESTABLISH A CUMULATIVE RECORD FILE ON YOUR CHILD 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._____

PARENT/GUARDIAN #1 NAME_____ CELL PHONE NO._____

PARENT/GUARDIAN #2 NAME_____ CELL PHONE NO._____

PARENT'S PLACE OF EMPLOYMENT
PARENT/GUARDIAN #1_____ WORK NO._____

PARENT/GUARDIAN #2_____ 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/GUARDIAN
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_____

New York State Housing Questionnaire

Identifying and serving students in temporary housing under the McKinney-Vento Act and NYS Ed Law §3209

This form is to be completed when a student first enrolls, and any time a change in housing status occurs. There are no wrong answers. This form may be filled out independently, or the McKinney-Vento Liaison can assist. To access a list of McKinney-Vento Liaisons, please visit https://www.nysteachs.org/liaisons

District or LEA	**School Name**

About this form and your rights

Schools are required by federal and state law to identify students living in temporary housing and ensure they can enroll, attend, and succeed in school. The **McKinney-Vento Homeless Assistance Act**, together with **New York State Education Law Section §3209**, protects students and families who no longer have a permanent, stable place to live; families who have lost housing; are staying with others temporarily; or are living somewhere that was never meant to be a home.

Eligible students have the right to:

- ✓ Stay in the school they attended when last permanently housed (called the school of origin), for as long as they are in temporary housing.
- ✓ Immediately enroll in the local school where they are temporarily staying (the school of current location).
- ✓ Enroll and start school right away, even without a birth certificate, proof of residency, immunization records, or school records.
- ✓ Receive free transportation to and from the school of attendance, as well as after-school activities (If within 50 miles).
- ✓ Receive free school meals without income paperwork as well as access to other school services including McKinney-Vento Grant resources, if available.

This information is confidential and will be shared only with school staff who have a legitimate educational need to support student access to McKinney-Vento rights and services. Providing this information is voluntary and will be used only to determine eligibility for services under the McKinney-Vento Act and NYS Education Law §3209. Please note that this information will not affect your immigration status, your child's enrollment, or your eligibility for other school services.

STUDENT INFORMATION:

Student Name (Last, First)	Student Grade Level (Preschool-12)
Student Gender ☐ M ☐ F ☐ X= Nonbinary	Student Date of Birth (Month/Day/Year)
Parent, Legal Guardian Name	
Phone Number	E-Mail Address
Address where the student is currently living	

Where is the student residing right now?

Under the McKinney-Vento Act, students are protected when their nighttime residence is not **fixed, regular, and adequate.** Check every box that describes where **the student** is residing right now.

☐ Permanent housing: you own, rent or lease a fixed, regular, and adequate home

☐ Doubled-up: staying with another family or person due to a loss of housing, economic hardship, eviction, or other similar reason

☐ In an emergency, transitional, or domestic violence shelter. Shelter or program name: _____

☐ In a hotel or motel because there is no other alternative, adequate place to stay

☐ In a car, park, campsite, bus/train station, abandoned building, or another place not meant for stable habitation or established dwelling

☐ In a place with no heat, running water, or electricity, or that is otherwise structurally unsafe or inadequate to reside in

☐ Displaced by a fire, flood, natural disaster, or other emergency

☐ Another temporary situation not listed here: _____

Is there anything else you would like us to know about your situation? (optional)

_____

Is the student an Unaccompanied Homeless Youth (UHY)?

The McKinney-Vento Act identifies students who are not living with a parent or legal guardian, and are not residing in permanent housing, as **Unaccompanied Homeless Youth (UHY)**. UHYs have the right to enroll in school and to complete and sign this form independently, without a parent or adult present. The McKinney-Vento Liaison can assist UHYs with this process.

☐ **Please check the box if you believe the student identified above may meet the McKinney-Vento eligibility criteria described above.**

Additional Children within the Household?

To help us identify and support all eligible children and youth, please list every child who is currently living with you, regardless of age or school enrollment status. This includes infants, preschool-aged children, and school-aged children.

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Student Name (Last, First)	Date of Birth	Grade	Current or Recent School	Last School Attended Before Current or Recent

Accuracy of Information and Signature

The person completing this form certifies that the information provided above is correct and accurate to the best of their ability.

Name (print): _____

Signature: _____ **Date:** _____

An unaccompanied homeless youth may sign on their own behalf.

Need help? Contact the McKinney-Vento Liaison listed at the top of this form or call the NYS-TEACHS Helpline at 800-388-2014. Visit nysteachs.org for more information.

OFFICIAL USE ONLY (School Staff)

Date received: _____ **Received by:** _____ Eligibility: ☐ Eligible ☐ Not Eligible ☐ Pending

Homeless Primary Nighttime Residence Code (SIRS):

☐ D = Doubled-up ☐ S = Shelter ☐ H = Hotel/Motel ☐ U = Unsheltered ☐ T = Transitional Housing

Unaccompanied Homeless Youth (UHY): ☐ Yes ☐ No

Designation Form: ☐ Yes ☐ N/A ☐ Coded in Student Information System (SIS)

Liaison notified (initials): _____ Date: _____ ☐ Family declined to provide information

Notes:

_____

_____

_____

_____

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT AT CENTEREACH

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

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

PREVIOUS SCHOOL FAX# or E MAIL _____

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

Cumulative Records
A copy of the Permanent Record
All pertinent psychological and testing information which will be of value in placing this student.
Current Report Card.
All science labs, if applicable.
All ENL related testing scores, including, NYSESLAT and NYSITELL

Thank you for your cooperation.

_____
Parent/Guardian's Signature

_____
Date

CENTEREACH HS
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.

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

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ❑ Male ❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ 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?	❑ Mother *specify*	❑ Father *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:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

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: ☐ **Mother** ☐ **Father** ☐ **Other:** _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ 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:

2026-27 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 shown on the schedule 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 gradeless 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 (Child Caring Center, 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 and the series was started at less than 1 year of age 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** given at age 10 years or older	
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 years 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** given at age 10 years or older	**Grade 12: 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.

   *Serological titers are never accepted for tetanus, diphtheria, pertussis, meningococcal, haemophilus influenzae type b, and pneumococcal diseases.

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.
   d. For further information, refer to the Catch-Up Guidance for Children 4 Months through 6 Years of Age.

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 12: 10 years).
   a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap given at age 10 years or older.
   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.
   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.
   d. For further information, refer to the Catch-Up Guidance for Children 7 through 9 Years of Age.
   e. For further information, refer to the Catch-Up Guidance for Children 10 through 18 Years of Age.

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 New York State 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.
   e. For further information, refer to the Catch-Up Guidance for Children 4 months through 18 Years of Age.

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 pre-kindergarten. Two doses are required for grades kindergarten through 12.
   c. Mumps: One dose is required for pre-kindergarten. Two doses are required for grades kindergarten through 12.
   d. Rubella: One dose is required for pre-kindergarten. One dose is required for grades kindergarten 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 12: 10 years).
   a. One dose of meningococcal conjugate vaccine 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 Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age (PedvaxHIB only).
   g. For further information, refer to the Catch-Up Guidance for Healthy Children 4 Months through 4 Years of Age (ActHIB, Hiberix, Pentacel, Vaxelis, or Unknown).

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 Catch-Up Guidance for Children 4 months through 4 Years of Age. *Depending on vaccine brand, schedule may change.

For further information, contact:

New York State Department of Health
Division of Vaccine Excellence
Room 649, Corning Tower ESP
Albany, NY 12237
(518) 473-4437
OSAS@health.ny.gov

New York City Department of Health and Mental Hygiene
School Compliance Unit, Bureau of Immunization
42-09 28th Street, 5th floor
Long Island City, NY 11101
(347) 396-2433
school_immunizations@health.nyc.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.

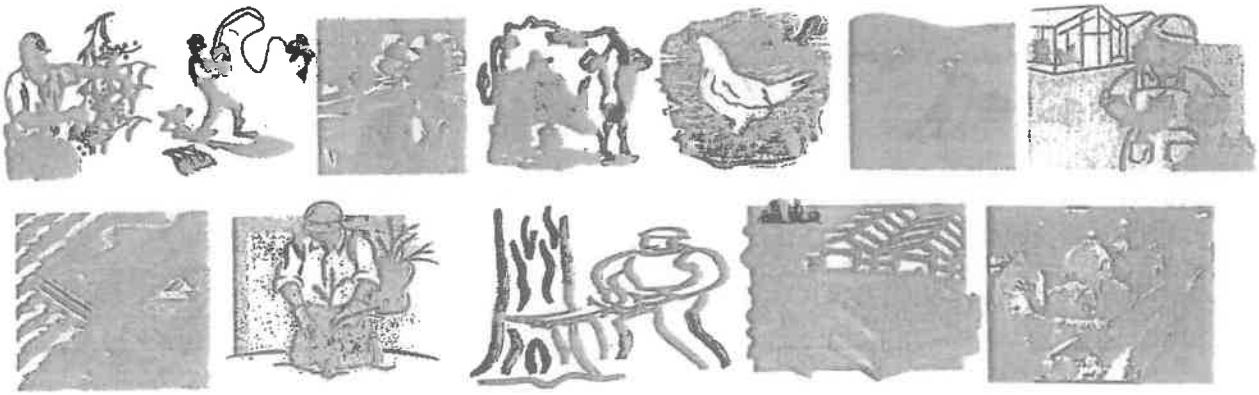
Please take a few minutes to complete this questionnaire.

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.