



ELWOOD UNION FREE SCHOOL DISTRICT

District Office

100 Kenneth Avenue

Greenlawn, NY 11740

KINDERGARTEN REGISTRATION

The Elwood Union Free School District invites residents to register eligible kindergarten children for the 2026-2027 school year. The child must be five (5) years old on or before December 1, 2026 to be admitted to kindergarten in September 2026. If you would like to register your child, please contact Lois Brezovsky-Vulpis at 631-266-5400 x1455 or email registration@elwoodufsd.org to schedule an appointment. Registration hours are 8:30 am – 11:30 am. Registration forms can be downloaded at www.elwoodufsd.org or are available for pick-up at the Security desk of Elwood Middle School. **Please have your packet completed prior to your appointment.**

REQUIREMENTS FOR REGISTRATION:

- Photo ID of parent/guardian registering child
- **ORIGINAL** Birth Certificate – (if foreign born, translated into English)
- Record of immunizations signed and stamped from a licensed physician. If scheduling a doctor's appointment, please provide most recent records.

PROOF OF GUARDIANSHIP:

- Divorce Papers
- Court issued legal guardianship papers
- Court order granting custody
- Court appointment as foster parent
- Notarized Parent affidavit and Custodial affidavit (forms provided by district)
- Copy of recent income tax return showing the student as a dependent

NOTE: In the event of divorce or separation, both parents have equal access to their children and information unless a filed court order is received instructing otherwise.

PROOF OF RESIDENCY FOR HOMEOWNERS:

- Deed or Suffolk County Tax Bill
- Three (3) additional documents with your name and address of them (see below)

PROOF OF RESIDENCY FOR RENTERS:

- Notarized Affidavit from Landlord (form provided by district)
- Copy of Deed or Tax Bill from Landlord
- Notarized Affidavit from Renter (form provided by district)
- Three (3) additional documents with your name and address on them (see below)

RESIDENCY DOCUMENTS FOR ALL STUDENTS MUST BE PROVIDED EVEN IF THERE ARE OTHER CHILDREN IN THE DISTRICT.

At registration, all foster parents must submit a letter from the placement agency indicating the licensed foster parent, the date of birth and grade of the child, and Form DSS 2999 completed by the placement agency.

ACCEPTABLE PROOFS OF RESIDENCY: Any three (3) of the following (**dated current or past month**):

Water Bill	Mortgage Statement	Electric Bill
D.S.S. Correspondence	Gas Bill	Social Security Correspondence
Telephone Bill	Unemployment Correspondence	Credit Card Statements
Cable or Satellite Bill	Mailed Bank Statement	Health Statements/Bills
Federal/State Mail	Voter Registration	Oil Bill
Auto registration/license	Paystub	



ELWOOD UNION FREE SCHOOL DISTRICT
100 Kenneth Avenue
Greenlawn, NY 11740
Central Registration – Student Information Form

DISTRICT USE ONLY: SCHOOL: _____ ID# _____

Student's Name: _____ Date of Birth: ____/____/____ Gender at Birth: _____
Sex: M / F

Address: _____
(Street) (Town) (Zip)

Primary Language(s) Spoken at Home: _____ Grade Entering: _____

Preferred language for materials to be mailed home: _____

Child's Primary Language: _____

Parent 1 Cell Number: _____ Parent 2 Cell Number: _____

School Last Attended: _____ / _____ Homeless: Yes / No
(School) (District)

School Address: _____ Contact Phone Number: _____

Country of Birth: ☐ USA ☐ Other _____ Date first Entered US School: ____/____/____

Has the student ever been enrolled in the Elwood School District? Yes / No If Yes, when? _____

Special Education Services: Yes / No ENL Services: Yes / No

If yes and your child **does not** have an Elwood IEP, please (English as a New Language)
provide a copy of the IEP from your district and Release of Info

Does the student have a 504? Yes/No

PARENT #1 INFORMATION			PARENT #2 INFORMATION		
Name: _____			Name: _____		
Relationship to Student: _____			Relationship to Student: _____		
Business Telephone: _____			Business Telephone: _____		
Cell Phone Number: _____			Cell Phone Number: _____		
Home Address: _____			Home Address: _____		
Email: _____			Email: _____		
CHECK ONE:	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐ Single

☐ STEP PARENT INFORMATION		☐ GUARDIAN INFORMATION (if other than parent)		
Step Parent/Guardian's Name: _____				
Business Telephone: _____		Cell Phone Number: _____		
Home Address: _____ _____		Email Address: _____		
Document(s):	☐ Birth Certificate	☐ Baptismal Certificate	☐ Student Passport	☐ Visa

ARE ONE OR BOTH PARENTS CURRENTLY ON ACTIVE DUTY IN THE MILITARY? YES NO

STUDENT RESIDES WITH: ☐ Parent(s) ☐ Designated Legal Guardian ☐ Other

1. Is the student Hispanic, Latino or of Spanish origin?

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

2. Select one or more races from the following five racial groups. Check all that apply; CHECK AT LEAST ONE:

- ☐ **AMERICAN INDIAN or ALASKA NATIVE:** A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition; e.g. Cherokee, Mohawk, Inuit.
- ☐ **ASIAN:** A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand and Vietnam.
- ☐ **NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
- ☐ **BLACK:** A person having origins in any of the black racial groups of Africa.
- ☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

SIBLINGS OF STUDENT

NAME:	BIRTHDATE:	SCHOOL:
NAME:	BIRTHDATE:	SCHOOL:
NAME:	BIRTHDATE:	SCHOOL:
NAME:	BIRTHDATE:	SCHOOL:

HIGH SCHOOL STUDENTS ONLY:

Did the student participate in interscholastic athletics at previous school? Yes / No What Sport(s) _____

Are you interested in playing High School sports? Yes / No If yes, please complete District Athletic Forms

What sport(s) are you interested in playing? _____

EMERGENCY CONTACT INFORMATION *(please print clearly):*

In case of illness or accident, I authorize the school to call any of the following people in the event a parent **CANNOT** be reached:

Name: _____ Relationship to Student: _____

Address: _____ Town: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Name: _____ Relationship to Student: _____

Address: _____ Town: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Name: _____ Relationship to Student: _____

Address: _____ Town: _____ State: _____ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

I understand that this statement is being made **UNDER THE PENALTIES OF PERJURY**, so that my child/ward may be admitted to the schools of the Elwood School District as a district resident. I further understand if my child/ward is found not to be a legitimate resident of the Elwood District that **I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE DISTRICTS ANNUAL TUITION RATE/PER CHILD retroactive to the first day of admission.** I also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement in connection with this application will also subject me to criminal prosecution. I have been informed that the school district will make unannounced home visits for purposes of residency verification.

SIGNATURE: _____ Relationship: _____ Date: _____

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
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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. Providing it will not affect your immigration status or your eligibility for enrollment or other 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 or rent 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 or 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:



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	☐ 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? _____

Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____
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.

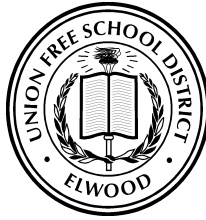
PROFICIENCY LEVEL
ACHIEVED ON
NYSITELL:

- ☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

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

Harley Avenue Primary School

Office of the Principal
30 Harley Avenue
Elwood, NY 11731
Phone: 631-266-5445
Fax: 631-266-3985



Board of Education

James Tomeo, President
Deborah Weiss, Vice President
Walter Edwards, Member
Thomas Scarola, Member
Sara Siddiqui MD, Member

Julie Bilello
Principal

Gayle Steele, Ed.D.
Superintendent of Schools

Welcome to the Elwood School District. My name is Mrs. Schwartz, the school nurse at Harley Avenue. I look forward to working with your children in the upcoming school year. Please review all documents/forms in the health packet.

New York State law requires a complete updated immunization record stamped by your physician and current physical examination that must be dated within 12 months prior to the first day of school. It would be a good idea to schedule your annual well visit now. If your child has already had a well visit after September 3rd of 2025, please send a copy of that exam to the health office.

Please have your physician complete the required **NYS School Health Examination Form**

https://resources.finalsite.net/images/v1759448419/elwoodk12nyus/cu5bmn2ehycil5f9f6pp/011624_Requied_NYS_School_Health_Examination_Form_2023.pdf

In addition, it is important to discuss any medical issues and allergies before school begins. Please contact me in the health office during school hours to review any medical history, family history, recent injuries or allergies. If medications are needed at school please contact me. I can be reached via email at eschwartz@elwoodufsd.org or in the health office at Harley by telephone. The phone number is (631) 266-5478. Our fax number is (631) 266-2059.

In the health packet is a summary of the NY State immunization requirements for school. Each of these immunizations can be administered by a family doctor or by a public health clinic. For public health information, families can call the Dolan Family Health Center (631) 425-5250. Private doctors will issue a certificate for the given vaccinations. **In order for your child to enter school in September, the district must have a complete signed immunization certificate from your doctor or clinic.** Please send all updated vaccination records to the health office as soon as possible as they are required for school attendance.

Sincerely,

Elizabeth Schwartz, RN/BSN

School Nurse - Harley Avenue Primary School

Elwood Union Free School District

STUDENT HEALTH HISTORY

Name:	DOB:	Age:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Grade:	Home Phone:	Date:
		Cell Phone:	

Has your child ever:	YES	NO	If Yes, please explain and include date:
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐ food ☐ environmental ☐ insect ☐ medication ☐ other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Family Heart Health History of:	YES	NO	If Yes, please specify:
Known heart abnormalities or sudden death before age 50; Structural heart abnormalities or unexplained fainting, seizures, drowning, or near drowning before age 50	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

- | | | |
|---|---|---|
| ☐ ADHD | ☐ GI Conditions (ulcer, reflux, IBS) | ☐ Scoliosis |
| ☐ Asthma/trouble breathing | ☐ Headaches/migraines | ☐ Single Organ (☐ kidney, ☐ testicle) |
| ☐ Autism/Asperger | ☐ Heart Conditions | ☐ Skin Condition |
| ☐ Dental Injuries | ☐ High Blood Pressure | ☐ Speech Condition |
| ☐ Diabetes | ☐ Mental Health Condition | ☐ Urinary Condition |
| ☐ Ear Infections | (depression, eating disorder, anxiety, OCD, ODD, etc.) | |

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	YES	NO	Please check all that apply
During or outside of school	☐	☐	☐ crutches ☐ walker ☐ wheelchair ☐ other:
TREATMENTS	YES	NO	
During or outside of school	☐	☐	☐ insulin/blood glucose monitoring ☐ inhaler/nebulizer/peak flow monitoring ☐ special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐ No ☐ Yes: _____

Please list any additional concerns: (use back of sheet if necessary) _____

Parent/Guardian Signature: _____ Date: _____

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
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥ 5 $\mu\text{g/dL}$
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*
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☐ **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 Dominic Murray Sudden Cardiac Arrest Prevention Act					
☐ Student may participate in all activities without restrictions. If Restrictions Apply – 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: <i>(please print)</i>					
Provider Address:					
Phone:			Fax:		
Please Return This Form to Your Child's School Health Office When Completed.					

2025-26 School Year

New York State Immunization Requirements

for School Entrance/Attendance¹

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 (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 after age 10 years	
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	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		

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 [CDC Catch-Up Guidance for Children 4 Months through 6 Years of Age](#).

e. For further information, refer to the [CDC Catch-Up Guidance for Children 7 through 9 Years of Age](#).

3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6 through 11: 10 years; minimum age for grade 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 2025-26, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6 through 11; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grade 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.

d. For further information, refer to the [CDC 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 [CDC Catch-Up Guidance for Children 4 Months through 17 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: At least one dose is required for all grades (pre-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 [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](#). *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**

**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**

New York State Department of Health/Division of Vaccine Excellence
health.ny.gov/immunization

2370

5/25



ELWOOD UNION FREE SCHOOL DISTRICT

100 Kenneth Avenue

Greenlawn, NY 11740

**SUFFOLK COUNTY SCHOOL EXAMINATION FORM (DENTAL)
TO BE SUBMITTED BY SEPTEMBER 30**

Dear Parents:

Maintaining a healthy mouth is an important part of a child's general health. Teeth that need treatment can cause a child to do school work inferior to his/her capabilities. A child's first teeth are important and should receive care as well as his/her permanent teeth. These temporary teeth maintain a space for the permanent teeth and help prevent malocclusion (crooked teeth).

Summer vacation is an excellent time to have dental work done. There is more time to make dental appointments and they do not interfere with the child's school work.

Please take your child to your family dentist for an oral examination and necessary treatment. This form should be completed by your dentist and returned to the school in the fall.

SCHOOL: _____ DATE: _____

GRADE: _____ TEACHER: _____

_____ has had his/her teeth examined by me and
Child's Name

1. Has had all necessary dental work completed _____
2. Is under my care _____
3. Is not in need of dental work at this time _____

Comments: _____

Dentist's Name
(please print or type)

Dentist's Signature

Address

Elwood Union Free School District
Business Office
100 Kenneth Avenue
Greenlawn, NY 11740
Phone: 631-266-5400
Fax: 631-368-2338



Board of Education
James Tomeo, President
Deborah Weiss, Vice President
Walter Edwards, Member
Thomas Scarola, Member
Sara Siddiqui, MD, Member

Lorraine Dunkel
Assistant Superintendent for Business

Gayle Steele, Ed. D.
Superintendent of Schools

Dear Parents/Guardians:

We are writing to inform you about your rights as parents or guardians of children with disabilities. Pursuant to Section 4402 of the Education Law, you have the right to refer your child for special education evaluations and services. Special education included specially designed instruction or special services or programs to meet the unique needs of students with disabilities. A parent or guardian who is concerned about his or her child's academic performance due to a disability may refer his or her child for a special education evaluation to determine whether he or she is in need of special education services. More specific information regarding referral and evaluation can be found in the New York State Education Department's handbook, "A Parent's Guide to Special Education," available in English at:

<https://www.nysed.gov/sites/default/files/programs/special-education/a-parents-guide-to-special-education.pdf>

Spanish at:

https://www.nysed.gov/sites/default/files/programs/special-education/spanish-parent-guide_0.pdf

You may also contact our Asst. Superintendent for Special Education & Pupil Personnel Services, Eileen Kelly-Gorman, at 100 Kenneth Avenue, Greenlawn, NY 11740, (631) 266-5400 x1358 for any questions you may have. We look forward to partnering with you to ensure that your child has a successful experience with our school district.

Sincerely,

Lorraine Dunkel
Assistant Superintendent for Business



ELWOOD UNION FREE SCHOOL DISTRICT
100 Kenneth Avenue
Greenlawn, NY 11740

RENTER'S/NON OWNER'S AFFIDAVIT

STUDENT(S) NAME (last name, first name)

**ATTACH A COPY OF
LEASE OR RENTAL AGREEMENT**

STATE OF NEW YORK)
COUNTY OF SUFFOLK) ss:

_____ being duly sworn, deposes and says:
(Name)

1. I/We understand that this statement is being made **UNDER THE PENALTIES OF PERJURY**, in order that the above name Child/Ward may be admitted to the schools of the Elwood UFSD as a district resident. I further understand that if the Child/Ward is found not to be a legitimate resident of the Elwood UFSD, that **I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE SCHOOL DISTRICT'S ANNUAL TUITION RATE OF APPROXIMATELY \$15,000 PER CHILD RETROACTIVE** to the first day of admission. I also realize that theft of government 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 have been informed that the school district will make unannounced home visits for purposes of residency verification. **It is the homeowner's responsibility to notify the District within ten (10) days of any changes regarding the individuals who permanently reside at this address.**
2. I _____ am the **(Parent/Guardian/Custodial Parent)** of the above named child/Ward. I reside at (state address and specify the exact nature of the space; basement Apartment, second floor apartment, number of rooms, etc.)

With my Child/Ward, and

1.	2.
3.	4.
5.	6.
7.	8.

(LIST EACH AND EVERY PERSON LIVING AT THE ABOVE ADDRESS)

This is my actual and only permanent residence. My Child/Ward lives with me and said address is his/her actual and only permanent residence.

3. My last address was _____

Where I lived with:

1.	2.
3.	4.
5.	6.
7.	8.

(LIST EACH AND EVERY PERSON LIVING AT THE ABOVE ADDRESS)

I began living at _____ (current address)
on _____. The terms and conditions of my tenancy are as follows (specify
rent, etc.)

MONTHLY RENT: _____
DURATION OF TENANCY: _____

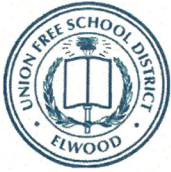
Signature of Renter/Non Owner

Sworn to before me
this ____ day of ____ 20__.

Print Name of Renter/Non Owner

NOTARY PUBLIC

Phone Number



ELWOOD UNION FREE SCHOOL DISTRICT
100 Kenneth Avenue
Greenlawn, NY 11740

LANDLORD/OWNER'S AFFIDAVIT

STUDENT(S) NAME (last name, first name)

**ATTACH A COPY
OF RECENT TAX BILL**

STATE OF NEW YORK)
COUNTY OF SUFFOLK) ss:

_____ being duly sworn, deposes and says:
(Landlord/Owner Name)

1. I/We understand that this statement is being made **UNDER THE PENALTIES OF PERJURY**, in order that the above name Child/Ward may be admitted to the schools of the Elwood UFSD as a district resident. I further understand that if the Child/Ward is found not to be a legitimate resident of the Elwood UFSD, that **I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE SCHOOL DISTRICT'S ANNUAL TUITION RATE OF APPROXIMATELY \$15,000 PER CHILD RETROACTIVE** to the first day of admission. I also realize that theft of government 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 have been informed that the school district will make unannounced home visits for purposes of residency verification. **It is the homeowner's responsibility to notify the District within ten (10) days of any changes regarding the individuals who permanently reside at this address.**
2. I am the legal owner of _____
(Address) **A COPY OF YOUR TAX BILL MUST BE ATTACHED**

I, the landlord/owner, reside at this address: YES NO

The terms and conditions of said tenancy are as follows: (Specify, Rent, Floor, Rooms, etc.)

3. To the best of my knowledge the above mentioned property is the current residence of _____
(Name of Parent/Guardian) and the above named Child/Ward
4. The following names include ALL other persons living at this address.

Signature of Owner

Sworn to before me
this ____ day of ____ 20__.

Print Name of Owner

NOTARY PUBLIC

Phone Number