Mount Sinai School District
Mount Sinai, New York

*** CHECKLIST FOR INCOMING STUDENTS ***

All forms must be completed, signed, and returned at registration.

✓ **Check the appropriate box after completing each form**
☐ **1. Registration Form**
☐ **2. Parent Questionnaire**
☐ **3. Health History**
☐ **4. Home Language Questionnaire**
☐ **5. Proper Use of Information Resources**
☐ **6. Physical Examination Form** *(to be completed by your child's physician)*
☐ **7. Dental Health Certificate** *(to be completed by your child's dentist)*

In addition to the above forms, you will also need the following items:

✓ **Check the appropriate box after obtaining each item**

☐ **1. Proof of Residency**

Owners:
- ☐ 1. Original Town of Brookhaven tax bill, or deed

and
- ☐ 2. Current utility bill

Renters:
- ☐ 1. Notarized statement of residence from lessor
- ☐ 2. Copy of Lessor's tax bill
- ☐ 3. Current Utility Bill

☐ **2. Original birth certificate with raised seal**

☐ **3. Immunizations record**

MOUNT SINAI SCHOOL DISTRICT
Mount Sinai, New York 11766

REGISTRATION FORM

Student Information (please print) Entering Grade ____________

Last Name______________________________ First Name______________________ MI_____ Sex: M F

Address____
(Street, City, State, Zip)

Telephone ( ) ___________________ Date of Entry Into Grade 9 (High School Only) _____/_____/_____

Date of Birth_____/_____/_____ Place of Birth_______________________________________
(City, State, Country)

Ethnicity/Race: Are you Hispanic/Latino or of Spanish Origin? _____Yes _____No

And Check one of the following:

American Indian/Alaskan Native_______ Asian_______ African American/Black _______

Native Hawaiian/Pacific Islander______ White ______

Primary Lang. Spoken at Home __________________________

Date of 1st Polio Vaccination _____/_____/_____

Previous Address ____
(Street, City, State, Zip)

Previous School ____
(Street, City, State, Zip)

Family Information (please print)
Is this child in legal/custodial guardianship? Yes_____ No_____
Father (Circle one: Natural Step Guardian)

Name ____ Occupation ______________________________

Home phone ____________________ Work phone ____________________ Cell phone ____________________

Email address ______________________________ Does the child reside with this parent? Yes _____ No _____

Address (If different than child's address)____
(Street, City, State, Zip)

Mother (Circle one: Natural Step Guardian)

Name ____ Occupation ______________________________

Home phone ____________________ Work phone ____________________ Cell phone ____________________

Email address ______________________________ Does the child reside with this parent? Yes _____ No _____

Address (If different than child's address)____
(Street, City, State, Zip)

NAMES OF SIBLINGS	Sex	Date of Birth	Grade

Parent Questionnaire / New Entrant Information

Please Print

Last Name_________________________________ First Name ___________________Grade_______

1. Has your child ever been retained? No____ Yes____ Grade_______

2. Has your child been previously classified in need of special education services? Yes_____ No_____

3. Does your child have a current Individualized Education Plan (IEP)? Yes____ No_____

4. Has your child ever received any remedial or support services? Yes_____ No_____

5. Does your child have any unusual abilities and/or limitations ? Yes _____ No ______

If yes, please explain ____

6. Does your child have a vision problem? Yes______ No______ A hearing problem? Yes ______ No ______

7. Are there any recent medical facts of importance? Yes______ No______

If yes, please explain____

____

8. Are there any special circumstances the school should be aware of regarding your child? Yes _____ No _____

If yes, please explain____

____

____

9. Is your family currently:

a) living in a shelter? Yes_____ No_____
b) living with relatives or others due to lack of housing? Yes_____ No_____
c) living in a motel/hotel, camping ground, car, train/bus station, or other similar situation due to lack of adequate housing? Yes_____ No_____
d) temporarily housed in a shelter awaiting permanent placement? Yes_____ No_____

Parent/Guardian Signature ____ Date ______________

11/9/10

FOR ATTENDANCE OFFICE USE ONLY

Date Entered in PowerSchool:____________

Routing: Curriculum Office__________ Nurse__________ PPS__________

The University of the State of New York • The State Education Department • Office of Bilingual Education
Albany, New York 12234

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 English. Your assistance in answering these questions is greatly appreciated.

Thank You

TO BE COMPLETED BY SCHOOL PERSONNEL

DISTRICT *Please print or type clearly*

SCHOOL GRADE

STUDENT NAME

DATE OF BIRTH Month: Day: Year:

STUDENT IDENTIFICATION NUMBER

COUNTRY OF BIRTH / ANCESTRY

NUMBER OF YEARS ENROLLED IN SCHOOL OUTSIDE THE U.S.

NAME/POSITION OF SCHOOL PERSONNEL COMPLETING THIS SECTION

DETERMINATION: ❑ Possible LEP ❑ English Proficient

(✔ boxes that apply)

1. What language(s) is spoken in the student's home or residence? ❑ **English** ❑ **Other** ______ *specify*
2. What language(s) are spoken most of the time to the student, in the home or residence? ❑ **English** ❑ **Other** ______ *specify*
3. What language(s) does the student understand? ❑ **English** ❑ **Other** ______ *specify*
4. What language(s) does the student speak? ❑ **English** ❑ **Other** ______ *specify*
5. What language(s) does the student read? ❑ **English** ❑ **Other** ______ *specify* ❑ **Does Not Read**
6. What language(s) does the student write? ❑ **English** ❑ **Other** ______ *specify* ❑ **Does Not Write**
7. In your opinion, how well does the student understand, speak, read and write English?

	Very well	*Only a little*	*Not at all*
Understands English	❑	❑	❑
Speaks English	❑	❑	❑
Reads English	❑	❑	❑
Writes English	❑	❑	❑

Signature of Parent/Guardian/Other

Date Month: Day: Year:

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: ☐ Mother ☐ Father ☐ Other: ______________________

OFFICIAL ENTRY ONLY - NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING HLQ

NAME: ______________________ POSITION: ______________________

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

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

NAME: ______________________ POSITION: ______________________

ORAL INTERVIEW NECESSARY: ☐ 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 ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

MOUNT SINAI SCHOOL DISTRICT
MOUNT SINAI, NEW YORK

HEALTH HISTORY

Name of Child ______________________ Grade _____ Teacher ______________

Sex _____ Date of Birth ______________ Place of Birth ______________________

Home Address ______________________________ Phone ______________

Father's Name ____

Place of Employment __________________________ Phone ______________

Mother's Name ____

Place of Employment __________________________ Phone ______________

Physician to be notified in emergency __________________ Phone ______________

Two local relatives/friends to notify in case of emergency:

Name __________________ Address __________________ Phone ____________

Name __________________ Address __________________ Phone ____________

Does your child wear glasses? _____ Doctor __________________ Date of last exam ________

Does your child have a hearing problem? _______ Doctor & number ____________________

Child's Dentist ______________________ Date of last exam ______________

Does your child have any allergies? __________ What is the allergy? ____________________

____

Does your child have asthma? ____

Does your child take medication regularly? _____ If so, what medication and why? ____________

____

Is there anything concerning the eyes, ears or general health of your child which the school should know in order to provide special care? ______________________________________

____

____

Operations (type/year) ____

Serious injuries (type/year) ____

Parent/Guardian Signature ______________________________ Date ______________

PROPER USE OF INFORMATION RESOURCES

It is the policy of the Mt. Sinai School District to maintain access for its staff and student's local, national and international sources of information and to provide an atmosphere that encourages access to knowledge and sharing of information. The Mt. Sinai UFSD works to create an intellectual environment in which students, staff and faculty may feel free to create and to collaborate with colleagues at any institution, without fear that the products of their intellectual efforts will be violated by misrepresentation, tampering, destruction and/or theft.

It is the policy of the Mt. Sinai UFSD that information resources will be used by members of its community with respect for the public trust through which they have been provided and in accordance with policy and regulations established from time to time by the State of New York, the State Board of Regents, the State Board of Education and the Mt. Sinai UFSD Board of Education and Administration.

For purposes of this policy, information resources are meant to include any information in electronic or audio-visual format or any hardware or software that make possible the storage and use of such information. As example, included in this definition are electronic mail, local databases, externally accessed databases, CD-ROM, On-Line services, the Internet, motion picture film, recorded magnetic media, photographs, and digitized information such as may be made available on the network or in the district.

Access to the information resource infrastructure within Mount Sinai UFSD, sharing of information and security of the intellectual products of the community, all require that each and every user accept responsibility to protect the rights of the community. Any member of the Mt. Sinai UFSD community who, without authorization, accesses, uses, destroys, alters, dismantles or disfigures any institution information technologies, properties or facilities, including those owned by third parties, thereby threatens the atmosphere of increased access and sharing of information , and threatens the security within which members of the community may create intellectual products and maintain records. That person(s) has engaged in unethical and unacceptable conduct and moreover, may be guilty of violating the New York State law. Access to the networks and to the information technology environment within Mt. Sinai UFSD is a privilege and must be treated as such by all users of the network and its associated systems.

To ensure the existence of this information resource environment, members of the Mt. Sinai UFSD community will take actions to identify and to set up technical and procedural mechanisms to make the information technology environment on the network resistant to disruption.

The Mt. Sinai UFSD characterizes as unethical and unacceptable, and just cause for taking disciplinary action, removal of networking privileges, and/or legal action, any activity through which an individual:

(a) violates such matters as institutional or third party copyright, license agreements and other contracts,

(b) interferes with the intended use of the information resources,

(c) seeks to gain or gains unauthorized access to information resources,

(d) uses or knowingly allows another to use any computer, computer network, computer system, program, or software to devise or execute any artifice or scheme to defraud or to

obtain money, property, services, or other things of value by false pretenses, promises, or representations.

This policy is applicable to any member of the Mt. Sinai UFSD community, whether at educational institutions or elsewhere, and refers to all information resources whether individually controlled, or shared, stand alone or networked. The individual buildings may define "conditions of use" for facilities under their control. Such statements should be consistent with this overall policy but may provide additional detail, guidelines and/or restrictions. Where such "conditions of use" exist, enforcement mechanisms defined therein shall apply. Disciplinary action, if any, for students, faculty and staff shall be consistent with the district' standard policies and practices. Where use of external networks is involved, policies governing such use also are applicable and must be adhered to.

FORMS

Student Name ____ Grade ____________

I have read the Acceptable Use Policy and Student Guidelines, and agree to abide by the provisions. I understand that violation of the use provisions stated in the policy may constitute suspension or revocation of network privileges, as well as other actions noted in the policy.

Student Signature ____ Date ______________

SPONSORING PARENT OR GUARDIAN (Required)

I have read the Acceptable Use Policy and I understand that administrators of the network have taken reasonable precautions to ensure that controversial material is eliminated. I hereby give my permission for my child to use the network and certify that the information contained on this form is correct.

Parent Signature ____ Date _____________

Address ____ Phone _____________

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / (Month Day Year)

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of ____________________________ on ________________ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp) Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here.

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.