



FRANKLIN SQUARE UNION FREE SCHOOL DISTRICT

DISTRICT OFFICES: Washington Street School
760 Washington Street, Franklin Square, NY 11010-3898

FAX: (516) 505-6972

Patrick J. Manley
Superintendent of Schools
(516) 505-6975

FOUNDATION
for SUCCESS

Dear Parent or Guardian:

Welcome to Franklin Square! We are pleased that you have expressed an interest in registering your child for our schools. As you work with our Central Registrar, please know that we are anxious to complete the necessary paperwork as quickly as possible. If you'll pay careful attention to these requirements, I am certain we will be able to successfully register your child quickly. To register, please call the Central Registration Office at 481-4100 ext. 3311 for an appointment.

Enclosed with this letter is a registration packet for you to complete. Included in this packet is a "Physician's Medical Form" which you may bring at the time of registration. Please note that the physical exam must be dated from September 2016 or any date thereafter. Your child will be excluded from all physical activity until the "Physician's Medical Form" is completed and returned to the Central Registration Office. The School Medical Doctor will examine any child who is not seen by his/her own physician. Also included in the packet is a "Record of Immunization" form for your physician to complete. Please bring this form with you to the registration. Your child may not begin school until a completed "Record of Immunization" form is presented to the Central Registration Office.

In order to register your child for school, please be sure to provide the following:

1. **Original birth certificate**
2. **Proof of immunization with physician's original signature**
(See attached sheet indicating New York State required immunizations.)
3. **Proof of residency (original documents). Current documentation must be provided.**

Students will not be registered unless proofs of residence are submitted. Since the cost to educate a child in this District is approximately \$16,451 per year, we must be certain that every child is a legal resident. The District requires proofs of residence in order to protect the taxpayers from the costs of educating non-resident students. We recognize that presenting these proofs may be somewhat bothersome, but we hope you understand the requirement is for your benefit as a new member of this community.

Warning: This District will take legal action to collect tuition charges if the student is illegally registered. Any person or persons, in addition to parents or guardians, who provide false evidence of residence will also be prosecuted. The District may investigate a student's residence by visits and other means.

You must submit one proof from each category:
(PLEASE SUBMIT ORIGINAL DOCUMENTS)

CHILD'S BIRTH – PART A

____ Birth Certificate (original)

PARENT/GUARDIAN'S IDENTITY – PART B

____ Driver's License
____ Photo Identification Card
____ Visa
____ Valid Passport
____ Other Photo Identification Issued by a
Government Agency

PROOF OF RESIDENCY – PART C

____ Deed

If you are a renter, you must provide one of the following:

____ Lease – Include a copy of Landlord Deed, Tax Bill
or Mortgage Statement

____ Notarized Affidavits from Owner and Parent/Guardian
Include a copy of Landlord Deed, Tax Bill or Mortgage Statement

PROOF OF RESIDENCY – PART D

Current Documentation Must Be Provided

____ Nassau County Tax Bill
____ Mortgage Statement/Mortgage Commitment
____ Payroll Check
____ Utility Bill _____ Fuel Bill _____ DDS ID
____ Any Utility Hook-up Agreement

PROOF OF PARENTAL RELATIONSHIPS AND FAMILY INFORMATION - PARTE

____ Birth Certificate or Adoption Order
____ Court Order Establishing Custody
____ Foster Parent Placement Order (DSS-2999)
____ Guardianship Documents or Court Order

Your child will not be able to attend school without receipt of all the required documents. Should you have any questions, please contact the Central Registrar's office at 516-481-4100 ext. 3311.

Again, I welcome you to our schools. We are very proud of all that this district represents and look forward to making you and your child a part of our educational community. If you have questions about this process, you can certainly direct them to our Central Registrar.

Sincerely yours,

Patrick J. Manley

Patrick J. Manley
Superintendent of Schools

PJM:cm

Type or Print

PUPIL'S NAME

(LAST)

(FIRST)

(MIDDLE INITIAL)

ELEMENTARY SCHOOL

FRANKLIN SQUARE SCHOOL DISTRICT

PROOF OF BIRTH

ENTRANCE DATE

SCHOOL LAST ATTENDED

Preference for Pre-K (NOT Guaranteed) AM or PM ENTERING GRADE

HOME ADDRESS

ETHNICITY (Choose One): Hispanic/Latino Non Hispanic/Latino

RACE: (Choose one or more)

White Black or African American Asian

Native Hawaiian or Other Pacific Islander American Indian or Alaska Native

(City) TELEPHONE 1. (State) 2. (Zip) 3.

(Home #)

(Cell #)

DATE OF BIRTH:

(MONTH)

(DAY)

(YEAR)

MALE

FEMALE

COUNTRY OF ORIGIN:

DATE ENTERED U.S.

YEARS IN U.S. SCHOOLS

BIRTHPLACE

(VILLAGE, TOWN OR CITY)

(STATE)

(COUNTY)

HOMELESS: Yes No

LIVING ARRANGEMENT:

Shelter Relatives Hotel Other

FAMILY INFORMATION

BIRTHPLACE

U.S. CITIZEN

OCCUPATION

BUSINESS ADDRESS

BUSINESS TELEPHONE

MOTHER

FATHER

Mother's Email:

Father's Email:

PUPIL LIVING WITH

(NAME of Parent/Guardian)

(RELATIONSHIP)

LANGUAGES SPOKEN IN HOME

Other Children in Family including Foster, etc. (give name and birth date)

Adults (other than parents) living in home

Relationship to Student

1. D.O.B.

D.O.B.

1.

2. D.O.B.

D.O.B.

2.

UNUSUAL HOME CONDITIONS AFFECTING PUPIL

i.e., Death, Divorce, Separation, Step Parent, Parental Handicaps (deaf, blind, etc.), One Parent Home, etc.

DATE REGISTERED

Entered on E-School

WITHDRAWAL DATA:

DATE:

REASON:

FRANKLIN SQUARE SCHOOL DISTRICT
PROOF OF RESIDENCY

STUDENTS WILL BE REGISTERED AND ADMITTED TO SCHOOL UPON THE DISTRICT'S RECEIPT OF PROOF OF THE CHILD'S BIRTH, PROOF OF THE PARENTS' IDENTITY, AND PROOF OF RESIDENCY.
The District's Registrar will determine any need for additional proofs.

The Franklin Square School District must determine that every child is a LEGAL resident. The District requires proofs from the following categories in order to protect the taxpayers from the costs of educating illegal registrants.

WARNING: The District will take legal action against anyone who participates in falsely providing information to register a child illegally. The District will investigate all residency claims that are suspect by visits or other means.

YOU MUST SUBMIT ONE PROOF FROM EACH CATEGORY (PLEASE SUBMIT ORIGINAL DOCUMENTS)

CHILD'S BIRTH:
Birth Certificate (original)

PARENT/GUARDIAN'S IDENTITY:

- Driver's License
- DMV Photo Identification Card
- Visa
- Valid Passport
- Other Photo Identification Issued by Government Agency

PROOF OF RESIDENCY:
If you are the Homeowner you must provide one of the following:
Deed

PROOF OF RESIDENCY:

- Current Documentation Must Be Provided*
- Nassau County Tax Bill
- Mortgage Statement/Mortgage Commitment
- Payroll Check
- Utility Bill
- Fuel Bill
- DDS ID
- Any Utility Hook-up Agreement

If you are a Renter you must provide one of the following:
Lease (Include a copy of Landlord Deed, Tax Bill or Mortgage Statement)
Notarized Affidavits from Owner and Parent/Guardian
(Include a copy of Landlord Deed, Tax Bill or Mortgage Statement)

PROOF OF PARENTAL RELATIONSHIPS AND FAMILY INFORMATION:

- Birth Certification or Adoption Order
- Court Order establishing custody
- Foster Parent Placement Order (DSS-2999)
- Guardianship documents or Court Order

I submit that the above documents have been presented and represent true information.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

FRANKLIN SQUARE SCHOOL DISTRICT

PARENT/GUARDIAN AFFIDAVIT IN LIEU OF LEASE

1. I/We _____

and my/our child(ren) _____

are residing at the residence of:

Name of Owner/Landlord

Street Address

Town County Zip

2. I/We understand that this statement is being made under the penalties of perjury in order that the above name(s) child(ren) may be admitted to the Franklin Square School District. I/We further understand that if the child(ren) is/are found not be a legitimate resident that I/we will be legally responsible for and will be billed for the school district's annual tuition rate of approximately \$16,451 per year, per child retroactive to the first day of admission. I/We also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application may make me/us liable to criminal prosecution. I/We have been informed that the school district will make unannounced home visits for purposes of residency and information verification.

Parent/Guardian Signature

Sworn before me this _____ day of
_____ 20 _____

Notary Public

FRANKLIN SQUARE SCHOOL DISTRICT

LANDLORD AFFIDAVIT IN LIEU OF LEASE

Please include a copy of Landlord Deed, Tax Bill or Mortgage Statement

1. I/We _____ am/are the owner(s)/landlord of the following premises:

Street

Town

County

Zip

2. Name(s) of Parent(s) or Guardian(s) residing full time at above address:

_____, _____

and child(ren)

_____, _____

_____, _____

3. I/We understand that this statement is being made under the penalties of perjury in order that the above name(s) child(ren) may be admitted to the Franklin Square School District. I/We further understand that if the child(ren) is/are found not be a legitimate resident that I/we will be legally responsible for and will be billed for the school district's annual tuition rate of approximately \$16,451 per year, per child retroactive to the first day of admission. I/We also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application may make me/us liable to criminal prosecution. I/We have been informed that the school district will make unannounced home visits for purposes of residency and information verification.

Signature of Landlord

Landlord's Name (Print)

Landlord's Address of Residence

Town

Zip

Landlord's Phone Number

Sworn before me this _____ day

of _____ 20 _____

Notary Public

2016-17 School Year New York State Immunization Requirements for School Entrance/Attendance¹

NOTES:

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). For grades Pre-k through 8, intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. (Exception: Intervals between doses of polio vaccine need to be reviewed only for grades prekindergarten, kindergarten, 1, 2, 6, 7 and 8.) Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. Intervals between doses of vaccine DO NOT need to be reviewed for grades 9 through 12. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should 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	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1 and 2	Grades 3, 4 and 5	Grades 6, 7 and 8	Grades 9, 10, 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap) ²	4 doses	5 doses or 4 doses If the 4th dose was received at 4 years of age or older or 3 doses If aged 7 years or older and the series was started at 1 year of age or older		3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap) ³		Not applicable		1 dose	
Polio vaccine (IPV/OPV) ⁴	3 doses	4 doses or 3 doses If the 3rd dose was received at 4 years of age or older	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years of age or older	3 doses
Measles, Mumps and Rubella vaccine (MMR) ⁵	1 dose			2 doses	
Hepatitis B vaccine ⁶	3 doses			3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years of age	
Varicella (Chickenpox) vaccine ⁷	1 dose	2 doses	1 dose	2 doses	1 dose
Meningococcal conjugate vaccine (MenACWY) ⁸		Not applicable		By Grade 7: 1 dose	Grade 12: 2 doses or 1 dose If the dose was received at 16 years of age 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	

Record of Immunization

NAME _____

Date of Birth _____

Hib Vaccine _____

Prevnar Vaccine _____

DTaP Vaccine _____

DT _____

Tdap _____

Oral Polio Vaccine (OPV) _____
(IPV) _____

MMR #1	_____	Measles	_____
MMR #2	_____	Mumps	_____
		Rubella	_____

MCV4 #1 _____ #2 _____

Hep B: # 1 _____ # 2 _____ # 3 _____

Varicella Vaccine: (1) _____ (2) _____ Varicella Disease _____

TB-Mantoux _____ TB PPD _____

Lead test date _____ Results _____

Other _____

Physician's Signature _____ Date _____

FRANKLIN SQUARE UFSD - PHYSICIAN'S MEDICAL FORM

STUDENT'S NAME: (print): _____ **DOB:** _____ **Grade:** _____ **Date:** _____
 (Fill in all blanks; write "N/A" if it does not apply) **School** _____

IMMUNIZATION HISTORY

Pprevnar	1) _____	Polio	1) _____	MMR	1) _____	Measles	_____	Serology	_____
	2) _____	(OPV	2) _____		2) _____	Mumps	_____	Serology	_____
	3) _____	or	3) _____			Rubella	_____	Serology	_____
	4) _____	IPV)	4) _____	Varivax	1) _____	2) _____	Had disease-Year	_____	Titers
DTaP	1) _____		5) _____	MCV4	1) _____	2) _____			
	2) _____	Tdap	_____	Hepatitis B	1) _____	2) _____	3) _____		
	3) _____			HIB	1) _____	2) _____	3) _____	4) _____	
	4) _____								
	5) _____								

TB Testing _____ **Lead Testing** _____ **Results** _____
Other _____

STUDENT HISTORY

	Date		Date		Date		Date
Chicken Pox		Lymes		Asthma		Serious Injury	
Ger. Measles		Pneumonia		Diabetes			
Measles		Poliomyelitis		Epilepsy		Operations	
Meningitis		Rheumatic Fever		Seizure			
Mononucleosis		Scarlet Fever		Ear Condition		Allergies	
Mumps		Pertussis		Heart Disease			
Hepatitis		Anemia		Tuberculosis			

PHYSICAL EXAMINATION

General Condition: Good _____ Fair _____ Poor _____

Height: _____ **Weight:** _____ **BMI:** _____ **Weight Status Category (BMI) Percentile:** _____ **B/P:** _____

Vision: _____ **Audio:** _____ **Scoliosis:** Neg: _____ Positive: _____

(Please indicate systems evaluated):

- | | |
|-------------------------------|--|
| 1. Neurological: _____ | 2. Genital/Urinary: _____ U/A: _____ |
| 3. ENT: _____ | 4. Gastro-Intestinal: _____ |
| 5. Endocrine: _____ | 6. Skeletal: _____ |
| 7. Respiratory: _____ | |

3. **Cardiac/Circulatory:** Hx. of Murmur _____ Any limitations? No _____ Yes _____
 Explain: _____

Has this pupil any handicapping disability: No _____ Yes _____ **Dx:** _____
 May child participate in all school activities? Yes _____ No _____

Explain: _____

Does this child need medication: No _____ Yes _____ **Dx:** _____

Name of Medication: _____ **QD** _____ **PRN** _____

Other: _____

Date of Exam: _____ **Dr. Signature:** _____ **Print Name of Dr.:** _____

Health History
(To be completed by Parent/Guardian)

Name: _____ DOB _____ Grade: _____

Allergies

Food Type: _____ (Ingestion _____ Touch _____ Airborne _____)
Insect _____ Seasonal _____ Medication _____ Other _____

Symptoms to look for: _____

Are these allergies: Self-dignosed or MD dignosed (circle one)

Uses an Epi-Pen _____

Student's Medical History: Please note date if possible

Anemia _____ Diabetes _____ Mumps _____ Seizure _____ Eczema _____
Asthma _____ German Measles _____ Mononucleosis _____ Epilepsy _____
Chickenpox _____ Hepatitis _____ Pneumonia _____ Heart Disease/Murmur _____
Cystic Fibrosis _____ Measles _____ Scarlet Fever _____ Rheumatic Fever _____
Tuberculosis _____ Ear Conditions _____ Frequent Cold/Sore Throats _____

Other Relevant Medical Information: _____

Past Surgical History: _____

Present Health:

Skin: Rashes, Bruises, Unexplained Lumps: _____

Eyes: Normal Vision _____ Amblyopia _____ Wears Glasses _____

Respiratory Illnesses: _____

Cardiovascular: Known Murmur _____ Shortness of breath _____ Limits to physical activity _____
Ever evaluated by a Cardiologist _____

Gastrointestinal: Frequent stomach aches _____ Frequent diarrhea _____ Frequent constipation _____
Urinary Problems _____ Skeletal/Neuromuscular Disorders _____

Developmental History:

When did your child reach the following milestones? (Month/Year)

Sit Alone _____ Walk Alone _____ Say single words _____ Use two word sentences _____ Toilet Trained _____

Psychosocial History:

Family: Intact Family _____ Divorced _____ Separated _____ Adopted _____ Guardianship _____ Other _____

Does your child receive outside services (tutoring, speech therapy, physical therapy, counseling): _____

Specify _____

Medication:

Does your child take any medication on a daily basis? _____ Specify _____

Other Comments:

Parent/Guardian Signature _____

Date _____

SAMPLE

Dental Health Certificate- Optional

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: / / Sex: Male Female Will this be your child's first visit to a dentist? Yes No
Month Day Year

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.

PRIOR SPECIAL EDUCATION SERVICES

NAME _____ GRADE _____ DOB _____
(Print First and Last Name)

SECTION I: PRE-KINDERGARTEN STUDENTS ONLY

- Has your child (age 3 to 5) ever received Special Education service through Committee on Preschool Special Education (CPSE) in the Franklin Square School District? Yes ___ No ___ (Check One) If "No" proceed to Section II
 - Dates of CPSE Service: From _____ To _____
 - Was a Transition Meeting held? Yes ___ No ___ Not Sure ___
(Check One) If "No" or "Not Sure" please go to the Special Education Office after registration
- I am registering my child for the Franklin Square Pre-K program. Yes ___ No ___
(Check One) If "No" discontinue registration and go to the Special Education Office. (See Carolyn Mione)

SECTION II:

- Has your child (age 5 & older) ever received Special Education service through Committee on Special Education (CSE)? Yes ___ No ___ (Check One) If "No" discontinue

SECTION III:

SCHOOL DISTRICT IN WHICH YOUR CHILD WAS PRESENTED TO CSE:

District

City

State

PLEASE CHECK THE HANDICAPPING CONDITION DETERMINED BY THE LAST CSE:

- | | | |
|--|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Deafness | <input type="checkbox"/> Orthopedically Impairment |
| <input type="checkbox"/> Emotionally Disturbance | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Other Health-Impairment |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Speech/Language Impairment | <input type="checkbox"/> Multiple Disabilities |
| <input type="checkbox"/> Intellectually Impairment | <input type="checkbox"/> Visually Impairment/Blindness | <input type="checkbox"/> Deaf-Blindness |

LAST SPECIAL EDUCATION SERVICE RECEIVED IN:

School

City

State

Date

Name & phone number of Contact Person: _____

CHECK TYPE OF SERVICE BELOW:

- | | | |
|---|---|---|
| <input type="checkbox"/> Resource Room | <input type="checkbox"/> Day School / Integrated | <input type="checkbox"/> Hospital Placement |
| <input type="checkbox"/> Integrated Class | <input type="checkbox"/> Residential School | <input type="checkbox"/> Court Placement |
| <input type="checkbox"/> Self-Contained Class | <input type="checkbox"/> Itinerant Service | |
| <input type="checkbox"/> BOCES / Special School | <input type="checkbox"/> Special Home Instruction | |

I, _____ (Print Your Full Name) authorize the release of information to the Franklin Square School District in order to obtain all special education data to assist in seeking the most appropriate placement for my son/daughter _____ (Print Childs Full Name).

Signature of Parent/Guardian

Date



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

Lissette Colon-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:		GENDER:
Month	Day	Year
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?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother _____ specify	<input type="checkbox"/> Father _____ specify	<input type="checkbox"/> Guardian(s) _____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak _____ specify
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read _____ specify
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not write _____ specify

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:	STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:
_____	_____
<i>District Name (Number) & School</i>	<i>Address</i>

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:



FRANKLIN SQUARE UNION FREE SCHOOL DISTRICT

District Offices, Washington Street School
760 Washington Street, Franklin Square, NY 11010

FAX No. (516) 505-6972

Patrick J. Manley
Superintendent of Schools
(516) 505-6975

Date: _____

To the Principal of: _____
(Name of last school attended)

Address: _____

The student listed below is newly registered in our district.

Name of Student: _____
(Please Print) Last Name First Name

Grade: _____ Date of Birth _____

Does the student have an I.E.P. in place? _____ Yes _____ No

Please forward all academic and health records you have pertaining to the above named child to:

John Street School
560 Nassau Blvd.
Franklin Square, NY 11010
Attention: Principal
Fax #: 516-505-6988

Polk Street School
960 Polk Avenue
Franklin Square, NY 11010
Attention: Principal
Fax #: 516-326-3794

Washington Street School
760 Washington Street
Franklin Square, NY 11010
Attention: Principal
Fax #: 516-505-6991

Thank you.

Signature of Parent/Guardian

Date