



**FRANKLIN SQUARE UNION FREE SCHOOL DISTRICT**

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

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FAX: (516) 505-6972

Office of the Superintendent  
(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 Registrars, 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 Registration Offices at each building listed below for an appointment.

JSS: 481-5780 ext. 3140

PSS: 352-6300 ext. 3240

WSS: 481-4100 ext. 3340

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 2018 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 Registrar at your home building.

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 Registrar at your home school.

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.

Sincerely,

*Office of the Superintendent*

Type or Print PUPIL'S NAME (LAST) (FIRST) (MIDDLE INITIAL)

ELEMENTARY SCHOOL FRANKLIN SQUARE SCHOOL DISTRICT

HOME ADDRESS

TELEPHONE 1. (City) (State) 2. (Zip) 3. (Home #) (Cell #)

DATE OF BIRTH: (MONTH) (DAY) (YEAR) MALE FEMALE

BIRTHPLACE (VILLAGE, TOWN OR CITY) (STATE) (COUNTY)

FAMILY INFORMATION

MOTHER BIRTHPLACE U.S. CITIZEN

FATHER BIRTHPLACE U.S. CITIZEN

Mother's Email: Father's Email:

PUPIL LIVING WITH (NAME of Parent/Guardian) (RELATIONSHIP)

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

1. D.O.B. 3. D.O.B. 2. D.O.B. 4. D.O.B.

UNUSUAL HOME CONDITIONS AFFECTING PUPIL i.e., Death, Divorce, Separation, Step Parent, Parental Handicaps (deaf, blind, etc.), One Parent Home, etc.

PROOF OF BIRTH ENTRANCE DATE

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

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

COUNTRY OF ORIGIN: DATE ENTERED U.S.

YEARS IN U.S. SCHOOLS

HOMELESS: Yes No

LIVING ARRANGEMENT: Shelter Relatives Hotel Other

OCCUPATION BUSINESS ADDRESS BUSINESS TELEPHONE

LANGUAGES SPOKEN IN HOME

Adults (other than parents) living in home Relationship to Student

1. 2.

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
- \_\_\_\_ Any Utility Hook-up Agreement
- \_\_\_\_ DDS ID

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 Affidavis 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

# 2018-19 School Year New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**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 10, 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 DO NOT need to be reviewed for grades 5, 11 and 12.) 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 11 and 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, 2, 3 and 4	Grade 5	Grades 6, 7, 8, 9 and 10	Grades 11 and 12
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td) <sup>2</sup>	4 doses	5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older		3 doses	
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap) <sup>3</sup>	Not applicable			1 dose	
Polio vaccine (IPV/OPV) <sup>4</sup>	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older	3 doses	4 doses or 3 doses if the 3rd dose was received at 4 years or older	3 doses
Measles, Mumps and Rubella vaccine (MMR) <sup>5</sup>	1 dose	2 doses			
Hepatitis B vaccine <sup>6</sup>	3 doses	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years			
Varicella (Chickenpox) vaccine <sup>7</sup>	1 dose	2 doses	1 dose	2 doses	1 dose
Meningococcal conjugate vaccine (MenACWY) <sup>8</sup>	Not applicable			Grades 7, 8 and 9: 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) <sup>9</sup>	1 to 4 doses	Not applicable			
Pneumococcal Conjugate vaccine (PCV) <sup>10</sup>	1 to 4 doses	Not applicable			

## Record of Immunization

NAME \_\_\_\_\_

Date of Birth \_\_\_\_\_

Hib Vaccine \_\_\_\_\_

Pevnar 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 \_\_\_\_\_



**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**  
**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

**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:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

**HEALTH HISTORY**

Allergies <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Anaphylaxis Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication	<input type="checkbox"/> Environmental

Asthma <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Asthma Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	

Seizures <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Seizure Care Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type: _____	Date of last seizure: _____

Diabetes <input type="checkbox"/> No	<input type="checkbox"/> Medication/Treatment Order Attached	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
<input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____	Date Drawn: _____

**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):  <5<sup>th</sup>  5<sup>th</sup>-49<sup>th</sup>  50<sup>th</sup>-84<sup>th</sup>  85<sup>th</sup>-94<sup>th</sup>  95<sup>th</sup>-98<sup>th</sup>  99<sup>th</sup> and >

Hyperlipidemia:  No  Yes      Hypertension:  No  Yes

**PHYSICAL EXAMINATION/ASSESSMENT**

Height:	Weight:	BP:	Pulse:	Respirations:
<b>TESTS</b>	<b>Positive</b>	<b>Negative</b>	<b>Date</b>	<b>Other Pertinent Medical Concerns</b>
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
<b>Lead Level Required Grades Pre- K &amp; K</b>			<b>Date</b>	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated $\geq 10$ $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____

System Review and Exam Entirely Normal

Check Any Assessment Boxes Outside Normal Limits And Note Below Under Abnormalities

<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal

<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list)	ICD-10 Code
	_____	_____
	_____	_____
	_____	_____

Additional Information Attached

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**SCREENINGS**

Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Scoliosis</b> Required for boys grade 9 And girls grades 5 & 7	<b>Negative</b>	<b>Positive</b>	<b>Referral</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:	Trunk Rotation Angle:			

**Recommendations:**

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

- Full Activity without restrictions including Physical Education and Athletics.
- Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications
  - No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling
  - No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field
  - Other Restrictions:

Developmental Stage for Athletic Placement Process ONLY  
 Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports  
 Student is at Tanner Stage:  I  II  III  IV  V

- Accommodations: Use additional space below to explain
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Brace*/Orthotic              | <input type="checkbox"/> Colostomy Appliance*       | <input type="checkbox"/> Hearing Aids             |
| <input type="checkbox"/> Insulin Pump/Insulin Sensor* | <input type="checkbox"/> Medical/Prosthetic Device* | <input type="checkbox"/> Pacemaker/Defibrillator* |
| <input type="checkbox"/> Protective Equipment         | <input type="checkbox"/> Sport Safety Goggles       | <input type="checkbox"/> Other:                   |

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

Explain: \_\_\_\_\_

**MEDICATIONS**

Order Form for Medication(s) Needed at School attached

List medications taken at home: \_\_\_\_\_

**IMMUNIZATIONS**

Record Attached  Reported in NYSIIS Received Today:  Yes  No

**HEALTH CARE PROVIDER**

Medical Provider Signature: \_\_\_\_\_  
 Provider Name: (please print) \_\_\_\_\_  
 Provider Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

Date: \_\_\_\_\_  
 Stamp: \_\_\_\_\_

**Please Return This Form To Your Child's School When Entirely Completed.**

**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: <span style="float:right">Last</span> <span style="float:right">First</span> <span style="float:right">Middle</span>		
Birth Date: / / <small>Month Day Year</small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Will this be your child's first visit to a dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No
School: <small>Name</small>		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:**

Month	Day	Year
-------	-----	------

**GENDER:**

Male  
 Female

**PARENT/PERSON IN PARENTAL RELATION INFO:**

Last Name	First Name	Relation to Student
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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	_____ specify <input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify <input type="checkbox"/> Does not write

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

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

## Home Language Questionnaire (HLQ)—Page Two

### Educational History

8. Indicate the total number of years that your child has been enrolled in school \_\_\_\_\_

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.  
 Yes\*  No  Not sure  \*If yes, please explain: \_\_\_\_\_

How severe do you think these difficulties are?  Minor  Somewhat severe  Very severe

10a. Has your child ever been referred for a special education evaluation in the past?  No  Yes\* \*Please complete 10b below

10b. \*If referred for an evaluation, has your child ever received any special education services in the past?  
 No  Yes – Type of services received: \_\_\_\_\_

Age at which services received (Please check all that apply):  
 Birth to 3 years (Early Intervention)  3 to 5 years (Special Education)  6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)?  No  Yes

11. Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

12. In what language(s) would you like to receive information from the school? \_\_\_\_\_

Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Signature of Parent or of Person in Parental Relation \_\_\_\_\_ Date \_\_\_\_\_

Relationship to student:  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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: MO _____ DAY _____ YR _____	OUTCOME OF INDIVIDUAL INTERVIEW: <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> 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: <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING <input type="checkbox"/> COMMANDING
FOR STUDENTS WITH DISABILITIES, LIST ACCOMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____	

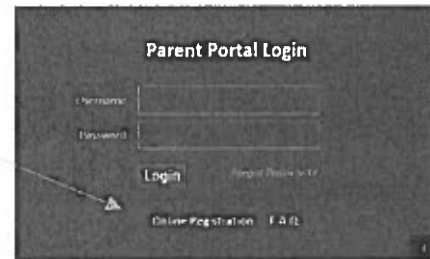
## **DIRECTIONS TO SET UP PARENT PORTAL**

Welcome to the Franklin Square School District. Below are directions and screenshots for the registration process. Please fill in the information requested.

**\*\*You must call the main office of your child's school to obtain the Student ID number 3 days after registration is complete.**

**Step 1:** Proceed to the district website and click on the Parent Portal quick-link on the bottom right side of the page. (<http://franklinsquare.k12.ny.us>)

**Step 2:** Click on "Online Registration"



**Step 3:** There are 3 short parts to fill out.

A: Account Information

B: Personal Parent Information

C: Student Information (need student ID number to complete) Please contact your child's school 3 days after registration to obtain ID number.

\*\*\*Please note that H. Frank Carey High School and Franklin Square School District (elementary schools) are two separate school districts. Even if you have an older child in the high school, you will need a separate parent portal account for your younger child.

If you need support, please email Michelle at the email shown below.

**[mbalsdon@franklinsquare.k12.ny.us](mailto:mbalsdon@franklinsquare.k12.ny.us)**





**FRANKLIN SQUARE UNION FREE SCHOOL DISTRICT**

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

---

FAX: (516) 505-6972

Superintendent of Schools  
(516) 505-6975

FOUNDATION  
for SUCCESS

Dear Parent or Guardian,

Franklin Square is committed to the safety and well being of all children. The district enforces strict policies in regards to acceptable use of computers and the internet. Attached are two forms that have been approved by the Board of Education to help protect your child from any unnecessary harm. We appreciate your support and ask that you return the signed forms to your school immediately.

More information about the district's internet/computer network policy and internet safety policy and regulations can be found on the district's website at <http://www.franklinsquare.k12.ny.us>.

Thank you again for your cooperation and support.

Sincerely yours,

*Office of the Superintendent*

attachment



## FRANKLIN SQUARE UNION FREE SCHOOL DISTRICT

### Student/Parent Internet/Computer Network Guidelines and Authorization Form

The terms and conditions contained in the Franklin Square Union Free School District's Internet/Computer Network Policy and Internet Safety Policy and Regulations have been explained to me. I understand and will abide by them. I understand that the use of the Internet/Computer Network and Internet Access is a privilege, not a right.

I may not do the following while using Internet/Computer Network Services on school property:

- share my password or use another person's password.
- disrupt the Internet or Network services of other people.
- use inappropriate language while using the Internet/Network.
- use the Internet/Network service for reasons other than those that are educational.
- download software from the Internet without teacher authorization
- violate the existing copyright laws.
- tamper with the security system of the Internet or Network services.

I understand that any violation of this policy is unethical and may constitute a criminal offense. If I commit any violation or fail to comply with the District's Internet/Computer Network Policy and Internet Safety Policy and Regulations, my access privileges may be revoked, school/district disciplinary action may be taken, and/or appropriate legal proceedings may be instituted against me.

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Class \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

### Parent Internet/Computer Network Permission Form

I am the parent of the child mentioned above. I have read and understand the provisions of the District's Internet/Computer Network Policy and Internet Safety Policy and Regulations. (Policies can be found on the district website) I understand that Internet access is designed for educational purposes, and the Franklin Square Union Free School District has taken reasonable precautions to discourage student access to controversial, obscene and inappropriate material. I also recognize that it is impossible for the District to restrict access to all such materials, and I will not hold the District responsible for materials acquired on the Internet by my child.

I hereby give my child permission to access the Internet for educational purposes.

Parent/Guardian Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

**\*\*Your son/daughter's work may be published on the school website. Their photograph may be posted on the district site to highlight events. There will be no personally identifying information. If you do not want photographs of your child to be shown on the school website, please indicate in writing to your building principal.**