

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT
REQUIREMENTS FOR REGISTRATION
25 N BICYCLE PATH SELDEN NY 11784 PHONE: 631-285-8890
CLOSED FRIDAYS IN JULY AND AUGUST

- **Original or a photocopy of proof of age document.**

- Examples:

- Birth certificate
 - Driver's license
 - Passport
 - Baptismal certificate
 - Notification of registration of birth certificate
 - Naturalization record
 - Immigration record
 - Vaccination record
 - School record
 - Census record
 - School photo with date of birth
 - Court orders or other court-issued documents

- **FAX number or email address to previous school and Transfer or Withdrawal paper from previous school**

- **Transcript for High School students**

- **Proof of residency in the Middle Country Central School District.**

- Examples:

- Current utility bills (Electric, Gas, Fuel, Water, Cable or Satellite television)
 - Current Mortgage Statement
 - Deed to your home
 - Post office change of address
 - Mortgage commitment
 - Current Renter's Insurance policy
 - Voter Registration
 - Original lease
 - Income tax form
 - Membership documents
 - Official driver's license
 - State or government issued identification
 - Pay stub

- Immunization record: A signed or stamped certificate of immunization on physician's letterhead or a previous school's signed health record indicating specific dates of quantities. (See required student immunizations).
- Parent/Guardian photo identification
- Custody paperwork if applicable



MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT STUDENT REGISTRATION FORM

☐ NEW STUDENT☐ RE-ENTRY

STUDENT INFORMATION

STUDENT ID #	Last Name		First Name		Middle Name		Sex	Date of Birth
	Birthplace City		State	Country				
BUILDING	CHILD'S ETHNIC AND RACE INFORMATION							
	Please answer the two-part question				Is the child Hispanic or Latino?		YES	NO
	Please indicate any race group that applies, select one or more.				B – Black or African American			
	P – Native Hawaiian/Other Pacific Islander				W – White			
GRADE	I – American Indian or Alaskan Native				A – Asian			
	PREVIOUS SCHOOL INFORMATION							
ESL	Last School Attended		Grade Level	Name of District				
SPED	Address							
ATTACHED	Does your child receive any Special Education Services?						Yes	No
	COMPLETE IF STUDENT IS RE-ENTERING THE MIDDLE COUNTRY SCHOOL DISTRICT							
	Last Date and School Attended							
Immunizations								
Custody Papers								

PARENT/GUARDIAN INFORMATION (where child resides)

Proof of Residence	Last Name – Parent 1 or Guardian 1		First Name		Relationship to child ____ Birth/Adopted Parent ____ Legal Guardian ____ Custodial Care ____ Foster Care ____ Step Parent			
	Cell Number ()		Work Number ()					
	Email:							
	Last Name – Parent 2 or Guardian 2		First Name		Relationship to child ____ Birth/Adopted Parent ____ Legal Guardian ____ Custodial Care ____ Foster Care ____ Step Parent			
	Cell Number ()		Work Number ()					
	Email:							
	Resident Address							
	STREET		TOWN		STATE		ZIP	
	Mailing Address (if different)						Home Telephone ()	
	Is a second language spoken in the home?		Yes	No	If yes, what is the language?			
Is enrollment related to Homelessness?						Yes	No	
IF APPLICABLE PROVIDE NAME, ADDRESS AND PHONE NUMBERS OF PARENT NOT LIVING WITH CHILD								
NAME						Home Number ()		
STREET						Cell Number ()		
TOWN						Work Number ()		
STATE						Email		
ZIP								
SHOULD THIS PARENT RECEIVE SCHOOL MAILINGS?						Yes	No	

Parent/Guardian Signature _____ Date: _____



SIBLING INFORMATION - Please list all other children in family including infants.

Last Name	First Name	Middle Name	Sex	Date of Birth	Grade (if any)

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT

ATTN: SCHOOL HEALTH OFFICE

DEAR PARENT;

WHEN YOUR CHILD ENTERS SCHOOL WE ESTABLISH A CUMULATIVE RECORD FILE ON HIM/HER TO ENABLE US TO HAVE A GREATER UNDERSTANDING OF YOUR CHILD'S NEEDS. ALL INFORMATION, OF COURSE, WILL BE KEPT STRICTLY CONFIDENTIAL, SO PLEASE ANSWER EVERY QUESTION, PLEASE PRINT NEATLY. THANK YOU FOR YOUR COOPERATION.

STUDENT'S

NAME _____ SEX _____ DOB _____ SCHOOL _____

ADDRESS _____ PHONE NO. _____

FATHER/GUARDIAN NAME _____ CELL PHONE NO. _____

MOTHER/GUARDIAN NAME _____ CELL PHONE NO. _____

PARENT'S PLACE OF EMPLOYMENT _____

FATHER/GUARDIAN _____ WORK NO. _____

MOTHER/GUARDIAN _____ WORK NO. _____

PHYSICIAN TO BE CALLED IN EMERGENCY (LOCAL) _____ PHONE NO. _____

TRANSPORTATION OF AN ILL CHILD IS TO BE ARRANGED BY PARENT OR PERSONS NAMED ABOVE
IT IS A PARENTAL RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF CHANGES IN THE ABOVE.

FOR OFFICE USE ONLY:

_____ IMMUNIZATION RECORD VERIFIED/ATTACHED

Initials of Central Registration staff member _____

TO BE COMPLETED BY PARENT. PLEASE INDICATE IF HISTORY AND DESCRIBE BELOW:

ANEMIA _____ ASTHMA _____ ALLERGIES _____ DIABETES _____ EPILEPSY _____

HEART DISEASE _____ KIDNEY DISEASE _____ TUBERCULOSIS OR CONTACT WITH TB _____

SERIOUS ILLNESS, INJURY, OPERATIONS _____

EXPLANATION OF ABOVE AS CHECKED: _____

IS MEDICATION GIVEN ON A REGULAR BASIS? NO _____ YES _____

WILL MEDICATION BE GIVEN DURING SCHOOL? NO _____ YES _____

NEW YORK STATE LAW REQUIRES THE PARENT TO SUBMIT A WRITTEN REQUEST TO THE SCHOOL, AND IT MUST BE ACCOMPANIED BY A WRITTEN REQUEST FROM THE PHYSICIAN, IN WHICH HE INDICATES THE FREQUENCY AND THE DOSAGE OF THE PRESCRIBED MEDICATION.
THIS MEDICATION MUST BE BROUGHT IN BY THE PARENT IN A PRESCRIPTION BOTTLE.

ANY VISION PROBLEMS: NO _____ YES _____ PLEASE SPECIFY _____

GLASSES WORN NO _____ YES _____ DATE OF EXAMINATION _____

DR./EXAMINER'S NAME/ADDRESS _____

HEARING DIFFICULTIES NO _____ YES _____ HEARING AID WORN NO _____ YES _____

PLEASE SPECIFY: _____

DATE OF LAST EXAMINATION _____

DOCTOR'S NAME _____

ADDRESS _____

IF ANY MODIFICATION IN THE SCHOOL'S PROGRAM IS REQUIRED, PLEASE SUBMIT A DOCTOR'S WRITTEN
RECOMMENDATION.

SIGNATURE OF PARENT/GUARDIAN _____



HOUSING QUESTIONNAIRE

Name of LEA: Middle Country Central School District

Name of School: TBD

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/____ Grade: ____ ID#: ____
Month Day Year (preschool-12) (optional)

Address: _____ Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (Please check one box.)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

**Print name of Parent, Guardian, or
Student (for unaccompanied homeless youth)**

**Signature of Parent, Guardian, or
Student (for unaccompanied homeless youth)**

Date



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
		<input type="checkbox"/> Male <input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

HOME LANGUAGE CODE

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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"/> Parent 1 _____ specify	<input type="checkbox"/> Parent 2 _____ 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:

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:

MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT AT CENTEREACH

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

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

PREVIOUS SCHOOL FAX# or E MAIL _____

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

Cumulative Records

A copy of the Permanent Record

All pertinent psychological and testing information which will be of value in placing this student.

Current Report Card.

All science labs, if applicable.

All ENL related testing scores, including, NYSESLAT and NYSITELL

Thank you for your cooperation.

Parent/Guardian's Signature

Date

CENTEREACH HS fax:

A-F 631-285-8195

G-N 631-285-8225

O-Z 631-285-8139

EUGENE AUER MEMORIAL ELEMENTARY

17 WING ST

LAKE GROVE NY 11755

Ph: 631-285-8500 fax: **631-285-8501**

OXHEAD ROAD ELEMENTARY

144 OXHEAD RD

CENTEREACH NY 11720

Ph: 631-285-8700 fax: **631-285-8701**

NEWFIELD HS

GUIDANCE DEPT

145 MARSHALL DR

SELDEN NY 11784

Ph: 631-285-8330 fax: **631-285-8336**

HAWKINS PATH ELEMENTARY

485 HAWKINS RD

SELDEN NY 11784

Ph: 631-285-8530 fax: **631-285-8531**

STAGECOACH ELEMENTARY

205 DARE RD

SELDEN NY 11784

Ph: 631-285-8730 fax: **631-285-8731**

DAWNWOOD MS

GUIDANCE DEPT

10 43RD STREET

CENTEREACH NY 11720

Ph: 631-285-8210 fax: **631-285-8201**

akostrna@mccsd.net

HOLBROOK ROAD ELEMENTARY

170 HOLBROOK AVE

CENTEREACH NY 11720

Ph: 631-285-8560 fax: 631-285-8561

UNITY DRIVE KDG CENTER

11 UNITY DR

CENTEREACH NY 11720

Ph: 631-285-8760 fax: **631-285-8761**

JERICHO ELEMENTARY SCHOOL

34 N COLEMAN RD

CENTEREACH NY 11720

Ph: 631-285-8600 fax: **631-285-8601**

BICYCLE PATH KDG CENTER

27 N BICYCLE PATH

SELDEN NY 11784

Ph: 631-285-8805 fax: **631-285-8801**

SELDEN MS

GUIDANCE DEPT

22 JEFFERSON AVE

CENTEREACH NY 11720

Ph: 631-285-8410 fax: **631-285-8423**

NEW LANE MEMORIAL ELEMENTARY

15 NEW LANE

SELDEN NY 11784

NEW LANE MEMORIAL ELEMENTARY

Ph: 631-285-8900 fax: 631-285-8901

SPECIAL EDUCATION/PUPIL PERSONNEL

25 N BICYCLE PATH STE. A

SELDEN NY 11784

Ph: 631-285-8850 fax: **631-285-8851**

CENTRAL REGISTRATION

centralreg@mccsd.net

NORTH COLEMAN RD ELEMENTARY

197 N COLEMAN RD

CENTEREACH NY 11720

Ph: 631-285-8660 fax: 631-285-8661

The mission of the MCCSD is to empower and inspire all students to apply the knowledge, skills, and attitudes necessary to be creative problem solvers, to achieve personal success, and to contribute responsibly in a diverse and dynamic world.

2024-25 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 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 grade-less 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 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
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 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	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			
Pneumococcal Conjugate vaccine (PCV) ¹⁰	1 to 4 doses			



Department
of Health

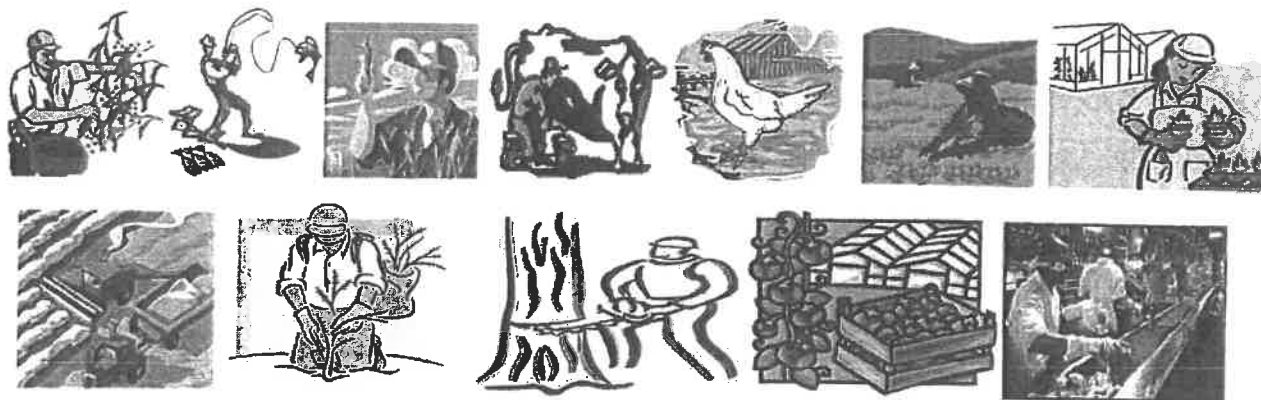
IDENTIFICATION & RECRUITMENT PARENT SURVEY

The Migrant Education Program (MEP) is authorized by Title I, Part C of the Elementary and Secondary Education Act (ESEA). The MEP provides a variety of educational services to families who work in agriculture, **regardless of their nationality or legal status**. This program is **free of charge** to all eligible families and may include tutoring, free school lunch eligibility, educational field trips, summer programs, parent involvement activities, emergency needs and referrals to other services as needed.

Please take a few minutes to complete this questionnaire.

Has anyone in your family worked or looked for work at the following occupations during the past 3 years?

- ☐ Any agricultural, farm, or fishing work (such as hay, dairy, fruit or vegetable crops, poultry, fishing, nursery/greenhouse, etc.)
- ☐ Work related to logging, harvesting, or initial processing of trees.
- ☐ Work at a food processing plant, (such as meat or poultry processing plants, packing fruits or vegetables, etc.)



If you answered YES, please provide your contact information below:

Parent/Guardian Name: _____

Home address: _____

Telephone number: (____) - ____ - ____ Best time to be reached: _____ AM/PM

Previous Address: _____

Student name: _____ Age _____ Grade _____

Student name: _____ Age _____ Grade _____

To submit this referral please email to migranteducation@esboces.org, or fax to 631-240-8912, or by mail to Long-Island-METRO Migrant Education Program- 969 Roanoke House Avenue, Riverhead, NY. 11901.