BETHPAGE UNION FREE SCHOOL DISTRICT
David Schneider
Superintendent of Schools

10 Cherry Avenue
Bethpage, New York 11714

Phone (516) 644-4000
Fax: (516) 931-8783
www.bethpagecommunity.com

TO: ______________________________

FROM: ______________________________

DATE: ______________________________

RE: **REGISTRATION PACKET**

REGISTRATION PACKET – RESIDENCY DETERMINATION

These instructions are intended to provide you with an understanding of Bethpage Union Free School District's (the "District") registration and enrollment process. To demonstrate that you are entitled to a tuition-free education within the District, please submit the contents of this packet and adhere to the following instructions. If you have any questions, concerns, or complaints regarding the process, please contact the District's Central Registration Office at (516) 644-4060.

The District registers its students in accordance with New York State law and regulations. Accordingly, upon request, your child shall be enrolled and begin attendance on the next school day (unless a determination of non-residency is made on the date of the request). The contents of this packet must be compiled as soon as practical, but no later than three (3) business days after the child's enrollment. The District will provide you with its residency determination, within three (3) business days of your child's enrollment. However, if you submit the contents of this packet on the third (3rd) business day after your child's enrollment, the District will provide its residency determination on the fourth (4th) business day.

You will also be required to provide a certificate of a physical examination (that is no more than one year old) conducted by a New York State licensed physician within thirty (30) days of your child's enrollment and an up-to-date certification of immunization record for your child. If such immunization records are not available at the time of enrollment, you will have fourteen (14) days to provide the necessary immunizations. If your child is transferring from another state or country and you demonstrate a good faith effort to obtain immunizations, you will have up to thirty (30) days to provide the necessary documents. Your registration/enrollment will not be delayed in the absence of these documents, however, the documents must be produced in accordance with the time frames required by law, as set forth in this paragraph.

Children entering the District who have been identified under Section 504 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education (IDEA/IDEIA) must provide a copy of their current 504 Plan or Individualized Education Program (IEP), as applicable.

The District's registration procedures are intended to make enrollment easier for parents and guardians and to ensure that only Bethpage residents remain enrolled in our schools. In accordance with law and Board policy, only *bona fide* residents of the District are entitled to attend the District's schools on a tuition-free basis. Please be advised that these registration procedures apply to all students.

PLEASE READ INSTRUCTIONS CAREFULLY

- Please complete one Registration Packet per child to be registered.
- Please print clearly and please do not fold packets.

PLEASE CALL CENTRAL REGISTRATION IF YOU HAVE ANY QUESTIONS.

**** PLEASE CALL MS. RENEE KATZ AT (516) 644-4060 TO ARRANGE AN APPOINTMENT**

TO COME IN AND REGISTER YOUR CHILD**

OFFICE HOURS: Monday-Friday … 8:00 AM to 3:00 PM

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FOR OFFICE USE ONLY

BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York

REGISTRATION – PROOF OF RESIDENCY*
SCHOOL YEAR 2019-2020

[ ] NEW ENTRANT [ ] RE-ENTER [ ] TRANSFER FROM PRIVATE/PAROCHIAL

DOES YOUR CHILD CURRENTLY HAVE AN IEP OR 504 PLAN? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE THE DISTRICT WITH A COPY OF THE CURRENT INDIVIDUAL EDUCATION PROGRAM/504 PLAN.

PROOF OF RESIDENCY*
Please provide the following, as applicable.
(Examples of documents are not exhaustive)

1. Evidence of Physical Presence of Parent(s)/Person(s) in Parental Relation and the Child in the District.

   ☐ Deed/Mortgage Statement/Tax receipt/Lease/Third Party Statement

   AND

   ☐ Two other Forms of Documentation Evidencing Residency**
   Other Acceptable Documents (Non-Exhaustive list)
   Include the Following:

   ☐ Motor Vehicle registration indicating address
   ☐ Utility bill (gas, electric, water, cable)
   ☐ Non-cellular phone bill
   ☐ Voter's registration documents
   ☐ Insurance bill (Homeowner's/Renter's/Auto, etc.)
   ☐ Bank statements or check with address
   ☐ Valid Personal Income Tax Returns
   ☐ Employment Pay Stub
   ☐ State, Federal, Local or other Governmental issued ID
   ☐ Other acceptable forms of proof ___________________________

   **The preference is for two other forms of evidence to be submitted. However, applications will be considered in the absence of such additional forms, with weight given accordingly.

   AND

2. Proof of Parental Relation or Proof that the Child Resides with the Parent or Person in Parental Relation. (Non-Exhaustive List) include the following:

   ☐ Affidavit of parent/person in parental relation
   ☐ Other acceptable proof ___________________________
   OR
   ☐ Proof of Your Identity
   (For Example, Without Limitation)

   ☐ Driver's License
   ☐ Non-Driver's Photo ID
   ☐ Passport

SCHOOL ______ GRADE ______ DOB ______ LAST NAME ______ FIRST NAME ______

AND Proof of Filiation
(For Example, Without Limitation)

- ☐ Birth Certificate
- ☐ Proof of Emancipation
- ☐ Foster Care Documentation (DSS 2999)
- ☐ Proof that Child Resides with a Sponsor with Whom the Child has been placed by a Federal Agency
- ☐ Other acceptable forms of proof ______________________

AND

3. Proof of Student's Age

A. ☐ Certified Transcript of a Birth Certificate

OR

IF A or B is NOT AVAILABLE then:

B. ☐ Record of Baptism including Date of Birth IF A or B is NOT AVAILABLE.

C. ☐ Passport (Including foreign Passport)

IF A, B or C is NOT AVAILABLE then:

D. ☐ Other Documentary or Recorded Evidence in Existence two (2) years or more (Except an Affidavit of Age)

(Non-Exhaustive List) include the following:

- ☐ Official Driver's License
- ☐ State or Other Government Issued Identification
- ☐ School Photo Identification with Date of Birth
- ☐ Consulate Identification Card
- ☐ Military Dependent Identification Card
- ☐ Documents issued by Federal, State, or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement)
- ☐ Court orders or other court-issued documents
- ☐ Native American Tribal Document
- ☐ Records From Non-Profit International Aid Agencies and Voluntary Agencies
- ☐ Other acceptable forms of proof _______________________

*All forms of documentation should be as current as possible. The District reserves the right to differentiate the weight given to each piece of documentation as it determines is necessary. Please submit documentation that is most supportive of your assertion of residency in the District. The District will view all documentation produced as a whole.

PARENT NOTIFIED ON ________________ **PARENT SIGNATURE** ___________________________________

BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York 11714

STUDENT INFORMATION

(PRINT LEGIBLY OR TYPE)

STUDENT INFORMATION				
LAST NAME	FIRST NAME	MIDDLE	SUFFIX (Jr., Sr., I, II, III, IV)	GENDER (M/F)

PERSON IN PARENTAL/GUARDIAN RELATIONSHIP IN HOUSEHOLD
RELATIONSHIP ________________________________ **GENDER (M/F)** _______________

LAST NAME	FIRST NAME	MIDDLE	NICKNAME
WORK PHONE	**CELL PHONE**	**E-MAIL**	**PREFERRED LANGUAGE**

PERSON IN PARENTAL/GUARDIAN RELATIONSHIP IN HOUSEHOLD
RELATIONSHIP ________________________________ **GENDER (M/F)** _______________

LAST NAME	FIRST NAME	MIDDLE	NICKNAME
WORK PHONE	**CELL PHONE**	**E-MAIL**	**PREFERRED LANGUAGE**

HOUSEHOLD INFORMATION (RESIDENCE):		
HOME PHONE	HOUSE # / STREET	TOWN/ZIP

OTHER CHILDREN AT SAME ADDRESS (UNDER 21 YEARS OF AGE)					
LAST NAME	FIRST NAME	DOB	GENDER	SCHOOL	GRADE

ALL OTHER PERSONS AT THIS RESIDENCE INCLUDING NON-FAMILY RESIDENTS:				
LAST NAME	FIRST NAME	AGE	RELATIONSHIP	SCHOOL/PLACE OF EMPLOYMENT

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

Lissette Colón-Collins, Assistant Commissioner

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:**
		❐ Male ❐ Female
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?	❐ English ❐ Other ____________ specify
2. What was the first language your child learned?	❐ English ❐ Other ____________ specify
3. What is the Home Language of each parent/guardian?	❐ Mother ________ specify ❐ Father ________ specify ❐ Guardian(s) ____________ specify
4. What language(s) does your child understand?	❐ English ❐ Other ____________ specify
5. What language(s) does your child speak?	❐ English ❐ Other ________ specify ❐ Does not speak
6. What language(s) does your child read?	❐ English ❐ Other ________ specify ❐ Does not read
7. What language(s) does your child write?	❐ English ❐ Other ________ specify ❐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:	
SCHOOL DISTRICT INFORMATION:	**STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:**
District Name (Number) & School *Address*	

Home Language Questionnaire (HLQ) – Page Two

Educational History
8. Indicate the total number of years that your child has been enrolled in school ___________________
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. ***Yes**** ***No*** ***Not sure*** ❒ ❒ ❒ ***If yes, please explain: ____** How severe do you think these difficulties are? ❒ Minor ❒ Somewhat severe ❒ Very severe
10. a. Has your child ever been *referred* for a special education evaluation in the past? ❒ No ❒ Yes* *Please complete 10b below **10. b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?**

BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York 11714

ENROLLMENT FORM – RESIDENCY QUESTIONNAIRE

Name of LEA: ____

Name of School: ____

Name of Student: ____
Last First Middle

Gender: ☐ Male ☐ Female Date of Birth ____ / ____ / ____ (*Month* *Day* *Year*) Grade: ______ ID #: ____________

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

* If the student is **NOT** living in permanent housing, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled.** **After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's LEA liaison must help the student get any other necessary documents or immunizations.

****If you have any questions, concerns or comments please contact the District's Homeless Liaison, Dr. Patricia Hantzidiamantis at 516-644-4020**

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OWNER/LANDLORD AFFIDAVIT

***The District may place greater weight on sworn statements regarding your residency within the District. However, you are not required to submit a sworn statement.**

****If you do not wish to submit a sworn statement, please complete the subsequent form entitled Owner/Landlord Statement.**

1. I/we ____ , being duly sworn, deposes and says under the
   Name(s)
   penalty of perjury that I/We am/are the Legal owner(s) of the following premises: (Please attach proof of ownership)

   ____

   ____
   Street

   ___________________________, NY ____________

   Section # ________ Lot # _______ Block # _____

2. To the best of my knowledge, the above mentioned property is the sole and only residence from
   _______________________ to _____________________ of

   ____
   Name of Parent/Guardian

   ____
   Name of Child(ren)

3. The following names include ALL other persons living at this address and their relationship to child(ren):

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

4. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that ____________ ____________________________ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.

____
(Initial Here)

5. I have been informed that the school district may conduct an investigation for purposes of residency verification, which may include home visits.

Date ____________________ Signature of Owner(s)/Landlord(s)____________________________________

Print Name ____

Sworn to me before this
________day of __________________ , 20 ____

Notary Public _____________________________

Lease Presented: [ ] Yes [ ] No

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1. I/we ____ , am/are the Legal owner(s) of the following
   Name(s)
   Premises: (Please attach proof of ownership)

   ____

   ____
   Street

   ____________________________, NY ____________

   Section # ________ Lot # _______ Block # _____

2. To the best of my knowledge, the above mentioned property is the sole and only residence from
   _______________________ to _____________________ of

   ____
   Name of Parent/Guardian

   ____
   Name of Child(ren)

3. The following names include ALL other persons living at this address and their relationship to child(ren):

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

4. I understand that this statement is being made, _________________in order that may admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.

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Date ____________________ Signature of Owner(s)/Landlord(s) ____________________________________

Print Name ____

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RENTER/NON OWNER AFFIDAVIT

***The District may place greater weight on sworn statements regarding your residency within the District. However, you are not required to submit a sworn statement.**

****If you do not wish to submit a sworn statement, please complete the subsequent form entitled Renter/Non Owner Statement.**

1. I/we ____ , being duly sworn, deposes and says under the
   Name(s)
   penalty of perjury that I/we am/are the Renter(s) of the following premises (state address, and specify the exact nature of the space, i.e., basement apartment, second floor apartment, number of rooms)

   ____

   ____
   Street

   ___________________________, NY ____________

2. I/we, ____
   Name(s) of Parent/Person in Parental Relation

   And my/our child/ward ____
   (Name of student)
   reside at the above address, which is my/our actual and only permanent residence. My/our child/ward lives with me/us at said address as his/her actual and only permanent residence.

3. The following names include ALL other persons living at this address and their relationship to child(ren):

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

4. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that ____________ ________________ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs, including but not limited to the cost of the school district's tuition, costs associated with

transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.

____
(Initial Here)

5. I have been informed that the school district may conduct an investigation for purposes of residency verification, which may include home visits.

Date ____________________ Signature of renter(s) ____

Print Name ____

Sworn to me before this
_________day of __________________ , 20 ____

Notary Public _____________________________

Lease Presented: [ ] Yes [ ] No

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RENTER/NON OWNER STATEMENT

***The District may place greater weight on sworn statements regarding your residency within the District. However, you are not required to submit a sworn statement.**

1. I/we ____ , am/are the Renter(s) of the following premises
   Name(s)
   (state address, and specify the exact nature of the space, i.e., basement apartment, second floor apartment, number of rooms)

   ____

   ____
   Street

   ___________________________, NY ____________

2. I/we, ____
   Name(s) of Parent/Person in Parental Relation

   And my/our child/ward ____
   (Name of student)
   reside at the above address, which is my/our actual and only permanent residence. My/our child/ward lives with me/us at said address as his/her actual and only permanent residence.

3. The following names include ALL other persons living at this address and their relationship to child(ren):

   1. ________________________________ 5. ________________________________

   2. ________________________________ 6. ________________________________

   3. ________________________________ 7. ________________________________

   4. ________________________________ 8. ________________________________

4. I understand that this statement is being made, in order that ____________________________________ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs, including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject

me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.

____
(Initial Here)

5. I have been informed that the school district may conduct an investigation for purposes of residency verification, which may include home visits.

Date ____________________ Signature of renter(s) ____

Print Name ____

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PARENT AFFIDAVIT*

(TO BE USED WHEN CHILD IS LIVING WITH A BIOLOGICAL/ADOPTIVE PARENT)

*This affidavit is not required but is one means that may be used to document that you are the child(ren)'s biological or adoptive parent.

STATE OF NEW YORK)
) ss:
COUNTY OF ______________)

____________________________________, being duly sworn, deposes and says:

1. I live at ____.
(Full Address of Biological/Adoptive Parent)

2. I am the biological/adoptive parent of:

____
(Full Name of Child) (Date of Birth) (M/F)

____
(Full Name of Child) (Date of Birth) (M/F)

____
(Full Name of Child) (Date of Birth) (M/F)

3. **I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that __________ _____________________________ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs, including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false instrument and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.**

____
(Initial Here)

____
(SIGNATURE(S) OF PARENT(S))

Sworn to me before this
_________day of __________________ , 20 ____

Notary Public ____________________________

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PARENT AFFIDAVIT*

(TO BE USED WHEN CHILD IS NOT LIVING WITH A BIOLOGICAL/ADOPTIVE PARENT)

*Although this affidavit is not required as a condition of enrollment, proof of the transfer of custody must be provided. A person in parental relation may have a biological parent complete this affidavit to further evidence of his or her custody and control of the child.

STATE OF NEW YORK)
) ss:
COUNTY OF ______________)

____________________________________, being duly sworn, deposes and says:

1. I live at ____.
(Full Address of Person in Parental Relation)

2. ____________________ if my ____.
(Full Name of Child) (Child's Relationship to Person in Parental Relation)

3. Statement of reasons why the child is not living with the parent(s).

____

____

____

4. Statement naming the individual having custody and control of the child.

____

____

____

5. Statement setting forth the child's current address and living arrangement.

____

____

6. Statement explaining the duration of the living arrangement (permanent, indefinite, to be terminated upon a specific date, action or event).

____

____

7. Statement describing any other location(s) where the child lives. Indicate the length of time the child is at the other address and provide an explanation. If the child does not have any other address, so indicate.

____

____

8. Statement establishing who has the right to make decisions pertaining to the health, welfare, and education of the child, including medical decisions.

    ____

    ____

9. Statement establishing who provides the child with food, clothing, medical care and all other necessities.

    ____

    ____

10. Statement of any other relevant facts:

    ____

    ____

11. As a result of the documentation provided I am authorizing the District to notify the Person in Parental Relation named in this affidavit of any matters pertaining to the education of this child unless and until such time as the District receives notification that the parents have regained custody.

    I understand that by executing this affidavit I am releasing the District from any obligation to notify me of any matters pertaining to the education of my child unless and until such time as I notify the District and establish that I have regained custody.

    I understand that any permission required for medical care of my child which may have to be provided during the course of school activities or any permission to participate in any school related activity will be sought from the Person in Parental Relation named in this affidavit and not from me. I understand further that in the event that my child appears to require special education or any change in educational placement, the custodian named in this affidavit will be asked by the School District to consent or withhold consent for evaluation, identification of educational disability, initial educational placement or any change in educational placement or declassification. The custodian named in the affidavit is fully authorized to consent on my behalf to medical care, participation in school-related activities, individual evaluation, identification of educational disability, educational placement, or declassification from special education.

    I hereby release the School District, its Board of Education, employees and agents from all claims or liabilities arising from reliance on this Affidavit.

12. **I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that ___________ ____________________________ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is/are found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child(ren) will be discharged and I agree to bear legal responsibility for any and all costs, including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false statement and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.**

____
(SIGNATURE(S) OF PARENT(S))

Sworn to me before this
_________day of __________________ , 20 ____

Notary Public ____________________________

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PERSON IN PARENTAL RELATION AFFIDAVIT

(TO BE USED WHEN CHILD IS NOT LIVING WITH A BIOLOGICAL/ADOPTIVE PARENT)

*Although this affidavit is not required as a condition of enrollment, proof of the transfer of custody must be provided. A person in parental relation may have a biological parent complete this affidavit to further evidence his or her custody and control of the child.

STATE OF NEW YORK)
) ss:
COUNTY OF ______________)

_______________________________________, being duly sworn, deposes and says:

1. I live at ____.
(Full Address of Person in Parental Relation)

2. _____________________ if my ____.
(Full Name of Child) (Child's Relationship to Person in Parental Relation)

3. _______________________________________ intends to reside with me for _________________________________
(Child's Name) (Length of Time)

4. Statement explaining the duration of the living arrangement (permanent, indefinite, to be terminated upon a specific date, action or event).

____

____

____

5. Statement of the reasons the child lives with the person in parental relation.

____

____

____

6. Statement describing any other location(s) where the child lives. Indicate the length of time the child is at the other address and provide an explanation. If the child does not live at any other address, so indicate.

____

____

7. Statement establishing who has the right to make decisions pertaining to the health, welfare, and education of the child, including medical decisions.

____

____

8. Statement establishing who provides the child with food, clothing, medical care and all other necessities.

____

____

9. Statement of any other relevant facts:

____

____.

10. **I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that __________ ____________________________ may be admitted to the schools of the Bethpage Union Free School District as a District Resident(s). I understand that the Bethpage Union Free School District will rely on the representations herein and I further understand that if the aforementioned child(ren) is found not to be a legitimate resident(s) of the Bethpage Union Free School District, that the child will be discharged and I agree to bear legal responsibility for any and all costs, including but not limited to the cost of the school district's tuition, costs associated with transportation, investigating and excluding non-residents, and reasonable attorney fees, retroactive to the first day of admission. I further understand that the filing of a false statement and the theft of services from a governmental agency such as a school district are crimes punishable under New York State Law. I further acknowledge that making false statements in this affidavit may subject me to criminal prosecution. Any person or persons, in addition to the parents or guardians, who provide false evidence of residence, will also be prosecuted and will bear the legal responsibility for any and all costs associated with the false production of evidence.**

____
(SIGNATURE(S) OF PERSON(S) IN PARENTAL RELATION)

Sworn to me before this
________day of _________________ , 20 ____

Notary Public ____________________________

BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York 11714

DECLARATION OF INFORMATION

(PRINT LEGIBLY OR TYPE)

____

CHILD'S NAME (Last, First) GRADE

____

ADDRESS PHONE #

****

I CERTIFY THAT THE INFORMATION WHICH I HAVE SUPPLIED IN THIS PACKET IS TRUE TO MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT FILING A FALSE INSTRUMENT AND THE THEFT OF SERVICES FROM A GOVERNMENTAL AENCY SUCH AS A SCHOOL DISTRICT IS A PUNISHABLE OFFENSE UNDER THE LAW AND MAY SUBJECT ME TO CRIMINAL PROSECUTION. I UNDERSTAND THAT THE DISTRICT MAY CONDUCT AN INVESTIGATION FOR THE PURPOSE OF CONFIRMING RESIDENCY WHICH MAY INCLUDE WITHOUT LIMITATION HOME VISITS. I UNDERSTAND THAT MY REGISTRATION OF A CHILD WHO IS NOT A BONA FIDE RESIDSENT OF THE BETHPAGE UNION FREE SCHOOL DISTRICT WILL RESULT IN THE CHILD'S EXCLUSION FROM THE DISTRICT'S SCHOOLS AND I AGREE TO BEAR LEGAL RESPONSIBILITY FOR ANY AND ALL COSTS, INCLUDING BUT NOT LIMITED TO TUITION EXPENSES, TRANSPORTATION EXPENSES, INVESTIGATION AND EXCLUSION COSTS AND ATTORNEY'S FEES, RETROACTIVE TO THE FIRST DAY OF ENROLLMENT. ANY PERSON OR PERSONS, IN ADDITION TO THE PARENTS OR GUARDIANS, WHO PROVIEDE FALSE EVIDENCE OF RESIDENCE, WILL ALSO BE PROSECUTED AND WILL BEAR THE LEGAL RESPONSIBILITY FOR ANY AND ALL COSTS ASSOCIATED WITH THE FALSE PRODUCTION OF EVIDENCE. I FURTHER AGREE TO PROMPTLY NOTIFY THE SCHOOL REGARDING ALL CHANGES IN THE RESIDENCY OR THE CUSTODY OF THIS CHILD.

SIGNED ______________________________________

DATE ______________________________________

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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: ☐ M ☐ F	DOB:
School:	Grade:	**Exam Date:**

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental
Asthma ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached ☐ Intermittent ☐ Persistent ☐ Other: ____________
Seizures ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached ☐ Type: ____________ Date of last seizure: ____________
Diabetes ☐ No ☐ Yes, indicate type	☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached ☐ Type 1 ☐ Type 2 ☐ 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):** ☐ <5th ☐ <5th-49th ☐ <50th-84th ☐ <85th-94th ☐ <95th-98th ☐ <99th-and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	**Positive**	**Negative**	**Date**	**Other Pertinent Medical Concerns**
PPD/PRN	☐	☐		One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
Sickle Cell Screen/PRN	☐	☐		☐ Concussion – Last Occurrence: ____________
Lead Level Required Grades Pre-K & K			**Date**	☐ Mental Health: ____________
☐ Test Done ☐ Lead Elevated				☐ Other:

☐ **System Review and Exam Entirely Normal**

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

☐ HEENT	☐ Lymph Nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ 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/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right** dB	**Left** dB	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	**Negative** ☐	**Positive** ☐	**Referral** ☐ Yes ☐ 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

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ 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:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York 11714

IMMUNIZATION RECORD

****YOU ARE REQUIRED TO SUBMIT AN UP-TO-DATE CERTIFICATE OF IMMUNICATION RECORD FOR YOUR CHILD. IF SUCH IMMUNIZATION RECORDS ARE UNAVAILABLE AT THE TIME OF YOUR CHILD'S ENROLLMENT, YOU WILL HAVE FOURTEEN (14) DAYS TO PROVIDE THE NECESSARY IMMUNIZATIONS. IF YOUR CHILD IS TRANSFERRING FROM ANOTHER STATE OR COUNTRY AND YOU DEMONSTRATE A GOOD FAITH EFFORT TO OBTAIN IMMUNIZATIONS, YOU WILL HAVE UP TO THIRTY (30) DAYS TO PROVIDE THE NECESSARY DOCUMENTS.**

Student Name ____ Date of Birth: __________________________

IMMUNIZATIONS: (Give full dates)

Measles: ________ (History of disease : ____________) (Presence of antibody: ______________)

Rubella: ________ (History of disease : ____________) (Presence of antibody: ______________)

Mumps: _________________ (History of disease : ____________) (Presence of antibody: ______________)

MMR: ________ ________

DPT: ________ ________ ________ ________ ________ ________ ________

DTaP: ________ ________ ________ ________ ________ ________ ________

DT/Td: ________ ________ ________ ________ ________ ________ ________

Tdap: ________ ________ ________ ________ ________ ________ ________

Polio:

OPV ________ ________ ________ ________ ________ ________ ________

IPV ________ ________ ________ ________ ________ ________ ________

Hib: ________ ________ ________ ________ ________ ________ ________

Hep B: ________ ________ ________ ________ ________ ________ ________

Varicella: _____________________ (History of disease : ____________) (Presence of antibody: ______________)

Hepatitis A ________ ________ ________ ________

Meningitis Vaccine ________ ________ ________

Other (Specify):

Immunization requirements waived because of: (Give date)

A. Parent's religion ________________ (Attach documentation)
B. Medical certificate ________________ (Attach documentation)

**Issuing Officials Signature: ____

Name Printed: (use stamp) ____

Title: ____

Date: ____________________________

**NYS recognized providers: MD, DO, NP, PA

Dental Health Certificate - Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, as your dentist/dental hygienist 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 Person in Parental Relation (Please Print)

Child's Name: Last First Middle

Birth Date: / / (Month Day Year)

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ 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/Dental Hygienist

I. The dental health condition of ___________________________ on ____________ (date of assessment)

The date of the assessment 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/Dental Hygienist's name address (please print or stamp)	**Dentist's/Dental Hygienist'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.

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Name: ______________________________ DOB: ______________

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations.** Please base restrictions/modifications on the following Interscholastic Sports Categories.

- ☐ **No Contact Sports** Includes: basketball, baseball, field hockey, ice hockey, lacrosse, soccer, football, softball, volleyball, competitive cheerleading and wrestling
- ☐ **No Non-Contact Sports** Includes: archery, bowling, cross-country, golf, gymnastics, rifle, swimming and diving, skiing, tennis, Track & field, fencing, badminton
- ☐ **Other Specific Restrictions:**

Accommodations / Protective Equipment:	☐ Athletic Cup	☐ Insulin Pump / Insulin Sensor	☐ Pacemaker
	☐ Brace / Orthotic	☐ Medical / Prosthetic Device	☐ Sports Safety Goggles
	☐ Hearing Aides	☐ Other:	

MEDICATION HISTORY (optional)
Please list names of prescribed or OTC medications used on a routine basis at home

______________________ ______________________

______________________ ______________________

______________________ ______________________

PROVIDER REQUEST FOR MEDICATION REQUIRED DURING SCHOOL/SCHOOL SPONSORED EVENTS – VALID 1 YEAR

Independent Carry and Use Option: NYS law requires both provider attestation that the student has demonstrated they can effectively self-administer inhaled respiratory rescue medication, epinephrine auto-injector, insulin, glucagon and diabetes supplies, or other medications requiring rapid administration along with parent/guardian permission to allow this option in schools.

☐ **Required Independent Carry and Use Attestation documentation is attached.**

Diagnosis	ICD Code	Medication Name	Dose	Route	Time

REQUIRED PARENT/GUARDIAN PERMISSION FOR MEDICATION USE AT SCHOOL

Parent/Guardian Permission: I request the school nurse give the medications listed on this plan; or after the nurse determines my child can take their own medications, trained staff may assist my child to take their own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with staff caring for my child.

Parent/Guardian Signature: ______________________________

HEALTH CARE PROVIDER

All information contained herein is valid through the last day of the month for 12 months from the date below.

Medical Provider Signature: ______________________ Date: ______________

Provider Name: (please print) ______________________ Phone #: (   ) ______________

Provider Address: ______________________ Fax #: (   ) ______________

Return to:

School Nurse: ______________________ School: ______________

Phone #: (   ) ____________ Fax: (   ) ____________ Date: ______________

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BETHPAGE UNION FREE SCHOOL DISTRICT
Bethpage, New York 11714

PARENT HEALTH QUESTIONNAIRE

***Please complete this questionnaire in order to inform the District of your child's medical needs.**

Child's Name: ______________________________ Birth Date: ___/___/___ Sex: M or F (circle one)

Mother's Name: ______________________________ Father's Name: ______________________________

Who is the Legal Guardian? ____

ALLERGIES AND ASTHMA

Please list and describe allergies or reactions to:

Medicines/Drugs: ____

Foods/Plants/Others: ____

Insect bites or stings (i.e. Bee, Wasp):

____

Does your child require any specific treatment in the event of an allergic reaction (i.e. Allergy Shots)?

____

Please explain any other recommended treatment in the event of an allergic reaction.

____

Has your child been diagnosed with asthma? ________ Yes ________ No

If yes, what specific treatment or medicine has been prescribed?

____

MEDICATIONS

Is your child currently prescribed daily medication? ______________________

If yes, please list all prescribed daily medication.

____

What medications are given frequently, but not daily? ______________________________

INJURIES, ILLNESSES, SURGERIES

Please list any severe injuries, illnesses, or surgeries:

Injuries, Illnesses, Surgeries	Age of Child	If Hospitalized (check here)

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:				
LAST NAME / FIRST NAME	**RELATIONSHIP**	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**

EMERGENCY CONTACT:				
LAST NAME / FIRST NAME	**RELATIONSHIP**	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**

EMERGENCY CONTACT:				
LAST NAME / FIRST NAME	**RELATIONSHIP**	**HOME PHONE**	**WORK PHONE**	**CELL PHONE**

ADDITIONAL INFORMATION

How physically active would you consider your child? ____

Please provide any additional comments or concerns regarding your child that you would like the District to be aware of. (i.e. Your child's health, wellbeing, development, behavior, family or personal life)

____

____

____

Completed by: _____________________________________ Date: _______/_______/_______

Relationship to Child: _______________________________

I would like a conference with the school nurse: ____ YES ____ NO