

Purpose of the Housing Questionnaire

All Local Education Agencies (LEAs) are required to identify students experiencing homelessness. LEAs include school districts, charter schools and BOCES. Additionally, all LEAs that receive Title I funds must ask enrolling students about their housing status. The New York State Education Department (NYSED) encourages all LEAs regardless of whether they receive Title I funds to do the same. To collect this information, LEAs may:

1. Use the Housing Questionnaire attached here,
2. Update/modify the Model Enrollment Form – Housing Questionnaire to address the needs of the LEA, or
3. Incorporate the housing status question from the Model Enrollment Form - Residency Questionnaire into the LEA’s Enrollment Form or other documents already used by the LEA during the enrollment process.

If an LEA elects the third option and incorporates the housing status question into the LEA’s Enrollment Form, the LEA should take steps to ensure that a student’s housing status does not become a part of the student’s permanent record, because of the sensitive nature of this information. Please see the section titled “Confidentiality” (below) for information about how and when housing information may be shared within the LEA.

Who should fill out the Housing Questionnaire?

A Housing Questionnaire should be filled out for all students enrolling in school and for all students who have a change of address in grades preschool-12. “Preschool” includes any LEA administered or funded preschool program, such as a pre-k or Head Start program administered by an LEA. The Housing Questionnaire should be completed by the student’s parent, person in parental relation, or in the case of an unaccompanied youth, by the student directly.

Confidentiality

Student housing information should be kept confidential to the maximum extent possible. This information should only be shared with LEA/school staff members who need information about housing status to ensure that the student’s educational needs are met. To this end, LEAs may share a student’s Housing Questionnaire with LEA personnel such as:

1. the LEA liaison,
2. the registrar,
3. the student’s teachers, and/or guidance counselor, and
4. the LEA staff member responsible for reporting data to SED

However, this information should only be shared with the above staff members to the extent that it will enable them to better meet the educational needs of the student in question and to fulfill reporting requirements mandated by SED.

Other than the above uses, housing information **should be kept confidential** and **should not be shared** with other LEA/school personnel due to its sensitive nature and the stigma attached to being labeled homeless. LEAs are also encouraged to seek out ways of preventing Housing Questionnaires and housing information from becoming a part of a student’s permanent record.

Discussing the Housing Questionnaire with Students and Families

In reviewing the Housing Questionnaire with parents, persons in parental relation, and unaccompanied youth, LEAs should emphasize that the purpose of gathering the information is to ensure that students in temporary housing arrangements are provided with the rights and services to which they are entitled under the McKinney-Vento Act. These rights and services include:

1. The right to stay in the same school the student had been attending before losing his/her housing or the last school attended (both known as the school of origin),
2. The right to immediate enrollment for students who decide to transfer schools, even if the student does not have all of the documents normally for enrollment,
3. Transportation services if the student continues to attend the school of origin,
4. Categorical eligibility for Title I services if offered in the LEA,
5. Categorical eligibility for free meals if offered in the LEA, and
6. Access to services provided with McKinney-Vento funds if available in the LEA.

The LEA should also ensure that the parent, person in parental relation, unaccompanied youth is aware that the student's housing status will be kept confidential and will only be shared with those LEA staff who are responsible for providing services to the student and those responsible for keeping track of how many students are identified as living in temporary housing in the LEA.

LEAs are advised to explain to parents that if a parent claims that her/his child is living in temporary housing, and the LEA wishes to conduct an investigation to verify this information, the LEA may conduct a home visit. However, LEAs **cannot contact a landlord or building superintendent** to verify a student's housing status without prior parental consent. Contacting a landlord or building superintendent without the parent's express prior written permission is a violation of FERPA, a federal law.

If the Parent, Person in Parental Relation, or Unaccompanied Youth Declines to Fill Out the Housing Questionnaire

If the parent, person in parental relation, or unaccompanied youth declines to complete the Housing Questionnaire, the LEA should note on the form that the parent, person in parental relation, or unaccompanied youth declined to provide the information requested.

Completing the Form

If a parent, person in parental relation, or unaccompanied youth enrolling in school indicates that a student is living in one of the five temporary housing arrangements, the school may not require proof to verify where the student is living before enrolling the student. The five temporary housing arrangements are listed below:

1. In a shelter,
2. With another family or other person (sometimes referred to as "doubled-up"),
3. In a hotel/motel,
4. In a car, park, bus, train, or campsite, or
5. Other temporary living situation.

After the student is enrolled and attending classes, the school or LEA is permitted to verify the student's housing arrangements. However, the student must first be enrolled in school. Again, LEAs **cannot not contact a landlord or building superintendent** to verify a student's housing status. (See above for more information.)

Definitions of Temporary Housing Arrangements

"With another family or other person" (also referred to as "doubled-up")

LEAs should be aware that students who are sharing the housing of others are eligible for services under the McKinney-Vento Act and State law, if sharing housing is due to loss of housing, economic hardship, or a similar reason.

"Other temporary living situation"

In addition to the four examples of temporary housing, students who lack a "fixed, adequate, and regular" nighttime residence are also covered as homeless under the McKinney-Vento Act and State law. This may include unaccompanied youth who have fled their homes or were forced to leave their homes and who do not otherwise meet the definition of "doubled-up."

"In permanent housing"

Permanent housing means that the student's living arrangements are "fixed, regular, and adequate."

Next Steps for LEAs with Students Living in Temporary Housing Arrangements

If the parent, person in parental relation, or unaccompanied youth indicates that a student is living in temporary housing, the LEA must complete a Designation Form. If the LEA believes additional information is needed before reaching a final decision on the student's eligibility under McKinney-Vento, enrollment should not be delayed and a Designation Form should still be filled out. For more information about determining eligibility see the National Center on Homeless Education's Determining Eligibility Brief, available at: http://nche.ed.gov/downloads/briefs/det_elig.pdf.

If a student who is identified as homeless was last permanently housed in a different school district, the district of attendance/local district will be eligible for tuition reimbursement from SED for the cost of educating the student. School districts should complete a STAC-202 form if eligible for tuition reimbursement. For more information about STAC-202 forms contact the STAC Office at 518-474-7116 or NYS-TEACHS at 800-388-2014.

Lindenhurst Union Free School District Personal Data Sheet

Please fill out all areas unless otherwise indicated

Name _____ Sex _____ Date of Birth _____
(First) (Middle) (Last)

Address _____

Home Phone Number _____

Residence type: Own Rent Move in date: _____

Is the student Hispanic, Latino or of Spanish origin? (Person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture regardless of race)

Yes, Hispanic: No, not Hispanic:

Select 1 or more races from the following racial groups (check all that apply)

American Indian or Alaska Native Native Hawaiian or other Pacific Islander
 Asian Black White

All Lindenhurst students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission due to race, color, creed, national origin, sex, citizenship, handicap conditions or immigration status.

School last attended : _____ Date left: _____

Did the student previously attend Lindenhurst Schools: Yes No

Is your child receiving any special education services? Yes No

(If yes, please complete the Prior Special Education Services Form and submit with required information)

Student residing with: Both parents Mother only Father only Foster parents Legal Guardian
Step Parent Other

Custodial Papers: Yes No (If the student does not reside with both parents, please complete the custodial stipulation form)

Parent 1/Guardian 1 Name _____
(First) (Last)

Parent 2/Guardian 2 Name _____
(First) (Last)

Are one or both parents currently enlisted and active in the military? Yes No

Additional family members (if applicable)

Guardians Step Parent Foster Parents Other

Name _____ Relationship _____
(First) (Last)

Name _____ Relationship _____
(First) (Last)

Guardian's Work Phone Number _____

| Brothers/Sisters Name(s) | Date of Birth | Age | School/Grade Level |
|--------------------------|---------------|-------|--------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Number of Adults Residing in Home: _____ Number of Seniors: _____

Additional Contact Information

Parent/Guardian 1 cell #: _____ Parent/Guardian 2 cell # _____

Parent/Guardian 1 work #: _____ Parent/Guardian 2 work # _____

Emergency Contact: _____ Relationship _____ Phone _____
(First) (Last)

Emergency Contact: _____ Relationship _____ Phone _____
(First) (Last)

Under PENALTIES OF PERJURY, the statements contained in this application are true. I understand that the statements in the application are subject to verification by the School District and that false statements could subject me to transportation and/or tuition charges where applicable. I also understand that it is my responsibility to notify the school of any changes/circumstances affecting this application. ANY FALSE STATEMENTS MADE IN THIS APPLICATION ARE ALSO PUNISHABLE AS A CLASS A MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.

Date: _____

Date: _____

PRINT Name of Parent/Guardian

PRINT Name of Parent/Guardian

Signature

Signature

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: LINDENHURST UNION FREE SCHOOL DISTRICT | 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"/> HgbA1c 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 | <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: _____ |
| | | | | <input type="checkbox"/> Mental Health: _____ |
| | | | | <input type="checkbox"/> Other: _____ |
| Lead Level Required | Grades Pre- K & K | Date | | |
| <input type="checkbox"/> Test Done | <input type="checkbox"/> Lead Elevated \geq 10 μ g/dL | | | |

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 |

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

| | |
|-------|------|
| 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 | |
| Scoliosis <small>Required for boys grade 9</small> | Negative | Positive | Referral | |
| <small>And girls grades 5 & 7</small> | <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 |
|---|

| | | | | | | | | | |
|--|---|---|---------------------------------------|---|---|---|---|---|---------------------------------|
| <input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <input type="checkbox"/> No Contact Sports Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling <input type="checkbox"/> No Non-Contact Sports Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field <input type="checkbox"/> Other Restrictions: | | | | | | | | | |
| <input type="checkbox"/> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V | | | | | | | | | |
| <input type="checkbox"/> Accommodations: Use additional space below to explain <table style="width:100%; border: none;"> <tr> <td style="width:33%;"><input type="checkbox"/> Brace*/Orthotic</td> <td style="width:33%;"><input type="checkbox"/> Colostomy Appliance*</td> <td style="width:33%;"><input type="checkbox"/> Hearing Aids</td> </tr> <tr> <td><input type="checkbox"/> Insulin Pump/Insulin Sensor*</td> <td><input type="checkbox"/> Medical/Prosthetic Device*</td> <td><input type="checkbox"/> Pacemaker/Defibrillator*</td> </tr> <tr> <td><input type="checkbox"/> Protective Equipment</td> <td><input type="checkbox"/> Sport Safety Goggles</td> <td><input type="checkbox"/> Other:</td> </tr> </table> | <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: |
| <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 |
|--------------------|

| | | |
|--|--|--|
| <input type="checkbox"/> Order Form for Medication(s) Needed at School attached | | |
| List medications taken at home: | | |

| |
|----------------------|
| IMMUNIZATIONS |
|----------------------|

| | | |
|--|---|--|
| <input type="checkbox"/> Record Attached | <input type="checkbox"/> Reported in NYSIIS | Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|--|

| |
|-----------------------------|
| HEALTH CARE PROVIDER |
|-----------------------------|

| | |
|--------------------------------------|--------------|
| Medical Provider Signature: | Date: |
| Provider Name: <i>(please print)</i> | Stamp: |
| Provider Address: | |
| Phone: | |
| Fax: | |

| |
|--|
| Please Return This Form To Your Child’s School When Entirely Completed. |
|--|



Lissette Colón-Collins Assistant Commissioner
 Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
 Brooklyn, New York 11217
 Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
 Albany, New York 12234
 (518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

*Dear Parent or Guardian:
 In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.*

| Please write clearly when completing this section. | | | |
|--|--------|------------|--|
| STUDENT NAME: | | | |
| First | Middle | Last | |
| DATE OF BIRTH: | | | GENDER: |
| Month | Day | Year | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| PARENT / PERSON IN PARENTAL RELATION INFO: | | | |
| Last Name | | First Name | Relation to Student |

HOME LANGUAGE CODE

| Language Background (Please check all that apply.) | |
|---|--|
| 1. What language(s) is (are) spoken in the student's home or residence? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>Specify</i> |
| 2. What was the first language your child learned? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>Specify</i> |
| 3. What is the Home Language of each parent/guardian? | <input type="checkbox"/> Mother _____ <i>Specify</i> <input type="checkbox"/> Father _____ <i>Specify</i> <input type="checkbox"/> Guardian(s) _____ <i>Specify</i> |
| 4. What language(s) does your child understand? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> |
| 5. What language(s) does your child speak? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> <input type="checkbox"/> Does not speak |
| 6. What language(s) does your child read? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> <input type="checkbox"/> Does not read |
| 7. What language(s) does your child write? | <input type="checkbox"/> English <input type="checkbox"/> Other _____ <i>specify</i> <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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *If yes, please explain: _____ How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe |
| 10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* *Please complete 10b below |
| 10b. *If referred for an evaluation, has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____ Age at which services received (Please check all that apply): <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education) |
| 10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> 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: _____

_____ **Date**

Signature of Parent or of Person in Parental Relation

Relationship to student: Mother Father 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: <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| **DATE OF INDIVIDUAL INTERVIEW: _____ <small style="display: flex; justify-content: space-around; width: 100%;">Mo. Day YR.</small> | 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: _____ <small style="display: flex; justify-content: space-around; width: 100%;">Mo. Day YR.</small> | 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 ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____ | |

**Lindenhurst Union Free School District
Elementary Entrance Profile
Grade K – 5**

To be completed by parent or legal guardian:

Student's name: _____ Parent/Guardian name: _____
 Address: _____ Parent/Guardian name: _____
 Date of Birth: _____ Grade: _____
 Home phone: _____ Registration date: _____

Entering or transferring from:

| | | | | | |
|----------|----------|---------|------|-------|-----|
| (School) | (City) | (State) | | | |
| | Siblings | | | | |
| Name | Grade | Age | Name | Grade | Age |
| | | | | | |
| | | | | | |
| | | | | | |

For Office Use Only. Do Not Write Below This Line

Home Language Identification Survey Complete: Yes _____ No _____

To Be Completed by Principal

Retained: Yes _____ No _____ Grade _____
 Special Program: Yes _____ No _____
 If yes, explain: _____
 Parent's signature: _____ Date: _____

COMSI Screening: Yes _____ (If yes, see attached form)
 No _____ (If no, complete this form)

To Be Completed by Nurse

Physical, health or other need that teacher should be aware of _____

To Be Completed by Elementary Math Specialist

Slosson-Diagnostic Screening

Concepts: Grade Level _____
 Problem Solving: Grade Level _____
 Calculation: Grade Level _____
 Comments/Results:

Key Math

Basic Concept: Grade Level _____
 Operations Grade Level _____
 Applications Grade Level _____

To Be Completed by Speech Teacher

Articulation: _____
 Language: _____

Original - Teacher
 Copy-Cumulative File

 Principal's Signature Date

Lindenhurst Union Free School District
Administration Building, Central Registration Office
350 Daniel Street
Lindenhurst, NY 11757
Tel: (631) 867-3055

Request for Release of School Records

I hereby authorize (*name of last*) SCHOOL DISTRICT _____
ADDRESS _____

Date _____ Phone number _____
Fax number _____

To release and forward all educational, psychological, and medical information to the Lindenhurst Union Free School District concerning my child _____.

Please forward all information to the school circled below.

Relationship _____ Signature _____

Albany Ave Elementary School
180 Albany Avenue
Lindenhurst, NY 11757
Phone (631) 867-3150 Fax (631) 867-3158

Harding Ave Elementary School
2 Harding Avenue
Lindenhurst, NY 11757
Phone (631) 867-3350 Fax (631) 867-3588

Alleghany Ave Elementary School
250 S. Alleghany Avenue
Lindenhurst, NY 11757
Phone (631) 867-3200 Fax (631) 867-3208

Wm. Rall Elementary School
761 N. Wellwood Avenue
Lindenhurst, NY 11757
Phone (631) 867-3450 Fax (631) 867-3458

Daniel St. Elementary School
289 Daniel Street
Lindenhurst, NY 11757
Phone (631) 867-3308 Fax (631) 867-3300

West Gates Elementary School
175 West Gates Avenue
Lindenhurst, NY 11757
Phone (631) 867-3400 Fax (631) 867-3408

Lindenhurst Middle School
350 S. Wellwood Avenue
Lindenhurst, NY 11757
Phone (631) 867-3550 Fax (631) 867-3558

Lindenhurst High School
300 Charles Street
Lindenhurst, NY 11757
Phone (631) 867-3750 Fax (631) 867-3768

Lindenhurst Union Free School District
Office of Central Registration
Prior Special Education Services

If you have responded yes to your child receiving special education services, you must complete this form and submit it along with a current IEP.

Student's name _____ Date of Birth _____
Current Address _____ Phone number _____
Anticipated Start Date _____ Last School Attended _____
School District _____ Address _____
Phone number _____ Last Grade completed _____

Type of Special Education Program Attended:

- Special Class Resource Room
 Integrated Co-Teaching Related Services only
 BOCES Special Education: School Name _____
 Other (specify type of program or name of the school) _____

Related Services Provided in Most Recent Placement: (check all that apply)

- Speech/Language Occupational Therapy Other (please list) _____
 Counseling Physical Therapy _____
 Vision Services Hearing Services _____

Classification: (if known)

- Learning Disabled Other Health Impaired Hearing Impaired
 Intellectual Disability Multiple Disabilities Deaf/Blind
 Speech/Language Impairment Autism Visually Impaired
 Emotionally Disturbed Deaf Traumatic Brain Injury
 Orthopedic Impaired

Do you have a copy of your child's most recent IEP? _____ No _____ Yes (please attach copy)

Name of CSE Chairperson/Special Education Director _____

Address of CSE Office _____ Phone number _____

Release of Records/Information to the Lindenhurst Union Free School District

I authorize the school and CSE indicated above to release academic, psychological, psychiatric, medical and all other evaluations, IEPs and records to the Lindenhurst Union Free School District. I am aware that all records will be kept confidential and access limited to school personnel who work with my child. I understand that I may review all records. I also consent to having school district personnel who work with my child (principal, psychologist, social worker, regular or special education teachers, related service providers, guidance counselor and/or CSE Chairperson) speak with individuals from the school and CSE office indicated above. I am aware my consent is voluntary and can be withdrawn at any time.

Signature of Parent/Guardian

Date

**Lindenhurst Union Free School District
Custodial Stipulation Form**

Please answer all questions listed below:

Student name _____ Date of birth _____

Current address _____ Phone _____

Parent/Guardian Name _____ Legal Custody: Yes or No
(first) (last) (please circle one)

Parent/Guardian Name _____ Legal Custody: Yes or No
(first) (last) (please circle one)

Legal Guardian _____ Legal Custody Yes or No
(if applicable) (first) (last) (please circle one)

With whom does the child reside within the Lindenhurst School District?

Both parents Mother only Father only Other

Is there a custody agreement in effect? Yes or No (circle one)

If yes, please attach a copy of the custodial document, divorce decree or guardianship papers.

If no, please sign to verify the following statement:

I attest to the fact that a custody agreement does not exist or pertain to my child as indicated in this registration process.

(Signature)

(Date)

Is the non-custodial parent permitted to pick up the student from school for illness, appointments, etc.?

Yes, ok to pick up student No, not permitted to pick up student

**Note: the only person permitted to sign your child out of the building for any reason is the parent/legal guardian or designee as indicated on this document and emergency contacts card.*

