Comsewogue Central Registration
Melinda Ornstein l Registrar
mornstein@comsewogue.k12.ny.us
Phone: 631-474-8225 l Fax: 631-474-3639

Welcome to Comsewogue School District!

Documents Required to Register for a Pre-School Evaluation

1. **Copy of Student's Birth Certificate (preferred,) Passport or Baptismal Certificate**

2. **CPSE Registration Packet**
   Registration packet provided on this webpage or at the central registration office must be filled out in it's entirety.

3. **Health Examination as Mandated by the New York State Department of Health**
   All new entrants must have a health examination dated within one year of their child's first CSE/CPSE meeting. If your child has not had a physical within the last year, forms are provided on our website under the central registration tab and are also provided at the Central Registration office.

4. **Immunizations as mandated by the New York State Department of Health**
   Proof of required immunizations for school entry is mandated by the New York State Department of Health and must be presented at the time of registration.

5. **TWO (2) proofs of residency from Parent/Guardian**
   Registration cannot take place prior to the move in date.

   Homeowners First Proof
   a. Current Mortgage statement or
   b. Current yearly town of Brookhaven property tax bill
   c. Deed

   Renters/Other
   A notarized (may be sworn or unsworn) statement of Landlord or Owner from whom the parent or guardian leases or shares property with and a copy of the lease agreement.

   Second Proof for Homeowners AND renters
   Any of the following forms of documentation are accepted for your second proof. A copy of your pay stub, income tax return, utility bill, voter registration documents, official driver's license, learner's permit or non-drive identification, state or other governmental issued identification, documents issued by federal, state or local agencies.

Students with existing IEPs

If your preschool aged child has an IEP from their previous school district, please provide the IEP at the time of registration. If the IEP is not available to you, you will be required to sign a Release of Information form allowing Comsewogue School District to obtain this information from your previous school district.

Custody Issues (if applicable) - Please supply any court documents regarding custody.

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Comsewogue School District
Ethnicity Policy

The Comsewogue School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Comsewogue School District in accordance with the federal categories and definitions. The information will be used to:

- **Report information to the State and Federal Education Departments.**
- **Plan educational programs and make sure they are readily available to all students.**
- **Analyze differences in academic performance, attendance, and completion of school.**

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions listed below before completing the question on the first page of this packet.

Hispanic: Hispanic Latino or of a Spanish origin- A person of Cuban, Mexican, Puerto Rican, Central/South American or other Spanish culture or origin regardless of race.

White: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East

Black or African American: A person having origins in any of the Black racial groups of Africa

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

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

The Comsewogue School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and federal student privacy laws and regulations. If the information requested is not provided on the form on behalf of your child, a student records officer from the school or the district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging. Thank you for your cooperation.

The Family Educational Rights and Privacy Act (1974) prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

COMSEWOGUE SCHOOL DISTRICT

OFFICE OF PUPIL PERSONNEL SERVICES

290 Norwood Avenue, Port Jefferson Station, NY 11776 | Phone 631.474.8100 | Fax 631.474.8112

Timothy Dornicik
District Administrator for Pupil Personnel Services
tdornicik@comsewogue.k12.ny.us | 631.474.8127

Jennifer Quinn, Ed.D.
Superintendent of Schools

Dear Parent/Guardian,

The District provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. Any parent or guardian who suspects that their child has a disability may refer their child for an evaluation by the District's Committee on Special Education (CSE) or the District's Committee on Preschool Special Education (CPSE) for eligibility determination for special education services and programs.

More detailed information on this process is available in **A Parent's Guide to Special Education,** which is published on the New York State Education Department's website in English and Spanish:

https://www.nysed.gov/special-education/parents-guide-special-education

Parents or guardians should contact the District's Pupil Personnel Offices at 631-474-8127.

Sincerely,

Timothy Dornicik
District Administrator for Pupil Personnel Services

Accredited by the Middle States Association of Colleges and Secondary Schools
Commissions on Elementary and Secondary Schools

NEW ENTRANT FORM

For Office Use Only

Registration Date: _______________

Student ID# ________________

Immunizations Y/N

Physical Y/N

Custody Flag Y/N

Existing IEP Y/N

ESL/ENL Y/N

____

Last name of student (As appears on birth certificate) First name of student M.I.

____

Male/Female/Non-Binary Date of birth Grade registering for

____

Address

Child's Ethnic Code (Circle all that apply)

Hispanic
American Indian/Alaskan Native
Asian
Black
White
Native Hawaiian/Pacific Islander

Parent/Guardian #1 (primary contact)

____

Last name First name Marital Status Relationship to child

____

Address(write SAME if not different from child)

Please list phone numbers in the order you would like to receive calls.

1. ________________________________ (Home Work Cell) 2. _____________________________________ (Home Work Cell)

3. ________________________________ (Home Work Cell) **Email:** ____

Parent/Guardian #2

____

Last name First name Marital Status Relationship to child

____

Address **(if different from student, will this parent be receiving mail from the school? YES___ NO___)**

Please list phone numbers in the order you would like to receive calls.

1. ________________________________ (Home Work Cell) 2. _________________________________ (Home Work Cell)

3. ________________________________ (Home Work Cell) **Email:** ____

Who does this child live with? Parents ___ Parent/Guardian 1 ___ Parent/Guardian 2 ___ Legal Guardian___

Is your child currently receiving special education services? Yes __ No __
Does your child have an existing IEP? Yes __ No __

Are there any special custody regulations or court orders regarding your child? Yes __ No __
If yes, please provide a copy of court order

Does this child receive any ESL/ENL services? Yes __ No __

Is either parent a member of the Armed Forces on Active Duty? Yes __ No __

Parent/Guardian Signature ___________________________ Date ______________________

HOUSING QUESTIONNAIRE

Name of LEA: **Brookhaven-Comsewogue School District**
Name of School: ____
Name of Student ____

Last First MI

Gender: _____ DOB ____/____/____
Grade: ___________

Student ID#_______________
Address _______________________________ Phone: ____________

The answer you give below may 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. Students who are protected under the McKinney-Vento Act may also be entitled to transportation and other services.

Where is the student currently living? Please check **one.**

____ In permanent housing (house, apartment, trailer)
____ In a shelter
____ With another family because of a loss of housing or as a result of economic hardship
____ In a hotel/motel
____ In a car, park, bus, train or campsite
____ Other temporary living situation (please describe) ______________________
____ Foster Care Placement. Start date: _____________

If the student is NOT living in permanent housing, please ensure that a Designation Form is completed.

____
Print Name of Parent, Guardian
(or student if Unaccompanied Youth)

Parent/Guardian Signature ________________________ 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:**
		❑ Male ❑ Female
Month	*Day*	*Year*
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	*First Name*	*Relation to*

HOME LANGUAGE CODE ______________

Language Background

(Please check all that apply.)

Question			
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?	❑ Parent 1 ______ *specify*	❑ Parent 2 ______ *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

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

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

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

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

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

____

____

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

________________________________ Month: Day: Year: ________________

Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ 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:

PARENT REFERRAL TO THE
COMMITTEE ON SPECIAL EDUCATION (CPSE)
COMSEWOGUE UFSD
OFFICE OF PUPIL PERSONNEL SERVICES

Date of Referral: ___________

Student's Name ________________________________ Student's DOB __________

Dear CPSE Chairperson:

I am hereby referring my child to the Committee on Preschool Special Education due to the following concerns:

____
____
____
____
____.

I understand that I will receive further information regarding consent for the evaluation and the CPSE meeting.

____
Parent's Name

____
Parent's Signature

Address:
____

Home Phone #
____

Name of Preschool: ______________________________________ Phone # ____________________

Comsewogue School District
Office of Pupil Personnel Services
290 Norwood Avenue
Port Jefferson Station, NY 11776
Phone (631) 474-8127 Fax (631) 474-8112

RELEASE OF INFORMATION FORM

Date: ________________

I, ______________________________
(PARENT/GUARDIAN NAME)

HERBY REQUEST THAT PSYCHOLOGICAL, SOCIAL, EDUCATIONAL, MEDICAL AND ANY OTHER PERRTINENT INFORMATION REGARDING MY CHILD ______________________________,
(STUDENT'S NAME)
A STUDENT AT COMSEWOGUE SCHOOL DISTRICT BE RELEASED TO:

OFFICE OF PUPIL PERSONNEL SERVICES
COMSEWOGUE SCHOOL DISTRICT
290 NORWOOD AVENUE
PORT JEFFERSON STATION, NY 11776

I understand this information shall be kept confidential and shall be used only for the purpose of planning and coordinating educational programming and services.

____
(SIGNATURE)

____
(RELATIONSHIP)

Student ID ______________________________ Home school ____________________

Referral/Authorization to Committee on Preschool Special Education (CPSE)

Child's Name: ____ **Date of Birth:** __________

Address: ____________________________ **Parent/Guardian:**_________________________________

Preferred Phone Number:_________________
Nursery School/Daycare Attending (please include days and times): __________________________________

____

Is your child currently receiving Early Intervention services:
_______ YES (please write services in additional information) _______ No
Name of Early Intervention Coordinator/Designee:____
Has the student received services/Evaluation prior to this referral:
_______ YES (please write what type in additional information) _______ No
Additional Information:
____

____

Parent Concerns Checklist

Please check if your child has a history of:

______ seems too quiet/withdrawn

______ being very restless, difficult sitting still or waiting

______ ear infections/fluid in ears

______ difficulty completing a task or following directions

______ answering questions inappropriately

______ complaints about noises being too loud

______ saying "what" a lot

______ talking in a loud voice/hearing loss

______ poor eating habits

______ late speech development/not speaking clearly

______ stuttering

______ difficulty holding a crayon or marker

______ difficulty stacking blocks

______ poor sleeping habits

______ vision problems/amblyopia

______ difficulty with social interaction

______ being clumsy/awkward

______ difficulty tolerating touch, hair cuts or textures

______ poor adjustment to nursery school

______ not paying attention

______ blood relative with delay/disability

______ other medical ___________________________

****

OFFICE USE ONLY:

Agency: ________________________________ Tentative CPSE Date/Time __________________________

Psychological	Social History	Physical/Medicaid			

Parental Consent for the Use of Public Benefits or Insurance Pursuant to the Individuals with Disabilities Education Act (IDEA)

I, ___________________________ the parent/guardian of ______________________, have received a written notification from the Comsewogue School District that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the school district/county may ask for a Client Identification Number (CIN), check on Medicaid eligibility, and/or access Medicaid to pay for special education and related services provided to my child. I understand that:

- Providing consent will not impact my child's/my Medicaid coverage;
- Upon request, I may review copies of records disclosed pursuant to this authorization;
- Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid and/or provide my child's CIN;
- I have the right to withdraw consent at any time; and
- The school district, county must give me annual written notification of my rights regarding this content.

I also give my consent for the school district/county to release the following records/information about my child to the State's Medicaid Agency for the purpose of checking Medicaid eligibility and/or billing for special education and related services that are in my child's IEP. The following records may be shared:

- Student demographic information (name, age, address, SSN, etc.)
- Student services information (special education services provided to student)

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Student's CIN (if known) ________________________

Date: ____

Print Name: ___________________________________

Parent/Guardian Signature ______________________

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTHCARE 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:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	☐ Intermittent ☐ Persistent ☐ Other: ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ **Seizures**	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

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: ☐ Yes ☐ Not Done **Hypertension:** ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

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

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB- PRN	☐	☐		☐ Test Done ☐ Lead Elevated ≥5 µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**

☐ **Abnormal Findings – List Other Pertinent Medical Concerns Below** (e.g., concussion, mental health, one functioning organ)

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

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list) ICD-10 Code*

☐ Additional Information Attached

*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for PreK or K, 1, 3, 5, 7, & 11

Vision Screening	**With Correction** ☐Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening	☐ Pass ☐ Fail				☐

Notes

Hearing Screening: Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes

Scoliosis Screening: Boys grade 9, Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes	☐

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

☐ ***Family cardiac history reviewed –** required for Dominick Murray Sudden Cardiac Arrest Prevention Act

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply – Complete the information below

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Other Accommodations*:** Provide Details (e.g., brace, insulin pump, prosthetic, sports goggles, etc.):

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

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:	
Provider Name: *(please print)*	
Provider Address:	
Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.