

**HYDE PARK CENTRAL SCHOOL DISTRICT**

Administration Offices: P.O. Box 2033, Hyde Park, New York 12538-8033

Telephone: (845) 229-4000

[www.hpcsd.org](http://www.hpcsd.org)

**Aviva Kafka**

*Superintendent of Schools*

**Melissa Lawson**

Assistant Superintendent

for Pupil Services

Phone: 845-229-4005

**Gregory S. Brown, Ed.D.**

Deputy Superintendent

Phone: 845-229-4008

**Linda Steinberg**

Assistant Superintendent

for Finance & Operations

Phone: 845-229-4009

Dear Families,

Children that live in the Hyde Park Central School District's attendance zone and are 4 years old by December 1, 2023 may apply for enrollment in the Universal Pre-Kindergarten program starting in September, 2023. There is no cost for this full day program.

The program is offered at two locations -

- Hyde Park Elementary School Building
- Holy Trinity Annex (formerly St. Peters' School)

Please be aware that there are a limited number of spaces available for this program. All applications will be reviewed and acceptance letters will be mailed out on or around May 16, 2023.

The next page of this packet has a list of forms to be filled out and documents that need to be provided in order to complete the application process.

**Appointments are required to submit your application.**

Please call the Student Registration Department at (845)229-4000 ext. 1606 to make your appointment. You may also schedule your appointment online at

<https://calendar.app.google/vToTPdsDnWxMpcAA7> or visit our website at [www.hpcsd.org](http://www.hpcsd.org).

Sincerely,



Melissa Lawson

Assistant Superintendent for Pupil Services.

# HYDE PARK CENTRAL SCHOOL DISTRICT

## STUDENT REGISTRATION OFFICE

11 Boice Road, Hyde Park, NY 12538  
Telephone: 845-229-4000, Extension 1606

### APPLICATION FOR UNIVERSAL PRE-KINDERGARTEN PROGRAM

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

Registration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Person Registering Student: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Phone #: \_\_\_\_\_

DOCUMENTS to be PROVIDED by PARENT/GUARDIAN TO COMPLETE REGISTRATION:	STAFF INITIALS ↓
<b>PROOF OF RESIDENCY:</b> <b>Homeowners:</b> The most recent school or property tax bill, AND 1 current, recurring bill with your name and address for services you receive at this address, such as your electric, cable or telephone bill. <b>Renting in an apartment complex:</b> Your current signed lease AND 1 current, recurring bill for services you receive at this address, with your name and address, such as your electric, cable or telephone bill. <b>Renting from a private owner:</b> Your current lease AND the owners school or property tax bill, AND 1 current bill with your name and address for services you receive at this address, such as your electric, cable or telephone bill. If you do not have a formal lease, your landlord will need to complete the attached Residency Affidavit which must be notarized. If utilities are included in your lease, you will need to provide an additional form of proof of residency.	
<b>Proof of Birth:</b> <ul style="list-style-type: none"> <li>• Birth Certificate OR Passport</li> </ul>	
<b>Photo ID of <u>parent/guardian</u></b> registering the student, which may include: <ul style="list-style-type: none"> <li>• Driver's license</li> <li>• Passport (must be current)</li> <li>• NYS Identification Card</li> </ul>	
<b>Proof of Immunizations</b> – See attached sheet for immunization requirements	
<b>Physical Exam Report</b> (exam must be dated less than one year before the start of school)	
<b>Current IEP</b> (special education services), if applicable	
<b>DS2999 form</b> (for foster care children), if applicable	
<b>Court Documents</b> - such as Custody Order, Order of Protection, etc., if applicable	
<b>STAC 202</b> , if applicable	
<b>ATTACHED FORMS TO BE COMPLETED:</b>	
Registration form	
Enrollment Form/Residency Questionnaire	
FERPA	
Home Language Questionnaire	
Emergency Contact Information Form	
Transportation Form	
Income Form	
Residency Affidavit – to be completed for renters where no formal lease exists	

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# PUPIL REGISTRATION FORM

PLEASE PRINT ALL INFORMATION

Child's Name: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Last</span> <span>First</span> <span>MI</span> </div>			<b>THIS BOX TO BE FILLED OUT BY DISTRICT STAFF</b>  <b>REGISTRATION TYPE:</b> <input checked="" type="checkbox"/> Universal Pre-School <input type="checkbox"/> CPSE Referral  <b>School Preference:</b> <input type="checkbox"/> HPE <input type="checkbox"/> Holy Trinity Annex  Pupil ID# : _____  Home School: _____  Attending School: _____  Registration Date: ____/____/____		
Child's Street Address: _____  City: _____ State: _____ Zip Code: _____  Home Phone #: _____					
Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Grade: <b>UPK</b>	Date of Birth: ____/____/____			
City of Birth: _____		State of Birth: _____			
How many years has child attended school in the USA?: _____					
<b>ETHNIC ORIGIN (CHOOSE ONE):</b> <input type="checkbox"/> YES, Hispanic <input type="checkbox"/> NO, not Hispanic					
<b>RACE (SELECT ALL THAT APPLY):</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White					
<b>CHILD'S LEGAL GUARDIAN:</b> <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> OTHER: _____					
<b>CHILD LIVES WITH:</b> <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> OTHER: _____					
Is there a custody order for this child?: <input type="checkbox"/> YES <input type="checkbox"/> NO			Is there an Order of Protection: <input type="checkbox"/> YES <input type="checkbox"/> NO		

<b>Parent/Guardian #1</b>	<b>This will be the FIRST parent/guardian contacted</b>
<b>Name:</b> _____ <b>Relationship to student:</b> _____ <b>Email:</b> _____	
<b>Residential address:</b> _____ <b>Mailing address:</b> _____	
<b>PHONE CONTACT #1 for Guardian #1:</b> _____ <b>Circle one:</b> HOME   CELL   WORK	
<b>PHONE CONTACT #2 for Guardian #1:</b> _____ <b>Circle one:</b> HOME   CELL   WORK	
<b>PHONE CONTACT #3 for Guardian #1:</b> _____ <b>Circle one:</b> HOME   CELL   WORK	
Does parent/guardian need accommodations for hearing impairment? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>TYPE:</b> _____	
Is this parent/guardian in Active Military Service: <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Entry Date:</b> ____/____/____ <b>Exit Date:</b> ____/____/____	

<b>Parent/Guardian #2</b>	<b>This will be the SECOND parent/guardian contacted</b>
<b>Name:</b> _____ <b>Relationship to student:</b> _____ <b>Email:</b> _____	
<b>Residential address:</b> _____ <b>Mailing address:</b> _____	
<b>PHONE CONTACT #1 for Guardian #2:</b> _____ <b>Circle one:</b> HOME   CELL   WORK	
<b>PHONE CONTACT #2 for Guardian #2:</b> _____ <b>Circle one:</b> HOME   CELL   WORK	
<b>PHONE CONTACT #3 for Guardian #2:</b> _____ <b>Circle one:</b> HOME   CELL   WORK	
Does parent/guardian need accommodations for hearing impairment? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>TYPE:</b> _____	
Is this parent/guardian in Active Military Service: <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Entry Date:</b> ____/____/____ <b>Exit Date:</b> ____/____/____	

Continue on Page 2 →

# HYDE PARK CENTRAL SCHOOL DISTRICT

## CHECK ALL SUPORT SERVICES THAT YOUR CHILD CURRENTLY RECEIVES:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> SPEECH            | <input type="checkbox"/> OCCUPATIONAL THERAPY | <input type="checkbox"/> ENGLISH AS A NEW LANGUAGE |
| <input type="checkbox"/> SPECIAL EDUCATION | <input type="checkbox"/> PHYSICAL THERAPY     | <input type="checkbox"/> COUNSELING                |

If your child received Special Education services prior to enrolling in this district, complete the following:

Name of the School District child was enrolled in: \_\_\_\_\_ Phone #: \_\_\_\_\_

Services that were provided: \_\_\_\_\_

## CENSUS INFORMATION

THE FOLLOWING INFORMATION IS NECESSARY TO KEEP THE SCHOOL CENSUS UP TO DATE.

PLEASE INCLUDE ALL CHILDREN FROM BIRTH TO 18 YEARS OLD, INCLUDING REGISTRANT.

NAME OF CHILD	PLACE OF BIRTH	DATE OF BIRTH	GRADE	SCHOOL
		/ /		
		/ /		
		/ /		
		/ /		

*I understand the requirements for enrollment and request that my child(ren) be admitted to schools in the Hyde Park Central School District. This is my actual and only permanent address.*

*I am the legal guardian of the above listed child(ren). This/these child(ren) reside with me at this address.*

*I certify that the information provided on this form is true and correct and that the statements made herein are being made under penalty of perjury, knowing that the Hyde Park CSD will rely upon them in determining whether the above child(ren) will be admitted to its schools.*

*I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the district may commence legal proceedings against me to collect the annual tuition rate, determined by the New York State Education Department, retroactive to the first date of admission for each child, and may seek criminal action against me for filing a false document.*

*I understand that the district reserves the right to investigate any student's residency by any legal means available, including but not limited to, public records, site visits and any other lawful methods of investigation.*

*I understand that any false statements made herein are punishable as a Class A misdemeanor pursuant to Section 210.45 of the penal law of the State of New York and may be referred to the office of the district attorney.*

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

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**Hyde Park Central School District**  
**P.O. Box 2033**  
**Hyde Park, NY 12538**  
**Phone: 845-229-4000**

**ENROLLMENT FORM - RESIDENCY QUESTIONNAIRE**

Name of LEA: **HYDE PARK CENTRAL SCHOOL DISTRICT**

Student Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Gender: ☐ Male ☐ Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Grade: **UPK**  
Month Day Year

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*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? (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 if Unaccompanied homeless youth

\_\_\_\_\_  
Signature of Parent/ Guardian  
Or student if Unaccompanied homeless youth

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY:**

**Circle One: New to District Re-Entry New Address Change of Guardian \_**

**School (Check One):** ☐ FDR ☐ HMS ☐ NES ☐ NPE ☐ RRS ☐ VAS ☐ CPSE ☒ UPK  
☐ Homeschooled ☐ Private School: \_\_\_\_\_

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**FERPA RELEASE of INFORMATION**

The purpose of the Family Educational Rights and Privacy Act (FERPA) is to protect the privacy of information concerning individual students by placing certain restrictions on the disclosure of "non-directory information" contained in a student's educational records. I understand that I have the right not to consent to the release of my educational records and I have the right to receive a copy of such records upon request.

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Please print)

I, the undersigned, hereby authorize the Hyde Park Central School District ("District") to request the following:

Education Records

Health Records

IEP

Psychological Evaluation

All evaluation reports

Other: \_\_\_\_\_

Other: \_\_\_\_\_

Please FAX records to:

From the following Person and/or Agency:

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

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

I understand that this authorization remains in effect from today through \_\_\_\_/\_\_\_\_/\_\_\_\_.

I also understand that it will be necessary to send a written request to the District to revoke this authorization, but that any such revocation shall not affect disclosures previously made by the District prior to the receipt of any such written authorization.

Signature of Parent Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Eligible Student Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



# HYDE PARK CENTRAL SCHOOL DISTRICT

## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
GRADE: <u>UPK</u>		
PARENT / GUARDIAN INFO:		
LAST NAME: _____		FIRST: _____
RELATIONSHIP TO STUDENT: _____		

HOME LANGUAGE CODE:

### Language Background

1. What language(s) is(are) spoken in the student's home or residence?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
2. What was the first language your child learned?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
3. What is the Home Language of each parent/guardian?	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	_____ specify
	<input type="checkbox"/> Guardian(s)		_____ specify
4. What language(s) does your child understand?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ specify
5. What language(s) does your child speak?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not speak
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<input type="checkbox"/> Does not read
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	<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:
Hyde Park Central School District PO BOX 2033, Hyde Park, NY 12538	
School: _____	
District Name (Number) & School	Address

## Home Language Questionnaire (HLQ)—Page Two

<b>Educational History</b>	
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* <input type="checkbox"/> No <input type="checkbox"/> Not sure <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. <u>*If referred for an evaluation</u> , 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: \_\_\_\_\_

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

\_\_\_\_\_  
Date

Relationship to student: ☐ Mother ☐ Father ☐ Other: \_\_\_\_\_

<b>OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ</b>	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
<b>NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW</b>	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: _____ <small>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
<b>NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL</b>	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: _____ <small>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:	

## EMERGENCY CONTACT FORM

STUDENT'S NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address: \_\_\_\_\_ Town/City: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: Universal Pre-K

Bus Route: \_\_\_\_\_ (to be determined by Transportation Dept.)

### PARENT/GUARDIAN INFORMATION:

Student Resides With (Check all that apply): \_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Other

(Explain, if other): \_\_\_\_\_

#### Parent/Legal Guardian #1 (FIRST PARENT/GUARDIAN TO BE CONTACTED)

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # to be called 1<sup>st</sup>: \_\_\_\_\_ Phone type: \_\_\_\_\_

Phone # to be called 2nd: \_\_\_\_\_ Phone type: \_\_\_\_\_

Phone # to be called 3rd: \_\_\_\_\_ Phone type: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Home \_\_\_\_ Work \_\_\_\_

#### Parent/Legal Guardian #2: (SECOND PARENT/GUARDIAN TO BE CONTACTED)

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_

Phone # to be called 1<sup>st</sup>: \_\_\_\_\_ Phone type: \_\_\_\_\_

Phone # to be called 2nd: \_\_\_\_\_ Phone type: \_\_\_\_\_

Phone # to be called 3rd: \_\_\_\_\_ Phone type: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Home \_\_\_\_ Work \_\_\_\_

### PERSONS TO CALL IF PARENT(S)/GUARDIAN IS NOT AVAILABLE:

1. NAME: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Is this person permitted to pick student up from school? \_\_\_\_ YES \_\_\_\_ NO

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

2. NAME: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Is this person permitted to pick student up from school? \_\_\_\_ YES \_\_\_\_ NO

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION - Page 2

### MEDICAL INFORMATION:

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

ANY SPECIAL HEALTH ISSUES (i.e., allergies, etc.)? Yes ☐ No ☐

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

List current medications:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### EMERGENCY DISMISSAL

In the event of an emergency dismissal during the school day, where should your child be transported? \_\_\_\_\_ HOME \_\_\_\_\_ ALTERNATE LOCATION

**NOTE:** The alternate location *must* be within the Hyde Park Central School District's attendance zone.

### ALTERNATE LOCATION INFORMATION:

Name of Adult: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Print Parent/Guardian Name: \_\_\_\_\_

Signature of Parent or Legal Guardian

Date

C: Main Office / Transportation / School Nurse

REVISED JANUARY 2022

**HYDE PARK CENTRAL SCHOOL DISTRICT**  
**UNIVERSAL PRE-KINDERGARTEN TRANSPORTATION FORM**

CHILDS LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

GRADE: UNIVERSAL PRE-KINDERGARTEN

HOME ADDRESS: \_\_\_\_\_

PARENT NAME: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ HOME #: \_\_\_\_\_

PARENT NAME: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ HOME #: \_\_\_\_\_

SCHOOL ATTENDING: \_\_\_\_\_ SCHOOL YEAR: \_\_\_\_\_

DOES YOUR CHILD REQUIRE TRANSPORTATION TO & FROM SCHOOL? ☐ YES ☐ NO

MY CHILD WILL BE PICKED UP AT: \_\_\_\_\_ HOME \_\_\_\_\_ DAYCARE \_\_\_\_\_ ALTERNATE LOCATION

IF YOUR CHILD IS BEING PICKED UP AT A LOCATION OTHER THAN HOME, COMPLETE BELOW:

NAME OF ADULT AT OTHER LOCATION: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CIRCLE DAYS TO BE PICKED UP AT THIS LOCATION:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY AS NEEDED

MY CHILD WILL BE DROPPED OFF AT: \_\_\_\_\_ HOME \_\_\_\_\_ DAYCARE \_\_\_\_\_ ALTERNATE LOCATION

IF YOUR CHILD IS BEING DROPPED OFF AT A LOCATION OTHER THAN HOME, COMPLETE BELOW:

NAME OF ADULT AT OTHER LOCATION: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CIRCLE DAYS TO BE PICKED UP AT THIS LOCATION:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY AS NEEDED

PARENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*NOTE: CHANGES REQUIRE AN UPDATED FORM - ASSIGNED ROUTE WILL BE DETERMINED BY TRANSPORTATION\***

Revised January 2022

Pick Up Route: \_\_\_\_\_

Drop Off Route: \_\_\_\_\_

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**RESIDENCY AFFIDAVIT**

*Note: This affidavit is to be completed by the home owner or leaseholder when a person is renting an apartment or room(s) within a privately owned home or apartment, including their own home, or is sharing a house or apartment with another family where there is no formal lease.*

Please **PRINT** all information:

My name is \_\_\_\_\_, and I am the legal owner or leaseholder of this address: \_\_\_\_\_.

Please attach a copy of your school or property tax bill, deed, mortgage statement or lease.

What part of your home do these tenants occupy? (Example: basement apt., 1<sup>st</sup> floor, apartment #, number of rooms in the home, etc.): \_\_\_\_\_

The terms and conditions of tenancy are as follows:

Lease start date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Lease End date: \_\_\_\_/\_\_\_\_/\_\_\_\_ OR,

Month to month start date: \_\_\_\_/\_\_\_\_/\_\_\_\_ OR,

Temporarily residing in my home/apartment due to loss of housing as of \_\_\_\_/\_\_\_\_/\_\_\_\_.

I understand the requirements for enrollment and request that the following child/children be admitted to the schools of the Hyde Park Central School District as a district resident:

\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the above mentioned property is the current and only legal residence of \_\_\_\_\_ (Name of Parent/Guardian) and the child(ren)/ward(s) named above.

The following is a list of the names of ALL persons residing at this address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the information provided on this form is true and correct and that the statements made herein are being made under penalty of perjury, knowing that the Hyde Park Central School District will rely upon them in determining whether the above named child/children will be admitted to its schools. I understand that in the event the information contained in this affidavit is determined to be inaccurate or false, in whole or in part, the district may commence legal proceedings against me to collect the annual tuition rate retroactive to the first day of admission for such child/children and/or seek criminal action against me for filing a false document.

The most recent annual tuition rates, as determined by the New York State Department of Education, are as follows:

Grades K-6 = \$ 9,201                      Grades 7-12= \$11,791

NOTE: The following statement, signature requirement and notarization requirement apply to all sections of this form, and must be met for application to be accepted.

*As the property owner/landlord/leaseholder, I certify that I will notify the Hyde Park Central School District Central Registration Office, PO Box 2033, Hyde Park, NY 12538, within 30 days of termination of this living arrangement.*

**I understand that any false statements made herein are punishable as a class A misdemeanor pursuant to section 210.45 of the penal law of the state of New York and may be referred to the office of the district attorney.**

\_\_\_\_\_  
Signature of Property Owner/Landlord/Leaseholder

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Print Owner/Landlord/Leaseholder Name

\_\_\_\_\_  
Owner/Landlord/Leaseholder Phone

Owner/Landlord/Leaseholder Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Sworn to before me this

\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_

Notary Public

# New York State Immunization Requirements for School Entrance/Attendance<sup>1</sup>

**NOTES:**

Children in a prekindergarten setting should be age-appropriately immunized. The number of doses depends on the schedule recommended by the Advisory Committee on Immunization Practices (ACIP). Intervals between doses of vaccine should be in accordance with the ACIP-recommended immunization schedule for persons 0 through 18 years of age. Doses received before the minimum age or intervals are not valid and do not count toward the number of doses listed below. See footnotes for specific information for each vaccine. Children who are enrolling in grade-less classes should meet the immunization requirements of the grades for which they are age equivalent.

**Dose requirements MUST be read with the footnotes of this schedule**

Vaccines	Prekindergarten (Day Care, Head Start, Nursery or Pre-k)	Kindergarten and Grades 1, 2, 3, 4 and 5	Grades 6, 7, 8, 9, 10 and 11	Grade 12
<b>Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap/Td)<sup>2</sup></b>	<b>4 doses</b>	<b>5 doses or 4 doses</b> If the 4th dose was received at 4 years or older or <b>3 doses</b> If 7 years or older and the series was started at 1 year or older		<b>3 doses</b>
<b>Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine adolescent booster (Tdap)<sup>3</sup></b>		<b>Not applicable</b>		<b>1 dose</b>
<b>Polio vaccine (IPV/OPV)<sup>4</sup></b>	<b>3 doses</b>		<b>4 doses or 3 doses</b> If the 3rd dose was received at 4 years or older	
<b>Measles, Mumps and Rubella vaccine (MMR)<sup>5</sup></b>	<b>1 dose</b>		<b>2 doses</b>	
<b>Hepatitis B vaccine<sup>6</sup></b>	<b>3 doses</b>		<b>3 doses</b> or <b>2 doses</b> of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years	
<b>Varicella (Chickenpox) vaccine<sup>7</sup></b>	<b>1 dose</b>		<b>2 doses</b>	
<b>Meningococcal conjugate vaccine (MenACWY)<sup>8</sup></b>		<b>Not applicable</b>	<b>Grades 7, 8, 9, 10 and 11: 1 dose</b>	<b>2 doses or 1 dose</b> If the dose was received at 16 years or older
<b>Haemophilus Influenzae type b conjugate vaccine (Hib)<sup>9</sup></b>	<b>1 to 4 doses</b>		<b>Not applicable</b>	
<b>Pneumococcal Conjugate vaccine (PCV)<sup>10</sup></b>	<b>1 to 4 doses</b>		<b>Not applicable</b>	





1. Demonstrated serologic evidence of measles, mumps or rubella antibodies or laboratory confirmation of these diseases is acceptable proof of immunity to these diseases. Serologic tests for polio are acceptable proof of immunity only if the test was performed before September 1, 2019 and all three serotypes were positive. A positive blood test for hepatitis B surface antibody is acceptable proof of immunity to hepatitis B. Demonstrated serologic evidence of varicella antibodies, laboratory confirmation of varicella disease or diagnosis by a physician, physician assistant or nurse practitioner that a child has had varicella disease is acceptable proof of immunity to varicella.
2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a 5-dose series of DTaP vaccine at 2 months, 4 months, 6 months and at 15 through 18 months and at 4 years or older. The fourth dose may be received as early as age 12 months, provided at least 6 months have elapsed since the third dose. However, the fourth dose of DTaP need not be repeated if it was administered at least 4 months after the third dose of DTaP. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. If the fourth dose of DTaP was administered at 4 years or older, and at least 6 months after dose 3, the fifth (booster) dose of DTaP vaccine is not required.
  - c. For children born before 1/1/2005, only immunity to diphtheria is required and doses of DT and Td can meet this requirement.
  - d. Children 7 years and older who are not fully immunized with the childhood DTaP vaccine series should receive Tdap vaccine as the first dose in the catch-up series; if additional doses are needed, use Td or Tdap vaccine. If the first dose was received before their first birthday, then 4 doses are required, as long as the final dose was received at 4 years or older. If the first dose was received on or after the first birthday, then 3 doses are required, as long as the final dose was received at 4 years or older.
3. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) adolescent booster vaccine. (Minimum age for grades 6, 7 and 8: 10 years; minimum age for grades 9 through 12: 7 years)
  - a. Students 11 years or older entering grades 6 through 12 are required to have one dose of Tdap.
  - b. In addition to the grade 6 through 12 requirement, Tdap may also be given as part of the catch-up series for students 7 years of age and older who are not fully immunized with the childhood DTaP series, as described above. In school year 2022-2023, only doses of Tdap given at age 10 years or older will satisfy the Tdap requirement for students in grades 6, 7 and 8; however, doses of Tdap given at age 7 years or older will satisfy the requirement for students in grades 9 through 12.
  - c. Students who are 10 years old in grade 6 and who have not yet received a Tdap vaccine are in compliance until they turn 11 years old.
4. Inactivated polio vaccine (IPV) or oral polio vaccine (OPV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive a series of IPV at 2 months, 4 months and at 6 through 18 months, and at 4 years or older. The final dose in the series must be received on or after the fourth birthday and at least 6 months after the previous dose.
  - b. For students who received their fourth dose before age 4 and prior to August 7, 2010, 4 doses separated by at least 4 weeks is sufficient.
  - c. If the third dose of polio vaccine was received at 4 years or older and at least 6 months after the previous dose, the fourth dose of polio vaccine is not required.
  - d. For children with a record of OPV, only trivalent OPV (tOPV) counts toward NYS school polio vaccine requirements. Doses of OPV given before April 1, 2016 should be counted unless specifically noted as monovalent, bivalent or as given during a poliovirus immunization campaign. Doses of OPV given on or after April 1, 2016 should not be counted.
5. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)
  - a. The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. Measles: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - c. Mumps: One dose is required for prekindergarten. Two doses are required for grades kindergarten through 12.
  - d. Rubella: At least one dose is required for all grades (prekindergarten through 12).
6. Hepatitis B vaccine
  - a. Dose 1 may be given at birth or anytime thereafter. Dose 2 must be given at least 4 weeks (28 days) after dose 1. Dose 3 must be at least 8 weeks after dose 2 AND at least 16 weeks after dose 1 AND no earlier than age 24 weeks (when 4 doses are given, substitute "dose 4" for "dose 3" in these calculations).
  - b. Two doses of adult hepatitis B vaccine (Recombivax) received at least 4 months apart at age 11 through 15 years will meet the requirement.
7. Varicella (chickenpox) vaccine. (Minimum age: 12 months)
  - a. The first dose of varicella vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid.
  - b. For children younger than 13 years, the recommended minimum interval between doses is 3 months (if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid); for persons 13 years and older, the minimum interval between doses is 4 weeks.
8. Meningococcal conjugate ACWY vaccine (MenACWY). (Minimum age for grades 7, 8 and 9: 10 years; minimum age for grades 10 through 12: 6 weeks)
  - a. One dose of meningococcal conjugate vaccine (Menactra, Menveo or MenQuadfi) is required for students entering grades 7, 8, 9, 10 and 11.
  - b. For students in grade 12, if the first dose of meningococcal conjugate vaccine was received at 16 years or older, the second (booster) dose is not required.
  - c. The second dose must have been received at 16 years or older. The minimum interval between doses is 8 weeks.
9. Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive Hib vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. If 2 doses of vaccine were received before age 12 months, only 3 doses are required with dose 3 at 12 through 15 months and at least 8 weeks after dose 2.
  - c. If dose 1 was received at age 12 through 14 months, only 2 doses are required with dose 2 at least 8 weeks after dose 1.
  - d. If dose 1 was received at 15 months or older, only 1 dose is required.
  - e. Hib vaccine is not required for children 5 years or older.
10. Pneumococcal conjugate vaccine (PCV). (Minimum age: 6 weeks)
  - a. Children starting the series on time should receive PCV vaccine at 2 months, 4 months, 6 months and at 12 through 15 months. Children older than 15 months must get caught up according to the ACIP catch-up schedule. The final dose must be received on or after 12 months.
  - b. Unvaccinated children ages 7 through 11 months are required to receive 2 doses, at least 4 weeks apart, followed by a third dose at 12 through 15 months.
  - c. Unvaccinated children ages 12 through 23 months are required to receive 2 doses of vaccine at least 8 weeks apart.
  - d. If one dose of vaccine was received at 24 months or older, no further doses are required.
  - e. PCV is not required for children 5 years or older.
  - f. For further information, refer to the PCV chart available in the School Survey Instruction Booklet at: [www.health.ny.gov/prevention/immunization/schools](http://www.health.ny.gov/prevention/immunization/schools)

For further information, contact:

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