Oyster Bay - East Norwich Central School District

1 McCouns Lane, Oyster Bay, New York 11771
(516) 624–6555 · Fax (516) 624–6520
www.obenschools.org

Registration for Universal Pre-Kindergarten (UPK)

Please be advised that in order for your child to attend the Oyster Bay – East Norwich Central School District, you must be a resident of the District. If it is determined at any time that you are not a resident of the District, your child will be excluded from the District.

Completed applications and required documents are due **in person or by USPS mail only by March 15, 2024** to the Central Administration building at 1 McCouns Lane, Oyster Bay, NY 11771, Attn: UPK Registration. The office is open from 8 a.m. to 4 p.m. Email applications will not be accepted.

All families will be contacted upon review of their application. Applicants will not be processed until all documents are received. Only complete applications will be eligible for the UPK lottery on April 16, 2024 at Theodore Roosevelt Elementary. Should you require additional assistance, contact our Registrar, Ms. Teresa Bussi at 516-624-6555.

In order to complete your child's registration in the Oyster Bay East Norwich Central School District, the following documents **must** be provided for each child.

Documentation of Residence:

Parents/guardians must provide sufficient proof that they reside in the School District. We ask for three proofs of residence. Examples of proof of residence include, but are not limited to:

1. A copy of mortgage statement or copy of deed of ownership;
2. A tax bill for the Town of Oyster Bay;
3. A copy of a lease executed by the tenant and landlord, or a sworn or unsworn affidavit by a landlord that a lease is in effect with a copy of the landlord's mortgage statement or deed of ownership;
4. Statements for utility bills;
5. The portion of a current telephone bill showing name and address;
6. A pay stub or income tax form showing the in-district address;
7. A copy of a driver's license or insurance identification card; or
8. A voter registration document or a state- or other government- issued ID.
9. A third-party affidavit, sworn or unsworn, (usually by a neighbor or social services provider);
10. A letter from the person to whom you pay rent stating you live there;
11. Custodial papers or other government-issued document with evidence of address, as supplementary proof of residency; or
12. Membership document such as a library card with evidence of address, as supplementary proof of residency.

Documentation of Age

Provide a copy of the original or certified transcript of a birth certificate or record of baptism (including an original or certified transcript of a foreign birth certificate or record of baptism) giving the date of birth; **or** Passport (including foreign passport) giving the date of birth. Where such documentation is not available, other documents may be considered, including a school photo identification with date of birth, a consulate identification card, a military dependent identification card, documents issued by Federal State or local agencies (e.g., local social service agency, Federal Office of Refugee Resettlement); court orders or other court-issued documents, Native American tribal documents, or records from non-profit international aid agencies and voluntary agencies.

Parent(s)/Guardian(s) shall provide proper proof of parental relationship: Provide guardianship papers or a custodial affidavit for students not living with parents. If divorced or separated, provide judgment of divorce. For all others, please contact the Registrar for additional information.

Health Examination – Provide proof of a satisfactory health examination conducted by a physician, physician assistant, or nurse practitioner licensed in New York, upon first entering the district, and upon entering pre-kindergarten or kindergarten, and the first, third, fifth, seventh, ninth, and eleventh grades. To be acceptable, such examination must have been conducted no more than 12 months before the first day of school. **Dental Health Certificates** should be submitted upon entry into the District, in Kindergarten, and grades 2, 4, 7, and 10.

Immunizations – Proof of immunization in accordance with the age-appropriate schedule recommended by the Advisory Committee for Immunization Practice (ACIP). The school nurse will review and approve immunization records prior to enrollment of new students. No child may be admitted to, or allowed to attend, school for more than fourteen (14) days without acceptable evidence of immunization. Proof of immunization must be provided no later than fourteen (14) days upon enrollment of the child in the School District. This fourteen (14) day period may be extended, on a case-by-case basis, to thirty (30) days when a student has transferred from another state or country.

Administration of Medication at School – If it is necessary for a student to take medication in school, both the parent and physician must sign a written request which specifies the diagnosis, name of medication, dosage, frequency to be given in school, and possible side effects. These forms can be obtained in the Health Office. Medications should be delivered by the parent in the original container to the School Nurse. This includes over the counter medication.

Students taking Prescribed Medication at Home – The School District also requires that a parent notify the Health Office any time a student is on prescription medication, even if the medication is only being taken at home. It is beneficial to the School District to know the name of the medication in the event that the student suffers from side effects during the school day.

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HOUSING QUESTIONNAIRE

School: _____ Oyster Bay H.S. _____ Oyster Bay M.S. _____ Vernon _____ Roosevelt

Name of Student _____
Last First Middle

Gender: _____ Date of Birth _____ /_____ /_____ Grade _____ ID # _____
Month Day Year *(preschool-12)*

Address _____ Phone _____

_____ Cell _____

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

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

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

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

If ANY box other than "In Permanent Housing" is checked, then the student/family should be immediately referred to the McKinney-Vento liaison. In such cases, **proof of residency** and other documents normally needed for enrollment **are not required** and the **student is to be immediately enrolled. After** the student has been enrolled, the district/school must contact the previous district/school attended to request the student's educational records, including immunization records, and the enrolling district's Local Education Agency (LEA) liaison must help the student get any other necessary documents or immunizations.

NOTE TO SCHOOLS/LEAs: If the student is **NOT** living in permanent housing, please ensure that a Designation Form is completed.

Office use only

I certify that the above-named student is eligible for assistance under the provisions of the McKinney-Vento Act.

_____ _____
Date Signature of District Homeless Liaison

A copy of this form must be sent to the Office of Curriculum & Instruction if McKinney-Vento-eligible.

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REGISTRATION FORM FOR UNIVERSAL PRE-KINDERGARTEN

PLEASE PRINT CLEARLY IN BLUE OR BLACK INK ONLY.

Student's Legal Name_____ Sex: M____ F____
Last First Middle

Student's Address _____
Street/Apt # Town Zip Code

Move in Date _____ Years/months at this address _____

Date of Birth _____ Age _____ Phone_____

Name of person completing form: _____

Relationship to Student: ___Mother ___Father ___Guardian ___Other: _____

Is this student currently receiving CPSE services? ____No ____Yes

Ethnicity/Race: 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 or national origin, sex, citizenship, handicapping condition, or immigration status.

1. Is this student Hispanic, Latino, or of Spanish origin? *(A person of Cuban, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race)*
   _____ Yes, Hispanic _____ No, not Hispanic
2. Select one or more races from the following five racial groups. Check (√) all groups that apply to your child.
   _____American Indian or Alaska Native _____ Black or African American
   _____White
   _____Native Hawaiian or Other Pacific Islander _____Asian

For office use only: ☐ Initial Entry ☐ Re-enrollment ☐ CSE placement NR
☐ Resident NPS ☐ CSE only

Student ID#: _____
Registration Date: _____ School Year: _____
Enrollment Date: _____
School: TR Vernon OBMS OBHS Graduation Year: _____ Grade: ____
Other: _____
District of Residence: _____

☐ UPK Lottery Eligible ☐ UPK Waitlist #____

AGE/DOB	HEALTH EXAM
CUSTODIAL PAPERS	PHOTO ID
DENTAL	IMMUNIZATIONS
ENL	SPECIAL EDUCATION
PROOFS 1 2 3	

HOUSEHOLD INFORMATION

Student lives with: (check all that apply)

Mother_____ Father____ Stepparent_____ Guardian_____ Other: _____

Is one or more parent/guardian on active duty in the armed forces? Yes__ No ___ Date of Entry _____

Parent/Legal Guardian (PRIMARY CONTACT) Lives with student ____ Yes ____No

Name _____ Relationship to student _____

Address_____

Home Phone _____Cell_____ Work _____

E-mail address _____Preferred Language: _____

Married____ Divorced____ Separated____ Single Parent____ Widowed____ Remarried____
(Custody papers)

Parent/Legal Guardian Lives with student ____ Yes ____No

Name _____ Relationship to student: _____

Address_____

Home Phone _____Cell_____ Work _____

E-mail address _____Preferred Language: _____

Married____ Divorced____ Separated____ Single Parent____ Widowed____ Remarried____
(Custody papers)

If parent is not listed in the contacts above, please provide the following information:

Mother's Name _____ Phone Number _____
Mother's Address _____

Father's Name: _____ Phone Number _____
Father's Address _____

School Age Siblings

Name_____ School _____
Name_____ School _____
Name_____ School _____

Parent/Guardian Signature_____Date_____

Any misrepresentation about the student's residence could subject the parent or guardian to criminal or civil penalties.

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EMERGENCY CONTACT INFORMATION 20_____

Student's Name _____ Sex: M_____ F_____
Last First

Home Address _____
Street Town Zip

Home Telephone _____ Cell Phone_____

In my home, _____is spoken. *(Please list language(s).)*

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1 _____ Relationship to student: _____
Name

Phone # _____ ___Home ____Cell ___Work

Phone # _____ ___Home ____Cell ___Work

Parent/Guardian #1 _____ Relationship to student: _____
Name

Phone # _____ ___Home ____Cell ___Work

Phone # _____ ___Home ____Cell ___Work

EMERGENCY CONTACT NAMES & PHONE NUMBERS (*Other than parent)*

_____ _____
Name Relationship to student

Phone # _____ ____Home ____Cell ____Work

Is this person authorized to pick up the student from school? _____YES _____NO

_____ _____
Name Relationship to student

Phone # _____ ____Home ____Cell ____Work

Is this person authorized to pick up the student from school? _____YES _____NO

Office use only

SCHOOL: _____ GRADE: _____ TEACHER: _____

WALKER _____ A.M. BUS # _____ P.M. BUS # _____

Bus Stop _____

Please notify school office of any changes in the above information and we will update your file accordingly.

NEW YORK STATE EDUCATION DEPARTMENT
Emergent Multilingual Learners Language Profile for Prekindergarten Students[i]

Dear Parent or Guardian,
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE
Date Profile Completed:
Student Name:
Gender:
Date of Birth:
District or Community Based Organization Name:
Student ID (if applicable):
Name of Person Administering Profile:
Title:

Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile: ☐ mother ☐ father ☐ other _____

In what language(s) would you like to receive information from the school? ☐ English ☐ other home language:

Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home? ☐ yes ☐ no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings? ☐ yes ☐ no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

Language Outside the Home/Family

10. Has your child attended any nursery, Head Start or childcare program? ☐ yes ☐ no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

Language Goals

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual? ☐ yes ☐ no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?
☐ yes ☐ no

If yes, in what language(s)?

Emergent Literacy

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English? ☐ yes ☐ no

16b. Can your child recognize letters or symbols in another language? ☐ yes ☐ no

If yes, in what language(s)?

17a. Does your child pretend to read? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

17b. Does your child pretend to write? ☐ yes ☐ no ☐ unsure

If yes, in what language(s)?

18. Does your child tell the stories from his/her favorite books or videos? ☐ yes ☐ no

If yes, in what language(s)?

19. Does your child's childcare or nursery program describe goals for his or her learning? ☐ yes ☐ no

If so, what goals do they describe?

20. Please describe anything special you did to prepare your child to begin Prekindergarten.

[i] For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email OEL@nysed.gov or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email OBEWL@nysed.gov.

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HEALTH FORM

Dear Parent/Guardian:

New York State has laws in place that protect the confidentiality of your child's health records, which is something we have always taken seriously. In an effort to meet the needs of your child and to remain in compliance with the law, we ask you to review the following information.

If your child has a serious medical condition such as those listed below, we request that you sign the consent form below allowing the school nurse to discuss/share this important information with the school staff and your private physician.

- Asthma
- Diabetes
- Seizures
- Anaphylaxis (*You must provide emergency medication/form.*)
- Food allergy (*You must provide emergency medication/form.*)
- Attention deficit disorder
- Cardiac murmur
- Kidney disease
- Other

Please return this form to the School Health Office.

NOTE: If your child <u>does not</u> have a serious allergy or medical condition, it is not necessary to return this form.

My child, _____ in grade _____
(Name)

has _____
(State medical condition.)

Name of Pediatrician _____

Address _____ Phone _____

Print Parent/Guardian name (please print) _____

Parent/Guardian Signature _____ Date _____

High School Nurse – 516-624-6541 Fax – 516-624-7314

Vernon Nurse – 516-624-6565 Fax – 516-624-2024

Roosevelt Nurse – 516-624-6575 Fax – 516-624-6591

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

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:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

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

Notes

Hearing 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*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use additional space below to explain.

*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.

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Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first oral health assessment? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak, or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing, or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, the student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, the student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist's Signature**

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify): _____

II. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

Oyster Bay- East Norwich CSD

Office of Special Services

REQUEST FOR SPECIAL EDUCATION SERVICES

What should you do if you feel your child needs special education?

The District provides special education services and programs to students with disabilities pursuant to applicable federal and state laws. Any parent or person in parental relation who suspects that his/her child has a disability may refer the child for an evaluation to the District's Committee on Special Education (CSE) to determine eligibility for special education services and programs. For additional information or to make a referral to the Committee on Special Education, contact Lynette Abruzzo, Director of Special Services or Nicole Friedman, Assistant Director of Special Services, at 516-861-3200. 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. You may access this guide by clicking on the following link:

https://www.p12.nysed.gov/specialed/publications/policy/parentguide.htm