

ROSLYN PUBLIC SCHOOLS

DISCLOSURE STATEMENT

(MUST BE NOTARIZED)

NAME OF CHILD/CHILDREN:

(PRINT): _____
(First name) (Last name)

(PRINT): _____
(First name) (Last name)

PARENT NAME (PRINT): _____
(First name) (Last name)

ADDRESS: _____
(Street) (City) (Zip Code)

I understand that in order for my child/children to attend the Roslyn Public Schools, I must be a resident of the Roslyn School District. **I certify that I have actually taken up residency and am domiciled (living) at the above address with my child/children effective _____ (INSERT DATE).**

Section 210.25 of the Penal Law of the State of New York prohibits the making of false written statement. Therefore, I hereby swear/affirm that the statements contained in the student account and enrollment forms are true.

I further understand that if this certification is found to be false, my child/children will be excluded from the Roslyn Public Schools and I may be liable for payment of tuition from their date of enrollment through their date of termination, and may be subject to the penalties for perjury, which is a Class A misdemeanor.

I understand that, in addition to payment of non-resident tuition, the District will seek all costs of collection thereof, including reasonable attorney fees. **I recognize that it is my responsibility to notify the school district if I move.** I attest that all information provided by me on this document is true.

****PLEASE BE AWARE THAT THE DISTRICT MAINTAINS THE RIGHT TO VERIFY RESIDENCY THROUGH THE UTILIZATION OF A HOME VISIT****

Parent's Signature (MUST BE NOTARIZED-SEE BELOW) Date

State of New York)
County of _____)

Sworn to before me this ____ day of _____ 20__

NOTARY PUBLIC

PROOF OF RESIDENCY REQUIRED DOCUMENTS

***** According to NY State Law, in order to register your child/children in the Roslyn Public Schools, you must be physically domiciled at your Roslyn address.*****

Provide one (1) of the following:

- Notarized Deed of Premises
- Current Mortgage Statement from bank/lender
- Nassau County Real Estate Tax Bill (current year)
- Housing Agreement (All signatures must be notarized)
- Original Notarized Lease - if lease is NOT notarized we require both A & B:

A. Owner's/Landlord's - Attached; Must be notarized and A copy of the **OWNERS** deed OR mortgage statement OR real estate tax bill.

B. Renter's/Non-Owner's – Attached; Must be notarized.

****NOTE:** A signed Contract of Sale will **NOT** be accepted as proof of home ownership

Also Provide any two (2) of the following:

(Bills/Statements must be dated within three (3) months of your registration appointment)

- Paid Moving Company Statement with new Roslyn Address and date of move
- Current PSEG OR National Grid Statement (counts as 1 proof)
- Current Fuel Delivery Statement
- Current Roslyn Water District Statement (with attached payment stub)
- Current Cable/Internet Statement
- Current Car Insurance (Insurance ID card) OR Car Registration with new Roslyn Address
- Current Homeowner's/Renters Insurance Policy (FULL POLICY)

REGISTRANTS WHO CANNOT PROVIDE THE ABOVE ITEMS MAY BE REQUIRED TO SUBMIT ADDITIONAL DOCUMENTATION TO VERIFY RESIDENCY OR MAY BE REQUIRED TO SIGN A SWORN AFFIDAVIT. EXCEPTIONS WILL BE MADE WHERE APPROPRIATE.

LANDLORD/OWNER'S AFFIDAVIT

ANY FALSE STATEMENT MADE IN THIS AFFIDAVIT IS PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.

REQUIREMENTS: (1) Attach a copy of Deed OR Mortgage Statement OR Real Estate Tax Bill; and (2) Attach a copy of the Lease

STUDENT'S NAME: _____
(Print first name, last name)

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

I, _____, being duly sworn, depose and say:
(PRINT NAME OF LANDLORD/OWNER ABOVE)

1. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY, in order that the above-mentioned child may be admitted to the schools of the Roslyn School District as a district resident.
2. I am the legal owner of _____
(INSERT ADDRESS OF RENTAL PROPERTY)
3. My email address is _____. My phone number is: _____

A COPY OF THE DEED, MORTGAGE STATEMENT OR REAL ESTATE TAX BILL MUST BE ATTACHED

4. The terms and conditions of said tenancy are as follows: (Specify amount of monthly rent, lease term, etc...) **(Attach copy of Lease)**

5. To the best of my knowledge, the above-mentioned property is the current residence of the Child named above AND _____:
(INSERT NAME OF PARENT/GUARDIAN ABOVE)

6. The following names include ALL other persons living at this address:

1 _____ 4 _____
 2 _____ 5 _____
 3 _____ 6 _____

Sworn to be before me this
_____ day of _____, 20____

Print Name of Landlord/Owner

Notary Public

Signature of Landlord/Owner

RENTER/NON-OWNER'S AFFIDAVIT

ANY FALSE STATEMENT MADE IN THIS AFFIDAVIT IS PUNISHABLE AS A CLASS "A" MISDEMEANOR PURSUANT TO SECTION 210.45 OF THE PENAL LAW.

REQUIREMENTS: (1) *Attach a copy of Lease or Rental Agreement, (2) Attach Two (2) Bills/ Statements listing the parent's name and rental property address (see list of acceptable bills/ statements on RoslynSchools.org website), and (3) Attach the Landlord/Owner's Affidavit.*

STUDENT'S NAME: _____
(Print first name, last name)

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

I, _____ being duly sworn, deposes and says:
(PRINT NAME OF RENTER/NON-OWNER ABOVE)

1. I understand that this statement is being made UNDER THE PENALTIES OF PERJURY in order that my Child/Ward may be admitted to the schools of the Roslyn School District as a district resident. I further understand that if my Child/Ward is found not to be a legitimate resident of the Roslyn School District that I WILL BE LEGALLY RESPONSIBLE FOR AND WILL BE BILLED THE SCHOOL DISTRICT'S ANNUAL TUITION RATE, PER CHILD, RETROACTIVE to the first day of admission. I also realize that theft of governmental services is a crime punishable under the State Penal Law and that a false statement made in connection with this application will make me liable to criminal prosecution.
2. I have been informed that the school district may make unannounced home visits for purposes of residency verification.
3. I am the _____ of the above
(insert PARENT, GUARDIAN or CUSTODIAL PARENT above)
named Child/Ward. **I reside at** (state address and specify the exact nature of the space:
basement apartment, second floor apartment, number of rooms, etc...) _____

with my Child/Ward, and

- | | |
|---------|---------|
| 1 _____ | 4 _____ |
| 2 _____ | 5 _____ |
| 3 _____ | 6 _____ |

(LIST EACH AND EVERY OTHER PERSON LIVING AT THE ABOVE ADDRESS).

This is my actual and only permanent residence. My Child/Ward lives with me and said address is his/her actual and only permanent residence.

STUDENT'S NAME: _____
(Print first name, last name)

4. **My last address was at:** _____
where I lived with:

1 _____ 4 _____
2 _____ 5 _____
3 _____ 6 _____

(LIST EACH AND EVERY PERSON WHO LIVED AT THE ABOVE ADDRESS)

5. **I began living at** _____ **(CURRENT ADDRESS)**
on _____ **(DATE)**. My living arrangement is governed by:

(CHECK APPROPRIATE OPTION):

- Formal lease (attach copy of lease and Owner's Affidavit)
 Other (attach rental agreement or realtor's statement and Owner's Affidavit)

6. The terms and conditions of my tenancy are as follows (specify rent, term, etc...):

MONTHLY RENT: _____
DURATION/TERM OF TENANCY: _____

Sworn to be before me this
_____ day of _____, 20_____

Print Name of Renter/Non-Owner

Notary Public

Signature of Renter/Non-Owner



Computer Equipment Sign-out Form

FOR OFFICE USE ONLY	
NAME:	_____
GR:	_____
BLDG:	_____
STUDENT #:	_____
YR OF GRAD:	_____

This form assigns primary responsibility for Roslyn Public Schools equipment to the borrower. The borrower will be responsible for taking the necessary precautions to protect the equipment and to store it in a manner that provides adequate protection when it is not in use, thus not subjecting the equipment to possible theft or damage. If it is determined that loss or damage is a result of negligence, the borrower may be held financially responsible for the repair or replacement of the equipment.

Student's Name _____
Parent's Name _____
Item Description: <u>Dell ChromeBook 11 - 3189</u>

1. The borrower will be responsible for returning the ChromeBook and all accessories in like condition as received (i.e. ChromeBook and charging cable).
2. Students are not permitted to place any ornamental stickers on the ChromeBook. Screensavers and desktops images are expected to display appropriate content.
3. Students must take responsibility for having their ChromeBook prepared for class, which includes a charged battery.
4. Equipment cannot be loaned or transferred to a third party.
5. The borrower cannot modify the equipment in any way without written approval of the district.
6. Students are not to lend their ChromeBook to friends and/or family under any circumstances. No student may take another student's ChromeBook. Students are not to touch, use or alter another person's ChromeBook in any manner.
7. The borrower will make the equipment available at any time as requested by the district.
8. If loss or damage to the equipment/property occurs and determination is made that the loss or damage is a result of negligence, the borrower may be held financially responsible for the repair or replacement of the item(s). Reimbursement to the Roslyn Public Schools by the borrower who checked the equipment out should be at the fair market value of the equipment/property at the time of loss or damage (\$220 Chromebook and \$30 AC adapter as of 2022).

I have read the above information and agree to the terms and conditions herein contained.	
Parent Signature _____	Date _____

Student Signature _____	Date _____
(Upon Receipt)	

**ROSLYN PUBLIC SCHOOLS
HEALTH OFFICE REGISTRATION (TO BE COMPLETED BY PARENT/GUARDIAN)**

Name	Date of Birth	Grade
Address	Town / Zip Code	Phone Number of Student, if any
Parent 1/Father's/Guardian's Name		Phone Number
Parent 2/Mother's/Guardian's Name		Phone Number
Name of Physician To Be Called in an Emergency		Phone Number

Health History***

Allergies:	
Asthma:	Is inhaler needed? YES _____ NO _____
Diabetes:	
Heart Condition:	
Hearing Problems:	
Operations:	
Serious Accidents:	
Serious Illness:	
Seizure Disorder:	
Other Medical Diagnosis:	
Wears glasses:	Contact lenses:
Daily medications (other than vitamins);	
Medications during the school day:	
Does your child require any special accommodations?	
Do you have any special health related concerns about your child when he/she is in school?	

*****NOTE: Students may not carry any medication (including over-the counter) unless the student is in 6th -12th grade and the "Self-Medication Release Form" is completed by Parent and Doctor and provided to the nurse. The nurse cannot administer medication unless the nurse is provided with the "Permission for Administration of Medication in School" form completed by the Parent and Doctor. Both forms are located on the school building's webpage.**

PROOF OF IMMUNIZATIONS BY A PHYSICIAN IS REQUIRED FOR REGISTRATION. New York State Public Health Law 2164 mandates that the school shall not permit a child to be admitted unless the parent provides the school with proof of immunization by a physician. The School Nurse will determine validity of proof.

Information on this form may be shared with appropriate school personnel for health and educational purposes.

Please call the school building's Health Office if you have any questions or concerns.

Print name of Parent/Guardian: _____

Parent/Guardian Signature

Date

**REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTH CARE 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	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: _____ Date of last seizure: _____ <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Seizure Care Plan Attached
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> 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: No Yes Not Done **Hypertension:** No Yes Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
Laboratory Testing	Positive	Negative	Date	List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)
TB- PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Sickle Cell Screen-PRN	<input type="checkbox"/>	<input type="checkbox"/>		
Lead Level Required Grades Pre- K & K			Date	
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 5 $\mu\text{g/dL}$				
<input type="checkbox"/> System Review and Abnormal Findings Listed Below				
<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
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code*
<input type="checkbox"/> Additional Information Attached			*Required only for students with an IEP receiving Medicaid	

Name:				DOB:
Vision & Hearing SCREENINGS - Required for PreK or K, 1, 3, 5, 7, & 11				
Vision (w/correction if prescribed)	Right	Left	Referral	Not Done
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Near Vision Acuity	20/	20/		<input type="checkbox"/>
Color Perception Screening <input type="checkbox"/> Pass <input type="checkbox"/> Fail				<input type="checkbox"/>
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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Referral <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Notes				
Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	Negative	Positive	Referral	Not Done
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Student may participate in all activities without restrictions. <input type="checkbox"/> Student is restricted from participation in: <ul style="list-style-type: none"> <input type="checkbox"/> Contact Sports: Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling. <input type="checkbox"/> Limited Contact Sports: Baseball, Fencing, Softball, and Volleyball. <input type="checkbox"/> Non-Contact Sports: Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field. <input type="checkbox"/> Other Restrictions: 				
Developmental Stage for Athletic Placement Process <u>ONLY</u> 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: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Age of First Menses (if applicable) : _____				
<input type="checkbox"/> Other Accommodations*: (e.g. Brace, orthotics, insulin pump, prosthetic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School Attached				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached <input type="checkbox"/> Reported in NYSIIS				
HEALTH CARE PROVIDER				
Medical Provider Signature:				
Provider Name: <i>(please print)</i>				
Provider Address:				
Phone:		Fax:		
Please Return This Form To Your Child's School When Completed.				



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:
Month	Day	Year
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female
PARENT/PERSON IN PARENTAL RELATION INFO:		
Last Name	First Name	Relation to

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"/> Parent 1	_____	<input type="checkbox"/> Parent 2
		<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	_____ <input type="checkbox"/> Does not speak
			<i>specify</i>
6. What language(s) does your child read?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not read
			<i>specify</i>
7. What language(s) does your child write?	<input type="checkbox"/> English	<input type="checkbox"/> Other	_____ <input type="checkbox"/> Does not write
			<i>specify</i>

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? _____

Signature of Parent or of Person in Parental Relation

Month: Day: Year:

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: _____ PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
 MO. DAY YR. ENTERING EMERGING TRANSITIONING EXPANDING COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:



PUBLIC SCHOOLS

375 Locust Lane, Roslyn Heights, NY 11577 516-801-5060 Fax 516-801-5068 www.roslynschools.org

OFFICE OF PUPIL PERSONNEL SERVICES & SPECIAL EDUCATION

*Cindy Samide
Director*

*Marnie Cohen, Assistant Director
Rachel Barshak, Assistant Director*

AUTHORIZATION FOR TRANSFER OF STUDENT RECORDS

DATE: _____

STUDENT NAME: _____ DATE OF BIRTH: _____

LAST SCHOOL ATTENDED (NAME OF SCHOOL AND CONTACT INFORMATION): _____

GRADE ATTENDED AT LAST SCHOOL: _____

Please send **ACADEMIC, HEALTH, ATTENDANCE, and SPECIAL EDUCATION RECORDS (if applicable), as well as psychological reports (if applicable)**, concerning the above-named student. Authorization for release of all information is appended below. Please send us a description of your grading system as well as an English translation where necessary. Please forward to the school checked below:

____ Michelle Hazen, Principal
Harbor Hill School
3 Glen Cove Road
Greenvale, NY 11548
Fax: (516) 801-5408

____ Mrs. Sherry Ma, Principal
East Hills School
400 Round Hill Road
Roslyn Heights, NY 11577
Fax: (516) 801-5308

____ Mrs. Mary Wood, Principal
Heights School
240 Willow Street
Roslyn Heights, NY 11577
Fax: (516) 801-5508

____ Mr. Craig Johanson, Principal
Roslyn Middle School/Guidance
375 Locust Lane
Roslyn Heights, NY 11577
Fax: (516) 801-5208

____ Mrs. Tanya Baptiste
Director, Guidance & Counseling (K-12)
Roslyn High School
475 Round Hill Road
Roslyn Heights, NY 11577
Fax: (516) 801-5138

____ Mrs. Cindy Samide
Director, Pupil Personnel
Services & Special Education
375 Locust Lane
Roslyn Heights, NY 1577
Fax: (516) 801-5068

Your prompt response is greatly appreciated.

Cindy Samide

AUTHORIZATION FOR TRANSFER OF STUDENT RECORDS

I hereby give my permission to Roslyn Public Schools to obtain any and all the records indicated above for the following:

PLEASE PRINT STUDENT'S FULL NAME

SIGNATURE OF PARENT/GUARDIAN

DATE