New York City Early Childhood Education (3-K and Pre-K) Program Registration Form

School Day and School Year Services

Directions

Please print clearly in blue or black ink, **or** complete this form electronically. In order to be eligible to register for Pre-K or 3-K, students and caregivers must reside within the five boroughs of New York City. Please be prepared to provide proof of residence along with this registration packet.

Section 1. STUDENT INFORMATION	ON CONTRACTOR OF THE PROPERTY		
Last Name		Date of Birth	
Current Address (Building #, Stree	t)		Apt#
City	State	Zip Code	Gender (optional)
Section 2. HEALTH INSURANCE (o	ptional)		
Does this student have health insu	ırance?	Yes	No
If yes, what type of coverage?	Medicaid	Child Health Plus B	
If no, would you like to be contact	ed about getting coverage	Yes	No
Section 3. FAMILY/CAREGIVER IN	FORMATION		
Parent/Guardian Last Name	Parent/G	Guardian First Na	ame
Relationship to Student			
Primary (Cell) Phone Number			
Secondary Phone Number			
Email Address			



SECONDARY/EMERGENCY CONTACT	(Other than the primary contact above)
Emergency Contact Last Name	Emergency Contact First Name
Relationship to Student	
Primary (Cell) Phone Number	
Secondary Phone Number	
Email Address	
FAMILY/CAREGIVER ACKNOWLEDGEN	IENT
, ,	erstand that my child's daily attendance and punctuality are
	ble adult to bring my child to school and pick them up daily. I
understand that no transportation is p	rovided.
Signature	Date

Section 4. HOUSING QUESTIONNAIRE (Chancellor's Regulation A-101)

Information collected in this portion of the registration packet is intended to address the McKinney-Vento Act 42 U.S.C. 11432, and must be completed for each student. **The information you provide is confidential.** Your child will not be discriminated against based on the information provided.

Please complete the question below regarding the student's housing in order to help determine what services your student may be eligible to receive.

Note to NYCEECs/Temporary Housing Liaisons: Please assist students and families in completing this portion of the form. Please be aware that if the student qualifies as residing in temporary housing the **student's family is not required to submit proof of housing or other required documents included in this packet.** The program/DOE may not disclose housing status information without parental consent.

Please identify the student's current living arrangements. Please check one box:

Check Housing Questionnaire Choice

Doubled Up

With another family or other person because of loss of housing or because of economic hardship

Shelter

Emergency or Transitional shelter

Hotel/Motel

Living in what is NOT an emergency or transitional shelter and involves payment



	Other Temporary Living Situation						
	Trailer park, campground, car, park, public place, abandoned building, street or any other						
	inadequate living space						
	Permanent Housing						
	A fixed, regular, and adequate housing situation						
Note: The answer you give above will help determine what services you or your child may be eligible to receive under the McKinney-Vento Act. Students who are protected under the Act are entitled to immediate enrollment in school even if they do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. After the student has been enrolled, the new school must contact the last school attended to request the student's educational records, including immunization records, and Students in Temporary Housing (STH). Liaison(s) must help the student get any other necessary documents or immunizations. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services. Please refer to Chancellor's Regulation A-780. This form is accompanied by a one-page attachment titled, "McKinney-Vento Homeless Assistance Act - Students in Temporary Housing Guide for Parents & Youth."							
Parent/Guardian Signature							
•							
Signature		Date					

Section 5. FEDERAL PARENT OR GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

Dear Families and Caregivers,

Federal law requires the New York City Department of Education to collect and record the ethnic identity and race of public school students, including those participating in City-funded contracted care. This information is kept confidential in accordance with the Family Educational Rights and Privacy Act (1974) and Chancellor's Regulation A-820, which prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

To fulfill this data-collection requirement we need your help. Please respond to the ethnicity and race questions below. The first question provides an opportunity for you to indicate whether your child is of Hispanic, Latino, or Spanish origin; the second question provides an opportunity for you to indicate your child's race(s). Please be sure to respond to both questions. If you identify more than one race for your child, your child will be counted in a "two or more races" category. Hispanic students of all races will be counted in the Hispanic category.

The NYCDOE and our contracted programs understand the sensitive nature of this process. The options provided by the federal government may not allow for an accurate or complete portrayal of your child's own ethnic or race identification. We encourage you to provide responses using your best judgment. If you decline to respond to either question, federal guidelines require that the NYCDOE or its contracted program's staff make an identification of your child on your behalf.

Children may not be refused admission or enrollment to a program because of race, color, creed, national origin, gender (sex), gender identity, pregnancy, alienage, citizenship status, disability, sexual orientation, religion, weight or ethnicity.

Thank you for your cooperation.



Question 1: Is the student Hispanic, Latino or of Spanish origin? The Federal Government defines "Hispanic, Latino, or of Spanish origin" as a person of Cuban, Dominican, Mexican, Puerto Rican, Central							
or South American, or other Spanish culture or origin regardless of race.							
	Yes, Hispanic						
	No , not Hispanic						
-	Please check all boxes from the provided racial categories that a rederived from the U.S. Census.	pply to the student. All					
	American Indian or Alaskan Native – a person having origins in of North and South America (including Central America) and wh or community attachment.	,					
	Asian – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Sub-Continent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.						
	Native Hawaiian or Pacific Islander – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.						
	Black – a person having origins in any of the Black racial groups	of Africa					
	White – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.						
Parent/Guar	dian Signature						
Signature		Date					

Section 6. FOR CBO									
Program Name		Site ID							
Student Seat Type (check only one)		First Day of Attendance							
3-K SDY	Pre-K SDY								
Supplementary Doc	Date R	Date Received							
Proof of Birth: (type									
Proof of Residence									
Proof of Residence 2									
Home Language Sur									
Parental Consent to Photograph, Film, or Videotape a Student for Non-Profit Use									
Child and Adolescent Health Examination Form									



Section 7. HOME LANGUAGE SURVEY								
Dear Families and Caregivers,								
This survey is part of your child's enrollment package and provides your new program with important information about your family's language needs. Please return this form to your program administrator.								
Student: Last Name	udent: Last Name First Name Today's							
Person Completing Survey: Last Name	First Nar	me						
Relationship to Student								
Program Name								
LANGUAGE IN THE HOME								
Which language(s) do you speak at home? English		hat apply) Korean						
Spanish		Russian						
Cantonese		Urdu						
Mandarin		Albanian						
Arabic		Punjabi						
Bengali		Polish						
French		Other (please specify):						
Haitian-Creole								
Which language(s) does your child speak at home? If your child does not speak, which language(s) they most commonly understand, or which language(s) do you most commonly use to communica your child? (Please select all that apply) English Korean								
Spanish		Russian						
Cantonese		Urdu						
Mandarin		Albanian						
Arabic Punjabi								

Bengali

French

Haitian-Creole

Polish

Other (please specify):

T KIIVIAKT LANGOAGE T KEI EKENCES								
What is your child's primary language?								
What is your first language?								
In what language would you like to receive written information from your child's program?								
In what language would you prefer to communicate orally with program staff?								
Section 8. CONSENT TO PHOTOGRAPH, FILM, OR VI (e.g. educational, public service, or health awareness		NON-PROFIT USE						
Student Last Name Student Fi								
Program Name								
I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies, or video tapes of the Student named above by the program named above.								
I also grant to the program named above the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media.								
I also hereby release the New York City Department of Education and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.								
Parent/Guardian Last Name	Parent/Guardian First Na	me						
Signature		Date						



CHILD & ADOLESCEI NYC DEPARTMENT OF HEALTH & ME				AMINATION ARTMENT OF EDITION		ORM	Ple Print Cle	ease arly	NYC ID (OSIS)							
TO BE COMPLETED BY T	THE PA	RENT	OR C	BUARDIAN												
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Child's Address			l .				spanic/Latino	' ' '	Check ALL that apply	_			Asian □	Black	☐ Whi	te
City/Borough		State	Zip	Code	Schoo	I/Center/	Camp Name				District Number		Phone Nui Home	Phone Numbers Home		
Health insurance	Guardian	Last Nam	ie	Firs	t Name			Ema	ail				Cell			
(including Medicaid)? \square No \square Foster F	Parent												Work			
TO BE COMPLETED BY THE	HEALT	H CAF	RE PRA	ACTITIONER				<u> </u>								
Birth history (age 0-6 yrs)				e child/adolescei												
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Complicated by			Asthm	a Control Status		□ We	ell-controlled	F	Poorly Controlled or N				anci controller		one	
Allergies None Epi pen prescribed			☐ Anaph	nylaxis vioral/mental health o	disorder		eizure disorde beech, hearin		mnairment				if in-school m		needed))
☐ Drugs (list)			Conge	enital or acquired hea opmental/learning pr	art disordei	r ⊟Tù	uberculosis (la			☐ Nor	16	L	Yes (list belo	ow)		
			☐ Develo	opmental/learning pr tes <i>(attach MAF)</i>	roblem		ospitalization urgery			-						
Foods (list)				pedic injury/disability all checked items a			ther (specify) ddendum at t	toohod								—
Other (list)			Е лріані (an oncokeu nems a	ibove.	_ A	uucnuum au	аспси.		-						
Attach MAF in in-school medications nee			0													
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BMIkg/m ²	(%ile)	☐ ☐ La					Lungs			nitourinary		□ □ Neu	-		
Head Circumference (age <2 yrs) ci	m (%ile)	Describe	naviorai e abnormalities:		ческ		☐ ☐ Cardio	ovascular	□ □ Extr	remities		☐ ☐ Bacl	k/spine		
Blood Pressure (age ≥3 yrs) / _			Dooonibe	abilormandoor												
DEVELOPMENTAL (age 0-6 yrs)			Nutrition	l					Hearing			Date Don	e	- 1	Results	
Validated Screening Tool Used?	Date 9	Screened		☐ Breastfed ☐ Fo			3.0	¬ .	< 4 years: gros	s hearing	_	/	_/ □	NI 🗆	Abnl 🗆 F	Referred
☐ Yes ☐ No	/_	_/		□ Well-balanced □ Restrictions □ Nor				Referred	OAE		_	/	_/ [NI 🗆	Abnl 🗆 F	Referred
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 □ Delay or Concern Suspected/Confirmed (sp □ Cognitive/Problem Solving □ Adaptive/ 		below):	SCREEN	IING TESTS	Date Done	,	Results	s	Vision	annaara	ı	Date Don	e , :		Results I \(\Bar\) At	hm!
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☐ Social-Emotional or ☐ Other Are	ea of Concern	:	(required	d at age 1 yr and 2	',-				and children age			/_		eft	/	
Personal-Social Describe Suspected Delay or Concern:			yrs and i	for those at risk)	/_	/		μg/dL sk <i>(do BLL)</i>		210					able to t	
Describe Suspected Delay of Concern.				sk Assessment	/	/	□ AUIS	SK (UU DLL)	Screened with (Strabismus?	alasses?				☐ Ye	s \square	
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Health Care Practitioner Signature							Date Form (Completed ——			HMH PE		ONER			
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