

New York City Early Childhood Education (3-K and Pre-K) Program Registration Form – **Returning Student** for the 2022-2023 School Year School Day and School Year Services

Directions

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

UPDATED STUDENT INFORMATION

Last Name	First Name	Date of Birth

Has any of the following information changed since last year?
*(please check all that apply and **enter the new information** in the corresponding section)*

Residential Address

Health Insurance

Family/Caregiver Information (Primary Parent/Guardian or Secondary Emergency Contact)

Housing Status

Preferred Language(s)

In sections where your child’s information has not changed in the past year, please leave that section blank.

FAMILY/CAREGIVER ACKNOWLEDGEMENT

By signing this form, I certify that I understand that my child’s daily attendance and punctuality are required. I must arrange for a responsible adult to bring my child to school and pick them up daily. I understand that no transportation is provided.

Signature	Date
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STUDENT ADDRESS

Current Address (Building #, Street)		Apt #	
City	State	Zip Code	Gender (optional)

HEALTH INSURANCE (optional)

Does this student have health insurance?	Yes	No
If yes, what type of coverage?	Private Health Insurance	Medicaid Child Health Plus B
If no, would you like to be contacted about getting coverage	Yes	No

FAMILY/CAREGIVER INFORMATION

Parent/Guardian Last Name	Parent/Guardian First Name
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	

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 as a result 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

LANGUAGE IN THE HOME

Which language(s) do you speak at home? (please select all that apply)

- | | |
|----------------|-------------------------|
| English | 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) do they most commonly understand, or which language(s) do you most commonly use to communicate with your child? (Please select all that apply)

- | | |
|----------------|-------------------------|
| English | Korean |
| Spanish | Russian |
| Cantonese | Urdu |
| Mandarin | Albanian |
| Arabic | Punjabi |
| Bengali | Polish |
| French | Other (please specify): |
| Haitian-Creole | |

PRIMARY LANGUAGE PREFERENCES

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 VIDEOTAPE A STUDENT FOR NON-PROFIT USE
(e.g. educational, public service, or health awareness purposes)

Student Last Name	Student First Name	Today's Date

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 Name
Signature	Date

FOR CBO USE ONLY			
Program Name		Site ID	
Student Seat Type (check only one)	First Day of Attendance		
<input type="checkbox"/> 3-K SDY <input type="checkbox"/> Pre-K SDY <input type="checkbox"/> Pre-K HD	Official Class Code		
Supplementary Documents:	Date Received		
Proof of Residence 1: <i>(type)</i>			
Proof of Residence 2: <i>(type)</i>			
Parental Consent to Photograph, Film, or Videotape a Student for Non-Profit Use			
Child and Adolescent Health Examination Form			

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name		First Name		Middle Name		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address				Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
City/Borough	State	Zip Code	School/Center/Camp Name			District Number _____	Phone Numbers Home _____ Cell _____ Work _____	
Health insurance <input type="checkbox"/> Yes <input type="checkbox"/> No (including Medicaid)? <input type="checkbox"/> No	Parent/Guardian Last Name		First Name		Email			
		Foster Parent <input type="checkbox"/>						

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Asthma Control Status <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled					
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		<input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above.			<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ Addendum attached.		
Attach MAF in in-school medications needed		Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)					

PHYSICAL EXAM Date of Exam: ____/____/____		General Appearance: <input type="checkbox"/> Physical Exam WNL NI Abnl <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Language <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Behavioral <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine					
Height _____ cm (____ %ile)	Weight _____ kg (____ %ile)	BMI _____ kg/m ² (____ %ile)	Head Circumference (age ≤2 yrs) _____ cm (____ %ile)	Describe abnormalities:			
Blood Pressure (age ≥3 yrs) _____ / _____							

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		Nutrition <input type="checkbox"/> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both <input type="checkbox"/> ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		Hearing Date Done ____/____/____ Results < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
Describe Suspected Delay or Concern: _____		SCREENING TESTS Date Done Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) ____/____/____ _____ µg/dL ____/____/____ _____ µg/dL		Vision Date Done Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		Lead Risk Assessment (annually, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CIR Number []		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

IMMUNIZATIONS - DATES		Report only positive immunity:	
DTP/DTaP/DT	Tdap	Hepatitis B	
Td	MMR	Measles	
Polio	Varicella	Mumps	
Hep B	Mening ACWY	Rubella	
Hib	Hep A	Varicella	
PCV	Rotavirus	Polio 1	
Influenza	Mening B	Polio 2	
HPV	Other	Polio 3	

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
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Health Care Practitioner Signature	Date Form Completed ____/____/____	DOHMH ONLY PRACTITIONER I.D. []
Health Care Practitioner Name and Degree (print)	Practitioner License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____
Facility Name	National Provider Identifier (NPI)	Date Reviewed: ____/____/____ I.D. NUMBER []
Address	City	State
Telephone	Fax	Email
		REVIEWER: [] FORM ID# []