



NEW YORK CITY EARLY EDUCATION CENTER (NYCEEC) FULL-DAY PRE-K PROGRAM REGISTRATION FORM FOR 2021-2022 SCHOOL YEAR

DIRECTIONS:

Please print clearly in blue or black ink only. Please note that only parents/guardians who are New York City residents may submit a registration form. Sign and return this registration form directly to each NYCEEC you wish to register at. Be sure to make a copy of this registration form and retain for your records. For a list of NYCEECs, please review the Pre-Kindergarten Directory available at your local school, NYCEEC or online at nyc.gov/prek.

NAME OF NYCEEC YOU ARE REGISTERING AT: _____

Section A: STUDENT INFORMATION – Please print clearly in ink

STUDENT LAST NAME	STUDENT FIRST NAME	DATE OF BIRTH (mm/dd/yyyy)	GENDER (optional)
		/ / 2017	<input type="checkbox"/> M <input type="checkbox"/> F
STUDENT CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)			STUDENT HOME DISTRICT (optional)

Section B: OPTIONAL INFORMATION – Please print clearly in ink

HEALTH INSURANCE

Does the student have health insurance?

☐ Yes If yes, what type of coverage is it? ☐ Private Health Insurance ☐ Medicaid ☐ Child Health Plus B

☐ No If no, would you like to be contacted about getting coverage? ☐ Yes ☐ No

HOME LANGUAGE

In which language(s) would you like to receive written and/or oral communication regarding the Pre-Kindergarten Admission process?

Please check all that apply: ☐ English ☐ Arabic ☐ Bengali ☐ Chinese ☐ French ☐ Haitian Creole ☐ Korean
☐ Russian ☐ Spanish ☐ Urdu ☐ Other, please specify: _____

Section C: PARENT INFORMATION – Please print clearly in ink

I understand that daily attendance and promptness 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.

<u>PARENT/GUARDIAN LAST</u>	<u>NAME PARENT/GUARDIAN FIRST NAME</u>	<u>RELATIONSHIP TO STUDENT</u>
<u>DAYTIME TELEPHONE NUMBER</u>	<u>EVENING TELEPHONE NUMBER</u>	<u>PARENT/GUARDIAN EMAIL ADDRESS</u>

Parent/Guardian Signature

Date

To the Parent/Guardian:

Federal law requires the New York City Department of Education to collect and record the ethnic identity and race of public school students. This information is used to determine funding for your school, among other things, and is kept secure and confidential.

We need your help to accomplish this task. Please respond to the ethnicity and race identification questions on the back of this page. 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. Students identified with more than one race will be counted in the "two or more races" category. Hispanic students of all races will be counted in the Hispanic category.

The New York City Department of Education understands the sensitive nature of this process. The options provided by the federal government may not represent an accurate or complete portrayal of your family'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 New York City Department of Education school staff to make an identification of your child on your behalf.

Race and ethnicity information for students is protected by the confidentiality regulations cited at the bottom of this page.

Thank you for your cooperation.

Parents and Guardians: Please complete the form on the reverse side of this page and return it to your child's school.

School staff: File the completed form in the student's Cumulative Record folder as confidential information.

Confidentiality Procedures and Regulations

The Family Educational Rights and Privacy Act (1974) and Regulations of the Chancellor A-820 prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

¹ Race may be considered as a factor in school enrollment only where required by court order; gender is a factor only in single-gender schools.

- All students between 5 and 21 years of age have the right to a free public education.
- Federal law requires the New York City Department of Education to collect and record the ethnic identity and race(s) of public school students.
- Children may not be refused admission to a public school because of race, color, creed, national origin, gender, gender identity, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.¹

English Only

SCHOOL STAFF: PLEASE COMPLETE THIS SECTION

Borough District School

Name of
High School/
Mini School /Annex -----

Grade Code Class Code

NYC Student Identification Number

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(HIGH SCHOOL ONLY 4-DIGIT)

Date of Birth (Month/Day/Year)

Student Name: Last, First, Middle Initial

PARENT/GUARDIAN: PLEASE COMPLETE THIS SECTION

PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND.

For Question (1), check (✓) the box that best describes your child.

- 1. Is the student Hispanic, Latino, or of Spanish origin?** Hispanic, Latino, or of Spanish origin means 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**

For Question (2), check (✓) **all** boxes that apply to your child.

- 2. Select one or more races from the following five racial groups.**

☐ **AMERICAN INDIAN OR ALASKAN NATIVE:** A person having origins in any of the original peoples of North America and South America (including Central America). (ATS Code: B)

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. (ATS Code: C)

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, or other Pacific Islands. (ATS Code: D)

BLACK: A person having origins in any of the Black racial groups of Africa. (ATS Code: E)

WHITE: A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. (ATS Code: F)

Signature of Parent/Guardian/Other/School Staff Observer:

Date:

Relationship to Student:

☐ Parent ☐ Guardian ☐ Other (Specify):

School Staff Observer (Name):

HOUSING QUESTIONNAIRE

Parent/Guardian/Student:

This form is intended to address the McKinney-Vento Act 42 U.S.C. 11435, and must be completed for each student. **The information you provide is confidential.** Your child will not be discriminated against based upon the information provided.

Please complete the following questions regarding the student's housing in order to help determine services the student may be eligible to receive.

Note to Schools/Temporary Housing Liaisons: Please assist students and families in filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, **the student is not required to submit proof of residency** and other required documents that may be part of the registration packet. The district cannot disclose housing status information without parental consent.

Student Name			
Last	First	Middle	
OSIS #	Date of Birth (MM/DD/YY)	Gender	School

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

Please identify the student's current living arrangements. Please check <u>one</u> box:		School Use Only
Check (✓)	Housing Questionnaire Choice	ATS Code
	Doubled Up With another family or other person because of loss of housing or as a result of economic hardship	D
	Shelter Emergency or transitional shelter	S
	Hotel/Motel Living in what is NOT an emergency or transitional shelter and involves payment	H
	Other Temporary Living Situation Trailer park, campground, car, park, public places, abandoned building, street, or any other inadequate living space	T
	Permanent Housing Student who is living in a fixed, regular, and adequate housing situation	P

If the student is NOT living in permanent housing, also indicate if the below applies:

If the student is NOT living in permanent housing, also indicate if the below applies:		School Use Only
	Unaccompanied Youth Youth who is not in the physical custody of a parent or guardian	Enter "Y" if applicable

Parent/Guardian (print)

Parent/Guardian Signature

Date

Please return this form to your child's school as requested.

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".**

The New York City Department of Education Pre-Kindergarten Language Needs Survey

Dear Parent or Guardian of _____ (enter student name here),
This survey is an important piece of your pre-kindergarten enrollment package as it provides your new school with information about your family's language needs. Your assistance in answering the questions below is greatly appreciated. Please return this form to your school administrator, _____, and if you have questions, speak with _____ at _____.
Thank You Student ID: _____

PART 1. LANGUAGE NEEDS: This information will establish what language is used at home and the language of instruction requested by the family (if available).

1. Which language(s) do you speak at home? Please check (✓) all that apply:

- | | |
|---|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> French |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Albanian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Russian | <input type="checkbox"/> Other, please specify _____ |

2. What language does the child **understand**?

English ☐ Other Home Language(s) ☐

3. What language does the child **speak**?

English ☐ Other Home Language(s) ☐

4. What language does the child **read**?

English ☐ Other Home Language(s) ☐ Does not read yet ☐

5. What language does the child **write**?

English ☐ Other Home Language(s) ☐ Does not write yet ☐

6. What language is spoken in the child's home or residence **most of the time**?

English ☐ Other Home Language(s) ☐

7. What language does the child speak with parents/guardians **most of the time**?

English ☐ Other Home Language(s) ☐

8. What language does the child speak with brothers, sisters, or friends **most of the time**?

English ☐ Other Home Language(s) ☐

9. What language does the child speak with other relatives or caregivers (e.g., babysitters) **most of the time**?

English ☐ Other Home Language(s) ☐

10. Would you like your child to receive instruction using your home language (if available):

☐ All the time ☐ Most of the time ☐ Some of the time



The New York City Department of Education Pre-Kindergarten Language Needs Survey



PART 2. INSTRUCTIONAL PLANNING: Responses to these supplementary questions will be used for instructional planning. Enter the correct response for each of the following questions concerning your child.

1. Is this your child's first time participating in an instructional program or group experience in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF NO:	
a. Where did they go participate in daycare/preschool/play group?	
b. What was the date of enrollment?	
c. How long did they attend?	
d. Which language was used for instruction?	
2. Has your child participated in an instructional program or group experience in <u>another country</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES:	
a. Where did they participate in daycare/preschool/play group?	
b. How long did they attend?	
c. Which language was used for instruction?	
3. Does your child have any conditions that require special help or attention in school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES, please check all that apply:	
<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Emotionally impaired
<input type="checkbox"/> Visually impaired	<input type="checkbox"/> Asthma
<input type="checkbox"/> Speech impaired	<input type="checkbox"/> Developmentally Disabled
<input type="checkbox"/> Physically impaired	<input type="checkbox"/> Other (Please Specify) _____
IF YES, what early intervention has your child received, if any?	
4. Does the child use any other form(s) of communication, such as American Sign Language or Augmentative Communication Device (e.g., Communication Board-manual/electronic)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES: Which ones?	

PART 3. PARENT INFORMATION: Responses to these supplementary questions will be used so that the NYC Department of Education can communicate with you in the language of your choice.

1. What is your first language?	
Parent/Guardian: _____	Parent/Guardian: _____
First language: _____	First language: _____
2. In what language would you like to receive written information from the school?	
3. In what language would you prefer to communicate orally with school staff?	
Parent Signature _____	Date _____



The New York City Department of Education Pre-Kindergarten Language Needs Survey



TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY					
Date:		Name of Student/ID:			
Borough:	District:	School:			
Gender:	Ethnicity Code: (form PSE):	Date of Birth:			
Relationship of person providing information for survey (check one): <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Other (specify):					
If an interview is conducted, in what language is it conducted?					
Is a translator/interpreter used?					
OTELE Alpha Code <table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>					
Potential English Language Learner?					
Instruction will be provided in: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Both English and the home language of _____					

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 (including Medicaid)? <input type="checkbox"/> No						Parent/Guardian Last Name First Name						Email												
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 _____ 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) _____ Attach MAF in in-school medications needed										Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <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"/> Intermittent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Well-controlled <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Poorly Controlled or Not Controlled <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.													Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ _____	
PHYSICAL EXAM Date of Exam: ____ / ____ / ____ Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____										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 Describe abnormalities:														
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: _____ Describe Suspected Delay or Concern:										Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 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) SCREENING TESTS Date Done Results Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk) _____ μg/dL Lead Risk Assessment (annually, age 6 mo-6 yrs) _____ At risk (do BLL) _____ Not at risk Child Care Only Hemoglobin or Hematocrit _____ g/dL _____ %						Hearing Date Done Results < 4 years: gross hearing ____ / ____ / ____ NI Abnl Referred OAE ____ / ____ / ____ NI Abnl Referred ≥ 4 yrs: pure tone audiometry ____ / ____ / ____ NI Abnl Referred Vision Date Done Results <3 years: Vision appears: ____ / ____ / ____ NI Abnl Acuity (required for new entrants and children age 3-7 years) ____ / ____ / ____ Right ____ / ____ Left ____ / ____ Unable to test Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No 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								
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No CIR Number [] Physician Confirmed History of Varicella Infection <input type="checkbox"/>										Report only positive immunity: IgG Titers Date Hepatitis B ____ / ____ / ____ Measles ____ / ____ / ____ Mumps ____ / ____ / ____ Rubella ____ / ____ / ____ Varicella ____ / ____ / ____ Polio 1 ____ / ____ / ____ Polio 2 ____ / ____ / ____ Polio 3 ____ / ____ / ____														
IMMUNIZATIONS – DATES DTP/DtaP/DT ____ / ____ / ____ Tdap ____ / ____ / ____ Td ____ / ____ / ____ MMR ____ / ____ / ____ Polio ____ / ____ / ____ Varicella ____ / ____ / ____ Hep B ____ / ____ / ____ Mening ACWY ____ / ____ / ____ Hib ____ / ____ / ____ Hep A ____ / ____ / ____ PCV ____ / ____ / ____ Rotavirus ____ / ____ / ____ Influenza ____ / ____ / ____ Mening B ____ / ____ / ____ HPV ____ / ____ / ____ Other ____ / ____ / ____																								
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 _____														
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 Zip										REVIEWER:							FORM ID# []							
Telephone Fax Email																								

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

Student Name: _____ School: _____

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 _____ (program name) .

I also grant to _____ (program name) 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.

Signature of Parent/Guardian (if Student is under 18): _____ Date: _____

Address of Parent/Guardian: _____

OR

Signature of Student (if 18 or over): _____ Date: _____

Address of Student: _____



Ready4K



Text messages to boost your child's learning

Welcome to Ready4K! The NYCDOE is excited to give you this FREE resource to help your child stay on track with their learning goals all year long.

How does Ready4K help my child learn?

Ready4K texts you 3 easy-to-do learning tips and activities each week. Each text message you will get is written for your child's age or grade. Research shows that doing Ready4K activities is a great way to help your child stay on track.

Ready4K tips **build on your daily routines**, like activities to use when getting dressed, during bath time, or when preparing a meal. No internet, extra time, or special materials are required.

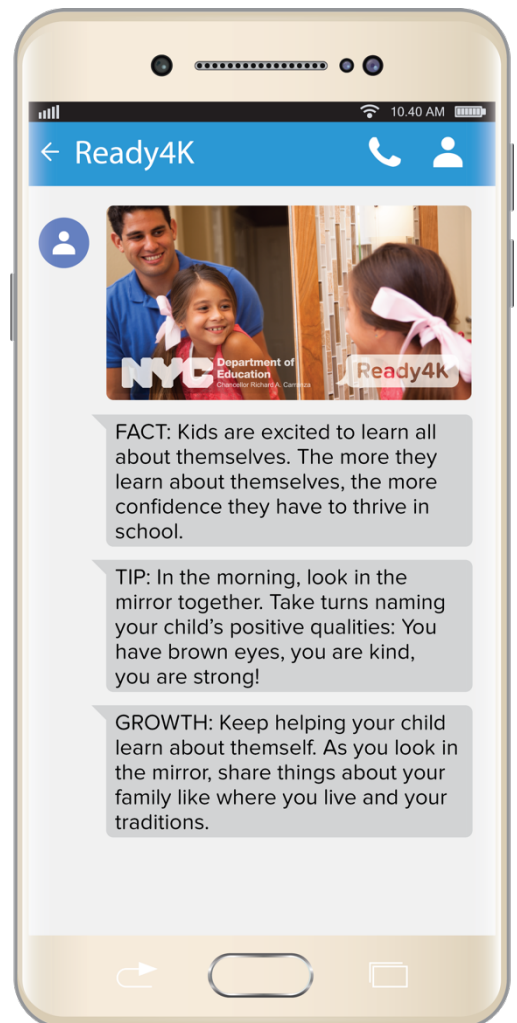
You'll also receive links to **NYC resources** that many families find helpful.

What do I need to do?

As a NYC family, your school will enroll you in the program.

There's **absolutely no cost**, though data and message rates may apply. You can opt out anytime by texting STOP to 70138.

Questions? Contact the program director at your child's school for more details.



Please note that Ready4K is only available in English, Spanish, Arabic, Vietnamese and Chinese.