

**New York City Early Childhood Education (3-K and Pre-K)
Program Registration Form 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. In order 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 proof of residence along with this registration packet.

Section 1. STUDENT INFORMATION			
Last Name	First Name	Date of Birth	
Current Address (Building #, Street)		Apt #	
City	State	Zip Code	Gender (optional)

Section 2. HEALTH INSURANCE (optional)	
Does this student have health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type of coverage?	<input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Child Health Plus B
If no, would you like to be contacted about getting coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 3. 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	
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

Section 4. HOUSING QUESTIONNAIRE (Chancellor's Regulation A-101)	
<p>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.</p> <p>Please complete the question below regarding the student's housing in order to help determine what services your student may be eligible to receive.</p> <p>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.</p>	
Please identify the student's current living arrangements. Please check one box:	
Check	Housing Questionnaire Choice
<input type="checkbox"/>	Doubled Up With another family or other person because of loss of housing or because of economic hardship
<input type="checkbox"/>	Shelter Emergency or Transitional shelter
<input type="checkbox"/>	Hotel/Motel Living in what is NOT an emergency or transitional shelter and involves payment

<input type="checkbox"/>	Other Temporary Living Situation Trailer park, campground, car, park, public place, abandoned building, street or any other inadequate living space
<input type="checkbox"/>	Permanent Housing A fixed, regular, and adequate housing situation
<p>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.</p> <p>This form is accompanied by a one-page attachment titled, "McKinney-Vento Homeless Assistance Act - Students in Temporary Housing Guide for Parents & Youth."</p>	
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.	
<input type="checkbox"/>	Yes, Hispanic
<input type="checkbox"/>	No, not Hispanic
Question 2: Please check all boxes from the provided racial categories that apply to the student. All definitions are derived from the U.S. Census.	
<input type="checkbox"/>	American Indian or Alaskan Native – a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
<input type="checkbox"/>	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.
<input type="checkbox"/>	Native Hawaiian or Pacific Islander – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/>	Black – a person having origins in any of the Black racial groups of Africa
<input type="checkbox"/>	White – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
Parent/Guardian Signature	
Signature	Date

Section 6. 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 Birth: <i>(type)</i>			
Proof of Residence 1: <i>(type)</i>			
Proof of Residence 2: <i>(type)</i>			
Home Language Survey: <i>(primary language)</i>			
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

First Name

Today's Date

Person Completing Survey: Last Name

First Name

Relationship to Student

Program Name

LANGUAGE IN THE HOME

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

- | | |
|---|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> Albanian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Polish |
| <input type="checkbox"/> French | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> 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)

- | | |
|---|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> Albanian |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Punjabi |
| <input type="checkbox"/> Bengali | <input type="checkbox"/> Polish |
| <input type="checkbox"/> French | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> 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		
<p>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.</p> <p>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.</p> <p>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.</p>		
Parent/Guardian Last Name	Parent/Guardian First Name	
Signature	Date	

CHILD & ADOLESCENT HEALTH EXAMINATION FORM NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION					Please Print Clearly		NYC ID (OSIS)																																																																																																																																																	
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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		<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Foster Parent		Last Name				First Name				Email																																																																																																																																												
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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): 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"/> 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. <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ _____																																																																																																																																																			
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) _____																																																																																																																																																								
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Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____					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 <table><tr><th></th><th>Date Done</th><th>Results</th></tr><tr><td>Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)</td><td>____/____/____</td><td>____ µg/dL</td></tr><tr><td></td><td>____/____/____</td><td>____ µg/dL</td></tr></table> Lead Risk Assessment (annually, age 6 mo-6 yrs) ____/____/____ <input type="checkbox"/> At risk (do BLL) ____/____/____ <input type="checkbox"/> Not at risk ____ Child Care Only ____ Hemoglobin or Hematocrit ____/____/____ _____ g/dL ____ %						Date Done	Results	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ µg/dL		____/____/____	____ µg/dL	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 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 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																																																																																																																																					
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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: <table><tr><th>IgG Titers</th><th>Date</th></tr><tr><td>Hepatitis B</td><td>____/____/____</td></tr><tr><td>Measles</td><td>____/____/____</td></tr><tr><td>Mumps</td><td>____/____/____</td></tr><tr><td>Rubella</td><td>____/____/____</td></tr><tr><td>Varicella</td><td>____/____/____</td></tr><tr><td>Polio 1</td><td>____/____/____</td></tr><tr><td>Polio 2</td><td>____/____/____</td></tr><tr><td>Polio 3</td><td>____/____/____</td></tr></table>					IgG Titers	Date	Hepatitis B	____/____/____	Measles	____/____/____	Mumps	____/____/____	Rubella	____/____/____	Varicella	____/____/____	Polio 1	____/____/____	Polio 2	____/____/____	Polio 3	____/____/____																																																																																																																			
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B	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Mening ACWY	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Hib	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Hep A	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	PCV	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Rotavirus	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Influenza	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Mening B	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	HPV	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	Other	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
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Department of
Education

Text messages to boost your child's learning



Welcome to Ready4K! The NYCDOE is excited to give you this FREE resource to help your PK-5th graders 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 of a child between 0 - 10, you can enroll for **FREE by texting NYC to 70138**.

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.

