New York City Early Childhood Education
Program Registration Form- School Day Year & Head Start
Welcome

Dear Parent(s)/Guardian(s):

We are excited to welcome you to NYC Public Schools for the upcoming school year in partnership with your child's early childhood program.

Please complete this registration packet and submit it to your early childhood program.

Important Note:
Your child's School Day and Year 3-K or Pre-K program, or Head Start or Early Head Start program is **free.** You and/or your child will not gain any advantage by, and are **not required** to participate in a:

- Pre-enrollment interview or developmental screening process.
- Optional services that require a fee (e.g., extended care hours, summer programs, and/or special classes).

Moreover, it is the policy of the NYC Public Schools to provide equal educational opportunities in accordance with applicable laws and regulations and without regard to actual or perceived race, color, religion, age, creed, ethnicity, national origin, alienage, citizenship status, disability, sexual orientation, gender (including actual or perceived gender identity, gender expression, pregnancy/conditions related to pregnancy or childbirth), or weight and to maintain an environment free of harassment on the basis of any of the above protected classifications, including sexual harassment and retaliation.

- Your child may not be denied enrollment in a 3-K or Pre-K seat or denied other educational opportunities for any of the reasons listed above.
- You may not be required to participate in religious activities as a condition of participation in your 3-K or pre-K program. You will not gain any advantage in your program by participating in any religious activities.

If you have questions or concerns, please contact earlychildhoodpolicy@schools.nyc.gov.

______________________________ ______________________________
Parent/Guardian Signature Vendor Representative Signature

Date: ________________________

NYC Public Schools

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

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, 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

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

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) 3-K SDY Pre-K SDY Pre-K HD	First Day of Attendance
	Official Class Code

Supplementary Documents:	Date Received
Proof of Residence 1: *(type)*	
Proof of Residence 2: *(type)*	
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 ☐ Female ☐ Male	Date of Birth *(Month/Day/Year)* ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Address	Hispanic/Latino? ☐ Yes ☐ No	Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough	State	Zip Code	School/Center/Camp Name	District Number __ __ __ __	Phone Numbers Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent	Last Name	First Name	Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______
☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ 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:

☐ Physical Exam WNL

Nl Abnl	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*	*Nl Abnl*
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? Date Screened

☐ Yes ☐ No ____/____/____

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ 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 ______ 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	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ______ /______ Left ______ /______ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

Vaccine	Dates
DTP/DTaP/DT	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Td	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Polio	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Hep B	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Hib	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
PCV	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
Influenza	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___
HPV	___/___/___ ___/___/___ ___/___/___ ___/___/___ ___/___/___

Vaccine	Dates
Tdap	___/___/___ ___/___/___
MMR	___/___/___ ___/___/___ ___/___/___
Varicella	___/___/___ ___/___/___ ___/___/___
Mening ACWY	___/___/___ ___/___/___ ___/___/___
Hep A	___/___/___ ___/___/___ ___/___/___
Rotavirus	___/___/___ ___/___/___ ___/___/___
Mening B	___/___/___ ___/___/___ ___/___/___
Other ______	___/___/___ ______ ___/___/___

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

______ ______

______ ______

______ ______

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: __ __ / __ __ / __ __

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature	Date Form Completed ______ /______ /______
Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State
Facility Name	National Provider Identifier (NPI)

Address	City	State	Zip

Telephone	Fax	Email

DOHMH ONLY **PRACTITIONER I.D.** ☐☐☐☐☐☐

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Date Reviewed: ______ / ______ / ______ **I.D. NUMBER** ☐☐☐☐☐☐☐

REVIEWER:

FORM ID# ☐☐☐☐☐☐☐☐☐☐