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	
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? 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

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

Last updated 5/2023

NYC Department of Education

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)

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

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.

	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.
	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/Guardian Signature	
Signature	Date

Section 6. 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 Birth: *(type)*	
Proof of Residence 1: *(type)*	
Proof of Residence 2: *(type)*	
Home Language Survey: *(primary language)*	
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)

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

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

	Please Print	NYC ID (OSIS)									

	Clearly										

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 ________________

Health insurance ! Yes **(including Medicaid)?** ! No	**First Name** ! **Parent/Guardian Last Name** ! **Foster Parent**	**Email**	Cell ________ Work

Birth history *(age 0-6 yrs)*	**Does the child/adolescent have a past or present medical history of the following?**	
! Uncomplicated ! Premature: ______ weeks gestation ! Complicated by ______________________________	! 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	
Allergies ! None ! Epi pen prescribed ! Drugs *(list)* ________________________________ ! Foods *(list)* ________________________________ ! Other *(list)* ________________________________ ***Attach MAF in in-school medications needed***	! Anaphylaxis ! Seizure disorder ! Behavioral/mental health disorder ! Speech, hearing, or visual impairment ! Congenital or acquired heart disorder ! Tuberculosis *(latent infection or disease)* ! Developmental/learning problem ! Hospitalization ! Diabetes ***(attach MAF)*** ! Surgery ! Orthopedic injury/disability ! Other (specify) ***Explain all checked items above.*** ! ***Addendum attached.***	**Medications** ***(attach MAF if in-school medication needed)*** ! None ! Yes *(list below)*

PHYSICAL EXAM Date of Exam: ___ /___ /___	**General Appearance:**	
Height ____________ **cm** (___ ___ %ile) Weight ____________ **kg** (___ ___ %ile) BMI ____________ **kg/m²** (___ ___ %ile) Head Circumference *(age ≤2 yrs)* _______ **cm** (___ ___ %ile) Blood Pressure *(age ≥3 yrs)* _________ / _________	*Nl Abnl* ! ! Psychosocial Development ! ! Language ! ! Behavioral	! Physical Exam WNL *Nl Abnl Nl Abnl Nl Abnl Nl Abnl* ! ! HEENT ! ! Lymph nodes ! ! Abdomen ! ! Skin ! ! Dental ! ! Lungs ! ! Genitourinary ! ! Neurological ! ! 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):	**Nutrition** < **1 year** ! Breastfed ! Formula ! Both ≥ **1 year** ! Well-balanced ! Needs guidance ! Counseled ! Referred **Dietary Restrictions** ! None ! Yes *(list below)*		**Hearing** ***Date Done Results*** < 4 years: gross hearing ____/____/____ !*Nl* !*Abnl* !*Referred* OAE ____/____/____ !*Nl* !*Abnl* !*Referred* ≥ 4 yrs: pure tone audiometry ____/____/____ !*Nl* !*Abnl* !*Referred*
! Cognitive/Problem Solving ! Adaptive/Self-Help ! Communication/Language ! Gross Motor/Fine Motor ! Other Area of Concern: ! Social-Emotional or Personal-Social ______________________	**SCREENING TESTS**	***Date Done Results***	**Vision** ***Date Done Results*** ! *Nl* ! *Abnl* <3 years: Vision appears: ____/____/____ Right ______ /______ **Acuity (required for new entrants** Left ______ /______ ____/____/____ **and children age 3-7 years)** ! Unable to test Screened with Glasses? ! Yes ! No Strabismus? ! Yes ! No
	Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	_________ μg/dL ____ /____ /____ ____ /____ /____ _________ μg/dL	
Describe Suspected Delay or Concern:	**Lead Risk Assessment** *(annually, age 6 mo-6 yrs)*	! At risk *(do BLL)* ____ /____ /____ ! Not at risk	**Dental**
	— — Child Care Only — —		Visible ! Yes ! No

Child Receives EI/CPSE/CSE services ! Yes ! No				Tooth Decay	
	Hemoglobin or Hematocrit	____ /____ /____	_________ g/dL _________ %	Urgent denta	(pain, swelling, infection) ! Yes ! No thin the past 12 months ! Yes ! No

CIR Number Physician Confirmed History of Varicella Infection Report only positive immunity:

IMMUNIZATIONS – DATES	IgG Titers
DTP/DTaP/DT ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Tdap ___ /___ /___ ___ /___ /___ Td ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ MMR ___ /___ /___ ___ /___ /___ ___ /___ /___ Polio ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Varicella ___ /___ /___ ___ /___ /___ ___ /___ /___ Hep B ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Mening ACWY ___ /___ /___ ___ /___ /___ ___ /___ /___ Hib ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Hep A ___ /___ /___ ___ /___ /___ ___ /___ /___ PCV ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Rotavirus ___ /___ /___ ___ /___ /___ ___ /___ /___ Influenza ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Mening B ___ /___ /___ ___ /___ /___ ___ /___ /___ HPV ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ ___ /___ /___ Other __ ___ /___ /___ _ ___ /___ /___	Hepatitis B ___ /_ /___ /___ Mumps _ ___ /___ /___ Varicella 1 ___ /___ /___ Polio 2

ASSESSMENT Well Child (Z00.129) Diagnoses/Problems *(list)* ICD-10 Code	RECOMMENDATIONS Full physical activity
	! Restrictions *(specify)* ______________________ Fo No ! Yes, for ______________ Appt. date: __ / __ / __ Referral(s): ! None ! Earl Dental ! Vision ! Other ______________________

Health Care Practitioner Signature	Date Form Completed _____ /_____ /_____	I.D.	PI IT

Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State	TYPE OF EXAM: NAE Current NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	D Review NU
Address City State Zip		_____ _____ REVIE

Telephone	Fax	Email	FORM ID#