# 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	g
section) Residential Address	
Health Insurance	
Family/Caregiver Information (Primary Parent/Guardian or Secondary E	mergency
Contact) Housing Status	
Preferred Language(s)	
In sections where your child's information has not changed in the past year, plea	ase leave that section blank.
FAMILY/CAREGIVER ACKNOWLEDGEMENT	
By signing this form, I certify that I understand that my child's daily attendance required. I must arrange for a responsible adult to bring my child to school and understand that no transportation is provided.	
Signature	Date
STUDENT ADDRESS	
Current Address (Building #, Street) Apt #	
City State Zip Code Gender (optional)	



#### Last updated 5/2023

# **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.



#### Page 2 of 6

#### Last updated 5/2023

Please identify the student's current living arrangements. Please check <b>one</b> box:								
Check Housing Questionnaire Choice								
	<b>Doubled Up</b> 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	KOTEATI						
Spanish	Russian						
	Urdu						
Cantonese							
Mandarin	Albanian						
	Punjabi						
Arabic							
Bengali	Polish						
Deliguii	Other (please specify):						
French							
Haitian-Creole							



Page 3 of 6

Last updated 5/2023

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

Urdu

Cantonese

Albanian

Mandarin

Punjabi

Arabic

Polish

Bengali

Other (please specify):

French

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

# 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.



Page 4 of 6

#### Last updated 5/2023

Parent/Guardian Last Name	Parent/Guardian First Name				
Signature		Date			

FOR CBO USE ONLY	1		
Program Name		Site ID	

Student Seat Type (check only one)	First Day of Attendance						
3-K SDY Pre-K SDY Pre-K HD	Official Class Code						
Supplementary Documents:		Date Received					
Proof of Residence 1: (type)							
Proof of Residence 2: (type)							
Parental Consent to Photograph, Film, or Video							
Child and Adolescent Health Examination Form							



# Page 5 of 6

# Last updated 5/2023

					Please Print Clearly	NYC ID (OSIS)								
TO BE COMPLETED BY THE PARENT OR GUARDIAN														
Child's Last Name First Name				Middle Name			Sex! Date Female! Male				e of Birth (Month/Day/Year			
Child's Address					Hispanic/L atino?! Yes! No	Race (Check ALL that apply)! American Indian! Asian! Black! White Native Hawaiian/Pacific Islander! Other							e!	
City/Borough		State	Zip Code	School/6	nool/Center/Camp Name			District Number			Phone Number Hom			_
Health insurance ! Yes (including Medicaid)? ! No	! Parent/Guardia ! Foster Parent	n Last Na	First Nan	me		Email					ell ork		-	

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)  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) /	Physical Exam WNL   Phys															
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):	ated Screening Tool Used? Date Screened!  No// Screening Results:! WNL ay or Concern Suspected/Confirmed (specify  < 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//!NI !AbnI !Referred OAE//!NI !AbnI !Referred ≥ 4 yrs: pure tone audiometry//!NI !AbnI !Referred										-		
! Cognitive/Problem Solving ! Adaptive/Self-Help ! Communication/Language ! Gross Motor/Fine Motor ! Other Area of Concern:	SCREENING TESTS	CREENING Date Done Results <3			Vision Date Done <3 years: Vision a		VI! A	bnl	/				,			
! Social-Emotional or Personal-Social	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)		μg/dL Acuity (required fo				/_		/	Le - !	eft _ Una	ble t	/ _/ to tes			
Describe Suspected Delay or Concern:	Lead Risk Assessment (annually, age 6 mo-6 yrs)	/	/	At risk <i>(do BLL)</i>  Not at risk	Screened with G No Dental	idsses::	165 :	INO	Sira	DISII	ius:	: 16:	s :			
Child Receives El/CPSE/CSE services ! Yes ! No	Cł	nild Care	Only — –	-	Visible Tooth Decay	! Yes ! No										
	Hemoglobin or Hematocrit		/ <u></u>	g/dL 	Urgent denta thir								/es!	No		
IMMUNIZATIONS – DATES		$\overline{}$	CIR Numb	oer Physician Conf	irmed History of Vari	cella Infed	ction	Re	port	only	posi	tive		<u>nity:</u> G Tit	ers	
DTP/DTaP/DT/////// ////////	_//Hep I _Hib/// /////	/ B/ // ng B/	'/  // // //	Polio / / / / / / / / Potavirus / _ / / / _ / / _ / / / _ / / _ /	_/ / / / / / Hep A	/ // //	// // /	_ Mo	ening _/ uenza _/	g a		/_	Hepat // /	Mu	umps /arice	
ASSESSMENT Well Child (Z00.129) Diagnoses/	/Problems (list) ICD-10 Co	ode	RECO	MMENDATIONS F	ull physical activity											
			No!Ye	es, for	A	ppt. date:		/	/		Ref			Non	<b>I</b> e ! Ea	
Haalib Oana Buratii				Date Form Comp	oleted / /		I	P 11								
Health Care Practitioner Signature													$\overline{\top}$	+	Τ	
Health Care Practitioner Signature  Health Care Practitioner Name and Degree (print)		F	Practitione	r License No. and	State	ТҮРЕ	•	EXA	1:MA	NAE	Curre	ent N	NAE F	Prior \	/ear(	
		-+		r License No. and a		TYPE	OF	EXA	1:MA	NAE	Curre	ent N	NAE F	Prior	/ear(:	

Telephone	Fax	Email					
			FORM ID#				

CH205 Health Exam 2016\_r4-16\_FINAL.indd

Page 6 of 6