## New York City Early Childhood Education (3-K and Pre-K) Program Registration Form – Returning Student 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. 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 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 of the last check all that apply and enter	•	ne corresponding	section)
Residential Address			
Health Insurance			
Family/Caregiver Information	(Primary Parent/Guardian	or Secondary En	nergency Contact)
☐ Housing Status			
Preferred Language(s)			
In sections where your child's informa	tion has not changed in tl	ne past year, plea	se leave that section blank.
FAMILY/CAREGIVER ACKNOWLEDGE	MENT		
By signing this form, I certify that I und I must arrange for a responsible adult 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?							
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.



the student's current living arrangements. Please check <b>one</b> box:								
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."								
an Signature								
Date								
THE HOME								
Re(s) do you speak at home? (please select all that apply)    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?									
What is your mist 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 VIDE	OTAPE A STUDENT FOR NON-P	ROFIT USE							
(e.g. educational, public service, or health awareness p	urposes)	T.							
Student Last Name Student Fir	st 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	5							
Student Seat Type (check only one)	First	First Day of Attendance						
3-K SDY Pre-K SDY Pre-K HD	Offic	ial Class Code						
Supplementary Documents:			Date Re	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 H NYC DEPARTMENT OF HEALTH & MENTAL HY	<b>EALT</b> GIENE -	H EXA – DEPAR	MINATIOI TMENT OF EDUC	N FO	Print Cle	ease early	NYC ID (OSIS)							
TO BE COMPLETED BY THE PARENT OR GUARDIAN		ARDIAN								·				
Child's Last Name		First Name			Middle Nam	Middle Name			Sex					
Child's Address					Hispanic/Latin		Check ALL that appl	. –	American Indi		Asian 🗆 B	lack [	] White	•
City/Borough	State	Zip Cod	le	School	/Center/Camp Name	е			District Number		Phone Num Home			
Health insurance ☐ Yes ☐ Parent/Guardian (including Medicaid)? ☐ No ☐ Foster Parent	Last Nam	е	First N	ame		Ema	ail				Cell Work			—
TO BE COMPLETED BY THE HEAL	TH CAR	RE PRAC	TITIONER											
Birth history (age 0-6 yrs)		Does the c	hild/adolescent l		oast or present m	· · · · · · · · · · · · · · · · · · ·								
☐ Uncomplicated ☐ Premature: weeks ge	station		check severity and att t, check all current med				Mild Persistent nhaled Corticosteroid		Moderate Persi Oral Steroid		Severe r Controller	Persisten  None		
☐ Complicated by		Asthma C	ontrol Status		☐ Well-controlled	F	Poorly Controlled or N	lot Contro	lled					
Allergies  None Epi pen prescribed		<ul><li>Anaphyla</li><li>Behaviora</li></ul>	al/mental health disc	order	<ul><li>☐ Seizure disord</li><li>☐ Speech, hearir</li></ul>		mpairment	Medi □ No	cations (attac		<b>in-school med</b> Yes (list below		eeded)	
☐ Drugs (list)		☐ Congenita	al or acquired heart nental/learning probl	disorder em	☐ Tuberculosis (A	latent infection (			DITE		163 (list below	,		
□ Foods (list)		Diabetes	(attach MAF) ic injury/disability	0111	☐ Surgery									_
Other (list)		Explain all o	checked items abo	ve.	<ul><li>Other (specify)</li><li>Addendum at</li></ul>									
Attach MAF in in-school medications needed														
PHYSICAL EXAM Date of Exam:	//_	General App	pearance:											
Height <b>cm</b> (	%ile)				ical Exam WNL	I								
Weight kg (	%ile)	NI AbnI  ☐ Psycho	social Development	<i>NI Abnl</i> □ □ H	FFNT	NI AbnI  □ □ LympI		<i>NI AbnI</i> □ □ Ab	ndomen		<i>NI AbnI</i> ☐ ☐ Skin			
BMI kg/m² (	i	☐ ☐ Langu		□ □ D		□ □ Lungs			enitourinary		☐ ☐ Neuro	logical		
Head Circumference (age ≤2 yrs) cm (	%ile\ F	☐ ☐ Behav		□ □ N	eck	☐ ☐ Cardio	ovascular	□	tremities		☐ ☐ Back/	spine		
Blood Pressure (age ≥3 yrs) /		Describe at	normalities:											
DEVELOPMENTAL (age 0-6 yrs)		Nutrition					Hearing		Dat	te Done		Res	ults	
			Breastfed 🗌 Formu				< 4 years: gros	s hearin	g	_/	/ \	II 🗆 Abn	I □Re	eferred
☐ Yes ☐ No/_	/	-	Well-balanced 🗌 None [	-	dance Counseled	Referred	OAE		_	_/	/ \^	II 🗆 Abn	I □Re	eferred
Screening Results: ☐ WNL		Dictary 1103	anodono 🗀 None	_ 103 (//	St Bolow)		≥ 4 yrs: pure tor	ne audior		_/	/ \	II 🗆 Abn		eferred
<ul> <li>□ Delay or Concern Suspected/Confirmed (specify area)</li> <li>□ Cognitive/Problem Solving</li> <li>□ Adaptive/Self-Help</li> </ul>	s) delow):	SCREENING	G TESTS D	ate Done	Result	ts	Vision <3 years: Vision	anneare		te Done	, :	Res		nl
☐ Communication/Language ☐ Gross Motor/Fine Mo	otor		Level (BLL)	/_	/	μg/dL	Acuity (required				-/ Rig		_/_	
☐ Social-Emotional or ☐ Other Area of Concel Personal-Social	rn:		age 1 yr and 2 == those at risk) ==			μq/dL	and children age			_/	_/ Left	t □ Unabl	/	
Describe Suspected Delay or Concern:						isk <i>(do BLL)</i>	Screened with (	Glasses?				_ Ullabi □ Yes	le to te N □	
			Lead Risk Assessment (annually, age 6 mo-6 yrs)		// Strabismus?							☐ Yes ☐ No		
			—— Ch	ild Care	□ Not at risk □ Dental  re Only ── Visible Tooth Decay			ıcav					'Δe [	□ No
		Hemoglobin or		,	,	g/dL			al referral <i>(pain, swelling,</i>		☐ Yes g, infection) ☐ Yes			
Child Receives EI/CPSE/CSE services	Yes □ No	Hematocrit	-	/	/	%	Dental Visit with	in the pa	ast 12 months	3		□ Y	es [	□ No
CIR Number			Phys	ician Cor	nfirmed History of Va	ricella Infectio	on 🗌				Report only	positive	immu	nity:
IMMUNIZATIONS – DATES											IgG Titer	s Date		
DTP/DTaP/DT//////	//	/_	//	/	//	1	Гdар/	/	/	/	Hepatitis I	3	//	······
Td/ /	//	/_	/	/	MMR	//	/	_/	/	/	Measle	3	//	
Polio//	//	/_	//	/	Varicella	//	/	/	/	/	Mump		//	
Hep B//	//	/_	//	/	Mening ACWY	//	/	_/	/	/	Rubella		//	_
Hib//	_//_	/_	/	_/	Hep A Rotavirus	//_	/	_/	/	/	Varicella Polio		//	
Influenza / / / /	''	/_	''	/	Mening B	//_	/	-'	/	/	Polio		//	
HPV / / / /	_''				Other	''		-/	/	/	Polio		'' 	
ASSESSMENT Well Child (Z00.129)	☐ Diagno	ses/Problen	ns (list) ICD-1	10 Code	RECOMMENDATION	NS 🗆 Fu	ıll physical activity	/			1			
					Restrictions (spe	cify)								
					Follow-up Needed	□ No □	Yes, for				Appt. date: _	/	/_	
					Referral(s):	None   E	arly Intervention		Denta	al 🗌	Vision			
Health Care Practitioner Signature					Other Date Form	Completed			OHMH PRA	CTITION	ER		T	_
Health Care Prostitioner Name and Decree				D	otitionar Lieazza M	and Ctat-	//		ONLY I.D.	. 🗆	F 0	1000	Dud	
Health Care Practitioner Name and Degree (print)					ctitioner License No.				PE OF EXAM Omments:	ı: ∟ NA	⊾ Current	NAE F	rior Ye	ear(s)
Facility Name				Nati	ional Provider Identif	ier (NPI)		De	Date Reviewed: I.D. NUMBER					
Address	ddress City			State Zip										
	1_				1_ ::			RE	VIEWER:					
Telephone	Fax				Email			FC	ORM ID#			$\overline{\Box}$	T	