

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 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
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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 NYCECs/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
<input type="checkbox"/>	Doubled Up With another family or other person because of loss of housing or as a result 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

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)

- | | |
|---|--|
| <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

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)	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 Residence 1: <i>(type)</i>			
Proof of Residence 2: <i>(type)</i>			
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, Date of Birth, Child's Address, Hispanic/Latino?, Race, City/Borough, State, Zip Code, School/Center/Camp Name, District Number, Phone Numbers, Health insurance, Parent/Guardian Last Name, First Name, Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history, Allergies, Attach MAF in in-school medications needed, Does the child/adolescent have a past or present medical history of the following?, Medications

PHYSICAL EXAM, Date of Exam, General Appearance, Describe abnormalities

DEVELOPMENTAL, Nutrition, Hearing, Vision, Dietary Restrictions, SCREENING TESTS, Blood Lead Level (BLL), Lead Risk Assessment, Hemoglobin or Hematocrit, Dental

Child Receives EI/CPSE/CSE services, CIR Number, Physician Confirmed History of Varicella Infection, Report only positive immunity

IMMUNIZATIONS - DATES, DTP/DTaP/DT, Tdap, Hep B, Hib, PCV, Influenza, HPV, MMR, Varicella, Mening ACWY, Hep A, Rotavirus, Mening B, Other, IgG Titers, Date

ASSESSMENT, Well Child (Z00.129), Diagnoses/Problems (list), ICD-10 Code, RECOMMENDATIONS, Full physical activity, Follow-up Needed, Referral(s)

Health Care Practitioner Signature, Date Form Completed, Health Care Practitioner Name and Degree, 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, Date Reviewed, REVIEWER, FORM ID#