NEW YORK CITY EARLY EDUCATION CENTER (NYCEEC)
FULL-DAY PRE-K PROGRAM REGISTRATION FORM
FOR 2021-2022 SCHOOL YEAR

DIRECTIONS:
Please print clearly in blue or black ink only. Please note that only parents/guardians who are New York City residents may submit a registration form. Sign and return this registration form directly to each NYCEEC you wish to register at. Be sure to make a copy of this registration form and retain for your records. For a list of NYCEECs, please review the Pre-Kindergarten Directory available at your local school, NYCEEC or online at nyc.gov/prek.

NAME OF NYCEEC YOU ARE REGISTERING AT: _____

Section A: STUDENT INFORMATION – Please print clearly in ink			
STUDENT LAST NAME	STUDENT FIRST NAME	DATE OF BIRTH (mm/dd/yyyy)	GENDER (optional)
		/ / 2017	☐ M ☐ F
STUDENT CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)			STUDENT HOME DISTRICT (optional)

Section B: OPTIONAL INFORMATION – Please print clearly in ink
HEALTH INSURANCE Does the student have health insurance? ☐ Yes If yes, what type of coverage is it? ☐ Private Health Insurance ☐ Medicaid ☐ Child Health Plus B ☐ No If no, would you like to be contacted about getting coverage? ☐ Yes ☐ No
HOME LANGUAGE In which language(s) would you like to receive written and/or oral communication regarding the Pre-Kindergarten Admission process? Please check all that apply: ☐ English ☐ Arabic ☐ Bengali ☐ Chinese ☐ French ☐ Haitian Creole ☐ Korean ☐ Russian ☐ Spanish ☐ Urdu ☐ Other, please specify: _____

Section C: PARENT INFORMATION – Please print clearly in ink		
I understand that daily attendance and promptness 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.		
PARENT/GUARDIAN LAST NAME	PARENT/GUARDIAN FIRST NAME	RELATIONSHIP TO STUDENT
DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	PARENT/GUARDIAN EMAIL ADDRESS
Parent/Guardian Signature		Date

THE New York City DEPARTMENT OF EDUCATION

FEDERAL PARENT/GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

To the Parent/Guardian:

Federal law requires the New York City Department of Education to collect and record the ethnic identity and race of public school students. This information is used to determine funding for your school, among other things, and is kept secure and confidential.

We need your help to accomplish this task. Please respond to the ethnicity and race identification questions on the back of this page. 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. Students identified with more than race will be counted in the "two or more races" category. Hispanic students of all races will be counted in the Hispanic category.

The New York City Department of Education understands the sensitive nature of this process. The options provided by the federal government may not represent an accurate or complete portrayal of your family'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 New York City Department of Education school staff to make an identification of your child on your behalf.

Race and ethnicity information for students is protected by the confidentiality regulations cited at the bottom of this page.

Thank you for your cooperation.

Parents and Guardians: Please complete the form on the reverse side of this page and return it to your child's school.

School staff: File the completed form in the student's Cumulative Record folder as confidential information.

Confidentiality Procedures and Regulations

The Family Educational Rights and Privacy Act (1974) and Regulations of the Chancellor A-820 prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

[1] Race may be considered as a factor in school enrollment only where required by court order; gender is a factor only in single-gender schools.

THE New York City DEPARTMENT OF EDUCATION

FEDERAL PARENT/GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

- All students between 5 and 21 years of age have the right to a free public education.
- Federal law requires the New York City Department of Education to collect and record the ethnic identity and race(s) of public school students.
- Children may not be refused admission to a public school because of race, color, creed, national origin, gender, gender identity, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.[1]

English Only

SCHOOL STAFF: PLEASE COMPLETE THIS SECTION

Borough ☐ District ☐☐ School ☐☐☐

Name of High School/ Mini School /Annex ----------

Grade Code ☐☐☐ Class Code ☐☐☐☐ (HIGH SCHOOL ONLY 4-DIGIT)

NYC Student Identification Number ☐☐☐☐☐☐☐☐☐

Date of Birth (Month/Day/Year) ☐☐☐☐☐☐

Student Name: Last, First, Middle Initial

PARENT/GUARDIAN: PLEASE COMPLETE THIS SECTION

PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND.

For Question (1), check (√) the box that best describes your child.

1. Is the student Hispanic, Latino, or of Spanish origin? Hispanic, Latino, or of Spanish origin means 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**

For Question (2), check (√) **all** boxes that apply to your child.

2. Select one or more races from the following five racial groups.

☐ **AMERICAN INDIAN OR ALASKAN NATIVE:** A person having origins in any of the original peoples of North America and South America (including Central America. (ATS Code: B)

☐ **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. (ATS Code: C)

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER:** A person having origins in any of the original peoples of Hawaii, Guam, or other Pacific Islands. (ATS Code: D)

☐ **BLACK:** A person having origins in any of the Black racial groups of Africa. (ATS Code: E)

☐ **WHITE:** A person having origins in any of the original peoples of Europe, North Africa, or the Middle East. (ATS Code: F)

Signature of Parent/Guardian/Other/School Staff Observer: ---------- Date: ----------

Relationship to Student:

☐ Parent ☐ Guardian ☐ Other (Specify): ☐ School Staff Observer (Name):

See reverse side for an important message to parents/guardians and for confidentiality procedures and regulations

FORM **PSE**

Department of Education

HOUSING QUESTIONNAIRE

Parent/Guardian/Student:

This form is intended to address the McKinney-Vento Act 42 U.S.C. 11435, and must be completed for each student. **The information you provide is confidential.** Your child will not be discriminated against based upon the information provided.

Please complete the following questions regarding the student's housing in order to help determine services the student may be eligible to receive.

Note to Schools/Temporary Housing Liaisons: Please assist students and families in filling out this form. Do not simply include this form in the registration packet, because if the student qualifies as residing in temporary housing, **the student is not required to submit proof of residency** and other required documents that may be part of the registration packet. The district cannot disclose housing status information without parental consent.

Student Name			
Last	**First**		**Middle**
OSIS #	**Date of Birth (MM/DD/YY)**	**Gender**	**School**

Please identify the student's current living arrangements. Please check one box:

Check (√)	Housing Questionnaire Choice	School Use Only ATS Code
☐	**Doubled Up** With another family or other person because of loss of housing or as a result of economic hardship	D
☐	**Shelter** Emergency or transitional shelter	S
☐	**Hotel/Motel** Living in what is NOT an emergency or transitional shelter **and** involves payment	H
☐	**Other Temporary Living Situation** Trailer park, campground, car, park, public places, abandoned building, street, or any other inadequate living space	T
☐	**Permanent Housing** Student who is living in a fixed, regular, and adequate housing situation	P

If the student is NOT living in permanent housing, also indicate if the below applies:

		School Use Only
☐	**Unaccompanied Youth** Youth who is not in the physical custody of a parent or guardian	Enter "Y" if applicable

Parent/Guardian (print) _____ Parent/Guardian Signature _____ Date _____

Please return this form to your child's school as requested.

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".

Enrollment Home Language Survey

Division of Early Childhood Education

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.

Date:

Student Name: _____

Student ID (if applicable): _____

Program Name: _____

Name of Person Completing this Survey: _____

Relationship to Student: _____

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):

What is your child's primary language? _____

Enrollment Home Language Survey

Division of Early Childhood Education

Family/Caregiver Information:

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? _____

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 ______

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

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? ☐ Yes ☐ No — Date Screened ____/____/____

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

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

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# ☐☐☐☐☐☐☐☐☐☐

Office of Communications and Media Relations
52 Chambers Street, New York, NY 10007
Tel: 212.374.5141 Fax: 212.374.5584

CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE A STUDENT FOR NON-PROFIT USE

(e.g. educational, public service, or health awareness purposes)

Student Name: _____ School: _____

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 _____(program name)_____ .

I also grant to _____(program name)_____ 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.

Signature of Parent/Guardian (if Student is under 18): _____ Date: _____

Address of Parent/Guardian: _____

OR

Signature of Student (if 18 or over): _____ Date: _____

Address of Student: _____

Ready4K

NYC Department of Education

Text messages to boost your child's learning

Welcome to Ready4K! The NYCDOE is excited to give you this FREE resource to help your PK-5th graders stay on track with their learning goals all year long.

How does Ready4K help my child learn?

Ready4K texts you 3 easy-to-do learning tips and activities each week. Each text message you will get is written for your child's age or grade. Research shows that doing Ready4K activities is a great way to help your child stay on track.

Ready4K tips **build on your daily routines**, like activities to use when getting dressed, during bath time, or when preparing a meal. No internet, extra time, or special materials are required.

You'll also receive links to **NYC resources** that many families find helpful.

What do I need to do?

As a NYC family of a child between 0 - 10, you can enroll for **FREE by texting NYC to 70138**.

There's **absolutely no cost**, though data and message rates may apply. You can opt out anytime by texting STOP to 70138.

Questions? Contact the program director at your child's school for more details.