NEW YORK CITY EARLY EDUCATION CENTER (NYCEEC)
FULL-DAY PRE-K PROGRAM REGISTRATION FORM
FOR 2020-2021 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)
		/ / 2016	☐ 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 Enter "Y" if applicable
☐	**Unaccompanied Youth** Youth who is not in the physical custody of a parent or guardian	

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".

The New York City Department of Education
Pre-Kindergarten Language Needs Survey

Dear Parent or Guardian of _____(enter student name here),
This survey is an important piece of your pre-kindergarten enrollment package as it provides your new school with information about your family's language needs. Your assistance in answering the questions below is greatly appreciated. Please return this form to your school administrator, _____, and if you have questions, speak with _____ at _____.

Thank You *Student ID:_____*

PART 1. LANGUAGE NEEDS: This information will establish what language is used at home and the language of instruction requested by the family (if available).

1. Which language(s) do you speak at home? Please check (√) all that apply:

□ English	□ Urdu
□ Spanish	□ French
□ Chinese	□ Korean
□ Bengali	□ Albanian
□ Arabic	□ Punjabi
□ Haitian Creole	□ Polish
□ Russian	□ Other, please specify_____

2.What language does the child **understand**?

English □ Other Home Language(s) □:

3. What language does the child **speak**?

English □ Other Home Language(s) □:

4. What language does the child **read**?

English □ Other Home Language(s) □: Does not read yet □

5. What language does the child **write**?

English □ Other Home Language(s) □: Does not write yet □

6. What language is spoken in the child's home or residence **most of the time**?

English □ Other Home Language(s) □:

7. What language does the child speak with parents/guardians **most of the time**?

English □ Other Home Language(s) □:

8. What language does the child speak with brothers, sisters, or friends **most of the time**?

English □ Other Home Language(s) □:

9. What language does the child speak with other relatives or caregivers (e.g., babysitters) **most of the time**?

English □ Other Home Language(s) □:

10.Would you like your child to receive instruction using your home language (if available):

□ All the time □ Most of the time □ Some of the time

The New York City Department of Education
Pre-Kindergarten Language Needs Survey

PART 2. INSTRUCTIONAL PLANNING: Responses to these supplementary questions will be used for instructional planning. Enter the correct response for each of the following questions concerning your child.

1. Is this your child's first time participating in an instructional program or group experience in the U.S.?

   □ Yes □ No

   IF NO:

   a. Where did they go participate in daycare/preschool/play group?

   b. What was the date of enrollment?

   c. How long did they attend?

   d. Which language was used for instruction?

2. Has your child participated in an instructional program or group experience in another country?

   □ Yes □ No

   IF YES:

   a. Where did they participate in daycare/preschool/play group?

   b. How long did they attend?

   c. Which language was used for instruction?

3. Does your child have any conditions that require special help or attention in school? □ Yes □ No

   IF YES, please check all that apply:

   □ Hearing impaired
   □ Visually impaired
   □ Speech impaired
   □ Physically impaired
   □ Emotionally impaired
   □ Asthma
   □ Developmentally Disabled
   □ Other (Please Specify)_____

   IF YES, what early intervention has your child received, if any?

4. Does the child use any other form(s) of communication, such as American Sign Language or Augmentative Communication Device (e.g., Communication Board-manual/electronic)? □ Yes □ No

   IF YES: Which ones?

PART 3. PARENT INFORMATION: Responses to these supplementary questions will be used so that the NYC Department of Education can communicate with you in the language of your choice.

1. What is your first language?

   Parent/Guardian: _____ Parent/Guardian: _____

   First language: _____ First language: _____

2. In what language would you like to receive written information from the school?

3. In what language would you prefer to communicate orally with school staff?

_____

Parent Signature Date

The New York City Department of Education
Pre-Kindergarten Language Needs Survey

TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY		
Date:	Name of Student/ID:	
Borough:	District:	School:
Gender:	Ethnicity Code: (form PSE):	Date of Birth:
Relationship of person providing information for survey (check one): □ Mother □ Guardian □ Father □ Other (specify):		
If an interview is conducted, in what language is it conducted?		
Is a translator/interpreter used?		
OTELE Alpha Code		
Potential English Language Learner?		
Instruction will be provided in: □ English □ Spanish □ Other _____ □ Both English and the home language of _____		

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 _____ Cell _____ Work _____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** **Last Name** **First Name** | **Email**

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 ___/___/___

DOHMH ONLY **PRACTITIONER I.D.**

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Date Reviewed: ___/___/___ **I.D. NUMBER**

REVIEWER:

Telephone | Fax | Email

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: _____