New York City Early Childhood Education (Early Learn, 3-K, and Pre-K) Program Registration Form – Returning Student for the 2022-2023 School Year

Extended Day and Extended Year Services

Directions

Please print clearly in blue or black ink or complete this form electronically. Please make sure that all of the information you enter matches the information on your family's Application for Child Care Assistance, which you submitted to the DOE Family Welcome Center or emailed to ccapplication@schools.nyc.gov.

UPDATED STUDENT INFORMATION		
Last Name	First Name	Date of Birth

Family Case Number

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

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 CBOs/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
☐	**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."

Parent/Guardian Signature

Signature	Date

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):

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) ☐ Infant EDY ☐ Toddler EDY ☐ 3-K EDY ☐ Pre-K EDY		First Day of Attendance SY22-23 Official Class Code Family Case Number	

Supplementary Documents:	Date Received
Home Language Survey: *(primary language)*	
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** ☐ 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

| | | |

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.