

DIRECTIONS:

Please type or print clearly in blue or black ink only. Complete, sign and return this application to the CBO of your choice and make a copy of the application(s) and retain for your records. To register you must bring your child and the following required documentation to the program for registration: proof of birth (birth certificate or passport), verifiable proof of residence (two documents), and immunization records. For more information regarding registration documents, please visit <http://schools.nyc.gov/Academics/EarlyChildhood/ParentResources>.

For a list of CBOs please review the Pre-Kindergarten Directory available at your local school or CBO. You may also visit the NYC Department of Education website at <http://schools.nyc.gov/choicesenrollment/prek>. If you have questions regarding UPK, please visit <http://schools.nyc.gov/Academics/EarlyChildhood/ParentResources>.

Please note that a separate application must be submitted to each CBO to which you apply. Duplicate a blank application if you intend to apply to more than one CBO. Please note that only Parent/Guardians who are New York City residents may submit an application.

NAME OF CBO YOU ARE APPLYING TO: _____

Section A: STUDENT INFORMATION – Please print clearly in ink			
STUDENT LAST NAME	STUDENT FIRST NAME	DATE OF BIRTH (mm/dd/yyyy) / / 2006	GENDER (optional) <input type="checkbox"/> M <input type="checkbox"/> F
STUDENT CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)			

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

Section C: PARENT INFORMATION – Please print clearly in blue or black 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 him/her 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

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other
City/Borough	State	Zip Code	School/Center/Camp Name	District Number
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name	Phone Numbers Home _____ Cell _____ Work _____	

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	Does the child/adolescent have a past or present medical history of the following? Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <i>If persistent, check all current medication(s):</i> <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____
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Explain all checked items above or on addendum

PHYSICAL EXAMINATION Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: <table border="0"> <tr> <td><i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/></td> <td><input type="checkbox"/> HEENT</td> <td><i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/></td> <td><input type="checkbox"/> Lymph nodes</td> <td><i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/></td> <td><input type="checkbox"/> Abdomen</td> <td><i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/></td> <td><input type="checkbox"/> Skin</td> <td><i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/></td> <td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Dental</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Back/spine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Behavioral</td> </tr> </table> Describe abnormalities: _____	<i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/>	<input type="checkbox"/> HEENT	<i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/>	<input type="checkbox"/> Lymph nodes	<i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/>	<input type="checkbox"/> Abdomen	<i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/>	<input type="checkbox"/> Skin	<i>Nl</i> <input type="checkbox"/> <i>Abnl</i> <input type="checkbox"/>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/>	<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral
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DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)</td> <td>____/____/____</td> <td>_____ µg/dL</td> </tr> <tr> <td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</td> <td>____/____/____</td> <td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td> </tr> <tr> <td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td> <td>____/____/____</td> <td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>____/____/____</td> <td>_____ g/dL _____ %</td> </tr> </tbody> </table>		Date Done	Results	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	_____ µg/dL	Lead Risk Assessment (annually, age 6 mo-6 yrs)	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	_____ g/dL _____ %	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> PPD/Mantoux placed _____/____/____ Induration _____ mm PPD/Mantoux read _____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Interferon Test _____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Chest x-ray (if PPD or Interferon positive) _____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl Vision <i>(required for new school entrants and children age 4-7 yrs)</i> _____/____/____ Acuity Right _____ / _____ _____/____/____ Left _____ / _____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes
	Date Done	Results															
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IMMUNIZATIONS - DATES CIR Number of Child _____ Hep B _____/____/____ Rotavirus _____/____/____ DTP/DTaP/DT _____/____/____ Hib _____/____/____ PCV _____/____/____ Polio _____/____/____	Influenza _____/____/____ MMR _____/____/____ Varicella _____/____/____ Td _____/____/____ Tdap _____/____/____ Hep A _____/____/____ Meningococcal _____/____/____ HPV _____/____/____ Other, Specify: _____; _____; _____
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RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature	Date ____/____/____	DOHMH PROVIDER ONLY I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____-____	Fax (____) _____-____	I.D. NUMBER _____
		REVIEWER: _____

THE NEW YORK CITY DEPARTMENT OF EDUCATION
PARENT/GUARDIAN STUDENT ETHNIC IDENTIFICATION

To the Parent/Guardian:

The No Child Left Behind Act requires the Department of Education to collect and record the ethnic identity of public school students. This information is used for statistical analysis, data reporting, and accountability determinations.

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the reverse side of this page. Put a check (✓) in the box for the category which best describes your child.

The New York City public school system understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential.

Thank you for your cooperation.

CONFIDENTIALITY PROCEDURES AND REGULATIONS

To School Staff:

This form will be filed in the student's Cumulative Record folder as confidential information

To the Parent/Guardian

The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

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.

Please complete the form on the reverse side of this page

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:	
Borough	District:	School:
Gender:	Ethnicity Code: (form PSE):	Date of Birth:
Relationship of person providing information for survey (check one): <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Other (specify):		
If an interview is conducted, in what language is it conducted?		
Is a translator/interpreter used?		
Pre-K Home Language Code		
Potential English Language Learner?		
Instruction will be provided in: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Both English and the home language of _____		