Department of Education
Carmen Fariña, Chancellor

APPLICATION FOR COMMUNITY-BASED ORGANIZATION (CBO) UNIVERSAL PRE-KINDERGARTEN (UPK) FOR THE 2014 - 2015 SCHOOL YEAR

DIRECTIONS:
Please print clearly in blue or black ink only. Please note that only Parent/ Guardians who are New York City residents may submit an application. Complete, sign and return this application directly to each CBO you wish to apply to. Be sure to make a copy of the application and retain for your records. For a list of CBOs, please review the Pre-kindergarten Directory available at your local school, CBO or online at http://schools.nyc.gov/ChoicesEnrollment/PreK.

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/ddyyyy)	GENDER (optional)
		/ / **2010**	☐M ☐F
STUDENT CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)			
			N.Y.

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 Admissions process? Please check all that apply: ☐English ☐Arabic ☐Bengali ☐Chinese ☐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 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

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** O Female O Male | **Date of Birth** *(Month/Day/Year)* / / 2010

Child's Address | **Hispanic/Latino?** O Yes O No | **Race** *(Check ALL that apply)* O American Indian O Asian O Black O White O Native Hawaiian/Pacific Islander O Other

City/Borough | State N.Y. | Zip Code | School/Center/Camp Name | District Number | **Phone Numbers** *Home* *Cell* *Work*

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

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

Birth history *(age 0-6 yrs)*

O Uncomplicated O Premature: _____ weeks gestation

O Complicated by _____

Allergies O None O Epi pen prescribed

O Drugs *(list)* _____

O Foods *(list)* _____

O Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

O Asthma *(check severity and attach MAF/Asthma Action Plan):* O Intermittent O Mild Persistent O Moderate Persistent O Severe Persistent

If persistent, check all current medication(s): O Inhaled corticosteriod O Other controller O Quick relief med O Oral steroid O None

O Attention Deficit Hyperactivity Disorder
O Chronic or recurrent otitis media
O Congenital or acquired heart disorder
O Developmental/learning problem
O Diabetes *(attach MAF)*
O Orthopedic injury/disability
O Seizure disorder
O Speech, hearing, or visual impairment
O Tuberculosis *(latent infection or disease)*
O **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*
O None O Yes *(list below)*

Dietary Restrictions
O None O Yes *(list below)*

PHYSICAL EXAMINATION

Height _____ **cm** (_____ %ile)
Weight _____ **kg** (_____ %ile)
BMI _____ **kg/m²** (_____ %ile)
Head Circumference *(age ≤2 yrs)* _____ **cm** (_____ %ile)
Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl	
O	O	HEENT	O	O	Lymph nodes	O	O	Abdomen	O	O	Skin	O	O	Psychosocial Development
O	O	Dental	O	O	Lungs	O	O	Genitourinary	O	O	Neurological	O	O	Language
O	O	Neck	O	O	Cardiovascular	O	O	Extremities	O	O	Back/spine	O	O	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* O Within normal limits

If delay suspected, specify below

O Cognitive *(e.g., play skills)* _____
O Communication/Language _____
O Social/Emotional _____
O Adaptive/Self-Help _____
O Motor _____

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)*	___/___/___	O At risk *(do BLL)* O Not at risk
Hearing O Pure tone audiometry O OAE	___/___/___	O Normal O Abnormal
—— Head Start Only ——		
Hemoglobin or Hematocrit *(age 9–12 mo)*	___/___/___	_____g/dL _____%

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	___/___/___	Induration _____mm
PPD/Mantoux *read*	___/___/___	O Neg O Pos
Interferon Test	___/___/___	O Neg O Pos
Chest x-ray *(if PPD or Interferon positive)*	___/___/___	O Nl O Abnl O Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	___/___/___ O with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus O No O Yes

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:* _____	___/___/___;		___/___/___

RECOMMENDATIONS O Full physical activity O Full diet

O Restrictions *(specify)*

Follow-up Needed O No O Yes, for _____ Appt. date: ___/___/___

Referral(s): O None O Early Intervention O Special Education O Dental O Vision

O Other _____

ASSESSMENT O **Well Child** (V20.2) O **Diagnoses/Problems** *(list)* **ICD-9 Code**

Health Care Provider Signature | Date ___/___/___

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone ( ) – | Fax ( ) –

DOHMH ONLY PROVIDER I.D.

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

Comments

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

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

THE New York City DEPARTMENT OF EDUCATION

FEDERAL PARENT/GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

FORM
PSE

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.

Department of Education
Carmen Fariña, Chancellor

THE New York City DEPARTMENT OF EDUCATION

FEDERAL PARENT/GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

FORM
PSE

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

Department of Education
Carmen Fariña, Chancellor

Residency 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.

Student Name			
Last	**First**		**Middle**
OSIS #	**Date of Birth** MM/DD/YY	**Gender**	**School**
	/ / **2010**		

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

Check (√)	Residency 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**
☐	**Awaiting Foster Care Placement**	**A**
☐	**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 Name (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."

Department of Education
Carmen Fariña, Chancellor

PARENT AFFIDAVIT OF RESIDENCY

In accordance with Chancellor's Regulation A-101, if a parent is subletting an apartment or home, or if more than one family shares a living space and there is only one leaseholder or homeowner, the parent must present a notarized "Address Affidavit" signed both by the primary leaseholder as well as the parent affirming that the family is residing in this home, and must attach the lease or deed.

Section A: STUDENT INFORMATION – Please print clearly in ink

STUDENT'S LAST NAME	STUDENT'S FIRST NAME	GENDER (optional)
		☐ MALE ☐ FEMALE

DATE OF BIRTH (MM/DD/YY)	OSIS #/STUDENT'S ID # (if available)	TELEPHONE #
2010		

STUDENT'S CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)

N.Y.

Section B: PARENT INFORMATION – Please print clearly in ink

PARENT/GUARDIAN'S LAST NAME	PARENT/GUARDIAN'S FIRST NAME

PARENT/GUARDIAN'S CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

Section C: PRIMARY RESIDENT/TENANT INFORMATION – Please print clearly in ink

PRIMARY RESIDENT/TENANT'S LAST NAME	PRIMARY RESIDENT/TENANT'S FIRST NAME

PRIMARY RESIDENT/TENANT'S CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS

RELATIONSHIP TO PARENT	ANTICIPATED DURATION OF STAY

To be completed by the Parent:

I, _____, the parent of _____,
(insert name and date of birth of student)

hereby affirm that I am residing with _____
(insert name)

at the following address _____.
(insert address and contact number of primary leaseholder)

I understand that the New York City Department of Education has the right to conduct an Attendance Investigation to verify my residence including a visit to the home of the primary leaseholder. I also understand that registration in school is based on eligibility determined by my residence, and the Department of Education has the right to transfer students for whom falsified documentation was provided at the time of registration.

In the event that my residency changes, I agree to notify my child's school and present new proof of address.

Parent Signature: _____

STATE OF NEW YORK

SS:

COUNTY OF _____

Sworn to before me this _____ day of _____, Year _____

_____
Notary Public

To be completed by Primary Leaseholder/Tenant:

I hereby affirm that _____
(insert name of parent and child/children)

are residing with me at _____.
(insert address)

I understand that by signing this affidavit I am verifying the residence of _____.
(insert names)

I also understand that the New York City Department of Education has the right to conduct an Attendance Investigation to verify the residence of the parties named in this affidavit, including a visit to my home and interviews with my neighbors. I can be contacted at the number(s) listed below should the Department of Education require further information.

Primary Leaseholder Signature: _____

STATE OF NEW YORK

SS:

COUNTY OF _____

Sworn to before me this _____ day of _____, Year _____

_____
Notary Public

Department of Education
Carmen Fariña, Chancellor

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

Dear Parent or Guardian,
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

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 read 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 he/she go participate in daycare/preschool/play group?

b. What was the date of enrollment?

c. How long did he/she 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 he/she participate in daycare/preschool/play group?

b. How long did he/she 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:	
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?		
Pre-K Home Language Code		
Potential English Language Learner?		
Instruction will be provided in: ☐ English ☐ Spanish ☐ Other _____ ☐ Both English and the home language of _____		

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_____.

I also grant to _____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: _____