Department of Education
Dennis M. Walcott, 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)* / **2008**

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** O **Foster Parent** Last Name | First Name

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 Not O Abnl 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:

CH-205 (5/08)

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

Department of Education
Dennis M. Walcott, Chancellor

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.