

## 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:** \_\_\_\_\_

<b>Section A: STUDENT INFORMATION – Please print clearly in ink</b>			
STUDENT LAST NAME	STUDENT FIRST NAME	DATE OF BIRTH (mm/dd/yyyy)	GENDER (optional)
		/ / <b>2010</b>	<input type="checkbox"/> M <input type="checkbox"/> F
STUDENT CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)			<b>N . Y .</b>

<b>Section B: OPTIONAL INFORMATION – Please print clearly in ink</b>
<b>HEALTH INSURANCE</b>
Does the student have health insurance?
<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> If no, would you like to be contacted about getting coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HOME LANGUAGE</b>
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: _____

<b>Section C: PARENT INFORMATION – Please print clearly in ink</b>		
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="radio"/> Female <input type="radio"/> Male	Date of Birth (Month/Day/Year) / 2008
Child's Address			Hispanic/Latino? <input type="radio"/> Yes <input type="radio"/> No	Race (Check ALL that apply) <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> White <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> Other
City/Borough	State N. Y.	Zip Code	School/Center/Camp Name	District Number
Health insurance (including Medicaid)? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Parent/Guardian <input type="radio"/> Foster Parent	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)*

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

<b>PHYSICAL EXAMINATION</b> Height _____ cm (_____%ile) Weight _____ kg (_____%ile) BMI _____ kg/m <sup>2</sup> (_____%ile) Head Circumference (age ≤2 yrs) _____ cm (_____%ile) Blood Pressure (age ≥3 yrs) _____ / _____	<b>General Appearance:</b> <table border="1"> <tr> <td>Ni Abnl</td> <td><input type="radio"/> HEENT</td> <td>Ni Abnl</td> <td><input type="radio"/> Lymph nodes</td> <td>Ni Abnl</td> <td><input type="radio"/> Abdomen</td> <td>Ni Abnl</td> <td><input type="radio"/> Skin</td> <td>Ni Abnl</td> <td><input type="radio"/> Psychosocial Development</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/> Dental</td> <td><input type="radio"/></td> <td><input type="radio"/> Lungs</td> <td><input type="radio"/></td> <td><input type="radio"/> Genitourinary</td> <td><input type="radio"/></td> <td><input type="radio"/> Neurological</td> <td><input type="radio"/></td> <td><input type="radio"/> Language</td> </tr> <tr> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/> Cardiovascular</td> <td><input type="radio"/></td> <td><input type="radio"/> Extremities</td> <td><input type="radio"/></td> <td><input type="radio"/> Back/spine</td> <td><input type="radio"/></td> <td><input type="radio"/> Behavioral</td> </tr> </table> <b>Describe abnormalities:</b> _____	Ni Abnl	<input type="radio"/> HEENT	Ni Abnl	<input type="radio"/> Lymph nodes	Ni Abnl	<input type="radio"/> Abdomen	Ni Abnl	<input type="radio"/> Skin	Ni Abnl	<input type="radio"/> Psychosocial Development	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Dental	<input type="radio"/>	<input type="radio"/> Lungs	<input type="radio"/>	<input type="radio"/> Genitourinary	<input type="radio"/>	<input type="radio"/> Neurological	<input type="radio"/>	<input type="radio"/> Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Cardiovascular	<input type="radio"/>	<input type="radio"/> Extremities	<input type="radio"/>	<input type="radio"/> Back/spine	<input type="radio"/>	<input type="radio"/> Behavioral
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<b>DEVELOPMENTAL (age 0-6 yrs)</b> <input type="radio"/> Within normal limits If delay suspected, specify below <input type="radio"/> Cognitive (e.g., play skills) _____ <input type="radio"/> Communication/Language _____ <input type="radio"/> Social/Emotional _____ <input type="radio"/> Adaptive/Self-Help _____ <input type="radio"/> Motor _____	<b>SCREENING TESTS</b> <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td><b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)</td> <td>____/____/____</td> <td>____ μg/dL</td> </tr> <tr> <td><b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)</td> <td>____/____/____</td> <td><input type="radio"/> At risk (do BLL) <input type="radio"/> Not at risk</td> </tr> <tr> <td><b>Hearing</b> <input type="radio"/> Pure tone audiometry <input type="radio"/> OAE</td> <td>____/____/____</td> <td><input type="radio"/> Normal <input type="radio"/> Abnormal</td> </tr> <tr> <td><b>Hemoglobin or Hematocrit (age 9-12 mo)</b></td> <td>____/____/____</td> <td>____ g/dL ____ %</td> </tr> </tbody> </table>		Date Done	Results	<b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	____ μg/dL	<b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs)	____/____/____	<input type="radio"/> At risk (do BLL) <input type="radio"/> Not at risk	<b>Hearing</b> <input type="radio"/> Pure tone audiometry <input type="radio"/> OAE	____/____/____	<input type="radio"/> Normal <input type="radio"/> Abnormal	<b>Hemoglobin or Hematocrit (age 9-12 mo)</b>	____/____/____	____ g/dL ____ %	<b>Tuberculosis</b> <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="radio"/> Neg <input type="radio"/> Pos Interferon Test _____/____/____ <input type="radio"/> Neg <input type="radio"/> Pos Chest x-ray (if PPD or Interferon positive) _____/____/____ <input type="radio"/> NI <input type="radio"/> Not <input type="radio"/> Abnl <input type="radio"/> Indicated <b>Vision</b> (required for new school entrants and children age 4-7 yrs) _____/____/____ Acuity Right ____/____ <input type="radio"/> with glasses Left ____/____ Strabismus <input type="radio"/> No <input type="radio"/> Yes
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<b>IMMUNIZATIONS - DATES</b> CIR Number of Child _____	<table border="1"> <tr> <td>Hep B</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>Rotavirus</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>DTP/DTaP/DT</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>Hib</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>PCV</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>Polio</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> </table>	Hep B	____/____/____	____/____/____	____/____/____	Rotavirus	____/____/____	____/____/____	____/____/____	DTP/DTaP/DT	____/____/____	____/____/____	____/____/____	Hib	____/____/____	____/____/____	____/____/____	PCV	____/____/____	____/____/____	____/____/____	Polio	____/____/____	____/____/____	____/____/____	<table border="1"> <tr> <td>Influenza</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>MMR</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>Varicella</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>Td</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>Tdap</td> <td>____/____/____</td> <td>Hep A</td> <td>____/____/____</td> </tr> <tr> <td>Meningococcal</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>HPV</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> <tr> <td>Other, Specify:</td> <td>____/____/____</td> <td>____/____/____</td> <td>____/____/____</td> </tr> </table>	Influenza	____/____/____	____/____/____	____/____/____	MMR	____/____/____	____/____/____	____/____/____	Varicella	____/____/____	____/____/____	____/____/____	Td	____/____/____	____/____/____	____/____/____	Tdap	____/____/____	Hep A	____/____/____	Meningococcal	____/____/____	____/____/____	____/____/____	HPV	____/____/____	____/____/____	____/____/____	Other, Specify:	____/____/____	____/____/____	____/____/____
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Other, Specify:	____/____/____	____/____/____	____/____/____																																																							

<b>RECOMMENDATIONS</b> <input type="radio"/> Full physical activity <input type="radio"/> Full diet <input type="radio"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="radio"/> No <input type="radio"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <input type="radio"/> None <input type="radio"/> Early Intervention <input type="radio"/> Special Education <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> Other _____	<b>ASSESSMENT</b> <input type="radio"/> Well Child (V20.2) <input type="radio"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature	Date	<b>DOHMH PROVIDER ONLY</b>
Health Care Provider Name and Degree (print)	Provider License No. and State	<b>I.D.</b> _____
Facility Name	National Provider Identifier (NPI)	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Address	City State Zip	Comments
Telephone (____) _____ - _____	Fax (____) _____ - _____	Date Reviewed: ____/____/____
		<b>I.D. NUMBER</b> _____
		REVIEWER: _____

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 one 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.

<sup>1</sup> 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.

