New York City Early Childhood Education
Program Registration Form- School Day Year & Head Start
Welcome

Dear Parent(s)/Guardian(s):

We are excited to welcome you to NYC Public Schools for the upcoming school year in partnership with your child's early childhood program.

Please complete this registration packet and submit it to your early childhood program.

Important Note:
Your child's School Day and Year 3-K or Pre-K program, or Head Start or Early Head Start program is **free.** You and/or your child will not gain any advantage by, and are **not required** to participate in a:

- Pre-enrollment interview or developmental screening process.
- Optional services that require a fee (e.g., extended care hours, summer programs, and/or special classes).

Moreover, it is the policy of the NYC Public Schools to provide equal educational opportunities in accordance with applicable laws and regulations and without regard to actual or perceived race, color, religion, age, creed, ethnicity, national origin, alienage, citizenship status, disability, sexual orientation, gender (including actual or perceived gender identity, gender expression, pregnancy/conditions related to pregnancy or childbirth), or weight and to maintain an environment free of harassment on the basis of any of the above protected classifications, including sexual harassment and retaliation.

- Your child may not be denied enrollment in a 3-K or Pre-K seat or denied other educational opportunities for any of the reasons listed above.
- You may not be required to participate in religious activities as a condition of participation in your 3-K or pre-K program. You will not gain any advantage in your program by participating in any religious activities.

If you have questions or concerns, please contact earlychildhoodpolicy@schools.nyc.gov.

______________________________ Parent/Guardian Signature

______________________________ Vendor Representative Signature

Date: ________________________

NYC Public Schools

New York City Early Childhood Education (3-K and Pre-K) Program Registration Form – Returning Student

School Day and School Year Services

Directions

Please print clearly in blue or black ink or complete this form electronically. To be eligible to register for Pre-K or 3-K, students and caregivers must reside within the five boroughs of New York City. Please be prepared to provide current or updated proofs of residence along with this registration packet.

UPDATED STUDENT INFORMATION

Last Name	First Name	Date of Birth

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 NYCEECs/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) ☐ 3-K SDY ☐ Pre-K SDY ☐ Pre-K HD	First Day of Attendance
	Official Class Code

Supplementary Documents:	Date Received
Proof of Residence 1: *(type)*	
Proof of Residence 2: *(type)*	
Parental Consent to Photograph, Film, or Videotape a Student for Non-Profit Use	
Child and Adolescent Health Examination Form	

CACFP
Child and Adult Care Food Program
New York State Department of Health

CACFP Agreement # 3410

DAY CARE CENTER ENROLLMENT FORM

Center Name: **BRYAN'S EDUCATIONAL CENTER**

Child's Name: ____________________

Male _____ Female _____ Date of Birth _______ Home Phone ____________

Home Address ____________________

Mother/Guardian Name ____________________

Father/Guardian Name ____________________

Parent/Guardian Address and Phone, if different ____________________

In case of emergency, notify ____________________ Phone ____________

Second person to notify ____________________ Phone ____________

Physician's name ____________________ Phone ____________

TIME MEALS SERVED

Breakfast _____ am to _____ am Lunch _____ am/pm and _____ pm Afternoon Snack _____ pm to _____ pm

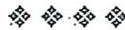
If your child is in care during these times, he/she will receive the meal or snack that is being served.

What days will your child usually be at the center? M____ Tu____ W____ Th____ F____ Sat____ Su____

What hours will your child usually be at the center? Arrive ________ ☐am ☐pm

Depart ________ ☐am ☐pm

Signature of a parent/guardian ____________________ Date ____________



After 1 year of care

Is all the information above still correct? Yes ________ No ________

If no, what has changed? ____________________

Signature of a parent/guardian ____________________ Date ____________

Income Eligibility Form for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME ______________________________

Print the name of the child(ren) enrolled in this child care center

1.______________ 2.______________ 3.______________

DIRECTIONS

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case #______________________

TANF #______________________

FDPIR #______________________

Names of Foster Children ______________________
____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature______________________

Date______________

FOR SPONSOR USE ONLY

CACFP Agreement #______________

Total Number of Household Members______________ (INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $______________

Free__________ Reduced__________ Paid__________

Date of Determination______________

Signature of Center Staff______________

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

	HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$
7.		$

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature______________________

Print Name______________________

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER [ ][ ][ ][ ] DATE______________

USDA is an equal opportunity provider and employer.

Department of Education

EMERGENCY CONTACT CARD

SCHOOL YEAR 20__ __ - 20 __ __

STUDENT INFORMATION

Student Last Name
Student First Name
M.I.

Date of Birth (mm/dd/yyyy)
Gender
OSIS ID #

Parent/Guardian Last Name (Student resides with)
Parent/Guardian First Name
Relationship

Parent's Preferred Language of Communication (Written)
Parent's Preferred Language of Communication (Oral)

Home Telephone
Work Telephone
Cell Phone

Email

Address (House Number)
Apartment #

City
N Y
State
Zip Code
Borough

Other Parent/Guardian Last Name
Other Parent/Guardian First Name
Other Relationship

Other Parent/Guardian's Preferred Language of Communication (Written)
Other Parent/Guardian's Preferred Language of Communication (Oral)

Other Home Telephone
Other Work Telephone
Other Cell Phone

Other Email

Other Address (House Number)
Other Apartment #

Other City
N Y
State
Other Zip Code
Other Borough

EMERGENCY CONTACTS

List below names of three (3) persons who may be called in case of emergency or if child is sick in school.

CHILD WILL BE RELEASED ONLY TO PERSONS NAMED ON THIS CARD.

Name	Telephone	Relationship

NO ACCESS

If there is a person who may **NOT HAVE ACCESS** to child, please indicate:

Name	Relationship	Order of Protection Exists?
		☐ Yes ☐ No

IMPORTANT- PLEASE COMPLETE NEXT PAGE >>>

Updated: 07/16/20

HEALTH INFORMATION

Name of Physician/Clinic: ______________________ Telephone ______________

Health Alert

Does child have any health condition that may affect participation in physical activities? ☒ Yes ☐ No

Limitations ______________________ (e.g., stair climbing, participation in gym)

Allergies ______________________

504 services for the current year? ☒ Yes ☐ No Previous Years? ☒ Yes ☐ No

My child has (X any that apply): ☐ Private health insurance ☐ Medicaid ☐ No health insurance

If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? ☒ Yes ☐ No

If none of the named contacts can be reached, what do you wish the school to do if your child is sick or injured?

____

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail.
The recommendation of the parent as indicated above will be respected as far as possible.

SIBLINGS

Sibling's Last Name	Sibling's First Name	Sibling's School of Attendance

SIGNATURE OF PARENT/GUARDIAN

Principal will be notified in writing of any changes to information on this card ______________________

Signature of Parent/Guardian

FOR SCHOOL USE ONLY

To be completed by school staff only.

Grade ____________ Class ____________ Room No. ____________ Teacher ____________

List below contacts made for emergency, illness or injury. Relevant records from Health Record ______________

Date	Contact	Reason	Disposition

Authorized Escorts List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/ guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/ guardian as a person who is authorized to escort a child out of the center.

Instructions: *The parent/ guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized escort information.*

I, ____, authorize this child care center to release my child,
(parent/ guardian name)

____, to the individuals I have identified below.
(child name)

Name:		
Relationship to child:		
Home address:		
Preferred contact:	☐ Mobile/Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Text (Mobile) ☐ E-mail	
Telephone:	*Mobile/Cell:*	
	Home:	*Work:*
E-mail:		

Name:		
Relationship to child:		
Home address:		
Preferred contact:	☐ Mobile/Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Text (Mobile) ☐ E-mail	
Telephone:	*Mobile/Cell:*	
	Home:	*Work:*
E-mail:		

Parent/ Guardian Signature: ____

Date: ____

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.

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 if 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

DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__
Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Polio	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hep B	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Hib	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
PCV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
Influenza	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	

Tdap	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	__/__/__
Mening ACWY	__/__/__	__/__/__	__/__/__
Hep A	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__
Mening B	__/__/__	__/__/__	__/__/__
Other	__/__/__		__/__/__

IgG Titers	Date
Hepatitis B	__/__/__
Measles	__/__/__
Mumps	__/__/__
Rubella	__/__/__
Varicella	__/__/__
Polio 1	__/__/__
Polio 2	__/__/__
Polio 3	__/__/__

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems *(list)* ICD-10 Code

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)*

Follow-up Needed ☐ No ☐ Yes, for ____ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ____

Health Care Practitioner Signature | Date Form Completed ___/___/___ | DOHMH ONLY PRACTITIONER I.D. ☐☐☐☐☐☐☐

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State | TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s) Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip | Date Reviewed: ___/___/___ I.D. NUMBER ☐☐☐☐☐☐☐ REVIEWER:

Telephone | Fax | Email | FORM ID# ☐☐☐☐☐☐☐☐☐☐

Bryan's Educational Center

3924 Church Avenue Brooklyn • New York 11203

Phone: (718) 282-6944 Fax: (718) 282-8074

www.bryanseducationalcenter.com

SUPPLY LIST

Preschool Supplies (age 2)
2 Composition books
1 Pack of jumbo pencils
1 Box of Jumbo crayons
1 Pack of markers
1 Pack of construction paper
Clear sheet protectors
1 Crib sheet set
Pull ups that opens on the side for children not potty trained
1 Box Ziploc Bags (gallon size)
2 change of weather appropriate clothes (tops, bottoms, underwear, socks)
Baby wipes (once per month)
1 bottle of hand sanitizer

3K Donation List
2 Composition books
2 plastic pocket folders
1 pack of jumbo pencils
2 boxes of tissue (monthly)
A set of crib sheets (1 fitted sheet, 1 flat sheet or thin blanket)
Pull ups that opens on the side for children not potty trained (as needed)
2 change of weather appropriate clothes (tops, bottoms, underwear, socks)
1 packages of wipes (monthly)
1 pack of sheet protectors
1 bottle of hand sanitizer (monthly)
1 box of Ziploc bags

4K Donation List
2 Composition books
2 plastic pocket folders
2 pack of jumbo pencils
2 boxes of tissue (monthly)
A set of crib sheets (1 fitted sheet, 1 flat sheet or thin blanket)
Pull ups that opens on the side for children not potty trained (as needed)
2 change of weather appropriate clothes (tops, bottoms, underwear, socks)
1 packages of wipes (monthly)
1 pack of sheet protectors
1 bottle of hand sanitizer (monthly)
1 box of facial tissue
1 box of Ziploc bags

Kindergarten
3 Composition books
3 Pocket Folders
2 packs of pencils
Crayons (box of 24)
1 pack of markers
1 bottle of glue
Clear sheet protectors
Index cards
Ziploc bags (sandwich and gallon size)
Erasers
Soft pencil case
Highlighters
1 pack of sticky notes
1 sheet for quiet time
1 box of facial tissue (monthly)
Baby wipes
Kindergartners will incur a book fee. The fee is TBA

*updated 2024

Department of Education

Pre-Registration Checklist

Be sure to bring the following when you pre-register for school.

- ❑ Proof of your child's age (child's birth certificate, passport, or record of baptism),
- ❑ Your child's immunization records (if available),
- ❑ Your child's latest report card/transcript (if available), and
- ❑ Two (2) of the documents below verifying proof of address:
  - ❑ Lease agreement, deed, mortgage statement for the residence;
  - ❑ A residential utility bill (gas or electric) in the resident's name issued by a utility company (such as National Grid or Con Edison) — must be dated within the past 60 days;
  - ❑ A bill for cable television services provided to the residence; must include the name of the parent and the address of the residence and be dated within the past 60 days;
  - ❑ Documentation or letter on letterhead from a federal, state, or local government agency, including the IRS, the City Housing Authority, the federal Office of Refugee Resettlement, the Human Resources Administration, or the Administration for Children Services (ACS), or an ACS subcontractor, indicating the resident's name and address — must be dated within the past 60 days;
  - ❑ A current property tax bill for the residence;
  - ❑ A water bill for the residence — must be dated within the past 90 days;
  - ❑ Rent receipt which includes the address of residence — must be dated within the past 60 days;
  - ❑ State, city, or other government issued identification (including an IDNYC card), which has not expired and includes the address of residence;
  - ❑ Income tax form for the last calendar year;
  - ❑ Official NYS Driver's License or learner's permit, which has not expired;
  - ❑ Official payroll documentation from an employer issued within the past 60 days, such as a paystub with home address, a form submitted for tax withholding purposes, or payroll receipt (a letter on the employer's letterhead is not adequate) — must include home address and be dated within the past 60 days;
  - ❑ Voter registration documents, which include the name of the parent and the address of residence;
  - ❑ Unexpired membership documents based upon residency (such as neighborhood residents' association), which include the name of the parent and the address of residence;
  - ❑ Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers; documents must have been issued within the past 60 days and include name of student and address of residence.

Note for Students in Temporary Housing

Students in temporary housing, as defined by McKinney-Vento, are not required to submit documentation (including address, proof of date of birth, and immunization) in order to enroll. Schools must provisionally pre-register the student and then work with the students in temporary housing DOE contact to obtain documentation.