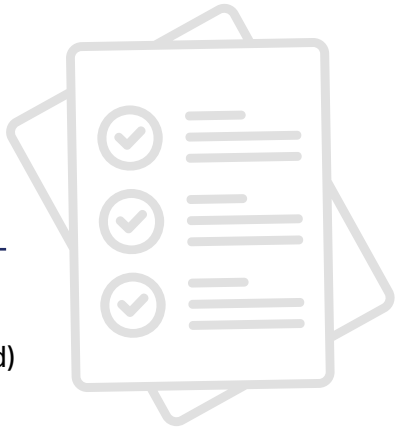
Registration Checklist



Bring these items when registering your child for school:

- ☐ **Proof of your child's age** (birth certificate, passport, or baptism record)
- ☐ **Your child's immunization records** (if available)
- ☐ **Your child's latest report card/transcript** (if available)
- ☐ **Two (2) of the below proofs of address.**
  Documents should include your name and address.
  - ☐ Lease agreement, deed, or mortgage statement
  - ☐ Residential utility bill (gas or electric) issued by a utility company (such as National Grid or Con Edison dated within the last 60 days)
  - ☐ Bill for cable television services provided to the residence (dated within the last 60 days)
  - ☐ Documentation or letter from a government agency (on official letterhead), including the Internal Revenue Service (IRS), the NYC Housing Authority, the Office of Refugee Resettlement, the Human Resources Administration, the Administration for Children's Services (ACS), or an ACS subcontractor (dated within the last 60 days)
  - ☐ Current property tax bill
  - ☐ Water bill (dated within the last 90 days)
  - ☐ Rent receipt (dated within the last 60 days)
  - ☐ Government-issued identification, including an IDNYC card (not expired)
  - ☐ Last year's income tax form
  - ☐ New York State driver's license or learner's permit (not expired)
  - ☐ Pay stub or official payroll document from an employer such as a tax withholding or payroll receipt. A letter on the employer's letterhead is not adequate (dated within the last 60 days).
  - ☐ Voter registration documents
  - ☐ Membership documents based upon residency, such as neighborhood residents' association (not expired)
  - ☐ Evidence of custody of the child, including but not limited to judicial custody orders or guardianship papers (issued within the last 60 days; must include student's name)

Note for Students in Temporary Housing

Students in temporary housing, as defined by the McKinney-Vento Act, 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 NYC Public Schools contact to obtain documentation.

New York City Public Schools Early Childhood Education Program Registration Form –

School Day Year and City Tax Levy Welcome Letter

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.

This registration packet must be completed and submitted to your early childhood program.

Important Note:

Your child's NYC Public Schools funded seat 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.
- Additional services that require a fee (e.g., extended care hours, technology, summer programs, and/or special classes).

Moreover, it is the policy of 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 your contracted seat or denied other educational opportunities at your program for any of the reasons listed above.
- You may not be required to participate in religious activities as a condition of participation in your program. You will not gain any advantage in your program by participating in any religious activities.

If you have questions or concerns, or if you believe your program has violated these expectations, please contact earlychildhoodpolicy@schools.nyc.gov.

Child's name: _____

Parent/Guardian Signature: _____
(under no circumstances may vendors sign on behalf of parents/guardians)

Vendor Representative Signature: _____
(vendors must retain a copy of the signed letter in each student's file)

Date: _____

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

School Day and School Year / City Transitional Services

Directions

Please print clearly in blue or black ink, **or** complete this form electronically. In order 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 proof of residence along with this registration packet. This packet may also be used for Birth-to-Two City Transitional (Infant CTL and Toddler CTL) and Pre-K Half Day enrollments.

Section 1. STUDENT INFORMATION			
Last Name	First Name		Date of Birth
Current Address (Building #, Street)			Apt #
City	State	Zip Code	Gender (optional)

Section 2. 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	

Section 3. 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	

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

Section 4. 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 because 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

Section 5. FEDERAL PARENT OR GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

Dear Families and Caregivers,

Federal law requires the New York City Department of Education to collect and record the ethnic identity and race of public school students, including those participating in City-funded contracted care. This information is kept confidential in accordance with the Family Educational Rights and Privacy Act (1974) and Chancellor's Regulation A-820, which prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

To fulfill this data-collection requirement we need your help. Please respond to the ethnicity and race questions below. 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. If you identify more than one race for your child, your child will be counted in a "two or more races" category. Hispanic students of all races will be counted in the Hispanic category.

The NYCDOE and our contracted programs understand the sensitive nature of this process. The options provided by the federal government may not allow for an accurate or complete portrayal of your child'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 that the NYCDOE or its contracted program's staff make an identification of your child on your behalf.

Children may not be refused admission or enrollment to a program because of race, color, creed, national origin, gender (sex), gender identity, pregnancy, alienage, citizenship status, disability, sexual orientation, religion, weight or ethnicity.

Thank you for your cooperation.

Question 1: Is the student Hispanic, Latino or of Spanish origin? The Federal Government defines "Hispanic, Latino, or of Spanish origin" as 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
Question 2: Please check all boxes from the provided racial categories that apply to the student. All definitions are derived from the U.S. Census.	
☐	**American Indian or Alaskan Native** – a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
☐	**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.
☐	**Native Hawaiian or Pacific Islander** – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐	**Black** – a person having origins in any of the Black racial groups of Africa
☐	**White** – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Parent/Guardian Signature	
Signature	Date

Section 6. FOR CBO USE ONLY			
Program Name		Site ID	
Student Seat Type (check only one) ☐ 3-K SDY ☐ Pre-K SDY ☐ Pre-K HD ☐ B-2 CTL		First Day of Attendance	
		Official Class Code	

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

Section 7. HOME LANGUAGE SURVEY

Dear Families and Caregivers,

This survey is part of your child's enrollment package and provides your new program with important information about your family's language needs. Please return this form to your program administrator.

Student: Last Name	First Name	Today's Date

Person Completing Survey: Last Name First Name

Relationship to Student

Program Name

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

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** **Last Name** **First Name** | **Email**
□ **Foster Parent**

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 in 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	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

TYPE OF EXAM: □ NAE Current □ NAE Prior Year(s)
Comments:

Date Reviewed: ____/____/____ **I.D. NUMBER**
REVIEWER:

FORM ID#

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.

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

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.

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 _____

CENTER

NAME:

ADDRESS:

BORO:

318K (REV. 8/02)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ____/____/____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME: (Last) (First) (Middle)	SEX F ☐ M ☐	DATE OF BIRTH Country/State of Birth
ADDRESS: (No.) (Street) (City/Boro) (State) (Zip)		
MOTHER'S NAME: (First) (Last) FATHER'S NAME: (First) (Last)		TELEPHONE NO Home: Work:
FOSTER PARENT		
FOSTER AGENCY ADDRESS TELEPHONE #		
LANGUAGE SPOKEN IN HOME		

PERSON/S TO CONTACT IN CASE OF EMERGENCY *(Other Than Parent)*	
NAME	RELATIONSHIP TO CHILD
ADDRESS	TELEPHONE NO. Home: Work:

*NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY		IS CHILD ALLERGIC TO ANY:
(____) Sickle Cell	(____) Heart Disease	(____) Medications *(Specify)*
(____) Diabetes	(____) Hypertension	(____) None
(____) Convulsive Disorder	(____) Tuberculosis	(____) Foods *(Specify)*
(____) Allergies *(Specify)*	(____) Vision	(____) Insect Bites
(____) OTHER *(Specify)*	(____) Hearing	(____) OTHER

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS (Long term or chronic)	AGE IT BEGAN	TREATMENT/MEDICATIONS
1.		
2.		
3.		
4.		
5.		

I, _____ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT *(REQUIRED FOR ADMISSION TO DAY CARE)*

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED _____ DATE _____ RELATIONSHIP _____

Subscribed and sworn to before me this _____ day of _____ 19 _____

_____ _____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

NYC Health | Department of Health and Mental Hygiene | Department of Education

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

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 *(at each well child exam, 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 ☐ | Please attach lab reports

IMMUNIZATIONS – DATES

DTP/DTaP	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Td	___/___/___	___/___/___	___/___/___
Tdap	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___	___/___/___
Polio (IPV or OPV if before 4/1/2016)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Varicella	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening ACWY	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Hep A	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Rotavirus	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Mening B	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Other _____	___/___/___	_____	___/___/___

	Positive IgG	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#