NYC Department of Education

Student Registration Form

For Official Use		
☐ ES	☐ MS	☐ HS
☐ GE	☐ SE	☐ ELL

To Be Completed by Parent/Guardian:

Student Information

LAST NAME	FIRST NAME	MIDDLE NAME	STUDENT ID #

HOME ADDRESS (House number, Street name, Apt #, City, State, ZIP)	HOME PHONE NUMBER ( )

DATE OF BIRTH (mm/dd/yyyy)	AGE	GENDER (optional) M ☐ F ☐	PLACE OF BIRTH	HOME/NATIVE LANGUAGE

NAME, CITY, STATE OF LAST SCHOOL (or current school)	LAST GRADE COMPLETED

HEALTH INSURANCE INFORMATION: Does the student have health insurance?	HEALTH ALERT: Any health condition that affects participation in physical activities.
☐ 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	☐ Yes ☐ No

SPECIAL EDUCATION INFORMATION: Does the student receive special education services?

☐ YES ⇨ If YES, do you have a copy of the Individualized Education Plan (IEP)? ☐ Yes ☐ No

☐ NO

Parent/Guardian Information

LAST NAME	FIRST NAME	RELATIONSHIP TO STUDENT

HOME ADDRESS (House number, Street name, Apt #, City, State, ZIP)	PARENT/GUARDIAN PREFERRED LANGUAGE WRITTEN: SPOKEN:

HOME PHONE NUMBER	WORK/CELL PHONE NUMBER	PARENT/GUARDIAN EMAIL
( )	( )	

To Be Completed by Enrollment Staff:

Registration (check one):
- ☐ New
- ☐ Re-admit to NYC DOE (less than 1 year)
- ☐ Re-admit to NYC DOE (longer than 1 year)
- ☐ Code 10 Return (If Code 10 Return):
  - ☐ Student has current transcript
  - ☐ Transcript request made to out-of – New York City school

Transfer Request (check one):
- ☐ Safety
- ☐ Medical
- ☐ Travel (HS only)
- ☐ Child Care (ES only)
- ☐ Sibling (ES only)
- ☐ Other (please specify):

Notes:

Disposition:

_____ _____
Enrolled School Name DBN

Referred to:

School Name DBN

1) _____ _____

2) _____ _____

3) _____ _____

I have met with a counselor and understand my options and the process for school placement. I understand the information presented and have received the information necessary to proceed.

Name/Signature of Parent/Guardian: _____ **Date:** _____

Name/Signature of Counselor: _____

Additional Comments: _____

STUDENT NAME: LAST FIRST DATE:

The New York City Department of Education
Parent/Guardian Home Language Identification Survey

Dear Parent or Guardian,

In order to provide your child with the best education possible, we need to determine how well he or she understands, speaks, reads, and writes English. In order to keep you informed, we would like to know your language preference when receiving important information from the school. Your assistance in answering the questions below is greatly appreciated.

Thank you.

PART 1. NYSITELL ELIGIBILITY This information provided below will be used along with other information provided to determine your child's home language and eligibility for the New York State Identification Test for English Language Learners (NYSITELL). Check (√) the box that applies. If another language is used, please specify.

1. What language(s) does the child understand?
☐ English ☐ Specify other language(s): _____
2. What language(s) does the child speak?
☐ English ☐ Specify other language(s): _____
3. What language(s) does the child read?
☐ English ☐ Specify other language(s): _____ ☐ Does not read
4. What language(s) does the child write?
☐ English ☐ Specify other language(s): _____ ☐ Does not write
5. What language is spoken in the child's home or residence most of the time?
☐ English ☐ Specify other language(s): _____
6. What language does the child speak with parents/guardians most of the time?
☐ English ☐ Specify other language(s): _____
7. What language does the child speak with brothers, sisters, or friends most of the time?
☐ English ☐ Specify other language(s): _____
8. What language does the child speak with other relatives or caregivers (e.g., babysitters) most of the time?
☐ English ☐ Specify other language(s): _____

PART 2. PRIOR EDUCATIONAL INFORMATION Responses to these questions will be used for instructional planning. Enter the information for each of the following questions concerning your child.

1. Is this the first time the child has attended a school in the United States? ☐Yes ☐No If NO, answer questions below:
• Where did he/she go to school?
• How long did he/she attend school?
o How many hours each day?
o How many years of school did he/she attend?
• Which language was used for instruction?
• Has there ever been a time when your child missed school for an extended time? If yes, please describe.
2. Has the child attended school in another country? ☐Yes ☐No If YES, answer questions below:
• Where did he/she go to school?
• How long did he/she attend school?
• Which language was used for instruction?
3. Did the child participate in any group experience prior to entering school (e.g., daycare, pre-school)? ☐Yes ☐No If YES, what language was used? _____
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, specify: _____

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. In what language would you like to receive written information from the school?
2. In what language would you prefer to communicate orally with school staff?

Student Name (last, first):_____

Parent/Guardian Signature_____ Date_____

Student Name (last, first):_____

The New York City Department of Education
Parent/Guardian Home Language Identification Survey

TO BE COMPLETED BY SCHOOL PERSONNEL
Please do not place student information sticker on this form

District: _____ Borough: _____ School Number: _____ Date: _____

Student Last Name: _____ Student First Name: _____

Student ID#: _____ Grade: _____ Official Class: _____

RELATIONSHIP OF PERSON PROVIDING INFORMATION FOR SURVEY (check one):
☐ Mother ☐ Father ☐ Guardian

☐ Self (Student 18 years or older) ☐ Other (specify): _____

MANDATED INTERVIEW WITH STUDENT AND PARENT (Interview must be in English and, if applicable, the parent's preferred language)

☐ English ☐ Specify home language: _____

Print full names and titles of trained pedagogue(s) conducting interview in English and home language with student and parent:

Last, First Name	Title	Last, First Name	Title
Last, First Name	Title	Last, First Name	Title

If an interpreter other than the above pedagogue(s) is used, print full name and title or relationship to student, if applicable.

Last, First Name _____ Title/Relationship _____

☐ Check here if over-the-phone Translation & Interpretation Unit services were used in lieu of school-based personnel.

TWO-LETTER OTELE ALPHA CODE

NYSITELL-ELIGIBILITY
Print full name and title of trained pedagogue determining NYSITELL eligibility (if student has an IEP, indicate date the *Language Proficiency Team NYSITELL Determination Form* was sent to the Language Proficiency Team). NOTE: Only students whose home language is other than English are eligible for NYSITELL-eligibility determination.

Last, First Name _____ Title _____

Signature _____ Date _____

Eligible for NYSITELL testing: ☐ YES ☐ NO
☐ Check here if this student has an IEP. Date *Language Proficiency Team NYSITELL Determination Form* was sent to LPT: _____

FURTHER SIFE SCREENING
Is the student eligible for further SIFE screening? (OTELE Code must be other than "NO")

☐ YES ☐ NO

Department of Education

Federal Parent/Guardian Student Ethnic and Race Identification

(PSE Form)

To the Parent or 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 safe and private.

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 gives you a chance to share if your child is of Hispanic, Latino, or Spanish origin. The second question gives you a chance to share your child's race or races. The federal government provides the options that you will choose from. Please respond to both questions.

We understand the sensitive nature of this process. The options may not represent a perfect or complete portrayal of your family's own ethnic or race identification. We encourage you to select the options using your best judgment. If you choose not to answer, federal guidelines require New York City Department of Education school staff to respond on your behalf.

Race and ethnicity information for students is protected by the confidentiality regulations cited at the bottom of this page.[1]

Thank you for your cooperation.

Directions for parents and guardians:
Please complete the form on the other side of this page and return it to your child's school.

Directions for school staff:
File the completed form in the student's cumulative folder as confidential information.

[1] **Confidentiality Procedures and Regulations:** the Family Educational Rights and Privacy Act (FERPA) 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.

NYC Department of Education

Federal Parent/Guardian Student Ethnic and Race Identification

- All students between 5 and 21 years of age have the right to a free and 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 identify, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.[2]

SCHOOL STAFF: PLEASE COMPLETE THIS SECTION

Student Name: _____
(Last name, first name, middle initial)

Date of Birth: __ __/__ __/__ __
(Month/Day/Year)

Name of School: _____

District Borough Number: __ __ __ __ __ __

Grade level: _____

Official Class Code: __ __ __

NYC Student Identification Number: __ __ __ __ __ __ __ __ __

PARENT OR GUARDIAN: PLEASE COMPLETE THIS SECTION

Please answer **both** questions 1 and 2. Please read them before you respond.

For question 1, mark 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 America, or other Spanish culture or origin, regardless of race.

   ◯ **YES, Hispanic**

   ◯ **NO, not Hispanic**

*For question 2, mark **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 ◯ Other (specify): _____

◯ Guardian ◯ School Staff Observer (name): _____

[2] 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.

NYC Department of Education

Chancellor's Regulation A-101
Housing 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. The district cannot disclose housing status information without parental consent.

Student Name & Information:

Last Name	First Name	Middle Name

OSIS Number	Date of Birth (MM/DD/YY)	School

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

Check (√)	Housing 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
○	**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:

☐	**Unaccompanied Youth** - Youth who is not in the physical custody of a parent or guardian	**(School Use Only) Enter "Y" if Applicable**

Parent/Guardian (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".

EMERGENCY CONTACT CARD (Print Information)

SCHOOL YEAR 20_____ Student ID:_____

Student Last Name_____**First**_____**DOB**_____**Sex**_____

Parent/Guardian (student resides with)_____Relationship_____Contact number/s_____

Other Parent/Guardian_____Relationship_____Contact number/s_____

Parent's preferred Language of Communication: Written_____Verbal_____

Student Address_____Zip_____Preferred email_____

OTHER THAN PARENT/GUARDIAN, CHILD WILL BE RELEASED ONLY TO THE FOLLOWING PERSONS (additional names may be written on back):

Name_____Telephone_____Relationship_____

Name_____Telephone_____Relationship_____

Name_____Telephone_____Relationship_____

Name_____Telephone_____Relationship_____

If there is a person who MAY NOT have access to child, please indicate:

Name_____Relationship_____ Order of Protection Exists: yes_____ no_____

HEALTH ALERTS/ALLERGIES_____ NAME OF PHYSICIAN_____Phone_____

Does child have any health condition that may affect participation in physical activities? Yes_____no_____

Notes/Comments:_____

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

_____

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	☐ Seizure disorder
☐ Behavioral/mental health disorder	☐ Speech, hearing, or visual impairment
☐ Congenital or acquired heart disorder	☐ Tuberculosis (latent infection or disease)
☐ Developmental/learning problem	☐ Hospitalization
☐ Diabetes (attach MAF)	☐ Surgery
☐ Orthopedic injury/disability	☐ Other (specify) _____
Explain all checked items above.	☐ ***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
	☐	☐	Psychosocial Development	☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐ Abdomen
	☐	☐	Language	☐	☐	Dental	☐	☐	Lungs	☐	☐ Genitourinary
	☐	☐	Behavioral	☐	☐	Neck	☐	☐	Cardiovascular	☐	☐ Extremities

Nl	Abnl	
☐	☐	Skin
☐	☐	Neurological
☐	☐	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 ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/17/2023	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___

Report only positive immunity:

	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 ___/___/___

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

DOHMH ONLY PRACTITIONER I.D.

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

Comments:

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

REVIEWER:

FORM ID#