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:

NYC Department of Education

Chancellor's Regulation A-101
Housing Questionaire

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	☐	☐	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 ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

																IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		Tdap	___/___/___	___/___/___					Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___		MMR	___/___/___	___/___/___	___/___/___				Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/17/2023			Varicella	___/___/___	___/___/___	___/___/___				Mumps	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Mening ACWY	___/___/___	___/___/___	___/___/___				Rubella	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Hep A	___/___/___	___/___/___	___/___/___				Varicella	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Rotavirus	___/___/___	___/___/___	___/___/___				Polio 1	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Mening B	___/___/___	___/___/___	___/___/___				Polio 2	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Other ___	___/___/___	___/___/___					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# ☐☐☐☐☐☐☐☐☐☐

P.S.3 2023 - 2024 Bus Stops

Updated: 1/26/2023

Child's Name: _____ Grade: _____ Phone: _____

Address: _____ Parent's Signature: _____

_____ My Child will be a Walker in the AM ANDPM - NO BUS SERVICE NEEDED

My child will take bus _____AM _____ PM _____BOTH

*** Important: Select stop closest to your address on file. Times are approximate*

Check with driver for more accurate times

Intersection/Spot #	AM Time	Run #	Intersection/Spot #	PM Time	PM Color/Run #
Shotwell & Tyron/234	7:30	1033	Powell & Shift/321	3:24	Green/9089
Russek & Dogwood/235	7:35		Russek & Dogwood/235	3:28	
Powell & Shift/321	7:42		Shotwell & Tryon/234	3:08	
Lenevar & Ressselear/227	7:53		Collyer & Bland/422	2:56	
			Hanover & Seguine/403	2:44	
Colleyer & Bland/422	7:47	1293	Oswald & Seguine/401	2:56	
Bayview & Amboy/419	7:52				
			Foster & Darlington/207	2:45	Tan/9304
Marisa & Bloomingdale/125	7:31	1297	Aaron & Rossville/327	3:04	
Herrick & Bloomingdale/130	7:37		Lenevar & Rennselear/227	2:49	
Outerbridge & Blooming/110	7:53				
Winant & Wirt/318	7:23		Blooming & Outerbridge/110	2:40	Blue/9084
Veterans & Pheasant/128	7:43		Bloomingdale & Herrick/130	2:43	
Aaron & Rossville/7:21	7:16		Bloomingdale & Marisa/125	2:51	
			Veterans & Pheasant/128	2:46	
Hylan & Indale/421	7:47	1089	Winant & Wirt/318	2:57	
Everett & Vail/602	7:50				
Excelsior & Bayview/418	7:52		Hylan & Indale/421	2:40	Pink/9259
Commadore & Johnston/7501	7:44		Bayview & Amboy/419	2:48	
			Evertt & Vail/602	2:43	
Keating & Ormsby/412	7:37	1122	Excelsior & Bayview/418	2:46	
Melville & Seguine/405	7:41		Commadore & Johnston/7501	2:44	
Oswald & Seguine/401	7:51				
Hanover & Seguine/403	7:45		Melville & Seguine/405	2:48	Orange/9298
Van Wyck & Marscher/406	7:35		Keating & Ormsby/412	2:46	
			Van Wyck & Marscher/406	2:50	
Foster & Darlington/207	7:17	1315			
Foster & Bradford/209	7:19		Uncas & Clearmont/105	2:40	Yellow/9295
Bradford & Minturn/104	7:28		Foster & Bradford/209	2:44	
Uncas & Clearmont/105	7:31		Bradford & Minturn/104	2:42	
P. Plains & Hallister/114	7:53		Foster & Valdemar/210	2:46	
Foster & Valdemar210	7:23				
Goff & Vogel/322	7:39		Craig & Fisher/505	3:30	Red/9293
Emerald & Drumgoole/127	7:48		Hylan & Main/501	3:22	
			Emerald & Drumgoole/127	2:51	
Craig & Fisher/505	7:26	2501	P. Plains & Hallister/114	2:53	
Main & Hylan/501	7:43		Goff & Vogel/322	2:40	
Bedell & Belverder/604	7:43		Bedell & Belverder/604	3:10	