Student Enrollment Packet Checklist

Welcome to the Neighborhood Charter School of Harlem! Enclosed are registration forms and a list of documents required for your child to be enrolled in our school. If you have any questions, please feel free to call the office at 646-701-7117 or email info@NCSHarlem.org.

- ☐ Proof of Residency – *Please provide **two** of the following documents*
  - Residential utility, property tax or water bill (past 60 days)
  - 2011 W-2 Form or an official payroll documentation (past 60 days)
  - Document from federal, state or city agency (past 60 days)
  - Deed to a house, mortgage or lease agreement
- ☐ Verification of Legal Name and Age
  - Birth certificate or passport
- ☐ Student Enrollment Form
- ☐ Media Release Form – *Please sign and return*
- ☐ Field Trip Release Form – *Please sign and return*
- ☐ Academic History
  - Authorization for Release of Information – *Please sign and return*
  - Transcript/Report Cards
- ☐ Transportation Request Form – *Please sign and return*
- ☐ Medical Information – *Please sign and return*
  - First Aid Release Form
  - Student Medical History Form
  - Child and Adolescent Health Examination Form. ***Please return by August 1.***
  - Medication Administration Form – Should be completed for requests involving administration of medication for students (e.g., asthma, allergies, diabetes, etc.). For cases of asthma, providers may attach an Asthma Action Plan with the MAF. ***Please return by August 1.***
- ☐ Home Language Identification Survey – *Please sign and return*
- ☐ Student Ethnic Identification Survey – *Please sign and return*
- ☐ Residency Questionnaire – *Please sign and return*
- ☐ Legal Documents (custody, power of attorney, protection orders)
- ☐ Special Education Information (if applicable)
  - Current IEP
  - Current 504 plan

The Neighborhood Charter School of Harlem

Student Enrollment Form

Student Information

Student's Name (Legal) _____
First Name Middle Name Last Name

Residence Address _____
Number Street Apt

_____
City State Zip

Mailing (if different) _____
Number Street Apt

_____
City State Zip

Date of Birth _____ / _____ / _____ Grade Entering _____

Name of most recent school attended: _____

Student lives with (check all that apply):

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandmother ☐ Grandfather ☐ Legal Guardian
☐ Shelter ☐ Other _____

Race/Ethnic Background:

☐ American Indian ☐ African American ☐ Asian ☐ American ☐ Hispanic ☐ White
☐ Other (Please Specify) _____

Gender: ☐ Male ☐ Female

National School Lunch Program: (Please note this information is not required and will only be used to determine school funding)

Does your child currently participate in the National School Lunch Program? ☐ No ☐ Yes

Does your child currently qualify for free/reduced price lunch? ☐ No ☐ Yes

Special Education Services (if YES, please attach evaluations to this form):

Has the student ever been identified as a special education student? ☐ No ☐ Yes

Does the student have a current IEP or 504? ☐ No ☐ Yes

Student Enrollment Form (Page 2)

Parent/Guardian Information

Mother's Full Name _____ Cell Phone: (_____) _____-_____

Address _____ Home Phone: (_____) _____-_____

Employer _____ Business Phone (_____) _____-_____

Email Address _____

Father's Full Name _____ Cell Phone: (_____) _____-_____

Address _____ Home Phone: (_____) _____-_____

Employer _____ Business Phone (_____) _____-_____

Email Address _____

Stepparent's, Legal Guardian's, or Sponsor's information (if applicable)

Full Name _____ Cell Phone: (_____) _____-_____

Address _____ Home Phone: (_____) _____-_____

Employer _____ Business Phone (_____) _____-_____

Email Address _____ Relationship _____

Other Information

How did you hear about The Neighborhood Charter School of Harlem? (check all that apply)

☐ Direct Mail/Postcard ☐ Word of Mouth ☐ Internet ☐ A Flier

☐ Other (Please Specify): _____

Parent/Legal Guardian _____ Date _____
Please Print

Parent/Legal Guardian _____ Date _____
Signature

Media Release Form

I hereby give my consent to the use of any photographs/video tape, audio recordings, and/or video recordings taken of my child by The Neighborhood Charter School of Harlem or the media for the purpose of advertising or publicizing events, activities, facilities and programs of The Neighborhood Charter School of Harlem in newspapers, newsletters, website, television, radio and other communications and advertising media. I also hereby release The Neighborhood Charter School of Harlem and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Please check one of the boxes below.

☐ Yes, I give my consent for my child to be interviewed, identified, and/or photographed/filmed for use in various publications and media including, but not limited to, websites, brochures, newspapers, magazines, videos, films, radio, and television. I understand this consent applies throughout the time my child is an enrolled student at The Neighborhood Charter School of Harlem.

☐ No, I do not give my consent.

Name of child _____

Parent/Guardian name _____

Parent/Guardian signature _____

Date_____

Field Trip Consent Form

At The Neighborhood Charter School of Harlem, we believe field studies are an important part of our curriculum. We are lucky to live in New York City where there are many opportunities to visit museums, parks and performance art institutions. In the 2012/2013 school year, we plan to take all students on field trips that will reinforce what they study in the classroom and provide a meaningful learning experience. We will send home information about each field trip for your review.

☐ Yes, I give my consent for my child to go on walking field trips within 5 blocks of the school. I understand I will be required to sign a permission slip for all field trips outside of the 5-block radius.

☐ No, I do not give my consent.

Name of child _____

Parent/Guardian name _____

Parent/Guardian signature _____

Date_____

Authorization for Release of Information

To Whom It May Concern:

The following student has enrolled at our school. Please send all records including:

1. **Scholastic records** (attendance records, current quarter grades, report card, standardized test scores, remediation information, etc.)
2. **Special Education Services** (current psychological, IEP, 504).
3. Other pertinent information (custody information, court documents, IST referral, etc.)
4. **All Medical Records**
5. **All Disciplinary records**

Student's Name _____ DOB _____ / _____ / _____

OSIS # (if known) _____

Name of Last School Attended _____

Mailing Address _____

_____

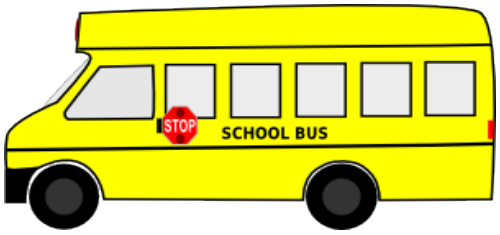
Please send requested records to:

The Neighborhood Charter School of Harlem
c/o NYC Charter Center
Attn: Sherita Smith
111 Broadway, Suite 604
New York, NY 10006

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____ Date _____

Transportation Request Form



Please be advised:

- The Department of Education does not allow students to receive both MetroCards and yellow bus service. You may only request one service.
- You must live at least one half mile from The Neighborhood Charter School of Harlem to be eligible for transportation.
    - Students not eligible for full fare transportation may be issued a half fare student MetroCard. Half fare MetroCards are good for use on buses only.
- You must reside in Manhattan to be eligible for yellow bus service.
- Yellow bus often serves multiple schools on one route, so your child will likely be on a bus with students from other schools.
- MetroCards and yellow bus service are provided at the discretion of the Office of Pupil Transportation, and The Neighborhood Charter School of Harlem has little control over eligibility and the routes assigned.

☐ If eligible, I would like yellow bus service for my child

☐ If eligible, I would like a MetroCard for my child

☐ I do not need yellow bus service nor a MetroCard for my child

Student Name _____

Parent/Guardian Signature _____ Date _____

First Aid Release Form

I authorize The Neighborhood Charter School of Harlem staff members who are trained in the basics of first aid and CPR to administer first aid and/or CPR to my child when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. If I cannot be reached or if the school determines that delay would be dangerous to my child's health, I hereby authorize the school's staff members to secure the necessary medical treatment for my child. If deemed necessary, emergency transportation will be arranged for all injuries and illnesses needing attention if the parent cannot be reached. The Neighborhood Charter School of Harlem will not be held responsible for transportation or hospital bills incurred as a result of this action and I hereby agree to indemnify The Neighborhood Charter School of Harlem against any such claim.

Emergency Contacts (Please provide the person or persons, other than the parents, who could be contacted in an emergency and/or pick up from school.)

Contact _____	Home Phone: (_____) _____-_____
Relationship to student _____	Cell Phone: (_____) _____-_____
Contact _____	Home Phone: (_____) _____-_____
Relationship to student _____	Cell Phone: (_____) _____-_____
Contact _____	Home Phone: (_____) _____-_____
Relationship to student _____	Cell Phone: (_____) _____-_____

Name of child _____

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____ Date _____

Student Medical History

Student's Name (Legal) _____
First Name Middle Name Last Name

Date of Birth _____ / _____ / _____ Grade Entering _____

Physician Information

Doctor's Name _____	Dentist's Name _____
Doctor's Phone Number _____	Dentist's Phone Number _____
Medical Insurance: ☐ No ☐ Yes	Dental Insurance: ☐ No ☐ Yes

Medicine Currently Taking

Past Medical History (Please include anything that will help us in providing health services to your child. For example, hospital stays, illnesses, broken bones, etc.)

Allergies

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____ Date _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY 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 | ☐ **Foster Parent**

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ **cm** (__ __ %ile)

Weight _____ **kg** (__ __ %ile)

BMI _____ **kg/m²** (__ __ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (__ __ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

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
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___ / ___ *Left* ___ / ___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus	__/__/__	__/__/__	__/__/__	__/__/__
DTP/DTaP/DT	__/__/__	__/__/__	__/__/__	__/__/__
	__/__/__	__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__		
Td	__/__/__	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__	
Meningococcal	__/__/__	__/__/__		
HPV	__/__/__	__/__/__	__/__/__	
Other, *specify:* _____	__/__/__	_____ ;		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

_____ __ __ __ __

_____ __ __ __ __

_____ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY **PROVIDER I.D.**

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

Comments

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

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian

NOTE: Parent signature required on reverse side of this form. Current photograph of student MUST be attached to upper left corner of this form.

MEDICATION ADMINISTRATION FORM

Authorization for Administration of Medication to Students for School Year 2012–2013

Student's Name *(Last, First, Middle)*	Male ☐ Female ☐	Date of Birth	I.D. Number

DOE District	School (PS, IS, etc. and Name)	Grade	Class	Borough

School Address	Zip Code

1. Diagnosis ASTHMA ☐ **Yes** ☐ **No**

Choose Severity:

☐ **Intermittent** ☐ **Moderate Persistent***
☐ **Mild Persistent*** ☐ **Severe Persistent***

***National guidelines recommend inhaled corticosteroids for children with persistent asthma.**

Stock supply only available for Ventolin HFA. ***(see back)***

Choose One:

☐ **Ventolin HFA (may be provided by school for shared usage).**

☐ _____ **HFA (to be provided by parent).**
ADD MEDICATION NAME

◯ **May substitute stock ventolin**
◯ **May not substitute stock ventolin**

INDICATE HOME MEDS IN BOTTOM LEFT BOX.

Choose all that apply

☐ **Standard order**. 2 puffs q 4 hrs. via MDI and spacer prn cough, wheeze, tightness in chest, difficulty breathing or shortness of breath. May repeat in 15 mins x 2 if no improvement (3 total).

☐ **Pre exercise**. 2 puffs via MDI with spacer 15-30 minutes before exercise.

☐ **URI or recent asthma flare** (within 3 days). 2 puffs @ noon via MDI inhaler and spacer for 3-5 days.

URI sx can include: Itchy watery eyes, nasal drainage and/or congestion, sneezing, sore throat, cough, headache
Asthma flare: sx can include: Shortness of breath, chest tightness or pain, coughing, wheezing

ICD9: _____

Instructions for lack of improvement or adverse reaction

If improved, but not enough to return to class, call parent. If significant respiratory distress persists, call 911 and notify parent and PMD. May provide additional puffs as needed until EMS arrives.

Choose all that are appropriate

☐ Student may carry medication and may self-administer. ***(PARENT MUST INITIAL REVERSE SIDE).***

☐ Store medication in medical room and student to self-administer under observation.

☐ Store medication in medical room and nurse to administer.

☐ Can this student self administer their personal MDI on school trips.
Check one: ☐ Yes ☐ No

2. Diagnosis: Anaphylaxis

Select One:

☐ EpiPen Auto-Injector: 0.3 mg/0.3 ml [1:1000]
☐ EpiPen Jr. Auto-Injector: 0.15 mg/0.3 ml [1:2000]

Intramuscularly into anterolateral aspect of thigh
911 will be called immediately

☐ **prn** _____
specific signs, symptoms or situations

Any repeats if no improvement? ☐ **Yes, in ____ mins, max ____ times**

ICD9: _____

Conditions under which medication should not be given:

_____
_____
_____

☐ Student may carry medication (includes epi pen and MDI) and may self-administer. ***(PARENT MUST INITIAL REVERSE SIDE).***
NOT FOR CONTROLLED SUBSTANCES.

☐ Store medication in medical room and student to self-administer under observation.

☐ Store medication in medical room and nurse to administer.

3. Diagnosis _____

_____
Medication/Preparation/Concentration

_____
Dose/Route

☐ Diagnosis substantially controlled with medication.
☐ Diagnosis not substantially controlled with medication.

☐ **Standing daily dose. Specify time(s):** _____

AND/OR

☐ **prn** _____
specific signs, symptoms or situations

Time interval: q ____ hours as needed

Any repeats if no improvement? ☐ **Yes, in ____ hr/mins, max ____ times**

ICD9: _____

Conditions under which medication should not be given:

_____
_____
_____

☐ Student may carry medication (includes epi pen and MDI) and may self-administer. ***(PARENT MUST INITIAL REVERSE SIDE).***
NOT FOR CONTROLLED SUBSTANCES.

☐ Store medication in medical room and student to self-administer under observation.

☐ Store medication in medical room and nurse to administer.

List medication(s) student takes at home and at what time:

_____
_____
_____

Health Care Practitioner (HCP) Name (PLEASE PRINT)

LAST NAME	FIRST NAME

HCP Signature

HCP/Clinic Address

Medicaid No. | **NPI No.**

HCP/Clinic Tel. No.	HCP/Clinic Fax No.	HCP/Email	NYS Registration No. (Required)	Date

FOR DOHMH USE: Revisions per DOHMH after consultation with prescribing provider

☐ **IEP**

_____
_____

INCOMPLETE PROVIDER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

MEDICATION ADMINISTRATION FORM (MAF): PARENT/GUARDIAN'S CONSENT AND AUTHORIZATION
2012-2013

I hereby authorize the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's physician. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I understand that if I provide an asthma inhaler, it must be supplied in its original and UNOPENED medication box. I further understand that I must immediately advise the principal and/or his/her designee(s) especially the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this Authorization is only valid until the earlier of: (1) June 28, 2013 (This prescription may be extended through August if the student is attending a New York City Department of Education (the "Department") sponsored summer instruction program); or (2) such time that I deliver to the principal or his/her designee(s) and nurse a new prescription or instructions issued by my child's physician regarding the administration of the above-prescribed medication. By submitting this MAF, I am requesting that my child be provided with specific health services by the Department and the New York City Department of Health and Mental Hygiene ("DOHMH") through the Office of School Health ("OSH"). I understand that part of these services may entail an assessment by an OSH physician as to how my child is responding to the prescribed medication. Full and complete instructions regarding the provision of the above-requested health service(s) are included in this MAF. I understand that the Department, DOHMH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. It is my intention that my child will be provided with health service(s) according to the information and instructions that are provided in this MAF. I further understand that the Department, DOHMH and their agents are not responsible for any adverse reaction to this medication.

I recognize that this form is not an agreement by the Department or DOHMH to provide the services requested, but, rather, my request, consent and authorization for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I hereby authorize the Department, DOHMH and their employees and agents, to contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care provider and/or pharmacist that has provided medical or health services to my child.

SELF-ADMINISTRATION OF MEDICATION: Initial this paragraph for use of an Epi-Pen, asthma inhaler and other approved self-administered medications):

_____ I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further authorize my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, as well as for any and all consequences of my child's use of such medication in school. I further hereby authorize the Department, DOHMH, their agents and employees; including the principal, his/her designee(s), school nurse and my child's teacher(s), to administer such medication in accordance with the instructions of my child's physician should my child be temporarily incapable of self-administering such medication. I understand that the school nurse will confirm my child's ability to self carry and self administer in a responsible manner with the school. In addition, I agree to provide "back up" medication in a clearly labeled bottle to be kept in the medical room in the event my child does not have sufficient medication to self administer.

_____ I also authorize the principal, his/her designee(s) and school nurse to store and/or administer to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

_____ I hereby certify that I have consulted with my child's health care provider and that I authorize the Office of School Health to administer stock Ventolin in the event that my child's asthma prescription medication is unavailable.

*You must send your child's **Personal Metered Dose Inhaler (MDI)** with your child on a **school trip day** in order that he/she has it available. The stock Ventolin is **only** for use while your child is in the school building.*

Please Print Parent/Guardian's Name & Address Below:

_____ _____

Parent/Guardian's Signature

_____ _____

Date Signed

_____ _____

Daytime Telephone No. **Home Telephone No.**

(DO NOT WRITE BELOW - FOR DOE AND DOHMH ONLY)

Student's Name:_____ OSIS No: _____

Received by: _____ _____ Reviewed by: _____ _____
Name Date Name Date

Referred to School 504 Coordinator ☐ Yes ☐ No Self-Administers/Self-Carries: ☐ Yes ☐ No

Services provided by: ☐ Nurse ☐ DOHMH Public Health Adv. ☐ School Based Health Center ☐ DOE School Staff

Signature and Title:_____ _____
(RN OR MD) (Date school notified and form forwarded to DOE Liaison)

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 also 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

TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL		
District:	Date:	
School:	Name of Student:	
Grade:	Class:	Student ID No.:
Relationship of person providing information for survey (check one): Mother □ Guardian □ Father □ Other □ (specify):		
If an interview is conducted, list interviewer's name and title or relationship.		
In what language?		
If an interpreter is provided, list name and position/relationship:		
Is the interpreter trained/qualified (e.g., bilingual teacher, Translation & Interpretation Unit staff)? Yes □ No □		
Eligible for LAB-R testing? Yes □ No □		
Person determining LAB eligibility and signature:		
Lab Coordinator name and signature:		
OTELE ALPHA CODE:		
Program Placement: Transitional Bilingual Education □ (Is this a transfer? Yes □ No □) Dual Language □ Freestanding ESL □		

PART 1. LAB-R ELIGIBILITY:. This information will establish eligibility for the English Language Assessment Battery-Revised (LAB-R). (√) the box that applies. If another language is used, please specify.

1. What language does the child **understand**?		
English □	Other □:	
2. What language does the child **speak**?		
English □	Other □:	
3. What language does the child **read**?		
English □	Other □:	Does not read □
4. What language does the child **write**?		
English □	Other □:	Does not write □

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

5. What language is spoken in the child's home or residence **most of the time**?
English □ Other □:
6. What language does the child speak with parents/guardians **most of the time**?
English □ Other □:
7. What language does the child speak with brothers, sisters, or friends **most of the time**?
English □ Other □:
8. What language does the child speak with other relatives or caregivers (e.g., babysitters) **most of the time**?
English □ Other □:

PART 2. INSTRUCTIONAL PLANNING: Responses to these supplementary questions will be used for instructional planning. Enter the correct response 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:
Where did he/she go to school?
How long did he/she attend school?
Which language was used for instruction?
2. Has the child attended school in another country? □ Yes □ No
IF YES:
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: Which ones?

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?
Parent Signature Date

Department of Education
Joel I. Klein, Chancellor

THE New York City DEPARTMENT OF EDUCATION

FEDERAL PARENT/GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

FORM
PSE

- All students between 5 and 21 years of age have the right to a free 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 identity, pregnancy, immigration/citizenship status, disability, sexual orientation, religion, or ethnicity.[1]

English Only

SCHOOL STAFF: PLEASE COMPLETE THIS SECTION

Borough ☐ District ☐☐ School ☐☐☐

Name of High School/ Mini School /Annex ----------

Grade Code ☐☐☐ Class Code ☐☐☐☐ (HIGH SCHOOL ONLY 4-DIGIT)

NYC Student Identification Number ☐☐☐☐☐☐☐☐☐

Date of Birth (Month/Day/Year) ☐☐☐☐☐☐

Student Name: Last, First, Middle Initial

PARENT/GUARDIAN: PLEASE COMPLETE THIS SECTION

PLEASE ANSWER BOTH QUESTIONS (1) AND (2). PLEASE READ THEM BEFORE YOU RESPOND.

For Question (1), check (√) 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 American, or other Spanish culture or origin, regardless of race.

☐ **YES, Hispanic**

☐ **NO, not Hispanic**

For Question (2), check (√) **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 ☐ Guardian ☐ Other (Specify): ☐ School Staff Observer (Name):

See reverse side for an important message to parents/guardians and for confidentiality procedures and regulations

Residency 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.

Student Name			
Last	**First**		**Middle**
OSIS #	**Date of Birth** MM/DD/YY	**Gender**	**School**

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

Check (√)	Residency 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**
	Awaiting Foster Care Placement	**A**
	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:

		School Use Only: Enter "Y" if applicable
	Unaccompanied Youth Youth who is not in the physical custody of a parent or guardian	

_____ _____ _____

Parent/Guardian Name (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."