Registration Checklist

Coney Island Prep requires the following documentation in order to register your child for school. These documents must be turned in prior to your student's first day:

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

Note for Students in Temporary Housing

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

Lista de verificación para la matrícula escolar

Coney Island Prep requiere la siguiente documentación para inscribir a su hijo en la escuela. Estos documentos deben entregarse antes del primer día de clases de su estudiante:

- ☐ Comprobante de la edad del niño (certificado de nacimiento).
- ☐ El registro de vacunación del niño (si lo tiene).
- ☐ El boletín de calificaciones o certificado de estudios más reciente del niño (si lo tiene).
- ☐ **Dos (2)** documentos de la siguiente lista como prueba de domicilio:
  - ☐ Contrato de alquiler, título de propiedad o estado de cuenta de la hipoteca de la vivienda;
  - ☐ Una factura de servicios públicos de la vivienda (gas o electricidad) a nombre de quien la habita emitida por una empresa de servicios públicos (por ejemplo, National Grid o Con Edison) y fechada dentro de los últimos 60 días;
  - ☐ Una factura del servicio de televisión por cable de la vivienda, con el nombre y el domicilio del padre, fechada dentro de los últimos 60 días;
  - ☐ Documentación o carta con membrete de una agencia del gobierno federal, estatal o local, entre ellas el Servicio de Impuestos Internos (Internal Revenue Service, IRS), la Autoridad de la Vivienda de la Ciudad de Nueva York (New York City Housing Authority, NYCHA), la Oficina de Reasentamiento de Refugiados (Office of Refugee Resettlement), la Administración de Recursos Humanos (Human Resources Administration), la Administración de Servicios para Niños (Administration for Children's Services, ACS), o un subcontratista de la ACS, con el nombre y el domicilio, y fechada dentro de los últimos 60 días;
  - ☐ Una factura actual del impuesto sobre la propiedad de la vivienda;
  - ☐ Una factura del servicio de agua de la vivienda fechada dentro de los últimos 90 días;
  - ☐ Un recibo de alquiler que incluya el domicilio, fechado dentro de los últimos 60 días;
  - ☐ Documento de identidad expedido por el gobierno estatal, municipal u otra instancia gubernamental (puede ser la tarjeta IDNYC), que esté vigente y que incluya el domicilio;
  - ☐ Formulario de declaración de impuestos sobre la renta del último año calendario;
  - ☐ Licencia de conducir oficial del Estado de Nueva York o permiso de aprendiz vigente;
  - ☐ Documentos oficiales de la nómina de un empleador emitidos en los últimos 60 días, como un recibo de sueldo con el domicilio, un formulario presentado con propósitos de retención del impuesto sobre la renta o un comprobante de pago de sueldo (una carta con el membrete del empleador no es aceptable). Estos documentos deben incluir el domicilio y estar fechados dentro de los últimos 60 días;
  - ☐ Documentación de inscripción electoral con el nombre y el domicilio del padre;
  - ☐ Documentos de afiliación vigentes, otorgados en función del domicilio (por ejemplo, de la asociación de vecinos), con el nombre y el domicilio del padre de familia;
  - ☐ Pruebas de custodia del menor, entre otras, órdenes de custodia judicial o documentos de tutela legal.

Aviso para estudiantes en vivienda temporal

Los estudiantes en vivienda temporal, según lo dispuesto en la Ley McKinney-Vento, no están obligados a presentar documentación (como dirección, comprobante de la fecha de nacimiento y de vacunación) para matricularse. La escuela debe preinscribir al alumno de manera provisional y luego ponerse de acuerdo con el funcionario del DOE a cargo de los estudiantes en vivienda temporal para obtener la documentación necesaria.

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 ____________

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent	Last Name	First Name	Email	Cell ____________ Work ____________

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? Date Screened

☐ Yes ☐ No ____/____/____

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ____________

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< **1 year** ☐ Breastfed ☐ Formula ☐ Both

≥ **1 year** ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	____ /____ /____ ____ /____ /____	________ μg/dL ________ μg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	____ /____ /____	☐ At risk *(do BLL)* ☐ Not at risk
—— Child Care Only ——		
Hemoglobin or Hematocrit	____ /____ /____	________ g/dL ________ %

Hearing	*Date Done*	*Results*
< 4 years: gross hearing	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
OAE	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*
≥ 4 yrs: pure tone audiometry	___/___/___	☐*Nl* ☐*Abnl* ☐*Referred*

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ *Nl* ☐ *Abnl*
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right _____ /_____ Left _____ /_____ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental	
Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

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

Tdap	___/___/___	___/___/___	___/___/___
MMR	___/___/___	___/___/___	___/___/___
Varicella	___/___/___	___/___/___	___/___/___
Mening ACWY	___/___/___	___/___/___	___/___/___
Hep A	___/___/___	___/___/___	___/___/___
Rotavirus	___/___/___	___/___/___	___/___/___
Mening B	___/___/___	___/___/___	___/___/___
Other ____________	___/___/___	____________	___/___/___

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

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

____________________________ ________

____________________________ ________

____________________________ ________

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ____________________________

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

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

☐ Other ____________________________

Health Care Practitioner Signature	Date Form Completed _____ /_____ /_____
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# ☐☐☐☐☐☐☐☐☐☐