RSJ NURSERY SCHOOL
REGISTRATION DOCUMENT CHECKLIST

Welcome to Redeemer St. John's Nursery School! We are thrilled to have you join our family for the upcoming 2025-2026 school year!

Below is the checklist of documents you will need to bring to the school to register your child. Please make copies ahead of time. If you have any questions, please call the school office at 718.833.7789. Thank you! 💜

Completed New York City Early Childhood Education Program Registration Packet - *signatures required*

Completed Emergency Contact Card (2 pages)

2 Proofs of Address
cell phone bills not accepted

1 Proof of Birth for your child
copy of birth certificate or passport

Medical Form to be filled out by Pediatrician
Please bring to the 1st day of school in September

New York City Early Childhood Education
Program Registration Form- School Day Year & Head Start
Welcome

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.

Please complete this registration packet and submit it to your early childhood program.

Important Note:
Your child's School Day and Year 3-K or Pre-K program, or Head Start or Early Head Start program 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.
- Optional services that require a fee (e.g., extended care hours, summer programs, and/or special classes).

Moreover, it is the policy of the 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 a 3-K or Pre-K seat or denied other educational opportunities for any of the reasons listed above.
- You may not be required to participate in religious activities as a condition of participation in your 3-K or pre-K program. You will not gain any advantage in your program by participating in any religious activities.

If you have questions or concerns, please contact earlychildhoodpolicy@schools.nyc.gov.

_____ _____
Parent/Guardian Signature Vendor Representative Signature

Date: _____

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

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	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

EMERGENCY CONTACT CARD

SCHOOL YEAR 20__ __ – 20 __ __

You can update your contact information online using your NYC Schools Account at schoolsaccount.nyc.
Don't have an account? Check out schools.nyc.gov/nycsa.

STUDENT INFORMATION

Student Last Name **Student First Name** **M.I.**

Date of Birth (mm/dd/yyyy) OSIS ID #

If you have filled out the information in NYCSA:

- ❑ **Emergency contact information is correct in NYCSA. No need to update form.**
- ❑ **Updated emergency contact information is below.**

This Guardian Can : ___ Be Contacted in Emergencies ___ Pick Up Student ___ Receive School Mailings (check all that apply).

Parent/Guardian Last Name (Student resides with) **Parent/Guardian First Name** **Relationship**

Parent's Preferred Language of Communication (Written) Parent's Preferred Language of Communication (Oral)

Home Telephone Work Telephone Cell Phone Y N OK to Text

Email

Address (House Number) Apartment #

City State Zip Code Borough

This Guardian Can: ___ Be Contacted in Emergencies ___ Pick Up Student ___ Receive School Mailings (check all that apply).

Secondary Parent/Guardian Last Name **Secondary Parent/Guardian First Name** **Relationship**

Secondary Parent/Guardian's Preferred Language of Communication (Written) Secondary Parent/Guardian's Preferred Language of Communication (Oral)

Secondary Home Telephone Secondary Work Telephone Secondary Cell Phone Y N OK to Text

Secondary Email

Secondary Address (House Number) Apartment #

City State Zip Code Borough

EMERGENCY CONTACTS

List below names of three additional people who may be called in case of emergency or if child is sick in school.

CHILD WILL BE RELEASED ONLY TO PEOPLE NAMED ON THIS CARD.

Name	E-mail	Telephone	Relationship

IMPORTANT – PLEASE COMPLETE NEXT PAGE >>

Updated: August 2021

NO ACCESS

If there is a person who may **NOT HAVE ACCESS** to child, please indicate:
Please submit a copy of the order of protection to your child's school.

Name	Relationship	Order of Protection Exists?	Effective Date of Court Order
		❑ Yes ❑ No	

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone _____

❑ Allergist/Immunologist ❑ Cardiologist ❑ Dermatologist ❑ Development/Behavioral Specialist
❑ Neurologist ❑ Pulmonologist ❑ Other _____

Health Alert

Does child have any health condition that may affect participation in physical activities? ❑ Yes ❑ No

Limitations _____
(e.g., stair climbing, participation in gym)

Known Diagnoses (please check all that apply)

❑ Asthma ❑ Seizures ❑ Allergies/Anaphylaxis ❑ Diabetes ❑ None ❑ Other _____

Allergies (select all that apply)

❑ Milk ❑ Eggs ❑ Peanuts ❑ Tree Nuts (Other Nuts) ❑ Fish
❑ Shellfish ❑ Soy ❑ Wheat ❑ Other _____

My child has (X any that apply): ❑ Private health insurance ❑ Medicaid ❑ No health insurance

If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? ❑ Yes ❑ No

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail.
The recommendation of the parent as indicated above will be respected as far as possible.

SIBLINGS

Sibling's Last Name	Sibling's First Name	Sibling's School of Attendance

SIGNATURE OF PARENT/GUARDIAN

❑ By checking this box, I agree to be contacted by elected School, District, and/or City-wide parent leader volunteers regarding events, updates, and other matters connected to my school community.

❑ By checking this box, I agree that my contact information can be shared with elected School, District, and/or City-wide parent leader volunteers so I can be updated on events and other matters connected to my school community.

Principal will be notified in writing of any changes to information on this card _____
Signature of Parent/Guardian

FOR OFFICE USE ONLY

To be completed by school staff only.

Grade _____ **Class** _____ **Room No.** _____ **Teacher** _____

List below contacts made for emergency, illness or injury. Relevant records from Health Record _____

Date	Contact	Reason	Disposition

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** ☐ **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 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

															IgG Titers	Date
DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			Tdap	___/___/___	___/___/___			Hepatitis B	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			MMR	___/___/___	___/___/___			Measles	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___			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# ☐☐☐☐☐☐☐☐☐☐