



## NEW YORK CITY EARLY EDUCATION CENTER (NYCEEC) FULL-DAY 3-K PROGRAM REGISTRATION FORM FOR 2021-2022 SCHOOL YEAR

### DIRECTIONS:

**Please print clearly** in blue or black ink only. Please note that only parents/guardians who are New York City residents may submit a registration form. Sign and return this registration form directly to each NYCEEC you wish to register at. Be sure to make a copy of this registration form and retain for your records. For a list of NYCEECs, please review the Pre-Kindergarten Directory available at your local school, NYCEEC or online at [nyc.gov/prek](http://nyc.gov/prek).

**NAME OF NYCEEC YOU ARE REGISTERING AT:** \_\_\_\_\_

### Section A: STUDENT INFORMATION – Please print clearly in ink

STUDENT LAST NAME	STUDENT FIRST NAME	DATE OF BIRTH (mm/dd/yyyy)	GENDER (optional)
		/ / <b>2018</b>	<input type="checkbox"/> M <input type="checkbox"/> F
STUDENT CURRENT ADDRESS (House #, Street, Apt. #, City, State and Zip Code)			STUDENT HOME DISTRICT (optional)

### Section B: OPTIONAL INFORMATION – Please print clearly in ink

#### HEALTH INSURANCE

Does the student have health insurance?

☐ 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

#### HOME LANGUAGE

In which language(s) would you like to receive written and/or oral communication regarding the Pre-Kindergarten Admission process?

Please check all that apply: ☐ English ☐ Arabic ☐ Bengali ☐ Chinese ☐ French ☐ Haitian Creole ☐ Korean  
☐ Russian ☐ Spanish ☐ Urdu ☐ Other, please specify: \_\_\_\_\_

### Section C: PARENT INFORMATION – Please print clearly in ink

**I understand that daily attendance and promptness are required. I must arrange for a responsible adult to bring my child to school and pick him/her up daily. I understand that no transportation is provided.**

PARENT/GUARDIAN LAST	NAME PARENT/GUARDIAN FIRST NAME	RELATIONSHIP TO STUDENT
DAYTIME TELEPHONE NUMBER	EVENING TELEPHONE NUMBER	PARENT/GUARDIAN EMAIL ADDRESS

Parent/Guardian Signature

Date

To the Parent/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 secure and confidential.

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 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. Students identified with more than one race will be counted in the "two or more races" category. Hispanic students of all races will be counted in the Hispanic category.

The New York City Department of Education understands the sensitive nature of this process. The options provided by the federal government may not represent an accurate or complete portrayal of your family'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 New York City Department of Education school staff to make an identification of your child on your behalf.

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

Thank you for your cooperation.

Parents and Guardians: Please complete the form on the reverse side of this page and return it to your child's school.

School staff: File the completed form in the student's Cumulative Record folder as confidential information.

#### Confidentiality Procedures and Regulations

The Family Educational Rights and Privacy Act (1974) 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.

<sup>1</sup> 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.

- 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.<sup>1</sup>

**English Only**

**SCHOOL STAFF: PLEASE COMPLETE THIS SECTION**

Borough  District  School

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

Grade Code    Class Code

NYC Student Identification Number

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(HIGH SCHOOL ONLY 4-DIGIT)

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):

**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			
Last	First	Middle	
OSIS #	Date of Birth (MM/DD/YY)	Gender	School

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

Please identify the student's current living arrangements. Please check <u>one</u> box:		School Use Only
Check (✓)	Housing Questionnaire Choice	ATS Code
	<b>Doubled Up</b> With another family or other person because of loss of housing or as a result of economic hardship	<b>D</b>
	<b>Shelter</b> Emergency or transitional shelter	<b>S</b>
	<b>Hotel/Motel</b> Living in what is NOT an emergency or transitional shelter <b>and</b> involves payment	<b>H</b>
	<b>Other Temporary Living Situation</b> Trailer park, campground, car, park, public places, abandoned building, street, or any other inadequate living space	<b>T</b>
	<b>Permanent Housing</b> Student who is living in a fixed, regular, and adequate housing situation	<b>P</b>

If the student is NOT living in permanent housing, also indicate if the below applies:

If the student is NOT living in permanent housing, also indicate if the below applies:		School Use Only
	<b>Unaccompanied Youth</b> Youth who is not in the physical custody of a parent or guardian	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".**



# The New York City Department of Education Pre-Kindergarten Language Needs Survey

Dear Parent or Guardian of \_\_\_\_\_ (enter student name here),  
This survey is an important piece of your pre-kindergarten enrollment package as it provides your new school with information about your family's language needs. Your assistance in answering the questions below is greatly appreciated. Please return this form to your school administrator, \_\_\_\_\_, and if you have questions, speak with \_\_\_\_\_ at \_\_\_\_\_.  
Thank You Student ID: \_\_\_\_\_

**PART 1. LANGUAGE NEEDS:** This information will establish what language is used at home and the language of instruction requested by the family (if available).

1. Which language(s) do you speak at home? Please check (✓) all that apply:

- |                                         |                                                      |
|-----------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> English        | <input type="checkbox"/> Urdu                        |
| <input type="checkbox"/> Spanish        | <input type="checkbox"/> French                      |
| <input type="checkbox"/> Chinese        | <input type="checkbox"/> Korean                      |
| <input type="checkbox"/> Bengali        | <input type="checkbox"/> Albanian                    |
| <input type="checkbox"/> Arabic         | <input type="checkbox"/> Punjabi                     |
| <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> Polish                      |
| <input type="checkbox"/> Russian        | <input type="checkbox"/> Other, please specify _____ |

2. What language does the child **understand**?

English ☐ Other Home Language(s) ☐

3. What language does the child **speak**?

English ☐ Other Home Language(s) ☐

4. What language does the child **read**?

English ☐ Other Home Language(s) ☐ Does not read yet ☐

5. What language does the child **write**?

English ☐ Other Home Language(s) ☐ Does not write yet ☐

6. What language is spoken in the child's home or residence **most of the time**?

English ☐ Other Home Language(s) ☐

7. What language does the child speak with parents/guardians **most of the time**?

English ☐ Other Home Language(s) ☐

8. What language does the child speak with brothers, sisters, or friends **most of the time**?

English ☐ Other Home Language(s) ☐

9. What language does the child speak with other relatives or caregivers (e.g., babysitters) **most of the time**?

English ☐ Other Home Language(s) ☐

10. Would you like your child to receive instruction using your home language (if available):

☐ All the time ☐ Most of the time ☐ Some of the time



## The New York City Department of Education Pre-Kindergarten Language Needs Survey



**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 your child's first time participating in an instructional program or group experience in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF NO:	
a. Where did he/she go participate in daycare/preschool/play group?	
b. What was the date of enrollment?	
c. How long did he/she attend?	
d. Which language was used for instruction?	
2. Has your child participated in an instructional program or group experience in <u>another country</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES:	
a. Where did he/she participate in daycare/preschool/play group?	
b. How long did he/she attend?	
c. Which language was used for instruction?	
3. Does your child have any conditions that require special help or attention in school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF YES, please check all that apply:	
<input type="checkbox"/> Hearing impaired	<input type="checkbox"/> Emotionally impaired
<input type="checkbox"/> Visually impaired	<input type="checkbox"/> Asthma
<input type="checkbox"/> Speech impaired	<input type="checkbox"/> Developmentally Disabled
<input type="checkbox"/> Physically impaired	<input type="checkbox"/> Other (Please Specify) _____
IF YES, what early intervention has your child received, if any?	
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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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. What is your first language?	
Parent/Guardian: _____	Parent/Guardian: _____
First language: _____	First language: _____
2. In what language would you like to receive written information from the school?	
3. In what language would you prefer to communicate orally with school staff?	
Parent Signature _____	Date _____



## The New York City Department of Education Pre-Kindergarten Language Needs Survey



TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY					
Date:		Name of Student/ID:			
Borough:	District:	School:			
Gender:	Ethnicity Code: (form PSE):	Date of Birth:			
Relationship of person providing information for survey (check one): <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Other (specify):					
If an interview is conducted, in what language is it conducted?					
Is a translator/interpreter used?					
OTELE Alpha Code <table border="1" style="display: inline-table;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>					
Potential English Language Learner?					
Instruction will be provided in: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ <input type="checkbox"/> Both English and the home language of _____					

<b>CHILD &amp; ADOLESCENT HEALTH EXAMINATION FORM</b> NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION										Please Print Clearly		NYC ID (OSIS)																												
<b>TO BE COMPLETED BY THE PARENT OR GUARDIAN</b>																																								
Child's Last Name								First Name				Middle Name				Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth (Month/Day/Year) ____/____/____																						
Child's Address										Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No		Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____																												
City/Borough						State		Zip Code		School/Center/Camp Name				District Number ____		Phone Numbers Home _____ Cell _____ Work _____																								
Health insurance <input type="checkbox"/> Yes (including Medicaid)? <input type="checkbox"/> No		<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Foster Parent		Last Name				First Name				Email																												
<b>TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER</b>																																								
Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____										Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability <b>Explain all checked items above.</b>																														
Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed  <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____										<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Addendum attached.																														
Attach MAF in in-school medications needed										Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ _____																														
PHYSICAL EXAM Date of Exam: ____/____/____										General Appearance: <input type="checkbox"/> Physical Exam WNL  <table><tr><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td><td>Ni Abnl</td></tr><tr><td><input type="checkbox"/> Psychosocial Development</td><td><input type="checkbox"/> HEENT</td><td><input type="checkbox"/> Lymph nodes</td><td><input type="checkbox"/> Abdomen</td><td><input type="checkbox"/> Skin</td></tr><tr><td><input type="checkbox"/> Language</td><td><input type="checkbox"/> Dental</td><td><input type="checkbox"/> Lungs</td><td><input type="checkbox"/> Genitourinary</td><td><input type="checkbox"/> Neurological</td></tr><tr><td><input type="checkbox"/> Behavioral</td><td><input type="checkbox"/> Neck</td><td><input type="checkbox"/> Cardiovascular</td><td><input type="checkbox"/> Extremities</td><td><input type="checkbox"/> Back/spine</td></tr></table>											Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin	<input type="checkbox"/> Language	<input type="checkbox"/> Dental	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine
Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl	Ni Abnl																																				
<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin																																				
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<input type="checkbox"/> Behavioral	<input type="checkbox"/> Neck	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Extremities	<input type="checkbox"/> Back/spine																																				
Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m <sup>2</sup> (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____										Describe abnormalities: _____ _____ _____																														
DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____										Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ _____																														
Describe Suspected Delay or Concern: _____										Hearing Date Done Results < 4 years: gross hearing ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred																														
										Vision Date Done Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) ____/____/____ Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test																														
										Screened with Glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus? <input type="checkbox"/> Yes <input type="checkbox"/> No																														
										Dental Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No																														
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No										Child Care Only Hemoglobin or Hematocrit _____ g/dL _____ %																														
CIR Number _____										Physician Confirmed History of Varicella Infection <input type="checkbox"/> Report only positive immunity: IgG Titers Date Hepatitis B ____/____/____ Measles ____/____/____ Mumps ____/____/____ Rubella ____/____/____ Varicella ____/____/____ Polio 1 ____/____/____ Polio 2 ____/____/____ Polio 3 ____/____/____																														
IMMUNIZATIONS – DATES																																								
DTP/DTaP/DT _____ Tdap _____										MMR _____																														
Td _____										Varicella _____																														
Polio _____										Mening ACWY _____																														
Hep B _____										Hep A _____																														
Hib _____										Rotavirus _____																														
PCV _____										Mening B _____																														
Influenza _____										Other _____																														
HPV _____																																								
ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____										RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____																														
Health Care Practitioner Signature _____										Date Form Completed ____/____/____ DOHMH ONLY PRACTITIONER I.D. _____																														
Health Care Practitioner Name and Degree (print) _____										Practitioner License No. and State _____ TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____																														
Facility Name _____										National Provider Identifier (NPI) _____ Date Reviewed: ____/____/____ I.D. NUMBER _____																														
Address _____ City _____ State _____ Zip _____										REVIEWER: _____ FORM ID# _____																														
Telephone _____ Fax _____ Email _____																																								

CH205 Health Exam 2016\_r4-16\_FINAL.indd





**CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE A STUDENT FOR NON-PROFIT USE**  
(e.g. educational, public service, or health awareness purposes)

Student Name: \_\_\_\_\_ School: \_\_\_\_\_

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 \_\_\_\_\_.

I also grant to \_\_\_\_\_ 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.

Signature of Parent/Guardian (if Student is under 18): \_\_\_\_\_ Date: \_\_\_\_\_

Address of Parent/Guardian: \_\_\_\_\_

**OR**

Signature of Student (if 18 or over): \_\_\_\_\_ Date: \_\_\_\_\_

Address of Student: \_\_\_\_\_



# Ready4K

**NYC** Department of  
Education  
Chancellor Richard A. Carranza

## Text messages to boost your child's learning

Welcome to Ready4K! The NYCDOE is excited to give you this FREE resource to help your child stay on track with their learning goals all year long.

### How does Ready4K help my child learn?

Ready4K texts you 3 easy-to-do learning tips and activities each week. Each text message you will get is written for your child's age or grade. Research shows that doing Ready4K activities is a great way to help your child stay on track.

Ready4K tips **build on your daily routines**, like activities to use when getting dressed, during bath time, or when preparing a meal. No internet, extra time, or special materials are required.

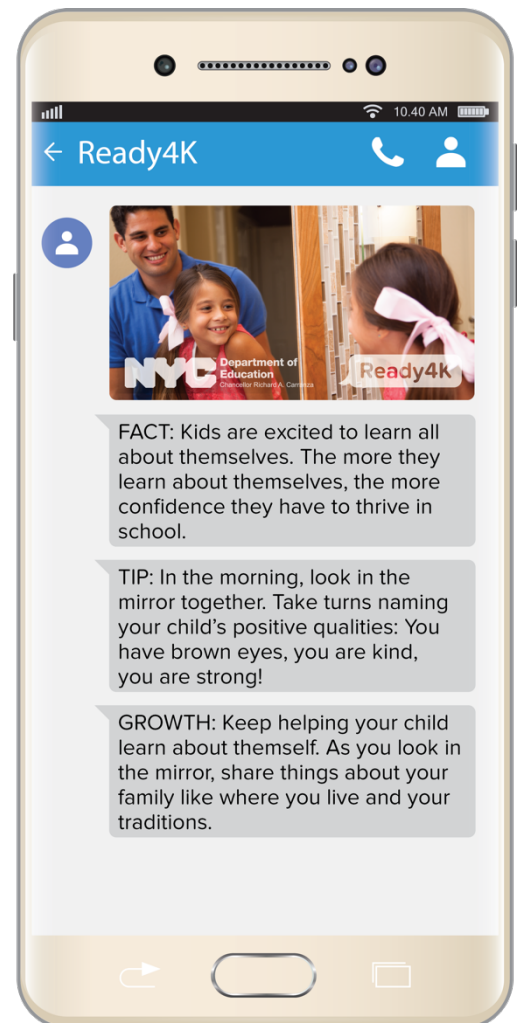
You'll also receive links to **NYC resources** that many families find helpful.

### What do I need to do?

As a NYC family, your school will enroll you in the program.

There's **absolutely no cost**, though data and message rates may apply. You can opt out anytime by texting STOP to 70138.

Questions? Contact the program director at your child's school for more details.



Please note that Ready4K is only available in English, Spanish, Arabic, Vietnamese and Chinese.