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Associated Beth Rivkah Schools
Preschool Division
470 Lefferts Avenue
Brooklyn, NY 11225
718-735-0400 x 1360 | Fax: 718-735-0745

Preschool Registration Application

Please carefully fill out the following forms to register your child for Bais Rivkah Preschool.

Two ways to fill:

1. These forms are fillable PDFs which means that you can fill them out on your computer without printing them if you have Adobe Acrobat Reader or Adobe X (or Preview on Mac).
2. Print and fill out by hand **in blue or black ink.** Please ensure that each field is filled out LEGIBLY and CLEARLY on every page. Scan and upload your filled out forms to bethrivkah.edu/preschool

To fill out this form on the computer:

1. Download form
2. Open with Adobe Acrobat (or Preview on Mac), **NOT with your web browser**.
3. Type your responses
4. Create a signature and insert into "Signature fields." (Click here for instructions on how to sign forms on Adobe Acrobat or Reader)
5. Save and rename the file with your child's name
6. Upload the filled out forms to bethrivkah.edu/preschool

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Registration Application

Child's name: _____ DOB: _____

Home address: _____ Zip code: _____

Cell phone [Mother]: _____ Cell phone [Father]: _____

Father's name: _____ Occupation: _____

Mother's name: _____ Occupation: _____

Home phone: _____ Mother's email address: _____

How many members in the family? _____

Ages: Boys: ____ ____ ____ ____ ____ ____ Girls: ____ ____ ____ ____ ____ ____

Parents' marital status: _____

☐ New student

☐ Returning student

☐ TANF/SSI

☐ Food Stamps

☐ WIC

☐ Working Mother

☐ IEP

Emergency Contact #1: Name _____ Number _____

Emergency Contact #2: Name _____ Number _____

Immunizations up-to-date: Yes ☐ No ☐

Medicaid: ☐ Yes ☐ No Card #: _____ Private

Medical Insurance: _____ Policy #: _____

Allergies:_____

Parent's Signature: _____

Date: _____

Print Name: _____

Relationship to Child: ☐ Mother ☐ Father

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Required Immunizations, Screenings and Physical Examinations

As per NYC Dept. of Health, all children attending Beth Rivkah Preschool **must** submit the necessary documentations on the forms provided. Please read the following guidelines carefully:

The **doctor's signature and stamp is required on all forms.

All well visits are valid for 12 months, preferably conducted after **July 1, 2021** (in order for them to be valid for the full 2021-2022 school year) and submitted no later than September 1, 2021 – to secure a place for your child in our program.

1. **SCREENING AND/OR TESTS**:
   A. HEIGHT.
   B. WEIGHT.
   C. BLOOD PRESSURE
   D. HEMATOCRIT or HEMOGLOBIN.
   E. LEAD RISK ASSESSMENT completed by parent (see attached) and/or TESTING.
   F. HEARING SCREENING – WNL or uncooperative is accepted.
   G. VISION SCREENING – WNL or uncooperative is accepted.

2. **COMPLETE PHYSICAL EXAMINATIONS**:

If you do not immunize your child, please contact Bryna Telsner at the Head Start office (718-735-0400 ext. 1356) to discuss an exemption, without exception. No child will be admitted to the program without a **completed immunization form** or an **exemption approved by the NYC Department of Health**.

3. **DENTAL – OPTIONAL:**

If your child needs follow-up dental care, please make every effort to complete the treatments before the new school term begins.

4. **ALLERGY FORM** – If applicable, list all allergies, reactions and treatments.

5. **NEW VACCINE REQUIREMENTS - Between July 1 and December 31 of each year, all children who are between the ages of 6 months and 59 months and attending a New York City licensed day care, Head Start, pre-K or nursery school, must receive one dose of flu vaccine.**

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 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? ☐ 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

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# ☐☐☐☐☐☐☐☐☐☐

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Individualized Health Care Plan for Allergies

Attention**:** Bais Rivkah Preschool

TO THE HEALTH COORDINATOR & STAFF,

Name: _____ DOB: _____ is under my care and is determined to be allergic to _____

_____

_____.

An Epipen has been prescribed? No ☐ Yes ☐ Extremely reactive to

_____.

In case of an allergic reaction the following steps should be taken:

_____

_____

Doctor's Name: _____ Date: _____

Telephone #: _____

Doctor's Stamp Required

Parent Signature: _____ **Date**: _____

Date Reviewed with Staff _____ **Initials** _____

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Authorization for Emergency Medical Care

I hereby authorize Associated Beth Rivkah Schools to obtain emergency medical/dental treatment considered necessary for my child _____ in the event that I am not available when treatment is needed.

_____ _____

Signature of Parent/Guardian Date

Name of MD: _____
Address: _____
Phone Number: _____
Hospital Preference: _____

Name of Dentist: _____
Address: _____
Phone Number: _____

INSURANCE INFORMATION

Private ◯ Medicaid ◯ Child Health Plus ◯

Insurance Policy Name: _____

Insurance Policy Number: _____

ALLERGIES/HEALTH CONCERNS:

_____
_____
_____
_____

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Lead Risk Assessment Questionnaire

Child's name: _____

Does your child:

1. Live in or regularly visit a house with peeling or chipping paint built before 1960? This could include a day care center, preschool, home of a babysitter or relative, etc.
   ☐ Yes ☐ No
2. Live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?
   ☐ Yes ☐ No
3. Have a brother or sister, housemate, or playmate being followed or treated for an elevated lead level (that is, a blood lead level of 5 mcg/dl or higher)?
   ☐ Yes ☐ No
4. Frequently come in contact with an adult whose job or hobby involves exposure to lead? Examples are construction, welding, or pottery.
   ☐ Yes ☐ No
5. Live or play near an active lead smelter, battery recycling plant, or other industry likely to release lead?
   ☐ Yes ☐ No
6. Live or play near a heavily travelled major highway, bridge or elevated train where soil and dust may be contaminated with lead?
   ☐ Yes ☐ No
7. Does your child put non-food items in her mouth i.e. pencils, toys, paint chips etc.?
   ☐ Yes ☐ No

If the answer to any of the above questions is YES, then the child is considered to be at risk of high dose lead exposure and should be screened with a blood lead test.

Parent Signature: _____ Date: _____

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Disability Service Form

Child's name: _____ DOB: _____

Was your child ever evaluated? Yes ☐ No ☐

Name of Evaluation Site: _____

Does your child currently receive services?

☐ EI, ☐ CPSE

If yes, which services? Check all that apply:

☐ Speech
☐ Occupational Therapy
☐ Physical Therapy
☐ Counseling/ Play Therapy
☐ SEIT/Special Instruction

Do you have any concerns regarding your child's development?

_____
_____
_____
_____
_____

Parent Signature: _____ Date: _____

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Consent for Screenings

I hereby give permission for my child _____ to receive the required mandated developmental screenings within 45 calendar days of enrollment in the Preschool Division of Associated Beth Rivkah School.

If deemed necessary, my child may receive additional screenings to identify:

- Gross Motor Skills
- Fine Motor Skills
- Social and Emotional Skills
- Cognitive and Perceptual Skills
- Speech and Language Skills

The screening procedure will be sensitive to my child's cultural background.

I understand that I will receive the results of the screenings.

Parent's Signature: _____

Print Name: _____

Date: _____

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Consent for Hearing and Vision Screenings

I have been informed that my child _____ may receive a hearing and/or vision screening.

I understand that these screenings will only serve as a basis to determine the need for a full hearing or vision examination.

I understand that I will receive the results of the hearing and vision screenings.

Parent's Signature: _____

Print Name: _____

Date: _____

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Consent for School Trips

I hereby give permission for my child _____ to go on all school trips.

I understand that I will be informed of any costs related to the trip[s] and I agree to pay such costs.

Parent's Signature: _____

Print Name: _____

Date: _____

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Photo Consent Form

Associated Beth Rivkah School Preschool staff may take photographs and/or videos of your child for publicity purposes. These images may appear in flyers, newsletters and/or websites.

Before using any pictures of your child[ren], we need your permission. Please answer the questions below, then sign and date the form.

May ABRS Preschool staff use pictures and/or videos of your child[ren] in material produced by the program, including:

- ✓ Class WhatsApp/Newsletters Yes ☐ No ☐
- ✓ Printed publications/other websites Yes ☐ No ☐

This form is valid for the duration your child is enrolled in our program.

Signature: _____ Date: _____

Print name: _____

Child's name: _____

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IEP Consent/Release Form

Childs Name: _____ DOB: _____

Each student with a disability who needs special education services must have an IEP developed by Committee on Preschool Special Education (CPSE). The IEP is the document that guides the delivery of specially designed instruction to meet the student's needs. Therefore, school personnel with responsibility for implementing a student's IEP must have that information readily available to them.

Under FERPA, school districts may disclose personally identifiable information in a student's education records, including the student's IEP, to school personnel with "legitimate educational interests." An IEP contains important instructional information that teachers, related service providers, paraprofessionals and others need to know to implement the IEP. An IEP often also contains sensitive personal information about the student. As IEPs are provided individuals are informed of their IEP implementation responsibilities, school personnel must take steps to protect the student's right to confidentiality. All records will be placed in your child's file and kept confidential.

In accordance with New York City regulations, it is mandatory to have a copy of your child's IEP on file. In order to obtain a copy of the IEP from the agency we need parental written consent.

I give Bais Rivkah Preschool permission to obtain and share information with:

- ☐ Evaluation Site _____
- ☐ School Personnel
- ☐ Current School/Teacher _____

Parent/Guardian Signature _____

Date _____

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Confidentiality Statement

Associated Beth Rivkah Schools – Preschool Division staff ensures that all information regarding the child and family enrolled in ABRS Preschool is kept confidential. Information includes, but is not limited to, medical, financial, educational, behavioral, etc. Information will be made accessible to staff on a 'need-to-know' basis only. All ABRS Preschool staff sign a 'confidentiality statement' and are trained in HIPPA regulations.

Written consent from the parent is needed to share or receive information with/from an outside agency.

I, _____, parent of _____, agree that all information I hear and/or see while at ABRS Preschool will be kept confidential. Information regarding my child/family or another child/family enrolled in the program will be shared with appropriate staff confidentially. I will not share information and/or pictures of other children enrolled in the program.

Parent's signature: _____ Date: _____

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Parent Workshops

Dear Parents,

Beth Rivkah Preschool strives to provide our families with optimum opportunities for personal growth and enhanced relationships with children and family. Throughout the year, we offer workshops and experiences to help you meet your goals.

Your input is imperative to assure that your needs are met. Please indicate below which topics would be most beneficial to you and your family. [check as many as applicable]

- ☐ Parent/Child Relationships
- ☐ Marriage Enhancement
- ☐ Nutrition
- ☐ Financial Empowerment/Family Budget
- ☐ Health/Safety for all family members
- ☐ Your Child – Self-esteem/ Bullying/Sibling Rivalry/Separation Anxiety
- ☐ Mom's Health and Mental Health Needs
- ☐ Other _____

We appreciate your cooperation. As a member of the Beth Rivkah Preschool family, your attendance at these events is obligatory.

Looking forward to greeting you,

The Staff at Beth Rivkah Preschool

Name:_____ Date: _____

Phone Number: _____

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Volunteering – Ways You Can Help at Bais Rivkah Preschool

PARENT'S NAME: _____

CHILD'S NAME: _____

DAYTIME TELEPHONE #:_____

Beth Rivkah Preschool is a family program. Parent Volunteers make the program work. Here are the types of jobs we need your help with, please check as many as apply:

Classroom activities:

- ☐ Assist teacher in the classroom i.e. read a book,
- ☐ Help on field trips
- ☐ Arrange a bulletin board
- ☐ Share a talent or special activity with children

  Activity: _____

Parent Activities:

- ☐ **Policy Council representative**
- ☐ Parent newsletter
- ☐ Share a special talent or hobby with parents

  Activity: _____

Comments:

_____

_____

_____