

THIS APPLICATION IS FOR CLARKSTOWN, NANUET AND PEARL RIVER SCHOOL DISTRICTS ONLY

UNIVERSAL PREKINDERGARTEN (UPK) APPLICATION

YOU MUST READ THIS PAGE FULLY BEFORE FILLING OUT APPLICATION

Dear Parents/Guardians:

Universal Prekindergarten (UPK) is a special early childhood program which was established by the New York State Education Department (NYSED) and contracted School Districts to provide an early learning experience for the children of eligible families. Eligible families are defined as: those who live in a contracted School District and have children who will be four years old by December 1, 2019 (your child must have been born between December 1, 2014 and December 1, 2015). Universal Prekindergarten is now accepting applications for the 2019-2018 school year (**pending funding approval in the NYS budget**).

This is an early childhood program conducted with a qualified teacher and an assistant in every class. The children attend five (5) half days for 2½ hours each day, for 180 days per school year, at no cost to you.

When you return the completed application, please include the following **copies that we may keep:**

1. A copy of your child's original birth certificate. (If the birth certificate is not in English, we need a copy of your child's passport).
2. **A completed signed or stamped record of up-to-date immunizations and health appraisal form with the physician's name and address included. The attached Health Appraisal form MUST be used. * See Immunization Requirements* (see page 14)**
3. Proof of district residency - 2 Documents are requested. (Documentation showing your name & address. Ex.: Mailing address on a current bank statement, tax bill, utility bill or credit card bill. **UNACCEPTABLE DOCUMENTS** as proof of residence are handwritten envelopes, magazine covers, termination notice for utility bills and income tax returns).
4. Proof of Custody (If child does not live with both parents)
5. A telephone number where you can be reached between 8:30a.m. and 5:00p.m.
6. Included in this application is important lead and dental screening information for you to review.

IT IS IMPORTANT TO RETURN THE COMPLETED UPK APPLICATION BY April 1ST, 2019 TO:

CHILD CARE RESOURCES OF ROCKLAND, INC.
235 NORTH MAIN STREET, SUITE 11
SPRING VALLEY, N.Y. 10977
FAX: (845) 425-5312
ATTN: Jenine Valentino email: jeninev@rocklandchildcare.org

INELIGIBILITY: Incomplete application, Immunization Record and/or students who are unable to attend UPK 5 days a week, 2½ hours per day, for the entire school year may be ineligible.

If an application is received and/or postmarked after April 1, 2019, the application will be placed into a district waiting pool unless slots are available.

STATEMENT OF METHOD FOR SELECTION OF CHILDREN

Child Care Resources of Rockland, Inc. (CCRR) will oversee the registration process. CCRR will accept the applications and verify eligibility. If more requests are made than NYSED has funded, for a specific school district and/or contracted early childhood program, a lottery will be used to select children to participate in the UPK program. **Children will be considered for the lottery if the complete application, birth certificate, complete immunization record, health appraisal form and proof of residency are on file with this office.** Children will be placed according to parent choice, if possible. Parents/Guardians will be notified of the status of their child, by mail, once slots have been filled. Notification will be sent mid May 2018. If your child(ren) are placed into PreK this application will become the property of the school district. For further information or assistance with this application please call Jenine Valentino at (845) 425-0009 x460.

Thank you for your cooperation in providing the necessary information.

Sincerely yours,
Karen Ross
Director of Family, Community and Operations Services



Child Care Aware® of America Member

For UPK Early Childhood**Program Use Only**

Date Received: _____

- ☐ Birth Certificate
☐ Immunizations
☐ Proof of Residency
☐ Health Appraisal Form
☐ Vision Screening
☐ Hearing Screening
☐ BMI Percentile
☐ Home Language Questionnaire

For CCRR Use Only

Date Received: _____

- ☐ Birth Certificate
☐ Immunizations
☐ Proof of Residency
☐ Health Appraisal Form
☐ Vision Screening
☐ Hearing Screening
☐ BMI Percentile
☐ Home Language Questionnaire
☐ Parent Survey
☐ Child Care Needs Assessment
☐ Proof of Custody (if applicable)

2019-2020 UNIVERSAL PREKINDERGARTEN APPLICATION

CIRCLE THE APPROPRIATE SCHOOL DISTRICT WHERE YOUR FAMILY RESIDES:

CLARKSTOWN NANUET PEARL RIVER

NOTE: Residents of EAST RAMAPO CENTRAL School District need to call (845) 577-6158

Child's First Name _____ **Last Name** _____

Date of Birth _____ **Gender** _____

Is the child Hispanic, Latino or of Spanish origin? ☐ Yes ☐ No **Language Spoken at Home (if other than English)** _____

Ethnicity: ☐ Black ☐ American Indian/Alaskan Native ☐ White ☐ Asian ☐ Native Hawaiian/Pacific Islander

Has the child had an educational evaluation: ☐ Yes ☐ No

Custodial Parent/Guardian _____ **Other (please explain)** _____

Parent First Name _____ **Last Name** _____

Parent First Name _____ **Last Name** _____

Where is the student currently living? (Please check one box)

- ☐ In a shelter ☐ In a hotel/motel ☐ In a car, park, bus, train or campsite ☐ With another family or other person because of loss of housing
 or as a result of economic hardship(sometimes referred to as "doubled up") ☐ Other temporary living situation (Please describe):
 _____ ☐ In permanent housing

Home Address: Street _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

***** Please circle which phone number should be used for communication*****

Parent Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Parent Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email address for correspondence _____

Siblings(Brothers/Sisters):

Name: _____ **DOB** _____ **Name:** _____ **DOB** _____

Name: _____ **DOB** _____ **Name:** _____ **DOB** _____

I have completed the application and submitted the required documentation. I have received information about lead, dental and developmental (Brigance) screenings with this application. I understand that my application will not be considered for selection unless all the following documentation has been submitted and is complete:

- | | | |
|--|---|---|
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Complete Immunization Record | <input type="checkbox"/> Health Appraisal Form |
| <input type="checkbox"/> Proof of Residence | <input type="checkbox"/> Home Language Questionnaire | <input type="checkbox"/> Parent Education/Engagement Survey |
| <input type="checkbox"/> Child Care Needs Assessment | <input type="checkbox"/> Proof of Custody (if applicable) | |

Signature of Parent/Guardian _____ **Date** _____

Please write the name of the UPK site you want your child to attend in order of preference

1st Choice _____ **2nd Choice** _____ **3rd Choice** _____



STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lisette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First Middle Last

DATE OF BIRTH:

GENDER:

Month Day Year

☐ Male
☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name First Name Relation to Student

HOME LANGUAGE CODE

Language Background (Please check all that apply.)

- | | | | |
|--|--------------------------------------|---------------------------------|---|
| 1. What language(s) is(are) spoken in the student's home or residence? | <input type="checkbox"/> English | <input type="checkbox"/> Other | specify |
| 2. What was the first language your child learned? | <input type="checkbox"/> English | <input type="checkbox"/> Other | specify |
| 3. What is the Home Language of each parent/guardian? | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | specify |
| | <input type="checkbox"/> Guardian(s) | | specify |
| 4. What language(s) does your child understand? | <input type="checkbox"/> English | <input type="checkbox"/> Other | specify |
| 5. What language(s) does your child speak? | <input type="checkbox"/> English | <input type="checkbox"/> Other | <input type="checkbox"/> Does not speak |
| 6. What language(s) does your child read? | <input type="checkbox"/> English | <input type="checkbox"/> Other | <input type="checkbox"/> Does not read |
| 7. What language(s) does your child write? | <input type="checkbox"/> English | <input type="checkbox"/> Other | <input type="checkbox"/> Does not write |

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

District Name (Number) & School

Address

Home Language Questionnaire (HLQ)—Page Two

Educational History	
8. Indicate the total number of years that your child has been enrolled in school _____	
9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them. <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 30%;"> Yes* <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> </div> <div style="width: 65%;"> *If yes, please explain: _____ How severe do you think these difficulties are? <input type="checkbox"/> Minor <input type="checkbox"/> Somewhat severe <input type="checkbox"/> Very severe </div> </div>	
10a. Has your child ever been <u>referred</u> for a special education evaluation in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes* <i>*Please complete 10b below</i>	
10b. <i>*If referred for an evaluation</i> , has your child ever <u>received</u> any special education services in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes – Type of services received: _____	
Age at which services received <i>(Please check all that apply):</i> <input type="checkbox"/> Birth to 3 years (Early Intervention) <input type="checkbox"/> 3 to 5 years (Special Education) <input type="checkbox"/> 6 years or older (Special Education)	
10c. Does your child have an Individualized Education Program (IEP)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
11. Is there anything else you think is important for the school to know about your child? <i>(e.g., special talents, health concerns, etc.)</i> _____ _____ _____	
12. In what language(s) would you like to receive information from the school? _____	

Signature of Parent or of Person in Parental Relation

Month: _____ Day: _____ Year: _____
Date

Relationship to student: ☐ Mother ☐ Father ☐ Other: _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ	
NAME: _____	POSITION: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:	
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW	
NAME: _____	POSITION: _____
ORAL INTERVIEW NECESSARY: <input type="checkbox"/> No <input type="checkbox"/> Yes	
**DATE OF INDIVIDUAL INTERVIEW: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> Mo. _____ Day _____ Yr. _____ </div>	OUTCOME OF INDIVIDUAL INTERVIEW: <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <input type="checkbox"/> ADMINISTER NYSITELL <input type="checkbox"/> ENGLISH PROFICIENT <input type="checkbox"/> REFER TO LANGUAGE PROFICIENCY TEAM </div> <div style="width: 55%;"></div> </div>
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL	
NAME: _____	POSITION: _____
DATE OF NYSITELL ADMINISTRATION: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> Mo. _____ Day _____ Yr. _____ </div>	PROFICIENCY LEVEL ACHIEVED ON NYSITELL: <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 80%;"> <input type="checkbox"/> ENTERING <input type="checkbox"/> EMERGING <input type="checkbox"/> TRANSITIONING <input type="checkbox"/> EXPANDING </div> <div style="width: 20%; text-align: right;"> <input type="checkbox"/> COMMANDING </div> </div>
FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION: _____ _____ _____	



VICKI CARAMANTE
Executive Director

235 North Main Street, Spring Valley, NY 10977
877-425-0009 | 845-425-0009 | fax: 845-425-5312
childcarerockland.org | info@rocklandchildcare.org

DO YOU HAVE A CHILD AGED 12 OR UNDER?
IS YOUR CHILD CURRENTLY IN CARE? • ARE YOU LOOKING FOR CHILD CARE?
HAVE YOU USED CHILD CARE IN THE PAST?

WE WANT TO HEAR FROM YOU! ALL SURVEY PARTICIPANTS WILL BE

The information we gather will help Child Care Resource and Referral Agencies across New York State to improve services to families. All responses are confidential and your information is not shared with other organizations. Surveys must be submitted by **April 1, 2019**

1. Which of the five towns do you reside? ☐ Clarkstown ☐ Haverstraw ☐ Orangetown ☐ Ramapo ☐ Stony Point
2. How did you hear about this survey?
☐ Email from CCRR ☐ Email other ☐ USPS Mail ☐ Local DSS ☐ Community event
☐ Child Care Provider ☐ Health care provider ☐ Relative/Friend ☐ Newspaper ☐ Social Media
☐ CCRR website ☐ CCRR staff ☐ Other _____
3. Do you currently have children in child care OR have you had children in child care in the past 12 months?
☐ Yes ☐ No
4. What is your family composition and employment status?
☐ Mother, single, working
☐ Mother, single, not working
☐ Father, single, working
☐ Father, single, not working
☐ 2 parents/guardians, both working
☐ 2 parents/guardians, 1 working
☐ 2 parents/guardians, neither working
5. What is your family size? (include you, your spouse and children) _____
6. How many children do you have? # in each age group
☐ Infants (0-17 months) _____
☐ Toddlers (18-35 months) _____
☐ Preschoolers (3-5 years) _____
☐ Kindergarten – 6th grade _____
☐ 7th grade to 9th grade _____

7. What is your current family income?
- | | | |
|--|--|--|
| <input type="checkbox"/> No income | <input type="checkbox"/> Less than \$32,000 | <input type="checkbox"/> \$32,001-\$40,000 |
| <input type="checkbox"/> \$40,001-\$50,000 | <input type="checkbox"/> \$50,001-\$60,000 | <input type="checkbox"/> \$60,001-\$70,000 |
| <input type="checkbox"/> \$70,001-\$80,000 | <input type="checkbox"/> \$80,001-\$90,000 | <input type="checkbox"/> \$90,001-\$100,000 |
| <input type="checkbox"/> \$100,001-\$150,000 | <input type="checkbox"/> \$150,001-\$250,000 | <input type="checkbox"/> \$250,001-\$500,000 |
| <input type="checkbox"/> \$500,001 + | <input type="checkbox"/> I do not wish to answer | |
8. While your children were in care, did you ever have trouble paying?
- ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
9. In order to pay for care, did you: (check all that apply)
- ☐ Borrow from family ☐ Borrow from friends ☐ Use credit cards ☐ Cut back on work hours
- ☐ Cut back on basic household expenses ☐ Cut back on child care hours
- ☐ Have a friend/relative watch your child/children
- ☐ Use a combination of child care types (examples: child care center and grandmother, or one provider during the week and a different provider on the weekend)
- ☐ None, I can pay
10. Do you receive assistance to pay for child care/child care subsidy?
- ☐ Yes ☐ No
11. If you do receive assistance, do you have trouble paying your parent share fee/co-pay?
- ☐ Yes ☐ No
12. Please indicate the reasons why you chose your specific child care arrangement:
- ☐ Quality ☐ Location – close to home ☐ Location – close to work ☐ Hours
- ☐ Cost ☐ Caregiver is a relative ☐ Children are happy in the program ☐ Small adult/child ratio
- ☐ The program accepts subsidy/assistance ☐ Good learning/educational program
- ☐ Caregiver is trained/educated ☐ Caregiver is knowledgeable ☐ How I was treated at the initial visit
- ☐ Heard good things from other parents ☐ Activities offered for children
- ☐ My other child was enrolled in this program (currently or previously)
- ☐ Provider had experience with special needs children ☐ Program nationally accredited
- ☐ Other _____
13. Of the reasons you indicated above, what are the **2 MOST** important?
- ☐ Quality ☐ Location – close to home ☐ Location – close to work ☐ Hour
- ☐ Cost ☐ Caregiver is a relative ☐ Children are happy in the program ☐ Small adult/child ratio
- ☐ The program accepts subsidy/assistance ☐ Good learning/educational program
- ☐ Caregiver is trained/educated ☐ Caregiver is knowledgeable ☐ How I was treated at the initial visit
- ☐ Heard good things from other parents ☐ Activities offered for children
- ☐ My other child was enrolled in this program (currently or previously)
- ☐ Provider had experience with special needs children ☐ Program nationally accredited
- ☐ Other _____

The next section of questions are about child care. You only need to complete the sections that apply to your children in care currently or in the past 12 months. Please enter your responses in the appropriate column(s).

14. Where is, or has your child(ren) been cared for in the past 6 months (check all that apply)

	Infant(s)	Toddler(s)	Preschooler(s)	School Age
How many children do you currently have in care or have had in care in the past 12 months?				
If you are currently seeking child care, how long have you been looking?				
0-3 months				
3-6 months				
Over 6 months				
What type of child care are you using/did you use for your child?				
Child Care Center				
Licensed/Registered Child Care Home				
Head Start/Early Head Start				
Nanny/Babysitter in home				
Nursery School				
Preschool				
Older sibling				
Care by parent				
Care by friend or relative				
Camp				
Before/After School care				
Library				
Combination of providers				
Other				
What type of care would be your first choice?				
Child Care Center				
Licensed/Registered Child Care Home				
Head Start/Early Head Start				
Nanny/Babysitter in home				
Nursery School				
Preschool				
Older sibling				
Care by parent				
Care by friend or relative				
Camp				
Before/After School care				
Library				
Combination of providers				
Other				
How much do you pay per week for care?	\$	\$	\$	\$
How many days a week are/is your child in care?				
If you are receiving subsidy/assistance, what is your parent share/co-pay?	\$	\$	\$	\$
How satisfied are you with your child care provider?				
Very satisfied				
Satisfied				
Neither satisfied or dissatisfied				
Dissatisfied				
Very dissatisfied				

15. If you have ever been dissatisfied or very dissatisfied with a child care provider, please indicate why (check all that apply):
- | | |
|---|---|
| <input type="checkbox"/> Child isn't in a good learning environment | <input type="checkbox"/> Provider hours |
| <input type="checkbox"/> Provider/teacher could be more nurturing | <input type="checkbox"/> Other children's behavior towards your child |
| <input type="checkbox"/> Provider schedule/availability (days of the week) | <input type="checkbox"/> Inconvenient location/long drive |
| <input type="checkbox"/> OCFS Violations (active or not yet reported) | <input type="checkbox"/> Do not agree with provider's child care philosophy |
| <input type="checkbox"/> Environment (pets, air quality, safety issues) | <input type="checkbox"/> Child is unhappy |
| <input type="checkbox"/> Provider's business practices (won't provide tax information, documentation, etc.) | |
| <input type="checkbox"/> Other _____ | |
16. Have you ever withdrawn your child from a provider/program for any of the following reasons (check all that apply):
- ☐ Cost of care was too high ☐ Change in your work hours ☐ Moved out of area of current child care
- ☐ Provider cannot take my infant (or 2nd child) ☐ Provider/Teacher could be more nurturing
- ☐ Frequent staff changes
- ☐ Personal dissatisfaction (doesn't like the person, doesn't like another staff/household member, child isn't happy but nothing is "wrong", etc.)
- ☐ Provider's business practices (won't provide tax information, documentation, etc.)
- ☐ Environment (pets, air quality, safety issues) ☐ OCFS Violations (active or not yet reported)
- ☐ My child was expelled/asked to leave ☐ Other _____
- ☐ No – I have never withdrawn my child from a provider/program

Employment Questions

17. Have child care issues ever caused you to (check all that apply):
- ☐ Call out of work ☐ Feel distracted/unproductive at work ☐ Leave work early
- ☐ Arrive late ☐ Cut back work hours ☐ Quit your job ☐ Lose your job
- ☐ Change your job within the company (less responsibility)
- ☐ Change jobs to another company ☐ Receive disciplinary action/be written up
- ☐ No issues ☐ Other _____
18. Does your employer offer (check all that apply)
- ☐ Work from home when child is sick or off from school
- ☐ Dependent Care Assistance (DAP) ☐ Resources to find child care
- ☐ Child care at work site ☐ Financial assistance for child care ☐ Extended maternity/paternity leave
- ☐ Flexible schedule ☐ Allow you to bring your child to work
- ☐ Other _____
19. If your employer offered any of the options in question 18, which 2 would be the most helpful?
- ☐ Work from home when child is sick or off from school
- ☐ Dependent Care Assistance (DAP) ☐ Resources to find child care
- ☐ Child care at work site ☐ Financial assistance for child care ☐ Extended maternity/paternity leave
- ☐ Flexible schedule ☐ Allow you to bring your child to work
- ☐ Other _____
20. Have child care issues impacted your job (check all that apply):
- ☐ Child care not always reliable ☐ Not always able to pay ☐ Worried child isn't safe
- ☐ Worried child isn't receiving best care ☐ Did not have someone to watch child ☐ No impact
- ☐ Other _____

21. Do you think the increase in minimum wage will (check all that apply):

- ☐ Affect your ability to pay for care ☐ Increase the cost of care
☐ Reduce the availability of child care providers ☐ No impact
☐ Other _____

22. Do you plan to/would you utilize Paid Family Leave?

- ☐ Mother only ☐ Father only ☐ Both parents/guardians ☐ One parent/guardian only
☐ Neither parent/guardian ☐ Not sure

23. Are you aware of Child Care Resources of Rockland's services for children and families?

- ☐ Yes ☐ No, but I have heard about them ☐ No, I have never heard about them

This survey is separated from your Pre-K application and the information provided has no impact on the selection process. Your contact information will be kept confidential.

Email address _____

Phone number (with area code) _____

First and Last Name (Optional) _____

Would you be interested in any of the following?

- ☐ Yes, send me the results of this survey
☐ Yes, I would like to join your email list
☐ No, I am not interested

**THANK YOU FOR RETURNING
THIS SURVEY**

Fax: 845-425-5312

**Mail: CCRR, 235 N. Main Street, Suite 11,
Spring Valley, NY 10977**

Email: info@rocklandchildcare.org

**Or take survey on-line at
www.childcarerockland.org**

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM**TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR**

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Food <input type="checkbox"/> Insects <input type="checkbox"/> Latex <input type="checkbox"/> Medication <input type="checkbox"/> Environmental	<input type="checkbox"/> Anaphylaxis Care Plan Attached
Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Other : _____	<input type="checkbox"/> Asthma Care Plan Attached
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type: _____	<input type="checkbox"/> Seizure Care Plan Attached Date of last seizure: _____
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes, indicate type	<input type="checkbox"/> Medication/Treatment Order Attached <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> HbA1c results: _____ Date Drawn: _____	<input type="checkbox"/> Diabetes Medical Mgmt. Plan Attached
Risk Factors for Diabetes or Pre-Diabetes: <i>Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.</i>		
BMI _____ kg/m2 Percentile (Weight Status Category): <input type="checkbox"/> <5 th <input type="checkbox"/> 5 th -49 th <input type="checkbox"/> 50 th -84 th <input type="checkbox"/> 85 th -94 th <input type="checkbox"/> 95 th -98 th <input type="checkbox"/> 99 th and >		
Hyperlipidemia: <input type="checkbox"/> No <input type="checkbox"/> Yes Hypertension: <input type="checkbox"/> No <input type="checkbox"/> Yes		

PHYSICAL EXAMINATION/ASSESSMENT

Height:	Weight:	BP:	Pulse:	Respirations:
TESTS	Positive	Negative	Date	Other Pertinent Medical Concerns
PPD/ PRN	<input type="checkbox"/>	<input type="checkbox"/>		One Functioning: <input type="checkbox"/> Eye <input type="checkbox"/> Kidney <input type="checkbox"/> Testicle
Sickle Cell Screen/PRN	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Concussion – Last Occurrence: _____
Lead Level Required Grades Pre- K & K			Date	<input type="checkbox"/> Mental Health: _____
<input type="checkbox"/> Test Done <input type="checkbox"/> Lead Elevated ≥ 10 $\mu\text{g/dL}$				<input type="checkbox"/> Other: _____
<input type="checkbox"/> System Review and Exam Entirely Normal				
Check Any Assessment Boxes <u>Outside</u> Normal Limits And Note Below Under Abnormalities				
<input type="checkbox"/> HEENT	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Extremities	<input type="checkbox"/> Speech
<input type="checkbox"/> Dental	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Back/Spine	<input type="checkbox"/> Skin	<input type="checkbox"/> Social Emotional
<input type="checkbox"/> Neck	<input type="checkbox"/> Lungs	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Assessment/Abnormalities Noted/Recommendations:			Diagnoses/Problems (list)	ICD-10 Code
			_____	_____
			_____	_____
			_____	_____
<input type="checkbox"/> Additional Information Attached				

Name:			DOB:	
SCREENINGS				
Vision	Right	Left	Referral	Notes
Distance Acuity	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail				
Hearing	Right dB	Left dB	Referral	
Pure Tone Screening			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scoliosis Required for boys grade 9 And girls grades 5 & 7	Negative	Positive	Referral	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				
RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK				
<input type="checkbox"/> Full Activity without restrictions including Physical Education and Athletics. <input type="checkbox"/> Restrictions/Adaptations Use the Interscholastic Sports Categories (below) for Restrictions or modifications <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> No Contact Sports <input type="checkbox"/> No Non-Contact Sports <input type="checkbox"/> Other Restrictions: </div> <div style="width: 65%;"> Includes: baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling Includes: archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field </div> </div>				
<input type="checkbox"/> Developmental Stage for Athletic Placement Process ONLY Grades 7 & 8 to play at high school level OR Grades 9-12 to play middle school level sports Student is at Tanner Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V				
<input type="checkbox"/> Accommodations: Use additional space below to explain <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> Brace*/Orthotic</div> <div style="width: 33%;"><input type="checkbox"/> Colostomy Appliance*</div> <div style="width: 33%;"><input type="checkbox"/> Hearing Aids</div> <div style="width: 33%;"><input type="checkbox"/> Insulin Pump/Insulin Sensor*</div> <div style="width: 33%;"><input type="checkbox"/> Medical/Prosthetic Device*</div> <div style="width: 33%;"><input type="checkbox"/> Pacemaker/Defibrillator*</div> <div style="width: 33%;"><input type="checkbox"/> Protective Equipment</div> <div style="width: 33%;"><input type="checkbox"/> Sport Safety Goggles</div> <div style="width: 33%;"><input type="checkbox"/> Other:</div> </div>				
*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.				
Explain: _____				
MEDICATIONS				
<input type="checkbox"/> Order Form for Medication(s) Needed at School attached				
List medications taken at home:				
IMMUNIZATIONS				
<input type="checkbox"/> Record Attached		<input type="checkbox"/> Reported in NYSIS		Received Today: <input type="checkbox"/> Yes <input type="checkbox"/> No
HEALTH CARE PROVIDER				
Medical Provider Signature:			Date:	
Provider Name: <i>(please print)</i>			Stamp:	
Provider Address:				
Phone:				
Fax:				
Please Return This Form To Your Child's School When Entirely Completed.				

Health notes for Universal Pre-Kindergarten Parents: REQUIREMENTS

Immunizations: Your child's application will NOT be entered into the lottery without proof of the following immunizations:

4 DTap, 3 Hepatitis B, 3 IPV, 4 Hib, 4 PNEUMMOCCAL, 1 MMR, 1 Varicella
(<http://www.health.ny.gov/publications/2370.pdf>)

Free immunizations are available at the Rockland County Health Department in Pomona at the Robert Yeager Health Center, Building A, 2nd Floor in the rotunda area. For appointments call (845) 364-2519. The clinic sees children under the age of 5 on the 2nd Wednesday of each month.

There are only three exceptions for proof of immunizations: 1) proof of an appointment to receive a missing immunization 2) a letter of religious exemption or 3) documentation by a health care provider of a medical exemption.

Health Appraisal/Medical Statement: You must use the form provided in this application. All required information must be complete as shown. Ensure that your doctor includes the vision and hearing screenings; BMI and BMI %. If a PPD test is not done, ask the doctor to write "not indicated" or another comment. In certain grades, weight status category BMI % is reported to the NYS Department of Health. No names are sent, however you may choose to have your child's information excluded from this report. In this case, please mark the appropriate box on the health appraisal form.

RECOMMENDATIONS

Lead Screening

Children can get "lead poisoning" from lead paint in older homes, contaminated soil, imported toys, ceramic dishes and water flowing from old pipes. The symptoms may look like minor illnesses but the potential damage is enormous, and may cause reduced IQ, slowed body growth, hearing problems, behavior and attention problems and kidney damage. Talk to your doctor about having your child's blood tested for lead.

Dental Screening:

The American Academy of Pediatric Dentistry recommends a dental check-up at least twice a year for most children. Some children need more frequent dental visits because of increased risk of tooth decay, unusual growth patterns or poor oral hygiene. Your pediatric dentist provides an ongoing assessment of changes in your child's oral health. For example, your child may need additional fluoride, dietary changes, or sealants for ideal dental health. A dentist will give you a dental certificate for your child, for your school district, which you can give to Child Care Resources of Rockland, if needed. Listed below are low cost dental facilities in Rockland County provided by New York State Education Department Student Support Services Team:

Community Medical & Dental, Monsey:	(845) 352-6800
Community Medical & Dental, Spring Valley:	(845) 426-5800
Refuah Health Center, Inc., Spring Valley:	(845) 354-9300
Hudson River Healthcare, Spring Valley	(845) 573-9860
Hudson River Healthcare, Haverstraw	(845) 429-4499

THE CREATIVE CURRICULUM FOR PRESCHOOL

The word curriculum is often defined as “a plan for learning”.

New York State Education Regulations require that the curriculum used in the Universal Pre-kindergarten classroom be aligned with the Early Learning Standards. In New York State Prek Learning Standards were approved by the Board of Regents at their P-12 Education Committee Meeting on January 10, 2011. These are known as the NYS Prek Foundation for the Common Core. These standards address the following areas: Approaches to Learning, Physical Development and Health, Social and Emotional Development, Communications, Language and Literacy, Cognitive and Knowledge of the World. These standards are available at the following web address:

<http://www.p12.nysed.gov/ciai/commoncorestandards/pdfdocs/nyslsprek.pdf>

The Creative Curriculum for Preschool 5th Edition was chosen by 7 of the 8 school districts in Rockland County for use in the Universal Pre-kindergarten programs because it is directly aligned with the NYS Prek Foundation for the Common Core and because it emphasizes developmentally appropriate practice. The curriculum is published by Teaching Strategies (www.TeachingStrategies.com) and is written by Diane Trister Dodge, Laura Colker and Cate Heroman. These three early childhood professionals are well known speakers, authors, educators and innovators in early childhood education.

The Creative Curriculum for Preschool 5th Edition is based on classic research in child development that has accumulated over the past 75 years. It is based on recent research and major theories that support the concept of developmentally appropriate practice, which means teaching children in ways that match the way they develop and learn. It is also based on current information about learning, the brain and resiliency.

What we know in the field about how four year olds develop and learn best tells us that they need many whole body, hands on, real life experiences to experiment, explore and pursue their own interests. They need ample opportunities to develop independence, decision-making and problem solving skills, creative expression and conflict resolution. The concept of developmentally appropriate practice tells us that children are most receptive to, and best acquire academic readiness skills when they are embedded within the child's naturally sought after play experiences. The curriculum guides teachers in structuring these experiences and the environment in such a way that maximizes the child's interest areas and skill levels. The teachers are involved in a continual process of observing, guiding and assessing a child's learning so that they may plan most effectively.

The Creative Curriculum for Preschool 5th Edition is a guide for teachers to support them in planning these types of learning experiences for their students. It helps teachers to understand individual differences in gender, temperament, interests, learning styles, cultural backgrounds, special needs or if a child is learning English as a second language. The curriculum also recognizes that the most recent research and findings indicate that a balance of teacher directed and child-initiated learning experiences is best.

BRIGANCE SCREENING

In New York State children are required to be screened at the first point of entry into the school district. This has typically occurred when children enter kindergarten. A screening will be required of your child at this time because they are entering the district as a four-year-old through the Universal Pre-Kindergarten program. If your child is selected for UPK, a diagnostic developmental screening will be administered to your child at their UPK site prior to December 1st of the 2019/2020 school year as per Part 117 of the New York State Education Regulations. The diagnostic screening tool used by all of the districts is the Brigance Early Childhood Screen III. This nationally standardized tool can be administered in approximately 15 minutes. It covers a broad sampling of a child's skills in key developmental areas such as language, literacy, math and physical skills. The information collected during the screening helps teachers and program directors to satisfy screening requirements, plan for individualized and group instruction and initiate referrals for further evaluation if necessary.

Universal Prekindergarten Program Site List

Please Read The Entire Page For Important Information

Is your child currently enrolled in an early childhood program? Yes ☐ No ☐

If yes, name of program? _____

(If your child is selected to participate in the Universal Prekindergarten program all efforts will be made to keep your child in his/her current early childhood program based on availability if that program is a UPK early childhood program).

All Universal Prekindergarten eligible, selected applicants are permitted to enroll their child(ren) in any of the listed early childhood programs, regardless of school district, subject to availability and authorization by the school district. For simplicity, the attached early childhood program list has been designed alphabetically by village with available early childhood programs.

Please number with a 1, 2 and 3 to show your 1st, 2nd and 3rd choices of early childhood programs that you want your child to attend for the Universal Prekindergarten Program.

We STRONGLY RECOMMEND that parents contact individual sites for information about the programs and their time of operation and visit the UPK early childhood program prior to selection.

Children will NOT be moved to another UPK program after October 1, 2019 unless there are extreme circumstances.

Child Care Resources of Rockland, Inc. can only place your child in a program NOT a classroom. Classroom assignments are made at the discretion of each early childhood program. Please note that session times may be subject to change. Please circle the session you are interested in attending. Any programs offering an extended day for an additional fee will be noted by an * sign.

AM Session	PM Session	Choice # (1, 2 or 3)	Program Name	Address	Point of Contact and Number
Blauvelt					
<u>9-2</u>	<u>1-3:30</u>		Preschool Playhouse/ Funland	557 Western Highway Blauvelt, NY 10913	Adam Fiala (845) 359-4562
<u>8:30-11:15</u> <u>8:30-2</u>			St. Catharine's Early Education Center	517 Western Highway Blauvelt, NY 10913	Barbara Feeney (845) 359-4330
St. Catherine's will only serve children in Clarkstown, Nanuet, Nyack, Pearl River and South Orangetown.					
Garnerville					
<u>8:30-11</u>	<u>3-5:30</u>		Time In Child Care Inc.	60 Captain Shankey Drive Garnerville, NY 10923	Denise Forsberg (845) 942-8149
<u>8-10:30</u> <u>8-2:40</u>	<u>12-2:30</u>		St. Gregory	26 Cinder Rd Garnerville, NY 10923	Dana Spicer (845) 947-1330
Haverstraw					
<u>10:45-1:15</u> <u>9:30-3:30</u>	<u>1:30-4</u>		Haverstraw Day Care, Inc.	212 Route 9W Haverstraw, NY 10927	Gabriella Armas (845) 429-2323
<u>9-11:30</u> <u>8:30-11</u>			Haverstraw Head Start	138-146 Maple Avenue Haverstraw, NY 10927	Danilsa Foster (845) 429-2225
<u>9-11:30</u> <u>9-2</u>	<u>12:30-3</u>		Benim Academy of Haverstraw	21 Ridge Street Haverstraw, NY 10927	Lana Benim (845) 521-7055
Nanuet					
<u>9:15-11:45</u>	<u>12:30-3</u>		Kids Kingdom	121 West Nyack Road Nanuet, NY 10954	Stacie Scollo (845) 624-0936

AM Session	PM Session	Choice # (1, 2 or 3)	Program Name	Address	Point of Contact and Number
<u>9:30-12</u>	<u>12:30-3</u>	*	George Miller School	50 Blauvelt Road Nanuet, NY 10954	RoseAnn Mercado (845) 627-4889
This program at George Miller will be operated by Nanuet Family Resource Center and will accept Nanuet School District children only.					
New City					
<u>9-11:30</u> <u>9-2</u>	<u>12:30-3</u>	* ***	Benim Scholastic Academy	114 So Main Street New City, NY 10956	Lana Benim (845) 521-7055
	<u>12:30-3</u>		Busy Bee Playschool	39 Germonds Road New City, NY 10956	Ric Rabinowitz (845) 623-0849
<u>9-11:30</u> <u>9-3:30</u>	<u>1-3:30</u>	* ***	Jawonio	260 Little Tor Road New City, NY 10956	Evelyn Bautista-Miller (845) 708-2000 x3255
	<u>12-2:30</u>	*	New City Jewish Center	47 Old Schoolhouse Road New City, NY 10956	Jacalyn Binstock (845) 638-9600 ext 117
<u>9-11:30</u>	<u>12:30-3</u>		Prime Time for Kids	60 Phillips Hill Road New City, NY 10956	David Saupaugh (845) 639-2425
<u>9-11:30</u> <u>9-3</u>	<u>1-3:30</u>	* ***	Smarty Pants Learning Center	484 New Hempstead Rd New City, NY 10956	Hisha Ewing (845) 678-3809
<u>9-11:30</u>		*	St. Paul's Christian Day School	323 So Main Street New City, NY 10956	Fran Taihi (845) 634-0929
<u>9-11:30</u>		*	Tutor Time – New City	227 North Main Street New City, NY 10956	Karen Wizeman (845) 708-8270
Nyack					
<u>9-3</u>	<u>12:30-3:15</u>	* ***	Montessori Center of Nyack	85 Marion Street Nyack, NY 10960	Dorothy Goren (845) 358-9209
<u>8:30-11</u>			Nyack Head Start	85 Depew Avenue Nyack, NY 10960	Kira Davenport (845) 358-2234

AM Session	PM Session	Choice # (1, 2 or 3)		Program Name	Address	Point of Contact and Number
Nyack(cont'd)						
<u>9-11:30</u>			*	Children of America	265 No. Highland Ave Nyack, NY 10960	Ann Marie Esposito (845) 348-1433
Palisades						
<u>9-11:30</u> <u>9-2:30</u>	<u>1-3:30</u>		* ***	Children's Corner	680 Oak Tree Lane Palisades, NY 10964	Farah Cleary (845) 680-0007
Pearl River						
<u>9-11:30</u> <u>9-2:30</u>	<u>12-2:30</u>		* ***	Children's Corner	1 Blue Hill Plaza Pearl River, NY 10965	Sari Altabet (845) 620-1669
<u>9-11:30</u>	<u>12:30-3</u>			Good Shepherd	112 North Main Street Pearl River, NY 10965	Maureen Connelly (845) 735-2737
<u>9-11:40</u>	<u>12-2:40</u>			Naurashaun Nursery School	51 Sickletown Road Pearl River, NY 10965	Tara DiRocco (845) 735-4787
<u>9:15-11:45</u>				Tall Pines Nursery School	84 Ehrhardt Road Pearl River, NY 10965	Diane Kayser (845) 735-7227
Pomona						
<u>9:30-12</u> <u>9:30-3</u>	<u>12:30-3</u>		* ***	Rockland Worksite Day Care	50 Sanatorium Road Bldg R Pomona, NY 10970	Maria Ceci (845) 364-2697
Sloatsburg						
<u>9-11:30</u>				Y's Beginnings-Sloatsburg	11 Second Street Sloatsburg, NY 10974	Marianna Resch (845) 357-3223
<u>9-2</u> <u>9-11:30</u>			* ***	Red Owl Academy LLC	645 Main Street Sparkill, NY 10976	Liana Sargsyan-Quinn (845) 848-2407
				Stony Point		
	<u>12:20-2:50</u> <u>12:30-3:10</u>		*	Children of Mary Nursery/Kindergarten	174 Filors Lane Stony Point, NY 10980	Kathleen Brooks (845) 947-3183

AM Session	PM Session	Choice # (1, 2 or 3)	Program Name	Address	Point of Contact and Number
<u>9-11:30</u>			*	Children of America 32 S Liberty Drive Stony Point, NY 10980	Amanda Munderville (845) 429-4621
Suffern					
<u>9-11:30</u>	<u>1-3:30</u>		*	Rockland Community College Campus Fun and Learn 145 College Road Suffern, NY 10901	Andrea Bogin (845) 574-4561
<u>9-11:30</u> <u>9-2</u>			* ***	Kindercare 36 Route 59 Suffern, NY 10901	Ashleigh Goldberg (845) 357-4048
<u>9-11:30</u>	<u>12:45-3:15</u>			Viola PreK 557 Haverstraw Road Route 202 Suffern, NY 10901	Alexis Fibble (845) 357-7783 ext 232
Suffern Central PreK is located in the Viola Elementary and will accept only Suffern Central children first.					
<u>8-10:30</u> <u>8-1</u>	<u>12-2:30</u>		* ***	Sacred Heart School 60 Washington Ave Suffern, NY 10901	Kathleen Grande (845) 357-1684
<u>9-11:30</u>			*	The Goddard School 334 Spook Rock Road Suffern, NY 10901	Carolina Krauthamer (845) 368-3773
Tappan					
<u>9-11:30</u>	<u>12:30-3</u>			Y's Beginnings – Suffern 18 Parkside Drive Suffern, NY 10901	Marianna Resch (845) 357-3223
<u>9:05-11:35</u>	<u>12:30-3</u>			Children's Enrichment Center 32 Old Tappan Road Tappan, NY 10983	Joanne Volpe (845) 398-3370
Valley Cottage					
<u>8-15-10:45</u>	<u>12-2:30</u>		* ***	St Paul's Pre-K 365 Kings Highway Valley Cottage NY 10989	Michelle Pitot (845) 268-6506

AM Session	PM Session	Choice # (1, 2 or 3)	Program Name	Address	Point of Contact and Number
West Haverstraw					
<u>9-11:30</u>	<u>12:30-3</u>		The Jan and Niles Davies Learning Center	Bldg. 40 Route 9W Helen Hayes Hospital West Haverstraw, NY 10993	Lindsay Smyth (845) 786-4595
*Note programs that offer extended hours for a fee. *** Note programs that offer Statewide Full Day					