

# Universal Pre-Kindergarten (UPK) Program Registration Packet



Utica City School District  
929 York Street  
Utica, NY 13502

# Welcome to the Universal Pre-K Program!

Preschool offers children a solid foundation in social, early academic and life skills, preparing them for school and beyond. The Universal Pre-Kindergarten Program is available to children who will be four years old by December 1 and reside in the Utica City School District. Options for half-day or full-day attendance are available, with no fees for eligible participants.

Attached is the Universal Pre-Kindergarten (UPK) registration packet and a list of participating agencies. After completing the packet, you may finalize your child's registration at the UPK Community Agency site of your choice.

Please note that partnering agencies operate independently of the Utica City School District and may require additional registration information, as well as offer additional services such as childcare beyond UPK program hours for an additional fee.

Registration packets are available at [uticaschools.org](http://uticaschools.org) and at participating UPK Community Agencies. In the event that more registrations are received than seats available, a lottery will be held on June 2.

Please complete the attached packet and submit it—along with the required documents listed below—to the agency of your choice:

Required Documents:

- **Birth Certificate**
- **Immunization Record** with all required vaccines
- **Current Proof of Residency**, such as:
  - National Grid, water, cable, or telephone landline bill
  - TANF Budget Sheet or SSI Award Letter
  - Lease/deed
  - Utica tax bill
  - Paystub



If you have any questions, please contact the Office of Early Childhood Education at 315-792-2216.

## UPK Community Agencies

Agency Information	UPK Hours	Child Care Available	Please rank the UPK sites in order of preference from 1 to 4. Only include agencies you are interested in applying to.
<p style="text-align: center;"><b>Head Start Mohawk Valley Community Action Agency</b></p> <p>Assistant Director of Child Development: Michelle Kelley 315-624-9930 x 2830</p>	<p>Full Day 8:30 - 2:30</p>	<p>Yes (At no cost)</p>	
<p style="text-align: center;"><b>Thea Bowman House</b></p> <p>Director: Jane Domingue 315-797-0748 315-724-6388</p>	<p>Full Day 9:00 - 3:00</p> <p>Half Day AM: 9:00 - 11:30 PM: 12:30 - 3:00</p>	<p>Yes</p>	
<p style="text-align: center;"><b>Neighborhood Center and North Community Center</b></p> <p>Director: Sabrina Lamie 315-272-2760/2600 315-724-2430</p>	<p>Full Day 8:30 - 2:30</p> <p>Half Day AM: 8:30 - 11:00 PM: 12:30 - 3:00</p>	<p>Yes (Elizabeth St. only)</p>	
<p style="text-align: center;"><b>Notre Dame Elementary</b></p> <p>Director: Carol Polito 315-732-4374</p>	<p>Full Day 8:00 - 2:30</p> <p>Half Day AM: 8:00 - 11:00 PM: 11:30 - 2:30</p>	<p>Yes</p>	

**To register for UPK, please follow these steps:**

- 1. Complete the entire registration packet.**
- 2. Gather all required documents (refer to the previous page for details).**
- 3. Contact your preferred UPK agency to schedule an appointment for dropping off the completed registration packet and completing required agency documents.**

# Student Contact Form

**Dear Parents or Guardians: Complete this form so that we may keep this on file for your child.  
If this information should change during the year, please notify us.**

Child's Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ (As of August 30th)

Address: \_\_\_\_\_

Primary Telephone Number: \_\_\_\_\_ Primary Cell Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

## **IMPORTANT MEDICAL INFORMATION: EMERGENCY TELEPHONE NUMBERS**

(In case we cannot reach you at home, cell, or work)

### **Contact 1**

Name: \_\_\_\_\_ Relation to Child \_\_\_\_\_

Telephone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

### **Contact 2**

Name: \_\_\_\_\_ Relation to Child \_\_\_\_\_

Telephone #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Baby sitter's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Floor # \_\_\_\_\_ Circle one: Home/Apt

### **Other Children in the family (in school)**

Name \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

# Student Residency Questionnaire

**NOTE TO SCHOOLS: 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.**

Name of School: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Last

First

Middle

Gender:  Male  
 Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_  
Month Day Year (preschool – 12)

Current Address: \_\_\_\_\_ Phone: \_\_\_\_\_

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

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

- In a shelter (one night at a time)
- In transitional housing (shelter for longer periods of time)
- "Doubled-Up" -living with relatives, another family, or other people because of loss of housing or as a result of economic hardship
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): \_\_\_\_\_
- Permanently housed (not eligible for McKinney Vento services)

Is the student an "unaccompanied youth" (not living with a parent or guardian)? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Print name of Parent, Guardian, OR  
Student (for unaccompanied homeless youth)

\_\_\_\_\_  
Signature of Parent, Guardian, OR  
Student (for unaccompanied homeless youth)

Date \_\_\_\_\_

If the student is NOT living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the student is to be immediately enrolled. The district's LEA liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled.

NOTE TO SCHOOL: If the student is NOT living in permanent housing, please ensure that a STAC-202 form is completed and sent with this form to the Office of Pre K/Early Childhood Education. Safe Schools coordinators are available to assist with this procedure. Send all documentation related to the student's temporary housing situation to the Office of Pre-K/Early Education. We do NOT retain copies of these forms in the student's permanent file.

# Physical History & Emergency Contact Information

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Address

\_\_\_\_\_  
DOB/Place

\_\_\_\_\_  
Parent/Guardian Name (s)

\_\_\_\_\_  
Place of Employment

\_\_\_\_\_  
Home #/Work #

\_\_\_\_\_  
Doctor to be called in case of Emergency

\_\_\_\_\_  
Name, Address, Phone Number

## PHYSICAL HISTORY

What Diseases has the child had? (GIVE DATES)

Chicken Pox \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Throat Infection \_\_\_\_\_ Scarlet Fever \_\_\_\_\_

Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Pneumonia \_\_\_\_\_ Ear Infection \_\_\_\_\_ Epilepsy \_\_\_\_\_

Other: \_\_\_\_\_

Does your child have allergies, asthma? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_

Does your child take medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give name of medication, dosage, & for what condition \_\_\_\_\_

Has your child ever had an accident, operation, or x-rays? \_\_\_\_\_

Does your child have any handicap or limitation that the school should know about? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

Is there anything about the eyes, ears, teeth, or general health of your child that the school should know of?

Emergency Care: In case our child is injured or becomes ill during school hours, we will contact you immediately by phone. **If that is not possible**, please state below what action you wish the school to take and the name of the hospital or emergency service to your child.

\_\_\_\_\_  
Name/Telephone of person to contact

\_\_\_\_\_  
Name of Hospital/Emergency Room

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# Health Certificate/Appraisal Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

## IMMUNIZATIONS / HEALTH HISTORY

Immunization record attached  
 No immunizations given today  
 Immunizations given since last Health Appraisal:

Sickle Cell Screen:  Positive  Negative  Not done Date: \_\_\_\_\_  
PPD:  Positive  Negative  Not done Date: \_\_\_\_\_  
Elevated Lead:  Yes  No  Not done Date: \_\_\_\_\_  
Dental Referral  Yes  No  Not done Date: \_\_\_\_\_

Significant Medical/Surgical History:  See attached \_\_\_\_\_

Allergies:  LIFE THREATENING  Food: \_\_\_\_\_  Insect: \_\_\_\_\_  Other: \_\_\_\_\_  
 Seasonal  Medication: \_\_\_\_\_

## PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Body Mass Index: _____	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	Vision - with glasses/contact lenses	R	L	
	Vision - Near Point	R	L	
	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L	

EXAM ENTIRELY NORMAL Tanner: I. II. III. IV. V. Scoliosis:  Negative  Positive: \_\_\_\_\_

Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

## MEDICATIONS

Medications (list all):  None  Additional medications listed on reverse of form

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage/Time: \_\_\_\_\_

If AM dose is missed at home: \_\_\_\_\_

I assess this student to be self-directed  Yes  No Student may self carry and self administer medication  Yes  No

Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

## PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

\_\_\_ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

\_\_\_ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

Specify medical accommodations needed for school: \_\_\_\_\_  None

Known or suspected disability: \_\_\_\_\_  Please monitor

Restrictions: \_\_\_\_\_  Please monitor

Protective equipment required:  Athletic Cup  Sport goggles/impact resistant eyewear  Other: \_\_\_\_\_

## OPTIONAL INFORMATION, if known

Specify current diseases:  Asthma  Diabetes:  Type 1  Type 2  Hyperlipidemia  Hypertension  
 Other: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ (Stamp below)

Provider's Name/Address: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

AREA OR SYSTEM	ABNORMAL FINDINGS
Eyes	
Ears, Nose, Throat	
Mouth, Teeth	
Thyroid	
Lymph Nodes	
Skin	
Chest, Lungs	
Heart	
Abdomen	
Genitalia (Tanner) <input type="checkbox"/> Refuse <input type="checkbox"/> Student states both testicles down, no masses	
Musculoskeletal	
Neck, Spine, Posture	
Shoulders	
Arms, Elbows, Hands	
Hips, Thighs	
Ankles, Feet	
ROM, Strength	
Knees	

Smoke: \_\_\_\_\_ ETOH: \_\_\_\_\_ Drug: \_\_\_\_\_

CP, SOB or dizzy with ex: \_\_\_\_\_

Concussion: \_\_\_\_\_ Mono: \_\_\_\_\_

Family History Early Cardiac: \_\_\_\_\_

Joint or Muscle Problem: \_\_\_\_\_

Referrals/Recommendation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Photo/Video Release Form

Our educational programming includes the documentation and presentation of student work in our buildings through digital media and photographs.

Some photographs and video recordings may capture your child's participation, directly or indirectly.

These media recordings may be used to share student lessons and presentations through public broadcasting in school or may be posted on our website, social media pages, news bulletins, billboards and ads.

## **STUDENT'S WILL AUTOMATICALLY BE OPTED IN.**

If you **DO NOT** wish to have your child appear in school district digital media and/or photographs, this form **MUST** be signed and returned to your child's homeroom teacher.

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I DO NOT give permission for the Utica City School District to use images and representations of my child in social related activities including filming, photography and presentation purposes.

Student's Name (print)

School

Teacher

Parent/Guardian (print)

Parent/Guardian (signature)

Date

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## Student Racial and Ethnic Identification

To the Parent/Guardian: The Utica City School District has adopted a policy which requires the collection and recording of the ethnic identity of students in the Utica City School District **in accordance with the federal categories and definitions.**

The information will be used to:

- Report information to the State and Federal Education Departments
- Plan educational programs and make sure that they are readily available to all students
- Analyze differences in academic performance, attendance and completion of school

We need your help in order to accomplish this task. Please review the Racial/Ethnic definitions on the next page. Put a check mark in the box for the category or categories which best describe your child. The Utica City School District understands the sensitive nature of this information and wishes to assure you that it will be kept secure and confidential in accordance with all State and Federal student privacy laws and regulations. If the information requested is not provided on this form on behalf of your child, a student records officer from the school or district will be required to identify the group to which the student appears to belong, identifies with, or is regarded in the community as belonging.

Thank you for your cooperation.

### **Confidentiality Procedures and Regulations**

To School Staff: This form will be filed in the student's permanent record as confidential information.

To the Parent/Guardian: The information which you have provided on this form is confidential. It is protected by the Confidentiality Regulations cited below.

The Family Educational Rights and Privacy Act (1974) FERPA, prohibits unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

Please complete form on the next page.

All students between 5 and 21 years of age have the right to a free public education. Children may not be refused admission because of race, color, creed, or national origin, sec citizenship, handicapping condition, or immigration status.

Name of Student \_\_\_\_\_ Date of Birth (MM/DD/YY) \_\_\_\_\_

Directions to Parents/Guardians:

Please answer **both** questions (1) and (2). PLEASE READ THEM BEFORE YOU RESPOND.

- [For question (1) check the box that best describes your child.] Check only one box.

1. Is the student Hispanic, Latino or of Spanish Origin? [Hispanic, Latino or of Spanish origin means a person of Cuban, Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.]

Yes, Hispanic

No, Not Hispanic

2. Select one or more races from the following five racial groups.

**- For question 2 check all groups that apply to your child, YOU MUST CHECK AT LEAST ONE line regardless of your answer to question 1.**

AMERICAN INDIAN OR ALASKA NATIVE: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

ASIAN: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

BLACK OR AFRICAN AMERICAN: A person having origins in any of the Black racial groups of Africa.

WHITE: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to Student (please check one below):

Mother     Father     Guardian     Other (Specify) \_\_\_\_\_

# Emergent Multilingual Learners Language Profile for UPK Students



## NEW YORK STATE EDUCATION DEPARTMENT

Dear Parent or Guardian,  
Thank you for completing the Emergent Multilingual Learners Language Profile. This survey will assist your new school with valuable information about your child's experience with languages. Information gathered will assist Prekindergarten educators in delivering academically and linguistically relevant instruction that strengthens the language and literacy of all students.

THIS SECTION TO BE COMPLETED BY ENROLLMENT OR SCHOOL PERSONNEL ONLY AND MAINTAINED ON FILE

Date Profile Completed:

Student Name:

Gender:

Date of Birth:

District or Community Based Organization Name:

Student ID (if applicable):

Name of Person Administering Profile:

Title:

### Parent or Person in Parental Relation Information

Name of parent or person in parental relation:

Relationship (to student) of person providing information for this profile:  mother  father  other

In what language(s) would you like to receive information from the school?  English  other home language:

### Language in the Home

1. In what language(s) do you (parents or guardians) speak to your child at home?

2. What is/are the primary language(s) of each parent/guardian in your home? (List all that apply.)

3. Is there a caretaker in the home?  yes  no

If yes, what language(s) does the caretaker speak most frequently?

4. What language(s) does your child understand?

5. In what language(s) does your child speak with other people?

6. Does your child have siblings?  yes  no

If yes, in what language(s) do the children speak with each other most of the time?

7a. At what age did your child begin to speak in short sentences?

In what language?

7b. At what age did your child begin to speak in full sentences?

In what language?

8. In what language does your child pretend play?

9. How has your child learned English so far (television shows, siblings, childcare, etc.)?

### ***Language Outside the Home/Family***

10. Has your child attended any nursery, Head Start or childcare program?  yes  no

If yes, in what language was the program conducted?

In what language does your child interact with other people in the nursery or childcare setting?

11. How would you describe your child's language use with friends?

### ***Language Goals***

12. What are your language goals for your child? For example, do you want child to become proficient in more than one language?

13. Have you exposed your child to more than one language to ensure that he or she is bilingual or multilingual?  yes  no

14. Does your child need to speak a language other than English in order to communicate with your relatives or extended family?

yes  no

If yes, in what language(s)?

### ***Emergent Literacy***

15. Does your child have books at home or does he or she read books from the library?

In what language(s) are these books read to him or her?

16a. Can your child name any letters or sounds in English?  yes  no

16b. Can your child recognize letters or symbols in another language?  yes  no

If yes, in what language(s)?

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17a. Does your child pretend to read?  yes  no  unsure

If yes, in what language(s)?

17b. Does your child pretend to write?  yes  no  unsure

If yes, in what language(s)?

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18. Does your child tell the stories from his/her favorite books or videos?  yes  no

If yes, in what language(s)?

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19. Does your child's childcare or nursery program describe goals for his or her learning?  yes  no

If so, what goals do they describe?

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20. Please describe anything special you did to prepare your child to begin Prekindergarten.

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<sup>i</sup> For more information contact: the New York State Education Department Office of Early Learning at (518) 474-5807 or email [OEL@nysed.gov](mailto:OEL@nysed.gov) or the New York State Education Department Office of Bilingual Education and World Languages at (518) 474-8775 or (718) 722-2445 or email [OBEWL@nysed.gov](mailto:OBEWL@nysed.gov).

# Registration Form



## Child Information

1st Child's FULL Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (Child must be between the ages of 0 and 5 to register.)  
MONTH DAY YEAR

2nd Child's FULL Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

Child's Mailing Address

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
COUNTY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP CODE

## Caretaker Information

Authorized Adult Name \_\_\_\_\_ Phone \_\_\_\_\_  
PLEASE PRINT

Email Address \_\_\_\_\_

"I hereby explicitly consent to allow the Dollywood Foundation, Inc. to use the information provided herein for the purposes of participating in Dolly Parton's Imagination Library book gifting program. To measure the benefits of this program we may create datasets with the information provided herein and share them with research and educational advancement partners. You agree to review our full Terms & Conditions and Privacy Policy by visiting [imaginationlibrary.com](http://imaginationlibrary.com). By signing and submitting this form you expressly consent to the terms set forth herein."

Authorized Adult Signature \_\_\_\_\_

## ENROLL YOUR CHILD TODAY!

Simply fill out the above form and mail to your local program partner.

To locate their mailing address visit: [imaginationlibrary.com/check-availability](http://imaginationlibrary.com/check-availability)

### OFFICE USE ONLY

Date Received \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Notes \_\_\_\_\_