ST. STEPHEN'S DAY CARE & AFTER SCHOOL PROGRAM

(An outreach ministry of Grace Neighborhood Development Corporation)
4201 Princeton Ave. Philadelphia, PA 19135
(215)624- 3262; FAX: (215)624-2368
ststephensdaycare@gmail.com

CENTER APPLICATION
FOR
PRE-K COUNTS PROGRAM

Reaching higher for quality early learning

pennsylvania PRE-K COUNTS For A Brighter Future

United Way SUCCESS BY 6™

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BACKGROUND:

St. Stephen's Day Care is an outreach ministry of Grace Neighborhood Development Corporation. The facility, located at 4201 Princeton Ave. in Northeast Philadelphia, will address the care needs of parents by providing safe, affordable, and stable care in an enriching educational environment for the children in the community.

SERVICES DAILY SCHEDULE:

St. Stephen's offers several types of programs, all of which will be exciting as well as educational. There will be an emphasis on social skills as the children are engaged in hands-on activities that will include math, science, language development, art, music, and more. The program will include full- time and part-time for Old Toddler and Preschool; Before/After School for School Age students **ONLY** and Summer Camp programs from June through August. The center will offer full – time day care for the school age students in accordance with the calendar days provided by the director for public school and/or charter schools.

St. Stephen's will be open from 7:00 a.m. through 6:00 p.m. The daily schedule will include: breakfast, teacher directed activities, child directed activities, large, small and/or individual group time, ***lunch – CBS Food Program*** age-appropriate nap time, and gross motor outdoor/indoor activities. The daily schedule for after school age children will include: snack time, homework assistance, teacher directed activities, child directed activities, large, small and/or individual group time and gross motor outdoor/indoor activities.

CLOTHING AND RESET TIME BEDDING:

Children are expected to arrive at the Center dressed in appropriate play clothing and sneakers or any closed toe shoe. CHILDREN MAY NOT WEAR SANDALS, FLI-FLOP, CLOGS, OR DRESS SHOES- TOES MUST BE COVERED. If your child wears diapers or pull-ups, you are responsible for supplying at least (5) five days diapers or pull-ups and a container of baby wipes. Your child's teacher will inform you when more diapers or pull-ups are needed. Every toddler and Preschool child need to keep **at least one complete change of seasonally appropriate clothing** in their cubbies. These items need to be stored in a closed container the size of a shoe box with the child's name on it for storage. **All clothing including jackets, hats, boots, etc. MUST be labeled with the child's first name and INITIAL of the last name.**

If your child naps at the center he/she will need to have **1 crib sized sheet and 1 small blanket** for rest time. Bedding will be sent home every Friday to be laundered and returned on Monday morning.

HEALTH POLICIES:

Children need to be able to fully participate in the indoor and outdoor program each day they attend school. If a child becomes ill while at school, you will be notified and asked to pick up your child at that time. Illnesses include vomiting, diarrhea, fever of 100.4, or higher or any contagious condition.

Medication will be administered ONLY with written permission from a licensed physician and all medications must be in its original container from the pharmacy. Administration for Medication form will be given and Medication logs must also be completed

SUPERVISION:
Children will be supervised at all times, both indoors and outdoors. Staff/ child ratio will be maintained.

TRANSPORTATION & PICK UP ARRANGEMENT:
The parents will provide transportation to and from the center and all students will be dropped-off in their classrooms and signed in. Please be sure that your child's teacher or assigned teacher is aware of their arrival. Children will only be released to a parent/guardian or someone who is authorized escort based on the most recent Emergency Contact on file with the director or a verbal release form is completed. All parents/guardians and/or escorts must have proper ID.
After school students will be picked from their schools and escorted by staff members back to the center at 4201 Princeton Ave. The classroom staff and director must be notified about: (1) Change of home address or phone number; (2) Change of employment, school or training program; (3) Change of emergency contact information: and/or (4) Change of person to whom child may be released.
IT IS IMPORTANT TO KEEP YOUR INFORMATION UPDATE IN CASE OF AN EMERGENGY. THE STAFF NEEDS TO BE ABLE TO REACH YOU AT ALL TIMES.

The weekly cost is as follow for FULL – TIME and SCHOOL AGE ONLY effective January 1, 2025

Young Toddler	Old Toddler	Preschool	Full Day After School
(Ages 13 months -2yrs.)	(Ages 2-3yrs.)	(Ages 3-5yrs.)	(Ages 5-12yrs.)
$325/ Weekly	$300/ Weekly	$290/ Weekly	$250/ Weekly

The cost for before & after school is as follows:
$90/ Weekly Before School (7AM-8:30AM)
$150/ Weekly After School (3PM- 6PM)
$225/ Weekly = Before/After School and ½ days
We do accept all forms of child care subsidies.

PAYMENT POLICY: **Tuition or co-payments are expected due in full by Monday morning prior to service.** Full tuition or ELRC family copayment is due regardless of illness, holidays, or inclement weather that center is closed, **no pro-rated rates will be given at any time**. Each family will be given (1) one-week vacation credit per academic year, if tuition payments are CURRENT, and two weeks written notice. Payments may be made in the office or left in the locked box located inside the Director's office. Please make checks and money orders payable to: GNDC. **There is a $35.00 service charge on all returned (bounced) checks and payments will no longer be accepted in a check form once this occurs.**

HOLIDAYS: St. Stephen's Day Care will be closed for the following 1 Federal holidays: All classrooms, parents bulletin board, and copies will be provided upon request.

WITHDRAWAL AND DISENROLLMENT: Two weeks written notification is required for any schedule change or withdrawal. The center reserves the right to dis-enroll a child if deemed necessary for the safety of others. This may be done with written notification.

NONDISCRIMINATION POLICY: St Stephen's Day Care & After School Program does not discriminate on the basis of a person's religion, color, sex, age, national origin or disability regarding considerations such as enrollment and hiring.

ELRC SUBSIDY CONTACT INFORMATION: For childcare Subsidies (preschool and afterschool)
Contac Address: 4601 Market St, Philadelphia, PA 19139 Email: ELRC18@PHMC.ORG.
Phone: (888) 535-2209 (610) 480-3190

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EMERGENCY CONTACT/ PARENT CONSENT FORM

CHILD'S NAME	BIRTHDATE
MOTHER'S NAME/ LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	
E-MAIL	CELL TELEPHONE NUMBER
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
BUSINESS ADDRESS	
FATHER'S NAME/ LEGAL GUARDIAN	HOME TELEPHONE NUMBER
ADDRESS	CELL TELEPHONE NUMBER
BUSINESS NAME	BUSINESS TELEPHONE NUMBER
BUSINESS ADDRESS	
EMERGENCY CONTACT PERSON(S) NAME	**TELEPHONE NUMBER (WHEN IN CARE)**
1.	
2.	
3.	
PERSON(S) TO WHOM CHILD MAY BE RELEASED (NAME AND ADDRESS)	**TELEPHONE NUMBER (WHEN IN CARE)**
1.	
2.	
3.	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	**PHYSICIAN'S TELEPHONE NUMBER**
ADDRESS	
SPECIAL DISABILITIES (IF ANY)	ALLERGIES (MEDICATION REACTION)
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION	MEDICATIONS, SPECIAL CONDITION
ADITIONAL INFORMATION SPECIAL NEEDS CHILD	
HEALTH INSURANCE COVERAGE OR MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT

OBTAINING EMERGENCY MEDICAL CARE X	ADMIN. OF MINOR FIRST- AID PROCEDURES X
WALKS AND TRIPS X	SWIMMING / WADING X
TRANSPORTATION BY THE FACILITY X	I ALLOW PHOTOS/ VIDEOS X

SIGNATURE OF PARENT GUARDIAN X	DATE X
SIGNATURE OF PARENT GUARDIAN X	DATE X

St. Stephen's Day Care & After School Program

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Victoria Vazquez, Director

GENERAL INFORMATION

Child's Name: _____ Child's Birth Date: _____

Admissions Date: _____ Withdraw Date: _____

TUITION AGREEMENT CONDITIONS

1. Services to be provided as part of tuition include: ***SEE PARENT HANDBOOK.***
2. Extra services to be provided at an additional fee, if applicable are: ***N/A.***
3. I agree to pay a Registration Fee of **$25.00** at the time of enrollment. I understand this is a non-refundable fee and not applicable toward tuition.
4. I understand that a deposit of _____ must accompany the approved enrollment application and will be applied to the child's first week's co-pay/tuition payment, if applicable.
5. I agree to pay by the preceding Friday, the sum of _____. I will automatically include a late fee of **$10.00** to the tuition payment when made after Monday at Noon. Should tuition remain unpaid, I will be asked to withdraw my child until the outstanding balance is paid in full. All legal and collection fees incurred in the collection of tuition are the responsibility of the parent/guardian.
6. If additional time or a change in schedule days is required during any given week, I understand that after prior approval is given, I may be required to pay an additional rate. If an occasion arises where fewer days are needed during the week, my usual week's tuition is still required.
7. I agree to pay a ***$25.00*** processing fee for any check that is returned by my bank for any reason. If more than two checks are returned, money orders or cash will be required.
8. I understand that in order for accurate emergency and bookkeeping records to be maintained, it is crucial that I sign my child in and out daily.
9. I understand that my child will only be released to the following individuals: -

   _____.
10. I understand that if my child remains at the Center past the designated closing time, I will be charged and agree to pay an additional fee of ***$1.00*** for each additional minute after ***6:05pm***, or any part thereof, he/she remains.
11. I understand there will be no reduction in tuition for holiday's, vacations (NO more than 1 week), illness, inclement weather, or any other absences from school. In the event my child contracts a contagious and/or infectious illness, I must notify the school and make alternative arrangements for my child's care until the danger to others has passed. I agree to notify the Center whenever my child is absent.
12. I understand the Center is opened all year, except for holidays declared by the Center Director.
13. I do____ do not_____ give permission for my child to be ***photographed/videotaped and the photos/tape to be displayed in the school.***
14. I agree to give two weeks written notice before withdrawing my child from the school or changing my guaranteed days. My account must be current.
15. I consent to all terms of this Agreement and have received a signed and dated copy of this contract. I have read, understand, and accept the conditions of this tuition agreement as school policy and realize that these fees and conditions may be revised as necessary without prior notice. The school further reserves the right to dismiss the named student if it is determined that the school's program does not benefit the child or in the event of non-payment of fees.

_____ _____
Parent/Guardian's Name (Print) Parent/Guardian's Name (Signature & Date)

_____ _____
Director's Name (Print) Director's Name (Signature & Date)

Attachment 6- CHILD PICK UP AUTHORIZATION

I, _____, authorize St. Stephen's to release my child(ren) to the person(s) designated. This is in consonance with the St. Stephen's Emergency Plan.

Child's Name: _____

Designated Custodian (s) : (Name & Relationship)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____

Print Name

_____

Street Address

_____

City, State, Zip Code

(Home Phone) _____ (Work Phone) _____ (Cell Phone) _____

NOTE: *Parents and guardians should designate themselves as designated custodians. Friends, neighbors and other relatives may also be designated.*

PLEASE PRINT CLEARLY

St. Stephen's Day Care & After School Program
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Email: ststephensdaycare@gmail.com

"GETTING TO KNOW YOU"

Child's Name: _____

Enrollment Date: _____

1. Tell me about your household. (Neighborhood, who lives there, names, and relationship to child)?

   _____
   _____
   _____

2. Does your child have any parents that do not live in the home?

   _____
   _____

3. Does your child visit this parent?

   _____
   _____

4. Are there any custody issues that we should discuss?

   _____
   _____

5. Does your child have any siblings (names and ages)?

   _____
   _____
   _____

6. Does your child have any special needs and do any of these needs require special care by our teachers?

   _____
   _____

7. Does your child have an IEP (Individualized Education plan) or ISFP (Individualized Family Service Plan)?

   _____
   _____

***NOTE* - if yes, we would like a copy of the plan, so we can provide the best possible learning experience for your child.**

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Victoria Vazquez, Director

IEP/IFSP PARENT SIGN-OFF SHEET

Child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

The information found on an IEP/IFSP is protected by privacy laws including the Health Insurance Portability and Accountability Act (HIPAA). Releases of information may also be required to speak to members of a child's treatment team. Professional development regarding privacy issues, and HIPAA in particular, is highly recommended.

_____ I am providing a copy of my child's IEP or IFSP

_____I am not providing a copy of my child's IEP or IFSP and/or this is not applicable to my child.

Parent's Signature: _____ Date: _____

Printed Name: _____

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CIVIL RIGHTS COMPLIANCE
Parents / Guardians

In Accordance with applicable Federal and State Civil Rights laws and regulatory requirements, you as a resident of this agency, have the right:

To be provided services at this agency and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, including Limited English Proficiency, age or sex.

To file a compliant of discrimination if you feel you have been discriminated against on the basis of your race, color, religious creed, disability, ancestry, national origin, age or sex.

Complaints of discrimination may be filed with any of the following:

St. Stephen's Day Care
Victoria Vazquez, Director
4201 Princeton Ave.
Philadelphia, PA 19135

Commonwealth of Pennsylvania
Department of Human Services
Bureau of Equal Opportunity
Southeast Regional Office
801 Market Street, Suite #5034
Philadelphia, PA 19107

DHS – BEO
Room #223, Health & Welfare Building
P.O BOX #2675
Harrisburg, PA 17105

Office of Civil Rights
U.S Department of Health & Human Services
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-9111

PA Human Relations Commission
Philadelphia Regional Office
110 North 8th Street
Suite #501
Philadelphia, PA 19107

Child's Name: _____

_____ _____
Parent / Guardia Signature Date

_____ _____
Director Signature Date

pennsylvania
PRE-K COUNTS
For A Brighter Future

KEYSTONE STARS
Reaching higher for quality early learning

St. Stephen's Day Care & After School Program

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(215)624-3262 FAX: (215) 624-2368

Dear Parents/ Guardians,

This letter is to assure you of our concern for the safety and welfare of children attending ***St. Stephen's Day Care & After School Program.*** Our Emergency Operations Plan provides for response to all types of emergencies. Depending on the circumstances of the emergency, we will use one of the following protective actions:

- Immediate evacuation: Students are evacuated to a safe area on the grounds of the facility in the eventy of a fire, etc.
- In-place Sheltering: Sudden occurrences, weather or hazardous materials related, may dictate that taking cover inside the building is the best immediate response.
- Evacuation: Total evacuation of the facility may become necessary if there is a danger in the area. In this case, children will be taken to Relocation Facility at **Over the Rainbow Preschool 4301 Tyson Ave. Philadelphia, PA 19135**
- Modified Operation: May include cancellation/ postponement or rescheduling of normal activities. These actions are normally taken in case of a winter storm or building problems that make it unsafe for students (such as utility disruptions), but may be necessary in a variety of situations.

Please listen for school number #3004 on KYW News Radio 1060AM; website kyw1050.com; or phone: (215)224-1060 for announcements relating any of the emergency actions listen above.

We ask that you not call during the emergency. This will keep the main line telephone free to make Emergency calls and relay information. We will call you to let you know that we have taken one of these protective actions. We will also call you when we have resolved the situation and it's safe for you to pick up your child.

The facility director may provide an alternate phone number (i.e. cell phone, etc.) to call in an emergency event.

The form designated persons to pick up your child is included with this letter for you to complete during time of enrollment. This form will be used every time your child is released. Please ensure that only those persons you list on the form attempt to pick up your child.

I specifically urge you not to make different arrangements during an emergency. This will only create additional confusion and divert staff from their assigned emergency duties.

In order to assure the safety of your children and our staff, I ask your understanding and cooperation. Should you have additional questions regarding our emergency operating procedures, contact **Victoria Vazquez, Director at (215)624-3262.**

Sincerely,
Victoria Vazquez

pennsylvania
PRE-K COUNTS
For A Brighter Future

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St. Stephen's Day Care & After School Program

4201 Princeton Ave. Philadelphia, PA 19135
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Dear Parent/ Guardian:

Thank you for your interest in St. Stephen's Day Care & After School Program. This is a PA state funded PKC program. In order to pre-register your child, you must complete the attached registration packet and provide the required documentation listed below. Once this application has been returned with the required documentation to the Center's Director, Ms. Victoria Vazquez, someone will contact you via phone call to setup *an interview with you and your child before you can be approved for this program.*
Although, your child meets the age requirements there are other requirements your family must meet in order to participate in this state funded program.

REQUIREMENTS:

- Resident of the Philadelphia School District
- Meet the Income Guidelines
- Attend to interview/enrollment (Director), Orientation Dates, Parent/Teacher Conference, Monthly Parent Meeting and Classroom Volunteer

MANDATORY DOCUMENT & RECORD KEEPING CHECKLIST TO APPLY FOR THE PRE-K COUNTS PROGRAM:

- Center and PKC Application
- Proof of Income (Tax Return)
- Proof of Residency (own, rent, other)
- Birth Certificate
- Physical and Immunization Shot Record (
- Dental Exam (Update Every 6 Months)
- Parent ID and Child Health Insurance Card
- Receiving SNAP – YES _____ NO_____
- Receiving TANF – YES $ _____ NO_____
- Receiving WIC – YES _____ NO _____

If you have any questions, please don't hesitate to contact me at (215)624-3262
Thank you for allowing us to meet your child's needs and help your child grow.

Sincerely,

Victoria Vazquez, Director

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY LEARNING CHILDHOOD EDUCATION

2025 POVERTY GUIDELINES
FOR THE 48 CONTIGUOUS STATE AND THE DISTRICT OF COLUMBIA

FAMILY HOUSEHOLD *	POVERTY GUIDELINES	POVERTY GUIDELINES 101% TO 130%	POVERTY GUIDELINES 131% TO 300%
1	$15,650	$23,475	$46,950
2	$21,150	$31,725	$63,450
3	$26,650	$39,975	$79,950
4	$32,150	$48,225	$96,450
5	$37,650	$56,475	$112,950
6	$43,150	$64,725	$129,450
7	$48,650	$72,975	$145,950
8	$54,150	$81,225	$162,450

*FOR FAMILIES/ HOUSEHOLDS WITH MORE THAN 8 PERSONS ADD

$5,500 FOR POVERTY LINE COLUMN

$8,250 FOR THE 150% COLUMN

$16,500 FOR THE 300% COLUMN

PA PRE-K COUNTS APPLICATION

This information is confidential to the PA Pre-K Counts Program

Date Completed: _____

Last Name (Child)	First Name (Child)	Middle Initial

Child's Date of Birth	Age	Household (Family) Size
/ /	☐ 2 ☐ 3 ☐ 4 ☐ 5	

Primary Language	Family Type
☐ English	☐ One Parent ☐ Two Parent
☐ Spanish	☐ Foster ☐ Child Living with Relative
☐ Other: _____ (Please Specify)	☐ Other: _____ (Please Specify)

Street Address		County	
City		State PA	Zip Code
Home Telephone	Work Phone:	Email Address:	

Household Income (Required) Check box

☐ Less than $5,000	☐ $5,001- $10,000	☐ $10,001- $15,000
☐ $15,001- $20,000	☐ $20,001- $25,000	☐ $25,001- $30,000
☐ $30,001- $35,000	☐ $35,001- $40,000	☐ $40,001- $45,000
☐ $45,001- $50,000	☐ $50,001- $60,000	☐ $60,001- $70,000
☐ $70,001- $100,000	☐ More than $100,000	

Actual Annual Verified Gross Household (Family) Income:_____
(Attach copies of documents used to verify income prior to enrollment)

☐ Family Income **is at or below 300%** of federal poverty level (Required Risk factor). Consider all sources of income. See beginning of document for income chart relative to family size. (Must be verified prior to enrollment)

Other Child Eligibility Risk Factor Criterion (Must check all that apply)

☐ **Behavioral Support:** A child who was referred to PA Pre-K Counts from an appropriately credential health or mental health practitioner who is not employed by the PA Pre- K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.

☐ **Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services.

☐ **Education level of guardian:** does not have a high school diploma or GED or post- secondary degree.

☐ **English Language Learner:** A child whose first language is not English and who is not in the process of learning English is considered an English Language Learner.

☐ **Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following:

A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
B. Children who have a primary nighttime residence that is a public or private place not designated for or ordinarily used as a regular sleeping accommodations for human beings;
C. Children who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.

☐ **Incarnated Parent:** A child for whom one of the child's parents is currently in prison.

☐ **Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.

☐ **Migrant (non-immigrant)/ Seasonal Student:** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent/ Guardian, who is a migratory worker or migratory fisher, within the preceeding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultureal or fishing work including agri-related business such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.

☐ **Teen Mother:** A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided is accurate. I understand that I may be asked to verify or substantiate information provided.

X _____ X _____

(Parent/ Guardian signature) (Date)

X _____ X _____

(Parent/ Guardian Name- Please print) (Date)

_____ _____

(Staff Verifying Income and Risk factors Signature) (Date)

_____

(Staff Verifying Income- Please Print)

Application for Preschool

Parent/ Guardian- The Application for Preschool is 2 pages- please complete both pages to the best of you knowledge.

Child Information

Name: _____ Date of birth: _____ Gender: Male Female

Address: _____ Apt.:_____ Zip: _____ Phone # _____

Does your child speak English? YES_____ NO_____ Does your child understand English? YES_____ NO_____.

If you answered "No" to either question, what language does your child speak and understand? _____

Parent/ Guardian Information

Name: _____ Gender: M F Address: _____ Zip:_____

Phone Numbers: Day: _____ Evening:_____ Cell:_____

Are you a single parent? YES_____ NO_____ Family Size: Number of Adults:_____ Number of Children: _____

Do you receive: TANF:_____ Food Stamps:_____ Medical Assistance:_____ If "Yes", welfare case #_____

Parent/ Guardian Information

Name: _____ Gender: M F Address: _____ Zip:_____

Phone Numbers: Day: _____ Evening:_____ Cell:_____

Are you a single parent? YES_____ NO_____ Family Size: Number of Adults:_____ Number of Children: _____

Do you receive: TANF:_____ Food Stamps:_____ Medical Assistance:_____ If "Yes", welfare case #_____

Child's Health Care Information

Name of Doctor/ Health Center/ Clinic: _____

Address: _____ Zip:_____ Phone Number: _____

Type of Health Insurance: Medical Assistance _____ CHIP _____ Private_____ Other_____

Name of Health Insurance Company:_____ Policy Number:_____

Name of Dentist/ Dental Clinic: _____

Address: _____ Zip: _____ Phone Number: _____

Child's Preschool Information (This information will be shared with the instructional staff to better assist your child while enrolled in preschool.)

Does your child have preschool experience?_____ Is your child currently enrolled in a preschool?_____

If you answered 'Yes' to either question, name of preschool:_____

Please share with us any educational concerns you have for your child:_____

_____

Application for Preschool

Child's Early Intervention Information (This information will be shared with the Special Needs Coordination to better assist your child while enrolled in preschool.)

Has your child been referred for a development screening?_____ If Yes, has it been completed? _____

Does your child have an Individualized Educational Plan (IEP)? _____ If yes, name of Early Interventional agency:_____

_____

Please share with us any developmental concerns you have for your child: _____

_____

Emergency Contact Information (Adult individuals, other than the parent/guardian, who have agreed to be an emergency contact- Photo ID will be required)

1. Name _____ Relationship to child _____

   Phone Numbers: Day _____ Evening:_____ Cell:_____

   Approximatly how long will it take for this individual to travel to your child's school? _____

2. Name _____ Relationship to child _____

   Phone Numbers: Day _____ Evening:_____ Cell:_____

   Approximatly how long will it take for this individual to travel to your child's school? _____

My signature below indicates that:

1. I UNDERSTAND THAT COMPLETING and SUBMITTING AN APPLICATION FOR PRESCHOOL DOES NOT GUARANTEE THAT MY CHILD WILL BE ACCEPTED IN TO A PRESCHOOL PROGRAM;
2. The information I have provided on both pages of the Application for Preschool is accurate;
3. I agree to inform my child's teach when any of this information changes;
4. I understand that this information must be kept accurate so that I can be contacted in the event my child becomes ill or injured while attending preschool;
5. I understand that if my child is enrolled in preschool, I agree to abide by the program policies and to adhere to the scheduled arrival and departure times.

Parent/ Guardian Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____

Section 3: PRIMARY PARENT/ GUARDIAN INFORMATION

First Name:		Last Name:	
Date of Birth:	O Male O Female	Primary parent/guardian is Hispanic or Latino/a O Yes O No	
Primary spoken language:		2nd spoken language (if applicable)	

Address :			
Apt. /Unit #:	City:	State:	Zip Code:

Home Phone #:	Cell Phone:
Email Address: _____	
Alternate Phone #:	Alternate Phone # belongs to:

Best way to reach you during the day: select all that apply	O Home Phone #	O Cell Phone #	O Work Phone #	O School Phone #
	O Email	O Other (specify)		

Marital Status Select One	O Married	O Single	O Domestic Partner	O Divorce
	O Separate	O Widowed	O Other (Specify)	

Relationship to child Select one	O Parent	O Step-Parent	O Foster Parent, not related to child	
	O Foster Parent, related to child		O Guardian	O Other: specify

Race: Select all that apply	O American Indian	O Asian	O Black or African American
	O Multi- Racial/ Bi-Racial	O Native Hawaiian	O Pacific Islander
	O White	O Other	

Status Select all that apply	O Lives with Child	O Single Parent	O Teen Parent	O Grandparent
	O Migrant Parent (non immigrant)		O United States Citizen	
	O Not a United States Citizen		O Provides financial support to child's family	

Does your family receive benefits from the Department of Public Welfare (DPW)?	O YES	O NO
If 'Yes' , your DPW Record/ Case #: 51/ _____ _____ _____ _____ _____ _____ _____ _____ _____.		

If 'Yes', which benefits? O TANF Cash Assistance O SNAP Food Stamps O Medical Assistance	Does your family receive WIC? O Yes O No O Previously

Education Select highest level completed	O Doctorate	O Masters	O Bachelors	O Associates
	O Vocational	O ESL (English as a Second Language		O GED
	O Some College	O 12th Grade	O 11th Grade	O 10th Grade
	O 9th Grade or lower	O Other (Specify):		

Section 3: PRIMARY PARENT/ GUARDIAN INFORMATION, continued

Employment, School, Job Training	O Employed	O In School	O Job Training	O Unemployed
	O Disabled	O Homemaker	O Retired	O None
	O Member of the U.S Military on active duty		O Veteran of the U.S Military	

Employer Information (Complete if you are employed)	Employer Name:			
	Address:			
	City:		State:	
	Zip Code:	Phone #		
	What type of work do you do?			
	How often are you paid?	O Every Week	O Every 2 Weeks	O Twice a month
		O Once a month	O Other(specify):	

School/ Job Training (complete if you attend school or a job training program)	School/ Job Training Name:	
	Address:	
	City:	State:
	Zip Code:	Phone #
	What are you studying?	

Including yourself and your child, how many people:
Are in your immediate family? _____. Live in your home? _____.

Do you have a disability or disabilities?	O Yes	O No
If 'Yes' please list your disabilities:		
Do you have Health Insurance?	O Yes	O No
If 'Yes', name of health insurance provider:		

Housing information Select your current situation	O Own	O Rent	O Transitional housing- since what date?
	O Homeless- since what date?		O Shelter- since what date?
	O Living with family- since what date?		O Living with friends- since what date?
	O Living with family due to a fire/ flood/ emergency in my home- since what date?		
	O Living with friends due to a fire/ flood/ emergency in my home- since what date?		

During the past 12 months, I/We have moved from temporary to permanent housing?	O Yes	O No
During the past 2 years, I/ We have moved into a new house.	O Yes	O No

Do you have mental health concerns?	O Yes	O No
Do you have a social concern (English language learner, eating disorder, custody issues, etc.)?	O Yes	O No
If 'Yes' please list your concerns:		

Section 3: SECONDARY PARENT/ GUARDIAN INFORMATION

First Name:		Last Name:	
Date of Birth:	O Male O Female	Primary parent/guardian is Hispanic or Latino/a O Yes O No	
Primary spoken language:		2nd spoken language (if applicable)	

Address :			
Apt. /Unit #:	City:	State:	Zip Code:

Home Phone #:	Cell Phone:
Email Address : _____	
Alternate Phone #:	Alternate Phone # belongs to:

Best way to reach you during the day: select all that apply	O Home Phone #	O Cell Phone #	O Work Phone #	O School Phone #
	O Email	O Other (specify)		

Marital Status Select One	O Married	O Single	O Domestic Partner	O Divorce
	O Separate	O Widowed	O Other (Specify)	

Relationship to child Select one	O Parent	O Step-Parent	O Foster Parent, not related to child	
	O Foster Parent, related to child		O Guardian	O Other: specify

Race: Select all that apply	O American Indian	O Asian	O Black or African American
	O Multi- Racial/ Bi-Racial	O Native Hawaiian	O Pacific Islander
	O White	O Other	

Status Select all that apply	O Lives with Child	O Single Parent	O Teen Parent	O Grandparent
	O Migrant Parent (non immigrant)		O United States Citizen	
	O Not a United States Citizen		O Provides financial support to child's family	

Education Select highest level completed	O Doctorate	O Masters	O Bachelors	O Associates
	O Vocational	O ESL (English as a Second Language		O GED
	O Some College	O 12th Grade	O 11th Grade	O 10th Grade
	O 9th Grade or lower	O Other (Specify):		

Section 3: SECONDARY PARENT/ GUARDIAN INFORMATION, continued

Employment, School, Job Training	O Employed	O In School	O Job Training	O Unemployed
	O Disabled	O Homemaker	O Retired	O None
	O Member of the U.S Military on active duty		O Veteran of the U.S Military	

Employer Information (Complete if you are employed)	Employer Name:			
	Address:			
	City:		State:	
	Zip Code:	Phone #		
	What type of work do you do?			
	How often are you paid?	O Every Week	O Every 2 Weeks	O Twice a month
		O Once a month	O Other(specify):	

School/ Job Training (complete if you attend school or a job training program)	School/ Job Training Name:			
	Address:			
	City:		State:	
	Zip Code:		Phone #	
	What are you studying?			

Do you have a disability or disabilities?	O Yes	O No
If 'Yes' please list your disabilities:		
Do you have Health Insurance?	O Yes	O No
If 'Yes', name of health insurance provider:		

During the past 12 months, I/We have moved from temporary to permanent housing?	O Yes	O No
During the past 2 years, I/ We have moved into a new house.	O Yes	O No

Do you have mental health concerns?	O Yes	O No
Do you have a social concern (English language learner, eating disorder, custody issues, etc.)?	O Yes	O No
If 'Yes' please list your concerns:		

Section 5: FAMILY/ HOUSEHOLD MEMBERS

List your name, the name(s) of your child(ren) and the names of all other adults and children who live in your home. Use additional paper if needed.

FIRST and LAST NAME	DATE of BIRTH MM/DD/YYYY	RELATIONSHIP to PRIMARY ADULT Self, Husband, Wife, Daughter, Son, Sister, Brother, Companion, Domestic Partner, Friend, etc.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Section 6: FAMILY INCOME INFORMATION

How you financially provide for your family- select each source of Income that the Primary Parent/ Guardian, Secondary Parent/ Guardian and all children receive.

O Employment	O Unemployed	O Self- Employed	O Social Security	O SSI
O Child Support	O Alimony	O Worker's Compensation	O Commission	O Tips
O TANF Cash Assistance	O Foster/ Kinship Care	O Scholarship, Grant, Stipend		
O Pension/ Retirement	O Financial support from Family/ Friend	O Rental Properties		
O Other (specify):				

Section 7: SIGNATURES

Read the following statements and sign where indicated.

I/ We have completed all sections on my/ our *Family and Child Information Form*, 2017-2018 Update, and certify the Information is correct. I/We understand that if any of my/ our information is false, my/ our participation in the preschool program may be terminated and I/we may be subject to legal action. I/We have attached copies of all income and monthly benefits that I/we and my/our children receive. I/We understand this information is being given so that my/our eligibility can be determined for The School District of Philadelphia preschool program. I/We understand that officials from The School District of Philadelphia, the Department of Health and Human Services and/or the Commonwealth of Pennsylvania may verify the information and the supporting documentation submitted with my/our Family and Child Information Form, 2017-2018 Update. I/We understand that my/our Income documentation is confidential and will be held in strict confidence within The School District of Philadelphia.

Signature of Primary Parent/Guardian Date

Signature of Primary Parent/Guardian Date

CHILD'S SOCIAL DEVELOPMENT

Parent/ Guardian: Please complete to the best of your knowledge. Your answers will help us to better understand and assist your child while enrolled in preschool.

Child's Name:_____ Date of Birth: _____
Parent/Guardian Name: _____ Today's Date:_____

1. Please list the activities your child enjoys:_____
2. Please list the activities your child does not enjoy:_____
3. Does your child take a nap:_____ No_____ Yes- if Yes, when? For how long?_____
4. What time does your child usually: Go to sleep at night? _____Wake up in the morning? _____
5. Does your child sleep with the light on? _____ No_____ Yes-
6. Does your child have a bedtime routine?_____ No_____ Yes- If Yes, please describe: _____
   _____
7. Does your child have trouble sleeping? _____ No_____ Yes- - If Yes, please describe: _____
   _____
8. a) What words or actions does your child use to indicated that he/she needs to use the bathroom? _____
   _____
   b) Does your child use diapers/pull-ups? _____ No_____ Yes- - If Yes, when? _____
   _____
9. How does your child act with children he/she does not know? _____
10. How does your child act with adults he/she does not know? _____
11. Please tell us what your child is afraid of. _____
12. How do you comfort your child?_____
13. Does your child have difficulty expressing what he/she wants? _____ No_____ Yes
14. Do you have difficulty understanding your child_____ No_____ Yes- If Yes, please explain how you communicate: _____
15. Have there been big changes in your child's life within the last 6 months? _____ No_____ Yes- If Yes, please describe:_____
16. Children learn to do things at different ages. So that we can better fit our program to meet your child's needs, please tell us, as best as u can remember, what age your child began to do the following tasks:

TASK	AGE	TASK	AGE
Sit up without help		Toilet trained	
Crawl		Respond to directions	
Walk		Play with toys	
Talk		Use crayons	
Food and dress self		Understand what is said	

Do you receive any of the following assistance? (circle one)			**Current housing Status: (circle one)**		
Cash assistance? If yes, since when?	Yes	No	Are you homeless? If yes, since when?	Yes	No
Food Stamps (SNAP) If yes, since when?	Yes	No	Are you doubled up with family or friends due to fire, flood, etc....	Yes	No
Social Security If yes, since when?	Yes	No	Other, please specify If yes, since when?	Yes	No
WIC If yes, since when?	Yes	No			
Child Care Vouchers If yes, since when?	Yes	No			
Child Support? If yes, since when?	Yes	No			
Medical Assistance	Yes	No			
What is frequency of pay (how often do you get paid? Parent 1: Weekly Bi-weekly Bi-monthly Monthly Parent 2: Weekly Bi-weekly Bi-monthly Monthly			Does your family have other Social Concerns? (English Language Learners, Custody Issues, Etc...) YES NO If yes, state concerns:		

Are you a United States Citizen? If no, how long have you lived in the USA?	Yes	No	Does your child have previous preschool experience?	Yes	No
I s there a sibling enrolled in Pre-K Counts?	Yes	No			
Do you have a medicallu fragile child? (chronic or terminal illness)	Yes	No			
Do you have disabilities or physical or mental health concerns?	Yes	No			

FAMILY STRENGTH ASSESSMENT

Dear Parent(s)/Guardian(s):

The Pre-K Counts Program requires each program to assess the strengths of each family it enrolls. The purpose of the family assessment is to enable the rogram staff to assist and support you and your family as you move towards your goals. Please complete the Family Profile so that we may provide you the necessary information and referrals in order to help you achieve the mutual goals you develop.

FAMILY PROFILE

CENTER:	DATE:
Child's Name:	Parent's Name
Address:	
Phone Number:	Cell Phone:

Ethnicity:

- ☐ Hispanic or Latino origin
- ☐ Black or African American
- ☐ American Ind. Or Alaskan Native
- ☐ Asian
- ☐ White
- ☐ Biracial/Multicultural
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other
- ☐ Unspecified

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Native Central/South American and Mexican
- ☐ African
- ☐ Caribbean (Haitian, Creole)
- ☐ Middle Eastern/South Asian (Arabic, Hebrew, Hindi, Urdu, Bengali)
- ☐ East Asian Language (Chinese, Vietnamese, Tagalong)
- ☐ Pacific Island (Passim, Fijian)
- ☐ European/ Slavic (German, Italian, Russian, Albanian, Polish)
- ☐ Naïve North American/ Alaskan
- ☐ Unspecified
- ☐ Other:_____.

Number of Adults in Household over 18 years old	#:
Other Children under 118 years of age:	Date of Birth
1.	
2.	
3.	
4.	
5.	

Have you been displaced due to hardship? _____No_____Yes
If yes, please check off or explain:

	Displaced due to fire
	Displaced due to domestic violence
	Displaced due to a loss of income
	Displaced due to an evacuation/ put out of home
	Displaced due to flood/housing repair
	Other:

How many times have you moved in the past year? _____

Please complete other side

Family Profile Questions	Yes	No
1. Are you the guardian or parent of the child?		
2. Are you the child's Grandparent/Relative?		
3. Is your family involved in Foster Care?		
4. Is the child in Foster Care?		
5. Is your family currently receiving services from DHS?		
6. Is your family receiving SCOH services? If yes, what is the name of the agency?:		
7. Were you referred by an agency? If yes, what is the name of the agency?		
8. Are you a United States Citizen?		
9. How long have you lived in the United States?		
10. Do you have any disabilities or other physical/mental health concerns that prevent you from caring for your family?		
11. Does your child have any disabilities?		
12. Are you currently seeking other housing arrangements?		
13. Do you live in a shelter or transitional housing?		
14. Do you feel safe in the place you are currently living at?		

Educational Profile	Yes	No
Do you have a high school diploma?		
Do you have a GED?		
Do you have some college credits?		
Do you have a College degree? If yes, please check box: ☐ Associates ☐ Bachelor ☐ Master ☐ Doctorate		
Are you currently enrolled in school/college? If yes, please check box: ☐ Full time ☐ Part time Where? _____. Length of program: _____.		
Are you interested in additional information for continuing education opportunities for yourself or family member?		

Do you need before and after school care for your child?		
Does/Will your child attend a child care facility or child care home after the Pre-K Counts program day?		

CHILD'S HEALTH HISTORY

Parent/ Guardian: Please complete both sides of this form to the best of your knowledge.

Child's Name:_____ Date of Birth: _____
Parent/Guardian Name:_____Date of Birth:_____

PREGNANCY and BIRTH INFORMATION

Did mother visit the physician fewer than 2 times during pregnancy? _____ No _____Yes- If Yes, explain:_____

_____

Did mother or child stay in the hospital for medical reasons longer than usual?_____ No _____Yes- If Yes, explain:_____

_____

Place of birth:_____Birth:_____lbs._____oz.

Type of delivery:_____Vaginal_____C-Section (please explain why)

_____

Was your child born more than 3 weeks before or after due date ?_____ No _____Yes- If Yes, explain:_____

_____

Were there any problems with the mother or child?:

During pregnancy _____ No _____Yes- If Yes, explain:_____

During delivery _____ No _____Yes- If Yes, explain:_____

After Delivery _____ No _____Yes- If Yes, explain:_____

During pregnancy, did the mother use: ____Cigarettes _____Alcohol _____Drugs _____Prescription Medication

Is this child's mother/ guardian pregnant now? _____ No _____Yes

CHILD'S HOSPITALIZATIONS and ILLNESSES

Overnight hospitalizations: _____ No _____Yes- If Yes, explain:_____

Emergency Rooms Visits: _____ No _____Yes- If Yes, explain:_____

Serious Accident: _____ No _____Yes- If Yes, explain:_____

Serious Illness: _____ No _____Yes- If Yes, explain:_____

Surgery: _____ No _____Yes

If 'Yes':

Type of surgery: _____

Date of surgery: _____ Name of Hospital: _____

Problems or complications: _____

Seizures: _____ No _____Yes

If 'Yes':

Type of seizure:_____

Reaction:_____

Duration: _____

Medication: _____

Part 1: Place a check mark in the No or Yes column to each item. For all Yes responses, please explain in the Comments column.

DOES YOUR CHILD	NO	YES	COMMENTS
Wear glasses			
Have lazy eye, crossed eyes, wandering eyes, other eye conditions			
Have a history of ear infections, tubes in ears, hearing loss, wear hearing aids			
Have excessive colds, sore throats, coughing episodes, or snores loudly			
Have a history of asthma or bronchitis			
Have a heart murmur, resolved heart murmur, rheumatic fever or other heart conditions			
Have a history of anemia, sickle cell disease, elevated lead level or other blood conditions such as G6PD, hemophilia, etc.			
Have or had an umbilical or inguinal hernia			
Have reflex, stomach pain, diarrhea, constipation			
Have a feeding tube			
Have trouble urinating, urinary tract infection or kidney disease			
Wear diapers/ pull-ups			
Have diabetes (if Yes, please indicate Type I or Type II diabetes)			
Have rashes, eczema, hives, boils			
Have neuropathy, muscle tics, muscular dystrophy, cerebral palsy			
Wear leg braces			
Use a cane, walker or wheelchair			
Have (or had) pollo, chicken pox, measles, mumps, scarlet fever, whooping cough			
Have car sickness			
Have allergies due to medication or food			
Have allergies due to seasonal changes, animals or other			
Take medication daily or on an 'As Needed' basis			

Please share with us any health concerns you have for your child _____

MEDICAL CONCERNS

Center:_____

Child's Name:_____ Date of Birth: _____

Dear Parent/ Guardian,

The office of Early Childhood recognizes the fact that some children have medical conditions. The health care provider may prescribe may prescribe medications for these conditions. When the prescribed dose is to be administer during preschool hours, the Health Services division, with written permission, will train staff at your child's center to administer the medication to your child. Written permission is given by submission of form MED-1: Request for Administration of Medication, completed by you and your child's health care provider for each medication. At no time will medication be given to your child without a completed MBD-1.

Please check one box and complete as necessary:

- ☐ At this time, my child does not have a medical condition.
- ☐ My child has the following medical condition(s):
  (A representative from Early Childhood Health Services many contact you for more information)
  1. Diagnosis or medical condition: _____
     - ☐ Does not require medication to be administered
     - ☐ Requires medication to be administrated DAILY
       Medication name, dose and time: _____
     - ☐ Requires medication to be administrated AS NEEDED
       Medication name, dose and time: _____
  2. Diagnosis or Medical Concerns: _____
     - ☐ Does not require medication to be administered.
     - ☐ Requires medication to be administered DAILY
       Medication name, dose and time: _____
     - ☐ Requires medication to be administered AS NEEDED
       Medication name, dose and time: _____

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to immediately inform my child's teacher or Early Childhood Health Services if there is any change to the change to the information indicated above.

_____ _____

Signature of Parent/ Guardian Date

DIETARY RESTRICTIONS

Center:_____

Child's Name:_____ Date of Birth:_____

Dear Parent/Guardian,

C.B.S Kosher Food Program provides daily nutritional breakfast, lunch and snack for your child. A monthly menu, provided in each center, list the foods and beverages that your child is offered at each meal component. The center recognizes the fact that certain foods, due to religious, medical or other reasons, are restricted from some children's diets. Please tell us about your child. This information will be shared with your child's nutritional, health and instructional staff. In order to ensure that your child is relieving an age appropriate, nutritionally sound diet, request for food restrictions must be verified by a note from your child's health care provider or religious leader. If your child has a dietary restriction, efforts will be made to provide your child with an allowable substitution.

If your child has a significant for allergy which requires the administration of an EPI-PEN, Benadryl, or other medication, please let us know immediately so that we can begin the process required to train the staff.

Please check one box and complete as necessary:

- ☐ At this time, my child does not have a dietary food restriction.
- ☐ My child has the following dietary food restriction(s):
- ☐ Name of restricted food:_____

Reason for restriction: Religious:_____ Other (please specify): _____
Medical:_____ Please indicate reaction and treatment: _____
_____
_____

1. Name of restricted food:_____

Reason for restriction: Religious:_____ Other (please specify): _____
Medical:_____ Please indicate reaction and treatment: _____
_____
_____

2. Name of restricted food:_____

Reason for restriction: Religious:_____ Other (please specify): _____
Medical:_____ Please indicate reaction and treatment: _____
_____
_____

The information on this form is true to the best of my knowledge. I will inform my child's teach if any of this information changes.

Signature of Parent/ Guardian: _____ Date:_____

NUTRITION HISTORY

Parent/Guardian: Please complete both sides of this form to the best of your knowledge.

Child's Name:_____ Today's Date:_____

1. What foods does your child like?_____
2. What foods does your child dislike?_____
3. Place a check mark in the No or Yes column next to each question:

	NO	YES
Does your child take vitamins?		
Do the vitamins contain iron?		
Do the vitamins contain fluoride?		
Are the vitamins prescribed by a doctor?		
Is your child on a special diet?		
Is this diet recommended by a doctor?		
Has there been a noticeable change in your child's appetite in the last month?		
Does your child drink from a bottle?		
Does your child eat or drink things that aren't food? (ex: dirt, clay, paint)		
Does your child have trouble chewing or swallowing?		
Does your child often have diarrhea?		
Does your child often have constipation?		
Do you have any concerns about what your child eats?		
Are you receiving WIC?		
Are your receiving Food Stamps?		

4. Place a check mark under the column that indicates the approximate number of times a week your child eats the following foods;

	0	1	2	3	4	5	6	7+
Milk- whole , skim, low fat, lactose free								
Cheese, yogurt								
Eggs								
Peanut butter								
Beans, peas, soy, tofu, lentils								
Nuts, seeds								
Beef, chicken, turkey								
Fish, shellfish								
Rice, noodles, bread, tortillas, crackers, cereal								
Green vegetables, spinach, collard greens								
Winter squash, pumpkin, sweet potatoes, carrots								
Oranges, grapefruit, tomatoes, broccoli, fruit juice								
Other fruits and vegetables								
Oil, butter, margarine, jams, jellies, olive oil								
Cakes, cookies, sodas, fruit drinks, candy								

5. Where do you usually take your child for health care services (Medical Home)?
   Name:_____
   Address:_____ Zip:_____ Phone number:_____

6. Where do you usually take your child for dental care services (Dental Home)?
   Name:_____
   Address:_____ Zip:_____ Phone number:_____

POLICIES AND CONSENT FOR EMERGECY MEDIACL CARE AND SCREENINGS

Child's Name: _____

The parent is responsible for making arrangements for alterative care for your child if he/she is ill, needs close supervision or has a contagious condition and cannot attend preschool. The parent is also responsible for transportation if your child has an illness or minor injury while at preschool, not sufficiently severe to warrant emergency medical transportation.

In the event your child becomes seriously ill or injured and requires immediate medical situation, he/she will be accompanied by a staff person and taken to the nearest hospital emergency room in an emergency medical vehicle. We will attempt to notify the parent at once. Under the Medical Service/Minor Act, Immediate emergency treatment will be initiated at the hospital. However, it is essential that both the center and the hospital be able to locate you as soon as possible, to give either written or monitored verbal permission for comprehensive treatment. Please be sure to keep your child's preschool teacher informed about how to reach you when you are not at home/school.

Parents are responsible for the cost of medical treatment if there is injured. Please contact Early Childhood health Services if your child needs medical insurance.

A Doctor's not will be required before you child can return to preschool if he/she has any of the following: an emergency room visit, certain cases of illness (contagious, serious, required a long absence or surgery, etc.) or certain cases of injury (needing doctor's care, cast or brace, special activities, etc.) If you have any doubt, please obtain a Doctor's not whenever your child goes for medical care.

CONSENT FOR EMERGENCY MEDICAL CARE AND PREVENTIVE SCREENING

My signature below indicates that I give consent for:

1. The administration of minor first aid to my child by preschool classroom staff.
2. The emergency medical and/or dental care which may be necessary to preserve the life of my child or to prevent impairment of his/her health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for on-going care.
3. My child to participate in the Office of Early Childhood screening program which may include, but not limited to; developmental screening, vision screening, hearing screening and dental screening. I understand that as part of the preventive health program, children participating in preschool programs of the School District of Philadelphia receive screening during the school year.

Signature of Parent: _____

If you have any questions about the above information, please speak with a representative from Early Childhood Health Services.

Early Childhood Use Only

Name of Early Childhood Location: _____

Signature of Early Childhood Staff: _____ Date: _____

White- File Yellow- Teacher Pink- Parent/ Guardian Revised 7.12

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET
PHILADELPHIA, PA 19130-4015

#10: CHILD DENTAL HEALTH/DENTAL EXAM FORM

Child's Name _____ Date of Birth _____

SECTION 1: Completed by parent/guardian

1. Has your child been to the dentist? ☐ No ☐ Yes – if 'Yes', date of child's last dental visit _____
2. Does your child have (or had) cavities or caries? ☐ No ☐ Yes – If 'Yes', how many? _____
3. Does your child have any problems with his/her teeth, gums, or mouth? ☐ No ☐ Yes
   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth? _____

SECTION 2: Completed by child's Dentist

1. Date of child's most recent:
   Dental Examination _____ Teeth Cleaning _____ Fluoride Treatment _____
2. Has child ever needed dental treatment? ☐ No ☐ Yes
   If Yes, type of dental treatment _____
   Has dental treatment been completed? ☐ No ☐ Yes – if 'Yes', date of completion _____
3. Date of child's next dental visit _____

Dental Office Stamp

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

The School District of Philadelphia
Office of Early Childhood of Education
440 N. Broad Street, Suite 170
Philadelphia, PA 19130

Form #7: CHILD HEALTH ASSESSMENT

Child's Name (Last)	Child's Name(First)	Child's Date of Birth:
Parent/Guardian Name:	Address:	Contact Phone #:

PA child care providers must document that enrolled children have recived age-appropriate health services and immunizations that meet the current schedule of the American Academy Pediatricians, 141 Northwest Point Blvd. Elk Grove Village, Il, 60007. The schedule is available at www.aap.org or Faxback 847/758/0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine care and emergencies (describe, if any): ☐ None	DATE OF MOST RECENT WELL-CHILD/PHYSICAL EXAM:
Allergies to food or medicine (describe, if any) ☐ None	Do not omit any information. This form may be updated by health professional (initial and date new date).

LENGTH/ HEIGHT	WEIGHT	BLOOD PRESSURE
_____ IN/CM____%ILE_____.	_____LB/KG %ILE_____.	(BEGINNING AT AGE 13) _____/_____.

PHYSICAL EXAMINATION	X = NORMAL	IF ABNORMAL- COMMENTS
HEAD/EYES/EARS/NOES/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/ BREASTS		
EXTREMETIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTap/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARCICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TEST	DATE OF TEST	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (US) at age 5		
HEARING (subjective till age 4)		
VISION(subjective till age 3)		
PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (attach additional sheets if necessary)

☐ NONE

NEXT APPOINTMENT- MONTH/ YEAR

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
ZIP CODE:	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED: