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OFFICE OF EARLY CHILDHOOD
HEAD START PROGRAM

CHILD AND FAMILY FILE

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6. Walk trip
7. Before/After Care Contract
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THE SCHOOL DISTRICT OF PHILADELPHIA

Preschool Application

for Academic Year

2020-2021

District and Childcare Partners

Full Day Pre-K!

Ages 3-5

3 yrs old before Sept 1st, 2020
5 yrs old after Sept 1st, 2020

Program Benefits

Free Nutritious Meals
High-Quality Curriculum
Access to Nurses
Special Needs Support
Parent Participation

The School District of Philadelphia
440 N Broad Street
Suite 170 – Preschool Program
Philadelphia, PA 19130-4015

THE SCHOOL DISTRICT OF PHILADELPHIA

Thank you for your interest in the School District of Philadelphia's preschool program! Completing and submitting a Preschool Application does not guarantee that your child will be accepted to a preschool program. For your best chance at acceptance, please submit your child's completed application on or before February 28th, 2020.

1. Complete ALL necessary steps below. As you collect each item, check off the box.

Applications will not be accepted without all supporting documentation.

- ☐ **I have filled out the entire application**
- ☐ **I have proof of child's date of birth** (Birth certificate, health insurance card, etc.)
- ☐ **I have documentation of family income** (Tax forms, 4 consecutive paystubs, or financial support letter)
- ☐ **I have proof of Philadelphia residency** (bill, driver's license, lease, etc.)
- ☐ **I have my child's health insurance card**
- ☐ **I have my child's physical** (health assessment within the year) **and immunizations**
- ☐ **I have proof of child's dental visit (within the year)**
- ☐ **I have picture identification of parent/guardian** (Current State or Federal Photo ID)
- ☐ I have proof of TANF (DPW) cash, SNAP/food stamps, medical assistance *(if applies to you)*
- ☐ I have a custody order *(if applies to you)*
- ☐ I have a foster letter *(if applies to you)*
- ☐ I have a homeless verfication letter/shelter letter *(if applies to you)*

2. Are you applying to a School-Based Location (pg. 3)? Bring the application and required documentation down to 440 North Broad. We are open M-F 8:30 am – 4 pm.

3. Are you applying to a Community Partner Location (pg. 4-6)? Take the application and supporting documents directly to that agency.

RECORD OF ACCESS

STUDENT NAME: _____ DOB: _____

NAME	DATE	PURPOSE OF ACCESS	DATE RETURNED

Soans Christian Academy

7912 Dungan Road
Philadelphia, PA 19111
Phone: (267) 388 - 7648 · Fax: (267) 731-1857

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124(a)(b) 3270.181 &182; 3280.124(a)(b),3280.181 &182; 3290.124(a)(b) 3290.181&.182

CHILD'S NAME: *(As it APPEARS on child's state/ government issued "Birth Certificate")*	Date of Birth: *(Required)*
MOTHER'S NAME/LEGAL GUARDIAN: *(Required: Unless Court Order, Incarcerated or Deceased, please specify):*	Home Phone: *(Required)*
ADDRESS: *(Required)*	
CITY, STATE, and 5- DIGIT ZIP CODE: *(Required)*	E-mail: *(Required)*
Business Name: *(Required if Employed))*	Cell Phone: *(Required)*
Address, City, State, and 5-Digit Zip Code: *(Required if Employed)*	Business Phone: *(Required if Employed)*
FATHER'S NAME/LEGAL GUARDIAN: *(Required: Unless Court Order, Incarcerated or Deceased, please specify):*	Home Phone: *(Required)*
ADDRESS: *(Required)*	
CITY, STATE, and 5-DIGIT ZIP CODE: *(Required)*	E-mail: *(Required)*
Business Name: *(Required if Employed)*	Cell Phone: *(Required)*
Address, City, State, and 5-Digit Zip Code: *(Required if Employed)*	Business Phone: *(Required if Employed)*
EMERGENCY CONTACT PERSON (s) (list below) *(Minimum of (3) Individuals Over 18 yrs. Old)*	Telephone Number (when in care) *(Required)*
1	
2	
3	
Person (s) Whom Child May Be Released and Address (list below) *(Min. (3) Over 18 yrs. Old)*	Telephone Number (when in care) *(Required)*
1	
2	
3	
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER: *(Required)*	Phone Number + Area Code: *(Required)*
ADDRESS, CITY, STATE, and 5-DIGIT ZIP CODE: *(Required)*	
Special Disabilities: *(Copy of IFSP or IEP Required, if applicable)*	All Allergies *(Listed on Health Assessment)*
Medical or Dietary Information necessary in an emergency situation *(Dietary Form Required)*	*Medications (List Medications Taken Daily)*
Additional Information on Special Needs of Child *(Copy of IFSP or IEP Report Required, if applicable)*	
Health Insurance Coverage or Medical Assistance Benefits	Policy Number *(Required)*

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

OBTAINING EMERGENCY MEDICAL CARE *(Required)* X	ADMIN. OF MINOR FIRST – AID PROCEDURES *(Required)* X
TRANSPORTATION BY THE FACILITY IN CASE OF EMERGENCY *(Required)* X	WALKS *(Required)* X
I allow child in (*Swimming: 3rd – 6th/Sprinkler-YT-PKC) (Required)* X	I allow Photos/Video Used for *Classrooms ONLY* (Required) X
Signature of Parent or Guardian *(Required)*	X *Date: (less than 6-months)*

Child's Name:	Date of Birth:

#1: CHILD and FAMILY INFORMATION FORM

Section 1: PRIMARY PARENT

The adult who is primarily responsible for the care and well-being of the child.

First Name:	Last Name:
Date of Birth:	Gender: O Male O Female
Primary language:	Other language(s):

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

Home Phone #:	Cell Phone #:
Email Address (please print clearly):	
Emergency Contact:	Emergency Contact Phone #:

Best way to reach you during the day:	O Home Phone #	O Cell Phone #	O Email	O Emergency Contact
Marital Status Select one	O Married	O Single	O Widowed	O Separated/Divorced

Relationship to Child Select one	O Parent/Step-Parent	O Grandparent
	O Foster/Kinship Parent, related to child	O Foster Parent, not related to child
	O Guardian, related to child	O Guardian, not related to child
	O Other (specify):	

Race/Ethnicity Select all that applies	O Hispanic or Latino/a	O American Indian	O Asian
	O Black or African American	O Multi-Racial or Bi-Racial	O Native Hawaiian
	O Pacific Islander	O White	O Other (specify):

Status Select all that applies	O Single Parent – cares for the child without physical or financial assistance from the other parent	O Teen Parent – parent was under the age of 18 when child was born

Education Select highest Diploma/Degree earned or highest Grade Level completed	O High School Diploma	O GED	O Vocational Degree
	O Associates Degree	O Bachelors Degree	O Masters Degree
	O Doctorate Degree	O Some College	O ESL – English as a Second Language
	O 11th Grade	O 10th Grade	O 9th Grade or lower
	O Other (specify):		

Employment, School, Job Training Select all that applies	O Employed/Self-Employed	O Unemployed/Not Employed	O Disabled
	O In School/Job Training	O Stay-at-Home Parent	O Retired
	O Member of the U.S. military on active duty	O Veteran of the U.S. military	

Name of Employer:	Name of Employer:		
How often are you paid?	O Monthly	O Twice a month	O Every Week
	O Every two weeks	O Other:	

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

Child's Name:	Date of Birth:

Section 2: SECONDARY PARENT

An adult who shares in the care of the child.

First Name:		Last Name:	
Date of Birth:		Gender: O Male O Female	
Primary language:		Other language(s):	
O Same as Primary Parent/Guardian		Home Address:	
Apt./Unit #:	City:	State:	Zip Code:
Home Phone #:		Cell Phone #:	
Email Address (please print clearly):			
Emergency Contact:		Emergency Contact Phone #:	

Best way to reach you during the day: Select all that applies	O Home Phone #	O Cell Phone #	O Email	O Emergency Contact
Marital Status Select one	O Married	O Single	O Widowed	O Separated/Divorced

Relationship to Child Select one	O Parent/Step-Parent		O Grandparent
	O Foster/Kinship Parent, related to child		O Foster Parent, not related to child
	O Guardian, related to child		O Guardian, not related to child
	O No Relation	O Other (specify):	

Status Select all that applies	O Spouse – husband/wife	O Companion/Partner	O Teen Parent – parent was under the age of 18 when child was born
	O Lives with child	O Does not live with child	O Provides financial support to child's family

Race/Ethnicity Select all that applies	O Hispanic or Latino/a	O American Indian	O Asian
	O Black or African American	O Multi-Racial or Bi-Racial	O Native Hawaiian
	O Pacific Islander	O White	O Other (specify):

Education Select highest Diploma/Degree earned or highest Grade Level completed	O High School Diploma	O GED	O Vocational Degree
	O Associates Degree	O Bachelors Degree	O Masters Degree
	O Doctorate Degree	O Some College	O ESL – English as a Second Language
	O 11th Grade	O 10th Grade	O 9th Grade or lower
	O Other (specify):		

Employment, School, Job Training Select all that applies	O Employed/Self-Employed	O Unemployed/Not Employed	O Disabled
	O In School/Job Training	O Stay-at-Home Parent	O Retired
	O Member of the U.S. military on active duty	O Veteran of the U.S. military	
Name of Employer:	Name of Employer:		
How often are you paid?	O Monthly	O Twice A month	O Every Week
	O Every two weeks	O Other:	

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

Section 3: LOCATIONS

CHOOSE THE LOCATION(S) WHERE YOU WOULD LIKE YOUR CHILD TO ATTEND: Your child may be selected for your second or third choice. Do not put a location that you are not willing or able to take your child regularly and on time. Transportation is not provided.

Name of your 1st Location Choice:

Name of your 2nd Location Choice:

Name of your 3rd Location Choice:

Section 4: CHILD

First Name:		Last Name:	
Date of Birth:		Gender: O Male O Female	
Race/Ethnicity Select all that applies	O Hispanic or Latino/a	O American Indian	O Asian
	O Black or African American	O Multi-Racial or Bi-Racial	O Native Hawaiian
	O Pacific Islander	O White	O Other (specify):
Primary language:		Other language(s):	

English is spoken in the home.	O Yes	O No
Child's English skills: O Very well O Well O Not well O Does not speak English		
There is an active custody arrangement for this child.	O Yes	O No
Child lives with (select all that applies): O Mother O Step-Mother O Foster Parent/Kinship Parent O Father O Step-Father O Grandparent O Relative O Other		
Child has a disability. If 'Yes', list all disabilities:	O Yes	O No
Child has an IEP, an IFSP and/or an ER and is receiving Early Intervention services from ChildLink, ELWYN or ELWYN Seeds. If 'Yes', indicate below which Early Intervention services your child is receiving (select all that applies):	O Yes	O No
O Speech Therapy O Special Instruction O Physical Therapy O Occupational Therapy O Other		
Is your child fully potty trained? (Fully Potty Trained means – Child does not wear pull-ups or diapers and does not need any assistance from an adult when going to the bathroom.)	O Yes	O No

If 'Yes', child will be expected to use the toilet without adult assistance while in preschool. Answering falsely may slow down the enrollment process. (Some locations cannot accept children in diapers/pull-ups.)

Child wears pull-ups/diapers? O Daytime O Naptime O Nighttime O Other?	O pull-ups	O diapers	O No
Child is/was in preschool or daycare.	O No	O Yes – name:	
Child's mother and/or father is currently incarcerated.		O Yes	O No
Child's mother and/or father is deceased.		O Yes	O No
There have been important changes in my child's life during the last 12 months.		O Yes	O No
If 'Yes', please explain:			
Child was referred to a preschool program from a mental health provider.		O Yes	O No

Please share any additional information about our child that you would like us to know.

Child's Name:	Date of Birth:

Section 5: FAMILY MEMBERS AND HOUSING

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

FIRST and LAST NAME	DATE of BIRTH MM/DD/YYYY	RELATIONSHIP to PRIMARY PARENT Self, Husband, Wife, Daughter, Son, Mother, etc.
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Housing Information Select your current situation	O Own	O Rent	O Transitional housing – Since what date?
	O Shelter – Since what date?		O Train or bus station, park or in car – Since what date?
	O Living with relatives or others to due to lack of alternative, adequate housing or due to the loss of housing – Since what date?		O Hotel/Motel, camping ground or other similar situation due to lack of alternative, adequate housing or due to the loss of housing – Since what date?
	O Temporary housing situation due to emergency: eviction, flood, fire, hurricane, etc.		O Abandoned apartment building
	O Other _____		

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
We have a medically fragile child (chronic illness, terminal illness, etc.) Name of child:	O Yes	O No
Does someone in the home have a mental health concern?	O Yes	O No
Does someone in the home have a social concern (English language learner, eating disorder, custody issues, etc.)? If 'Yes', please list your concerns:	O Yes	O No
Optional Information New to the country?	O Yes	O No
Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you?	O Yes	O No

Section 6: FAMILY INCOME

Select each source of income that the Primary Parent, Secondary Parent and all children receive.

O Employment	O Self-Employment	O Unemployment Compensation	O Workmen's
O Social Security	O SSI	O Child Support	O Alimony
O Military/ Veteran's Benefits	O Commission	O Foster Care/Kinship Care	O Tips
O Pension/Retirement	O Strike Benefits	O Scholarship/Grant/Stipend	O Other (specify):
O Financial support from Family or Friend		O Rental Properties – someone pays you rent	

Does your family receive welfare benefits? O TANF Cash Assistance O SNAP Food Stamps O Medical Assistance

Does your family receive WIC? O Yes O No O

Please share any additional information about your family that you would like us to know.

Child's Name:	Date of Birth:

Section 7: SIGNATURES

Read the following and sign where indicated.

I/We have completed all sections on my/our *Child and Family Information Form* and certify the information is correct. I/We understand that deliberate misrepresentation of my/our information may subject me/us to prosecution under applicable Federal and/or State laws and that, if enrolled, my/our child's participation in the preschool program may end. I/We have attached a copy of my/our child's proof of date of birth, verification of my/our Philadelphia, PA address and copies of all income and monthly benefits that I/we and my/our children receive. I/We understand that this information is required so that my/our eligibility can be determined for The School District of Philadelphia's preschool program. I/We understand that officials from The School District of Philadelphia, the Department of Health and Human Services, the Commonwealth of Pennsylvania and the City of Philadelphia will have access to and may verify the information and supporting documentation submitted with my/our *Preschool Application*. I/We further understand that, if necessary, additional documents may be requested and I/we will comply with this request. I/We understand that my/our child's complete *Preschool Application* is confidential and will be held in strict confidence within The School District of Philadelphia and affiliated Community Nonprofit Partner Agencies that have been determined to be school officials under the Family Educational Rights and Privacy Act with legitimate educational interests as part of The School District of Philadelphia's preschool program.

_____ _____

Signature of Primary Parent Date

_____ _____

Signature of Secondary Parent Date

Section 8: READY4K

Read by 4th and the Free Library of Philadelphia invite you to participate in Ready4K, a research-based text-messaging program for parents. Each week, you will receive approximately three (3) text messages with fun facts and easy tips to boost your child's learning – an approach that is scientifically proven to work. While there is absolutely no cost for enrolling in Ready4K, data and message rates may apply.

If your child is enrolled in a School District preschool program, would you like to receive helpful text messages with fun facts and easy tips on how to boost your child's learning?

☐ No, thank you.

☐ Yes, please send text messages to this number: _____

By opting to receive messages, you hereby agree to (i) the submission of this form to ParentPowered PBC, (ii) enroll in Ready4K ("the Program"), (iii) the ParentPowered PBC Terms of Use available at parentpowered.com/terms.html and Privacy Policy available at parentpowered.com/privacy.html, and (iv) receive approximately three Ready4K text messages per week from 70138. By providing us with your cell phone number above, you confirm that you want ParentPowered to send you information we think may be of interest to you, which involves ParentPowered using automated dialing technology to text you at the cell phone number you provided. While there is absolutely no cost for enrolling, data & message rates may apply. You can cancel your receipt of Ready4K text messages any time by texting STOP to 70138. For help with Ready4K text HELP to 70138 or email us at

Section 9: Family Well Being

Family Well Being is an important part of a child's educational success. Which aspects of Family Well Being are you interested in receiving workshops, training opportunities and other resources? (select all that applies):

O Adult Education O Employment O Food Assistance O Housing O Medical Home
O Mental Health O Physical Health O Safety O Substance Abuse

Section 10: SURVEY

How did you hear about The School District of Philadelphia's preschool program? (select all that applies):

O Neighbor O Friend/Family Member O Doctor's Office O Radio O Newspaper
O Informational flyer O Library O Internet O Facebook O Instagram O Other

THE SCHOOL DISTRICT OF PHILADELPHIA

Policy: Required Background Checks for Volunteers

PURPOSE
To clarify the District's position on required background checks for parent and community volunteers.

DEFINITIONS
The term "Visitor" shall include all who voluntarily participate in special events, field trips, or programs at or for a school on a one-time or occasional basis. Visitors will not be engaged in activities that provide them with unmonitored care, supervision, guidance, or control of children.

The term "Parent Volunteer" shall include any parent/caregiver of a District student who volunteers on a full-time basis, part-time basis, or periodically over an extended period (more than 60 days) at or for a school but is not an employee, contractor, or student of the District.

The term "Non-Parent Volunteer" shall include any individual who volunteers on a full-time basis, part-time basis, or periodically over an extended period (more than 60 days) at or for a school but is not an employee, contractor, or student of the District and is not a parent/caregiver of a District student.

The term "Volunteer" shall refer to both Parent Volunteers and Non-Parent Volunteers.

POLICY
Visitors are not required to obtain any criminal background checks.

Parent Volunteers must obtain two background clearances:
- Pennsylvania State Criminal History Record
- Child Abuse Report

Note: The District does not require Parent Volunteers to obtain FBI background checks. However, if the results from the two required background clearances show any criminal convictions, the Parent Volunteer will also be required to obtain an FBI background check.

Non-Parent Volunteers must obtain three background clearances:
- Pennsylvania State Criminal History Record
- Child Abuse Report
- FBI Background Check (for new Non-Parent Volunteers effective January 1, 2008)

Individuals with any serious criminal convictions (as defined by Procedure) within five years immediately preceding the date of the report will be barred from serving as a Volunteer.

In cases where the required background checks are cleared, the Principal still retains the right to exercise his/her discretion in declining to permit an individual to serve as a Volunteer in his/her school.

Prospective Volunteers may work at or for a school in advance of the results from the required background checks under the following conditions:
1. They provide a copy of the appropriate completed request forms for background checks to a District administrator;
2. They swear or affirm in writing via Affidavit that they do not have any criminal convictions that would disqualify them from being a Volunteer; and
3. They will not be engaged in any activities that will provide them with unmonitored care, supervision, guidance, or control of children.

Steps for Child Abuse Clearance:

1. Go to https://www.compass.state.pa.us/cwis/public/home
2. Click on Create Individual Account
3. Click Next
4. Type in all your information that it is asking for in the blank white boxes
   - KeystoneID must be 6-10 characters long
5. When you're done, click Finish
6. Log into your email for your temporary password
7. Highlight the password, right click and choose Copy
8. Go back to the web page https://www.compass.state.pa.us/cwis/public/home
9. Click Individual Login
10. Click Access my clearance
11. Scroll down the page, click continue
12. Enter your KeystoneID and your Temporary password, Click login
13. Create your own password in "Password" and retype your password in "Confirm Password"

    Password MUST contain at least:

    ONE number
    ONE upper case letter
    ONE lower case letter
    ONE special Character, such as @$%&*
14. Click close window
15. Log back in, enter your keystoneID and your new password, click log in
16. Click: I have read, fully understand and agree to the My Child Welfare Account terms and conditions, then click next
17. Scroll down and click continue
18. Click Create Clearance Application
19. Scroll down and click begin
20. Click on bubble for:

    ☑ Volunteer Having Contact with Children: Applying for the purpose of volunteering as an adult for an unpaid position as a volunteer with a child-care service, a school or a program, activity or service, as a person responsible for the child's welfare or having direct volunteer contact with children.

    Agency Name: SOANS CHRISTIAN ACADEMY 7940 DUNKS FERRY ROAD PHILADELPHIA, PA 19111
21. Scroll down to Click Next
22. Complete ALL of part 1 and part 2 and click next each time you finish a section
23. On Application payment – Click No.
24. Click Waive Application Fee and Submit Application
25. Wait within 14 days for your certificate in your email.

Steps for PA Criminal History Check:

1. Go to https://epatch.state.pa.us/Home.jsp
2. Click "New Record Check (Volunteers only)"
3. Scroll down, Check the box by clicking it, and click accept
4. Complete the following questions in the text box
   Volunteer Organization Name: Grace Neighborhood Academy
   Phone Number: 2155358200
5. Click Next, Click proceed,
6. Complete the following questions in the text box
7. Click "Enter This Request"
8. Click "View Queued Record Check Requests(1)"
9. Click "Submit"
10. Click on your Control #
11. Click on "Certification form"
12. Click Print – Make 2 copies.

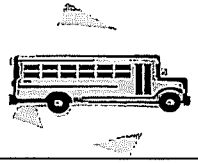
THE SCHOOL DISTRICT OF PHILADELPHIA
PREKINDERGARTEN HEAD START
VOLUNTEER DATA LOG

Total Hrs for Month:_____

Center: Grace Neighborhood Academy Child's name_____ Month_____ 20_____

Volunteer Name (Print)_____ Gender (of volunteer) : _____ Female _____Male

Volunteer Signature:_____ Head Teacher Signature:_____

Service Category	Classroom Volunteer 			Meetings and Workshop 			Class Field Trip Escort 			At Home Activities 			Social Activities 			Fund Raising Activities 			Literacy Activities 			Total Hours
Date	In	Out	Total Hours	In	Out	Total Hours	In	Out	Total Hours	In	Out	Total Hours	In	Out	Total Hours	In	Out	Total Hours	In	Out	Total Hours	
	Total=			Total=			Total=			Total=			Total=			Total=			Total=			_____	

The School District of Philadelphia
Office of Early Childhood Education
ELIGIBILITY VERIFICATION FORM

Child Name: _____ Date of Birth: _____

Primary Parent Name: _____

Secondary Parent Name: _____

INTERVIEW STATEMENTS	
HEAD START & PREK COUNTS: INTERVIEW	
O Interview was conducted:	
O In person.	O Over The Phone (explain):

HEAD START & PREK COUNTS: AGE			
O During the interview, parent/guardian provided proof of age with documents marked below:			
O Original Birth Certificate	O Hospital Record	O Health Insurance Card	O Baptismal Certificate
O Passport	O Visa	O Medical Exam	O Notarized Statement
O Prior School Record	O Court Document	O Shelter Letter	O Homeless Verification Letter
O Other (explain):			

HEAD START & PREK COUNTS: INCOME			
O During the interview, parent/guardian provided proof of income with documents marked below:			
O Pay Stubs	O SSI	O TANF Cash Assistance	O Alimony
O Child Support	O Pension	O Social Security	O Self-Employment
O 1040 Income Tax Form	O W-2	O Military Allotment	O Commission
O Tips	O Rental Properties	O Unemployment Compensation	
O Workmen's Compensation		O Strike/Veteran's Benefits	
O Scholarship/Grant/Stipend		O Foster Care/Kinship Care	
O Notarized Statement of Earnings		O Financial Support from Friend/Family Member	
O Homeless: [NOTE: PreK Counts needs some documentation of income – CAN accept the 'No Income Form' for homeless.]		O Other (explain):	

_____ _____
Signature of Early Childhood Staff Printed Name

_____ _____
Title Date

The School District of Philadelphia
Office of Early Childhood Education
ELIGIBILITY VERIFICATION FORM

Child Name: _____ Date of Birth: _____

FAMILY SIZE and ANNUAL INCOME	
Head Start	PreK Counts/PKC
Primary Parent Name:	Primary Parent Name:
1st Income Source	1st Income Source
Frequency	Frequency
Annual Income 1st Source $	Annual Income 1st Source $
2nd Income Source	2nd Income Source
Frequency	Frequency
Annual Income 2nd Source $	Annual Income 2nd Source $
Primary Parent: Annual Income HEAD START $	Primary Parent: Annual Income PREK COUNTS/PKC $
Secondary Parent Name:	Secondary Parent Name:
1st Income Source	1st Income Source
Frequency	Frequency
Annual Income 1st Source $	Annual Income 1st Source $
2nd Income Source	2nd Income Source
Frequency	Frequency
Annual Income 2nd Source $	Annual Income 2nd Source $
Secondary Parent: Annual Income HEAD START $	Secondary Parent: Annual Income PREK COUNTS/PKC $

FAMILY SIZE and TOTAL ANNUAL GROSS INCOME by PROGRAM	
HEAD START	PREK COUNTS/PKC
Verified Family Size	Verified Family Size
Verified Family Annual Gross Income: HEAD START $	Verified Family Annual Gross Income: PREK COUNTS/PKC $
	CACFP
	Verified Household Size:
	Verified Household Income: $
Name:	Name:
Signature:	Signature:
Date:	Date:

ELIGIBILITY STATEMENTS

HEAD START

O I have reviewed the information and documentation contained in this application and certify that the family is ELIGIBLE for Head Start funding according to the current income and eligibility guidelines.

O I have reviewed the information and documentation contained in this application and certify that the family is NOT ELIGIBLE for Head Start funding according to the current income and eligibility guidelines.

O Income Over Federal Poverty Guidelines O Child's Age O Philadelphia Residency

PREK COUNTS/PKC

O I have reviewed the information and documentation contained in this application and certify that the family is ELIGIBLE for Pennsylvania Pre-K Counts funding according to the current income and eligibility guidelines.

O I have reviewed the information and documentation contained in this application and certify that the family is NOT ELIGIBLE for Pennsylvania Pre-K Counts funding according to the current income and eligibility guidelines.

O Income Over 300% of Federal Poverty Guidelines O Child's Age O Philadelphia Residency

HEAD START SELECTION CRITERIA SCORING SHEET

CATEGORICALLY ELIGIBLE	INCOME ELIGIBLE
O Homeless	O 100% of the Poverty and Below
O Foster Care/Kinship Care	O Between 101 – 130% of Federal Poverty Guidelines
O TANF Cash Assistance	O Between 130% - 300% of Federal Poverty
O Supplemental Security Income - SSI	O Over 300% of Federal Poverty Guidelines
LIVING SITUATION	HEALTH
O Incarcerated Parent	O Special Needs child (IEP)
O Immigrant/migrant family	O Disabled parent/guardian
O Single Parent	O Medically Fragile child or sibling
O Teen Parent	MISCELLANEOUS
O Grandparent as guardian	O Other Social Concerns
O Sibling of enrolled child	O Parent in training/school
O Custody Order	O Child without previous preschool experience
	O TANF: Medical Assistance
	O TANF: Food Stamps

Signature of Early Childhood Staff

Printed Name

Title

Date

Proof of Birth Date: Documents which can be used for verification of age:

- Child's original birth certificate
- Hospital record of child's birth
- Child's health insurance card
- Baptismal certificate indicating the child's date of birth
- Copy of the record of baptism – notarized or duly certified and showing the date of birth
- Child's valid Visa or passport
- Official medical exam print out with child's date of birth
- Notarized statement from the parents or another relative indicating the date of birth
- Prior school records indicating the date of birth (previous preschool)
- Court documents

Definition of Income: The total annual cash receipts before taxes (gross income) from all sources.

Considered Income:

- Calculate income from ALL sources for ALL Family members including unearned income and benefits.
- Include income of:
  1. Parent/Guardian of child
  2. Spouse of parent/guardian of child
  3. Children's unearned income – excluding a child's earned income
- Deduct child support to a child in another household and medical expense not reimbursed through medical insurance that exceeds 10% of gross

Not Considered Income:

- Emancipated Minor earnings
- Tax refunds (income tax credits)
- Withdrawals of bank, brokerage deposits or money borrowed.
- Loans or grants, scholarships, student aid, work study program
- Volunteer payments (AmeriCorps/foster grandparent program)
- Foster Care payments including adoption assistance

Period of time for determining eligibility

- Accept all income twelve months immediately preceding the month in which the application or reapplication for enrollment of child is made.

Definition of Family for Head Start

1305.2 Family, for a child, means all persons living in the same household who are:

(1) Supported by the child's parent(s)' or guardian(s)' income; and

(2) Related to the child's parent(s) or guardian(s) by blood, marriage, or adoption; or

(3) The child's authorized caregiver or legally responsible party.

Definition of Family for PreK Counts

1. Parent is biological or adoptive mother or father, stepmother or stepfather, caretaker and spouse who exercises care and control over the child requesting PA Pre-k Counts. (Not boyfriend – unless biological father)
2. Biological, adoptive, unrelated or foster child or stepchild of the parent s or caretaker who is under 18 yrs. of age and not emancipated. (including Pre-k child)
3. A child who is 18 yrs. of age or older (under 22) who is enrolled in high-school a general educational development program or a post–secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent on the income of the parent or caretaker or spouse.

Definition of Homeless

"Homeless children" means

1. Individuals who lack a fixed, regular and adequate nighttime residence; and
2. Includes:

a. Children and youths who are sharing the housing of other persons due to loss of housing, economic hardship or a similar reason; are living in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

b. Children and youths who have a primary night time residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;

c. Children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

d. Migratory children who qualify as homeless because they are living in circumstances described in a-c above.

Sec. 725(2) of the McKinney-Vento Homeless Assistance Act.

Definition of Foster care : means 24-hour substitute care for children placed away from their parents or guardians and for whom the state agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the state or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is Federal matching of any payments that are made.

The School District of Philadelphia
Office of Early Childhood Education
ELIGIBILITY VERIFICATION FORM

Child Name: _____ Date of Birth: _____

ELIGIBILITY VERIFICATION STATEMENT (continued)
(EACH ENTRY REQUIRES A SIGNATURE)

DATE	NOTES

Parent /Guardian #1:	Parent/Guardian #2: *(Living at same address as child)*
Income source _____	**Income source** _____
Frequency of pay: _____	**Frequency of pay:** _____
Yearly income: _____	**Yearly income:** _____
Show calculations for yearly income:	*Show calculations for yearly income:*

Annual Income: (combined) _____ Family Size: _____

Partner Center: _____

Please list child and family members residing in household.

1.Child's Name: _____ Date of Birth: _____

Family Member Names	Age	Relationship to child
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Total Family Size = _____

*Family Size Defimition:

The number of people in the household to be counted for purposes of reporting "family size" include the child or children for whom PA Pre-K Counts is being requested and the following individuals who live with that child or children in the same household:

a. A parent of the child. (parent is the biological or adoptive mother or father, stepmother or stepfather, caretaker and spouse who exercises care and control of the child requesting PA Pre-K Counts)
b. A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
c. A child who is 18 years of age or older but under 22 years of age who is enrolled in a high school, a general educational development program or a post-secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent upon the income of the parent or caretaker or spouse of the parent or caretaker.

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

POLICIES AND CONSENT FOR EMERGENCY MEDICAL CARE AND SCREENINGS

This form will be taken with the child when emergency medical care is needed.

Child's Name: _____

The parent is responsible for making arrangements for alternative 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 attention, he/she will be accompanied by a CHILDSPACE TOO 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 Services/Minor Act, immediate emergency treatment will be initiated at the hospital. However, it is essential that both Early Childhood 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 or at work/school.

Parents are responsible for the costs of medical treatment if their child is injured. Please contact Early Childhood Health Services if your child needs medical insurance.

A Doctor's note will be required before your child can return to preschool if he/she has any of the following: an emergency room visit, certain cases of illness (contagious, serious, requiring 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 note whenever your child goes for medical care.

CONSENT FOR EMERGENCY MEDICAL CARE AND PREVENTIVE SCREENINGS

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 is not limited to; developmental screening, behavioral screening, vision screening, hearing screening and dental screening. I understand that as part of the preventative health program, children participating in preschool programs of the School District of Philadelphia receive screenings during the school year.

Signature of Parent: _____ Date: _____

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: _____

#4: POLICIES and CONSENT for EMERGENCY MEDICAL CARE and OTHER HEALTH SERVICES FORM

This form will be taken with your child when emergency medical care is needed.

Child's Name _____ Date of Birth _____

EMERGENCY MEDICAL CARE POLICIES

Parents, you are responsible for making arrangements for alternate care for your child if s/he is ill, needs close supervision or has a contagious condition and cannot attend preschool. You are 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 attention, s/he will be accompanied by staff and taken to the nearest hospital emergency room in an emergency medical vehicle. We will attempt to notify you at once. Under the Medical Services/Minor Act, immediate emergency treatment will be initiated at the hospital. However, it is essential that your child's teacher and the hospital is 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 teacher informed about how to reach you at all times.

You are responsible for the costs of medical treatment if your child is injured. Please contact Early Childhood Health Services if your child needs medical insurance.

A Doctor's note is required before your child can return to preschool if s/he has any of the following: an emergency room visit, certain cases of illness (contagious, serious, requires a long absence, 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 note whenever your child goes for medical care.

CONSENT for EMERGENCY MEDICAL CARE, PREVENTIVE SCREENINGS and OTHER HEALTH SERVICES

My signature below indicates that I understand the Emergency Medical Care Policies and 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 Education's screening program which may include, but is not limited to: developmental screening, behavioral screening, vision screening, hearing screening and dental screening. I understand that as part of the preventative health program, children participating in preschool programs of The School District of Philadelphia receive screenings during the school year;
4. The School District of Philadelphia's Office of Early Childhood Education Program Mental Health Consultation Services to provide services on an as needed basis. These services may include:
    a. Observation of my child in the preschool setting and consultation with teaching staff regarding strategies and techniques to support my child's healthy social/emotional development;
    b. Conduct assessments and behavioral/developmental screenings, using standardized tools, across all domains of my child's development;
    c. Provide behavioral health consultation services to my child and his/her teacher within the early childhood facility;
    d. An invitation to participate in team meetings and action plan development for my child's social/emotional well-being, where I will be provided with information about child-related issues and resources within my community that could be helpful.

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

_____ _____

Signature of Parent/Guardian Date

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
EDUCATION CENTER
440 N. BROAD STREET, 2nd FLOOR- PORTAL C
PHILADELPHIA, PENNSYLVANIA 19130-4015

Telephone: 215-400-4270 Fax: 215-400-4272

Notice # _____

Date: _____

TO: The Parent/Guardian of _____

Topic: **Requirements for: Entry** _____ **Kindergarten** _____ **Returning** _____

It has come to my attention that your child's health records indicate he/she does not have a complete health file. **Please make an appointment IMMEDIATELY** with your child's health care provider to get the information indicated below.

Please have your health care provider complete the attached form including the complete dates; e.g. Month/Day/Year for each item listed below.

Physical Exam	_____	{Last physical	_____}
Dental Exam	_____	{Last dental	_____}
Follow up Vision exam	_____		
Follow up Hearing exam	_____		
DPT	_____	TB TEST	_____
POLIO	_____	LEAD	_____
HEPATITIS B	_____	HEMOGLOBIN/	
MMR	_____	HEMATOCRIT	_____
VARICELLA	_____	BLOOD PRESSURE	_____
PNEUMOCOCCAL	_____		
HIB	_____		

Thank you for your cooperation and help in keeping your Preschool Child healthy.

Your Early Childhood Nurse

revised 6/11
revised 7/12
revised 7/14

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

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 received age-appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics, 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 data).

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?

☐ YES

☐ NO - IF NO, PLEASE EXPLAIN YOUR ANSWER:

LENGTH/HEIGHT	WEIGHT	BLOOD PRESSURE
_____IN/CM %ILE_____	_____LB/KG %ILE_____	(BEGINNING AT AGE 3) _____/_____

PHYSICAL EXAMINATION	☑ = NORMAL	IF ABNORMAL - COMMENTS
HEAD/EYES/EARS/NOSE/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						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TESTS	DATE OF TEST	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5		
HEARING (subjective until age 4)		
VISION (subjective until 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:

#3: 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 Education
Prekindergarten Programs
Suite 170
440 North Broad Street
Philadelphia, PA 19130

INFLUENZA (Flu) IMMUNIZATION

YOUR CHILD'S ANNUAL FLU SHOT

Name: _____ **DOB:** ___/___/___ **Classroom:** _____

Regulation: Influenza (Flu) Shot

- **The influenza (Flu) shot is now required for children in childcare and Preschool programs** unless there is a written exemption: medical, religious or personal.
- The Influenza (Flu) shot is typically given during a specified time frame, August 1st – December 31st, to afford the best protection against the Flu.
- The influenza (Flu) shot is on the recommended ACIP (Advisory Committee on Immunization Practices) schedule.
- **OCDEL (Office of Child Development and Early Learning) permits written exemptions for part or all immunizations.**

Parent's Name (printed): _____

Parent's Name (signature): _____ **Date:** _____

My child received an influenza (flu) shot this year **YES / NO Date:** _____

I understand I have to provide a record of this immunization for my child's file annually.

My child has not received an influenza (Flu) shot **YET** this year but will by _____.

I understand I have to provide a record of this immunization for my child's file annually.

My child did not and will not receive an influenza (Flu) shot this year.

Written Exemption as to why not:

_____

_____

PLEASE RETURN COMPLETED FORM TO YOUR CENTER BY: January 2, 2020

If you have questions contact the School Health Coordinator, Tracey Petty

215-400-5838/tpetty@philasd.org

Oct. 2019/tp

THE SCHOOL DISTRICT OF PHILADELPHIA

Office of Early Childhood Education
Prekindergarten Programs
Suite 170
440 North Broad Street
Philadelphia, PA 19130

Where Can I Go to Get a FLU SHOT? Your Local Walgreens Healthcare Clinic and the health centers below!

North Philadelphia

Esperanza Health Center: 4417 North 6th Street 215-302-3600

Health Center #9: Philadelphia Department of Public Health 131 East Chelten Avenue 215-685-5701

Lower/Central North Philadelphia

Broad Street Health Center: 1415 North Broad Street 215-235-7944

Eleventh Street Health Services of Drexel University: 800 North 11th Street 215-769-1100

Health Center #5: Philadelphia Department of Public Health 1920 North 20th Street 215-685-2933

Health Center #6: Philadelphia Department of Public Health 321 West Girard Ave 215-685-3803

PHMC Health Connection: 1035 West Berks Street 215-765-6690

QCHC Family Health Center: 2501 West Lehigh Avenue 215-227-0300

Strawberry Mansion Health Center: Philadelphia Department of Public Health 2840 Dauphin Street 215-685-2401

Northeast Philadelphia

Health Center #10: Philadelphia Department of Public Health 2230 Cottman Avenue 215-685-0639

South Philadelphia

Health Center #1: Philadelphia Department of Public Health 500 South Broad Street 215-685-6570

Health Center #2: 1720 South Broad Street 215-685-1803

West-Southwest Philadelphia

Health Center #3: Philadelphia Department of Public Health 555 South 43rd Street 215-685-7504

Health Center #4: Philadelphia Department of Public Health 4400 Haverford Avenue 215-685-7601

Oct. 2019/tp

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

#2: CHILD'S MEDICAL CONCERNS FORM

Child's Name _____ Date of Birth _____

Dear Parent/Guardian,

The Office of Early Childhood Education recognizes the fact that some children have a medical condition that requires prescribed medication. When the prescribed medication is to be administered during preschool hours, a representative from Early Childhood Health Services, with written permission, will train the staff at your child's preschool to administer the medication to your child. Written permission is given by submitting 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 MED-1.**

Please check one box and complete as necessary – use additional paper if needed:

☐ 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 may contact you for more information.

1. Diagnosis or medical condition: _____
   - ☐ Does not require medication to be administered
   - ☐ Requires medication to be administered DAILY
     Medication name, dose and times _____
   - ☐ Requires medication to be administered AS NEEDED
     Medication name and dose _____

2. Diagnosis or medical condition: _____
   - ☐ Does not require medication to be administered
   - ☐ Requires medication to be administered DAILY
     Medication name, dose and times _____
   - ☐ Requires medication to be administered AS NEEDED
     Medication name and dose _____

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 a change to the information indicated above.

_____ _____
Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: _____

Signature of Early Childhood Staff: _____ Date: _____

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

#3: CHILD'S MEDICAL HISTORY FORM

Place a check mark in the NO or YES column next to each item. For all YES responses, please explain in the COMMENTS column.

MY CHILD:	NO	YES	COMMENTS
Wears diapers and/or pull-ups			
Has/Had a seizure(s)			
Has/Had a serious accident or illness			
Had an emergency room visit			
Had an overnight hospital stay			
Had surgery			
Wears glasses			
Has a lazy eye, crossed eye, wandering eye or other eye conditions			
Has ear tubes, hearing loss, wears a hearing aid, has a history of ear infections or other ear conditions			
Has excessive colds, sore throats, coughing episodes, snores loudly			
Has a history of asthma or bronchitis			
Has a heart murmur, a resolved heart murmur, rheumatic fever or other heart conditions			
Has a history of anemia, sickle cell disease, elevated lead level			
Has G6PD, hemophilia or other blood conditions			
Has an umbilical or inguinal hernia			
Has reflux, stomach pain, diarrhea, constipation			
Has a feeding tube			
Has trouble urinating, urinary tract infection or kidney disease			
Has diabetes			O Type I O Type II
Has rashes, eczema, hives, boils			
Has neuropathy, muscle tics, spina bifida, muscular dystrophy, cerebral palsy			
Wears leg braces			
Uses a cane, walker or wheelchair on a daily basis			
Has/Had had polio, chicken pox, measles, mumps, scarlet fever, whooping cough			
Experiences car sickness			
Child's mother and/or child had problems during pregnancy, delivery and/or after delivery			
Child's mother/guardian is currently pregnant			Expected due date:

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 above information.

Signature of Parent/Guardian

Date

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

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 _____ Today's Date _____

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 weight _____ 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, please 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 Medicine

Is this child's mother/guardian pregnant now? _____No _____Yes

CHILD'S HOSPITALIZATIONS and ILLNESSES

Overnight hospitalization: _____No _____Yes ~ If Yes, explain _____

Emergency Room Visit: _____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 _____

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

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

DOES YOUR CHILD	NO	YES	COMMENTS
Wear glasses			
Have a lazy eye, crossed eyes, wandering eyes, other eye conditions			
Have a history of ear infections, tubes in ears, hearing loss, wear hearing aid			
Have excessive colds, sore throats, coughing episodes, or snores loudly			
Have a history of asthma or bronchitis			
Have a heart murmur, a 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 reflux, 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, spina bifida, muscular dystrophy, cerebral palsy			
Wear leg braces			
Use a cane, walker or wheelchair			
Have (or had) polio, 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 _____

_____

_____

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

Child Social Development

Parent/Guardian: Please complete both sides of this form 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 a light on? _____ No _____ Yes
6. Does your child have 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 indicate that s/he needs to use the bathroom? _____

   _____

   b) Does your child use diapers/pull ups? Yes____ No____ If yes, when?_____
9. How does your child act with children s/he does not know? _____
10. How does your child act with adults s/he 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 s/he 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 you can remember, what age your child began the following tasks?

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

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

Child's Name Today's Date

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

#5: CHILD'S DIETARY or FOOD RESTRICTIONS FORM

Child's Name _____ Date of Birth _____

Dear Parent/Guardian,

The Child and Adult Care Food Program (CACFP) provides a daily nutritional breakfast, lunch and snack for your child while enrolled in preschool at no cost to families. A monthly menu, posted in each location, lists the foods and beverages that your child is offered at each meal. The Office of Early Childhood Education recognizes the fact that certain foods, due to medical, religious 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. If your child has a non-disabling dietary restriction, efforts will be made to provide your child with an allowable substitution.

If your child has a food 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 preschool staff.

Please check one box and complete as necessary – use additional paper if needed:

☐ At this time, my child does not have a dietary or food restriction.

☐ My child has the following dietary or food restriction(s):

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 teacher if any of this information changes.

_____ _____
Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: _____

Signature of Early Childhood Staff: _____ Date: _____

SOANS CHRISTIAN ACADEMY
7912 DUNGAN ROAD
PHILADELPHIA, PA
19111

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

NUTRITION HISTORY

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 the 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 chew things that aren't food? (ex: dirt, clay, paint chips)		
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 you 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	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									

THE SCHOOL DISTRICT OF PHILADELPHIA

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PHILADELPHIA, PENNSYLVANIA 19130

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 _____

THE SCHOOL DISTRICT OF PHILADELPHIA

Office of Early Childhood Education Prekindergarten Programs 440 N Broad Street, Suite 170 Philadelphia, PA 19130

Child's Name: _____ **Center:** ACADEMY OANS CHRISTIAN ACADEMY 7912 DUNGAN ROAD PHILADELPHIA, PA 19111

Family Engagement Contract

By enrolling your child, you are joining us to achieve our program's mission: To bring a relentless focus on positive child and family outcomes to close the achievement gap and build a better future for children, families, and communities served by the Head Start program. To reach our *shared mission,* and recognizing your hopes and dreams for your child, *we need to work together as equal partners.* Please officially join us in **partnership** by signing and following through on this Family Engagement Contract.

One hope or dream I have for my child is ...

Our program will do the following for you and your child:

- **Provide** an excellent education program -- every day-- for all of our students.
- **Guide** you through the process of learning and doing high quality parent child activities that support your child's learning at home.
- **Support** you to keep your child healthy and well.
- **Honor** your family's unique strengths, needs and circumstances.
- **Build** an environment that welcomes ALL families as partners in our program.
- **Welcome** your voice...and create opportunities for you to provide feedback and to be heard.
- **Offer** many ways for you to participate and volunteer at our program.

I _____ will do the following:

[parent or guardian's name]

- **Bring** my child to school **on time and every day.**
- **Participate in my child's learning** by completing **home learning activities.**
- **Read with my child daily or as often as possible.**
- **Attend** center activities to help build community and to advocate for my child and family.
- **Partner** with our program to keep my child healthy.

Partnership Agreement: We agree that we will work together as equal partners to achieve goals set for my child's school readiness and my family.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

FAMILY STRENGTH ASSESSMENT

Dear Parent(s)/Guardian(s):

The Head Start Performance Standards requires each program to assess the strengths of each family it enrolls. The purpose of the family assessment is to enable the program staff to assist and support you and your families as you move toward accomplishing 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 ☐ American Ind. Or Alaskan Native ☐ Asian ☐ White

☐ Black or African American ☐ Biracial/Multiracial ☐ 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, Tagalog) ☐ Pacific Island (Palauan, Fijian)

☐ European/Slavic (German, Italian, Croatian etc.) ☐ Native North American/Alaskan ☐ Unspecified

☐ Other (specify) (ex. language)

Number of Adults in Household over 18 years old	#
Other Children under 18 years of age.	Date of Birth

(over)

Family Strength Assessment

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 this 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?		

15. Have you been displaced due to a hardship?
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 eviction/put out of home.
	Displaced due to flood/housing beyond repair.
	Other _____

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

Employment and Training

Parent/Guardian Status	Yes	No
Employed		
If yes, Employer Name:		
Employer address/phone number:		
Unemployed seeking work		
Homemaker		
Student If yes, go to Educational Profile		
Are you working part-time?		
Are you working full time? (35 hrs/week or more)		

Educational Profile

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, check appropriate box. ☐ Associate ☐ Bachelor ☐ Master ☐ Doctorate		
Are you currently enrolled in school/college? ☐ Full time ☐ Part time Where? Length of program:		
Are you interested in additional information for continuing education opportunities for yourself or family member?		
What type of information? ☐ GED ☐ Trade School ☐ College ☐ Financial Aid	N/A	N/A

What Skills or talents do you bring to the Head Start program?

☐ Secretarial ☐ Technical (computer ☐ Health ☐ Arts/Crafts

☐ Sewing ☐ Child Care ☐ Other (specify) _____

Child Care Survey

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 Head Start day?		

4/07 revised March 16, 2009

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

FAMILY INTEREST SURVEY

Head Start is committed to providing workshops and training opportunities that meet the needs of parents and caregivers. We want these opportunities to be interesting, informative, helpful and fun. Throughout the year you will receive information through many different resources such as information flyers, workshops and parent meetings. Please take a few minutes to complete the survey below to assist us in better serving you this year.

Family Name: _____ **Child's Name:** _____

CHILD DEVELOPMENT

___ Ages 3-5
___ Infants and toddler's
___ Reading with children
___ Potty training
___ Discipline
___ Other_____

PARENTING/ FAMILY LIFE

___ Child support laws
___ Peer pressure issues
___ Step parenting & blended families
___ Grandparents raising children
___ Childcare after school
___ Divorce / separation
___ Sibling rivalry
___ Fatherhood
___ Caring for the elderly
___ Custody Issues
___ Co-parenting/communication
___ Child Abuse laws
___ Other_____

MENTAL HEALTH

___ Building relationships
___ Building self – esteem
___ Stress management
___ Death, dying & grief support
___ Understanding anger
___ How to deal with fear
___ Dealing with substance abuse (alcohol or drugs)
___ Domestic violence
___ Counseling resources
___ Bullying
___ Time management
___ Becoming trauma informed
___ Other_____

HOME MANAGEMENT

___ Budgeting / money management
___ Credit counseling
___ Law on Renters rights
___ Cost saving household tips
___ Furniture / appliances
___ Housing repairs / weatherization
___ Energy assistance
___ Using coupons
___ Housing
___ Other_____

THE SCHOOL DISTRICT OF PHILADELPHIA

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PHILADELPHIA, PENNSYLVANIA 19130

PERSONAL

___ Expanding your education
___ Resume writing / job readiness
___ Setting realistic goals
___ GED
___ Financial aid for school
___ SSI or social security guidelines
___ Obtaining a driver's license
___ ESL
___ Other_____

JUST FOR FUN

___ Crafts – home decorations
___ Aerobics
___ Make over tips (hair, make –up, etc.)
___ Group sports (softball, bowling, etc.)
___ Computer classes
___ Sewing
___ Relaxation tips
___ Free Cultural activities
___ Other_____

HEALTH & SAFETY

___ Child proofing your home
___ Allergies & asthma
___ Diabetes
___ First Aid / CPR
___ Poisons and look-alikes/over the counter medication
___ Smoking cessation
___ Signs of drug /alcohol abuse
___ Health insurance coverage
___ Signs of lead poisoning
___ The importance of dental health
___ Women's health issues
___ Men's health issues
___ Other_____

NUTRITION

___ Cooking & baking workshops
___ Healthy snacks
___ Understanding food labeling
___ Cooking with children at home
___ Healthy eating & weight control
___ Exercising to good health
___ Overweight child
___ Underweight child
___ Low cost meal planning
___ Other_____

ADDITIONAL COMMENTS OR INTERESTS:

_____

_____

_____

FAMILY PARTNERSHIP AGREEMENT

CHILD'S NAME

PARENT(S)' NAME(S)

Choose a category from the Parent, Family & Community Engagement Framework (family well-being, parent-child relationships, families as lifelong educators, families as learners, family engagement in transitions, family connections to peers & community, & families as advocates and leaders).

GOAL

OBJECTIVES (action steps planned)

FOLLOW-UP INTERVAL (how often family partnership coordinator checks in with family)
[ ] daily [ ] weekly [ ] biweekly [ ] monthly

Target Goal Completion Date: ___/___/___

Parent Signature Date

Family Partnership Coordinator Signature Date

GOAL REVIEW: ___/___/___	GOAL REVIEW: ___/___/___	GOAL REVIEW: ___/___/___	GOAL REVIEW: ___/___/___
❑ Completed	❑ Completed	❑ Completed	❑ Completed
❑ Progress Made:	❑ Progress Made:	❑ Progress Made:	❑ Progress Made:
❑ Goal Modified:	❑ Goal Modified:	❑ Goal Modified:	❑ Goal Modified:

pennsylvania
PRE-K COUNTS

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.

Child's Name: _____

Parent's Signature: _____ Date: _____

Printed Name: _____ Date: _____

Office of Early Childhood Education
Prekindergarten Head Start

Joy Diljohn
Executive Director
Prekindergarten Head Start

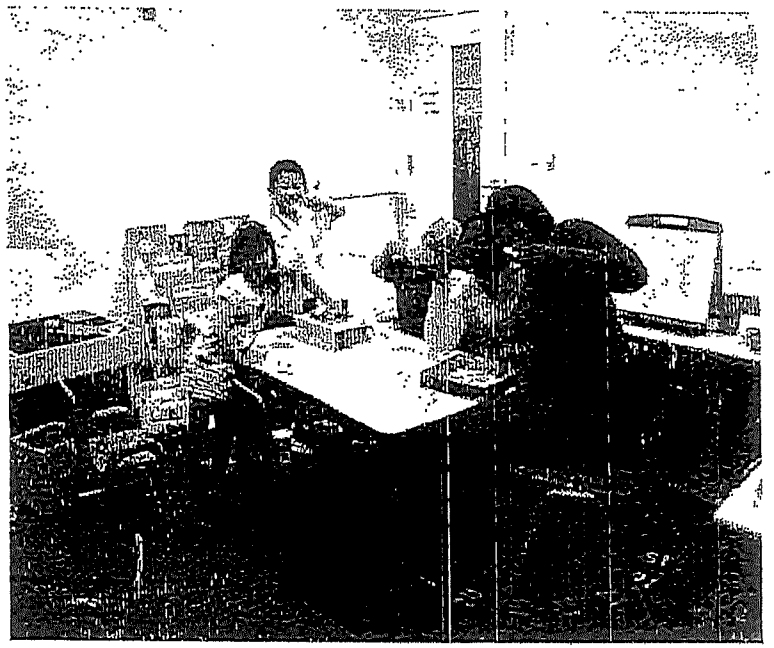
Susan M. Aichele
Health Coordinator
Prekindergarten Head Start

sma 8-19-12 reviewed 7-2-14

The School District of Philadelphia
Office of Early Childhood Education

Toothbrushing in the classroom

Parent's Guide



THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
EDUCATION CENTER
440 N. BROAD STREET, 2nd FLOOR- PORTAL C
PHILADELPHIA, PENNSYLVANIA 19130-4015

Telephone: 215-400-4270 Fax: 215-400-4272

GUIDELINES FOR IN CENTER TOOTHBRUSHING

The purpose of toothbrushing while in the center is to establish good oral health and develop the toothbrushing habit in the preschool child. The child should associate the use of the tooth brush with completion of a meal. The Head Start Performance Standards **1304.23(b)(3)** state that **"Staff must promote effective dental hygiene among children in conjunction with meals." The Early Childhood Environment Rating Scale** has been used in the development of these guidelines.

It is best for the children not to eat or drink for 30 minutes following brushing in order to get the most benefit from the fluoride toothpaste. Families should be encouraged to brush additional times at home especially before bedtime in order to prevent plaque and food particles from remaining in/on the teeth throughout the night.

Tooth brushing in the classroom

Dry tooth brushing, once a day after a meal, is the recommended way to brush teeth in the classroom setting because it allows the fluoride to remain in contact with the teeth for a longer period of time and it doesn't require rinsing or access to a sink.

Brushing can take place in a large group with the children seated at tables. This provides the best opportunity for the teacher to model and supervise.

The best brushing technique for this age group is a horizontal or a small circular motion depending on the manual dexterity of the child. Children should be encouraged to brush all three surfaces of the teeth as well as the tongue. A longer duration of brushing leads to more plaque removal. Rinsing should not take place. Studies have shown that rinsing washes away some of the benefits of fluoride.

Instructional staff is encouraged to brush their teeth with the children to promote oral health.

Use of tooth paste

The teaching staff should control the use of tooth paste. To avoid cross contamination, the toothpaste should not be applied directly to a toothbrush. Several options include: a) small squares of paper can be cut and a smear of toothpaste can be applied. These can be distributed and the children can "scoop" up the toothpaste from the paper using their toothbrush; or b) Small paper cups can be used for each child and a small amount of toothpaste can be dispersed inside the lip of the cup. Children can then "scoop" up the toothpaste from inside the cup using their toothbrush.

Storage of tooth brushes

The tooth brush must be marked with the child's name with an indelible marker.

Following each use, toothbrushes should be rinsed with tap water, stored in a toothbrush holder in an upright position and allowed to air dry. Toothbrushes should be spaced so that they do not touch each other ensuring enough spacing between brushes to avoid cross contamination. Do not let them drip on each other. Do not cover the toothbrushes for at least a half hour so that they can dry. Each tooth brush must be covered with the supplied plastic cap for overnight storage. Write the name of the child on the cap.

Hygiene for tooth brushes - unclean brushes can breed germs!

- ✓ Tooth brushes should be rinsed well after each use.
- ✓ Tooth brushing must be carefully supervised by the instructional staff to be certain that children use ONLY THEIR OWN TOOTH BRUSHES!
- ✓ **Tooth brushes should be discarded after a child's absence from school due to a serious illness,** i.e., strep throat/scarlet fever, and viral infections.
- ✓ New tooth brushes will be issued to each child every 3 months (or sooner if the bristles begin to mat).

Reviewed 8/11
Revised 6/12
Revised 7/14

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 NORTH BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19130

Telephone (215) 400-4270 Fax (215) 400-4274

FOOD SERVICE POLICY

Mealtime is an integral part of the school day and staff must participate. All mealtime participants must wash hands before assisting children with meals. If parents volunteer to assist with mealtime, they are to remove coats, hats, and wash their hands. Children must be permitted to serve and feed themselves. Children with special needs should be assisted as necessary.

All portions of the policy outlined below align with CACFP regulations; Head Start Performance Standards, Early Childhood Environment Rating Scale (ECERS), Keystone Stars position statements for ECERS, Caring for Our Children Healthy and Safety Performance Standards, and the Building Mealtime Environments and Relationships Inventory.

BREAKFAST

Each child is offered breakfast as he/she arrives in the classroom. A child who may have eaten at home can eat in the center if they desire. Children should be encouraged to eat. Every child who eats must be served a complete breakfast. A complete breakfast consists of 4 ounces of fruit juice, 1 ounce cold cereal, or a hot entrée, and 6 ounces of 1% (low-fat) or skim (fat-free) white milk. Thirty to 45 minutes is allowed for breakfast. Children who arrive late are to be offered breakfast. Breakfast is not provided for staff, parents, or children not enrolled in the Early Childhood programs.

LUNCH

Lunch is always served in the center, even on early dismissal days. Lunch is served to all children in attendance. The Noontime Aide or cook heats lunches and delivers them to the classrooms. Assigned children and staff are to assist in setting of tables.

- Children are encouraged to eat but are not forced to eat.
- Fruit is part of the meal and can be eaten at any time during the meal.
- Food is not to be used as a reward or punishment.
- Staff and volunteers will sit with the children during lunch and eat the same food that is served to children. Sodas and food not served to children must not be eaten during lunch.
- An adult must be at each table during lunch. The adult to child ratio during meals is 1 adult for every 10 children.

Soans Christian Academy

7912 Dungan Road, PHILADELPHIA, PA 19111

Kristen L. Domico, Director

September 2020-2021

Dear Parents/Guardians:

Soans Christian Academy's Pre-K Counts program will provide a comprehensive program appropriate for children ages 3, 4, and 5 year olds who have not met the Philadelphia School District's entry age for kindergarten. We will provide a program with varying developmental levels for children enrolled based on how young children develop and learn; include instruction to support each child's development in the areas of approaches to learning – creative expression, language and literacy, math, logic and science, social-personal development, and physical development and health and open to children with disabilities.

Soans Christian Academy's PKC program is a federal funded "FREE" full-day program for eligible children and their families from the hours of 8:30 a.m. until 2:30 p.m., school year from September through June, for a total of 180 days. Children should arrive on time and stay for the full instructional day. Regular attendance is a requirement of Soans Christian Academy's program. All children enrolled in Soans Christian Academy's PKC program are expected to attend when school is open, arrive on time, and depart on time.

Parents/Guardians and/or family members' engagement is a critical part of a child's success in school and those individuals are encouraged to be involved in the child's development by some of the following ways: visiting on a regular basis; serving as a "guest reader"; volunteering to assist with special class projects; accompanying child (ren) on field trips; or other ways to support the child's development.

Policies and Procedure for Soans Christian Academy's Program:

- **Application:** REQUIRED documentation: Proof of Income, Birth Certificate, Updated Health Assessment Form with Immunization Records (Annually), Updated Dental Assessment (6 months), and Updated Emergency Contact Form (Every 6 months or as soon as there is a change in the information).
- **Enrollment/Attendance:** Excused absences are defined as: illness (written documentation to return to care if out for more than (3) days from a doctor), death of a family member, health or dental appointments (appointment card or stamped note from doctor's office), fire, natural disaster, or other extenuating circumstances; three (3) consecutive absent days, parent/guardian will be contacted to learn the nature of the absence and offer support, as appropriate; five (5) consecutive unexcused absences, Director and parent/guardian together, must discuss the

reasons for the absence and determine ways to support the child's attendance at the Center; ten (10) or more consecutive unexcused absences or more than 10% unexcused absences over the course of the school year (more than 18 days total) and parent/guardian has not responded to support will be dismissed from Soans Christian Academy's program and replaced with another eligible student from the waiting list or from the community.

- **Arrival Time: 8:30a.m. is the time all students will be ADMITTED into the classrooms**; after 9:30 a.m. your child (ren) will be marked late for the day. If your child is late three (3) consecutive days they will be assessed one (1) unexcused absence. NO child (ren) WILL BE ADMITTED into the program after 10:00 am without a doctor's note and ***No SERVICE WILL BE PROVIDED AFTER 11AM,*** NO EXCEPTIONS. Excessive lateness may affect your child's enrollment in the program.
- **Pick-up Time: 2:30 p.m. is the time all children who are not contracted by ELRC or Private Pay for "After Care" MUST be picked up at this time.** ***After 2.35 p.m. you will be assessed a $1.00 per minute fee for "Late Pick-up" form must be signed at the time pick-up, and ALL fees must be paid in order for your child to RETURN to the program the following day CASH ONLY.***
- **Closed Days:** Soans Christian Academy's program doesn't provide service on days when the Philadelphia School District and/or CENTER are **CLOSED**. Soans Christian Academy will only provide service to children who are **contracted by ELRC, or Private Paying parents.**
- **Meals:** Students beginning in the Center on the first day of school will be **provided all of their meals, please do not bring outside non-nutritional meals or snacks.** All meals served are **FREE** of charge during the Soans Christian Academy's program school year. If you qualify for **REDUCE or PAID** you must sign the **"NOTICE OF APPROVAL/DENIAL"** form from the vendor C.B.S. Food Program and return it to the DIRECTOR as soon as possible. Breakfast will be served from 9:00a.m. until 9:30a.m., **children arriving after 9:30a.m., will *NOT* be provided *BREAKFAST*. ALL CBS food must stay in the building; no CBS food is permitted to leave Soans Christian Academy.**
- **Parent/Teacher Conferences:** Parent/Guardians are **REQUIRED** to attend **Fall, Winter, and Spring term Conferences** to discuss the child's developmental progress resulting from observations and assessments performed by the child's teachers. If additional conferences are needed the teachers can accommodate the parent/guardian. Additionally, **all students** will be **DISMISSED at 1:30pm** during the days the Parent/Teacher Conferences are provided based on the schedule provided by the Director.
- **Family Engagement:** Parents/Guardians and/or Family Members over the age of 18 must **VOLUNTEER** in the child's classroom on a monthly basis.
- All other policies please refer to ***Soans Christian Academy's Parent Handbook.***

Child's Name _____ Classroom_____

ACKNOWLEDGMENT OF THE

PA PRE-K COUNTS CONTRACT

I acknowledge by my signature that I have received a copy of the Soans Christian Academy's Parent/Guardian PA Pre-K Counts Contract. I also acknowledge that it is my responsibility to read this contract, to ask questions if I do not understand, to observe and follow the policies and procedures as outlined herein. I understand further that from time to time the contents herein may change and that I will be responsible for keeping abreast of the changes as they occur after I have been informed of the changes.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Date: _____
(Name-Please Print)

Director Signature: Kristen Domico Date: ***September 1, 2020***

Director Name: Kristen Domico Date: ***September 1, 2020***
(Name-Please Print)

Soans Christian Academy

Kristen Domico, Director

Before and After Care for Head Start Students:

Extended Care: Before Care from 7:00 am –8:30 a.m. for a fee of **$40.00** a **Week**, After Care from 2:30 pm.- 6:00 p.m. for a fee of **$80.00** a **week,** and Before and After Care for a fee of **$120.00** a **week** can be provided to children who parents have a signed contract on file. This is a yearly commitment. The child must be enrolled in the program in order to arrive before 8:30am and stay after 2:30pm.

Child's Name_____

Classroom_____

__ I want to enroll my child for Before Care.

__ I want to enroll my child for After Care.

__ I want to enroll my child for Before/After Care.

Parent/Guardian Signature: _____ Date: _____

Director Signature: _____ Date: _____

Soans Christian Academy
7912 Dungan Road
Philadelphia PA 19111
Tel: (267) 388-7648
Fax: (267) 731-1857
Email-soanschristianacademy7912@gmail.com

GENERAL INFORMATION

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

Admissions Date: _____ Withdraw Date: _____

Hours of Operation: 7:00 AM to 6:00 PM

(Circle One): Young Toddler Older Toddler Preschool
Before School-ONLY After School-ONLY Before & After School Summer Camp: *June – August ONLY*

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 *6:00pm*, 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 (Print) Parent/Guardian (Signature & Date)

Kristen S. Dantes _____
Director's (Signature & Date) Periodic Review (Parent/Guardian Signature & Date)

Soans Christian Academy

7912 Dungan Road
Philadelphia PA 19111
Tel: (267) 388-7648
Fax: (267) 731-1857
Email-soanschristianacademy7912@gmail.com

I, _____, authorize ***Soans Christian Academy*** to release my child (ren) to the person(s) designated. This is in consonance with the ***Soans Christian Academy*** Emergency Plan.

Child's Name	**Designated Custodian (s) Name & Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

_____

Your Signature Relationship Date

_____

Print Name

_____

Street Address

_____

City, State, Zip Code

_____

(Home Phone) (Work) (Cell)

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

PLEASE PRINT CLEARLY.

Soans Christian Academy
7912 Dungan Rd
Philadelphia, PA 19111
Telephone:267-388-7648
Fax: 267-731-1857

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:

Soans Christian Academy
Kristen Domico, Director
7912 Dungan Rd
Philadelphia PA 19111

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 and
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

_____ _____
Parent/Guardian Signature Date

Kristen Domico _____
Director Signature Date

Child's Name _____

PARENT/GUARDIAN AGREEMENT FORM

FOR

SOANS CHRISTIAN ACADEMY
PARENT/GUARDIAN HANDBOOK

1. I/We agree to comply with the rules and regulations of the Soans Christian Academy.

2. I/We will immediately notify the Soans Christian Academy if my child/children will be absent or lateness.

3. I/We agree to give two weeks written notice to Soans Christian Academy if my child/children will be withdrawing from the program.

4. I/We agree to pick up my child at the agreed upon dismissal time designated on the enrollment form. Failure to do so will result in late fee charges and possible termination from the program.

5. I/We understand that tuition payments can be paid in advance, on Thursday and no later than Friday by 5:00 p.m. for the following week of care. Tuition payments are due no later than Monday morning for the current week.

6. I/We agree to cooperate with Soans Christian Academy staff to ensure that my child/children will have a rewarding learning experience.

I/We understand that my/our failure to comply with any of the above statements could jeopardize my/our child's/children's enrollment at Soans Christian Academy.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Director Signature: Kristen Damico Date: _____

ORIGINAL of the Parent/Guardian Agreement Form and the Acknowledgement of Handbook is given to the PARENT/GUARDIAN. **COPY** is kept in the CHILD'S FILE.

Child's Name _____

ACKNOWLEDGMENT OF HANDBOOK

I acknowledge by my signature that I have received a copy of the Soans Christian Academy Parent/Guardian Handbook. I also acknowledge that it is my responsibility to read this handbook, to ask questions if I do not understand, to observe and follow the policies and procedures as outlined herein. I understand further that from time to time the contents herein may change and that I will be responsible for keeping abreast of the changes as they occur after I have been informed of the changes.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Director Signature: Kristen Domico Date: _____

Note: Both forms (Parent/Guardian Agreement and Acknowledgment of Handbook) must be signed and returned for your child/children's file.

Intake Questions for: Name:_____ **DOB:**_____ **M / F**

1. What is the child's primary language spoken?

2. What is the child's nationality?

   (Info used for demographics only & can choose not to answer.)

3. What is parent highest education level?

4. What is child's living status? (w/ parent, guardian, grandparent, foster, single family, multiple family..etc)

5. Has child ever attended school before? **Yes / No** If Yes...

   Where?_____ Why they left?_____

6. At what age was the child potty trained?

7. Does parent assist child in toileting in any way? **Yes / No** If Yes... How?

8. Does child have accidents? **Yes / No** If Yes... When & How often?

9. Does child wipe themselves? **Yes / No**

10. Can child dress themselves (shirt, underwear, pants, socks, shoes, coat)? **Yes / No**

11. Does child nap? **Yes / No** If Yes... How long?

12. Is the child a picky eater? **Yes / No** If Yes... Explain?

13. Does child have any dietary restrictions? **Yes / No** If Yes... Explain?

14. Does child have any known allergies? **Yes / No** If Yes... Explain?

15. Is child comfortable being away from parent/caregiver? **Yes / No**

16. Does child have detachment stress? **Yes / No** If Yes... What is their reaction?

17. Has child received Early Intervention Services (through ELWYN or any other related services)? **Yes / No** If Yes...

Does child have an IEP? **Yes / No** If Yes...

What is the nature of the learning/behavior supported in the IEP?

Are there any specific support services included in IEP? **Yes / No** If Yes...

Who provides them? When/Where/Duration?

18. Is parent concerned or believe child needs to be referred for services that address speech, learning, physical, and/or behavior development? **Yes / No** If Yes...

What are the concerns?

19. Are there court or custody agreements we need to be aware of? **Yes / No** If Yes...

What is the nature of the agreement?

20. Are there any other concerns, routines, medical issues, learning or behaviors issues that have not been discussed that we need to be aware of?

pennsylvania
PRE-K COUNTS
For a Brighter Future

KEYSTONE STARS

Soaus Christian Academy
Toddlers, Preschool, Pre-k and Afterschool
7912 Dungan Road. Philadelphia, PA 19111
(267)388-7648, (267)538-2446; Fax: (267)731-1857 soanschristianacademy7912@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 IFSP (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.

8. What program or individuals work with your child in regard to these special needs? Would you sign a release of information form with them, so they can speak with us about how to provide enhanced support to your child?

9. Does your child have any allergies?
   a. Food Allergies
   b. Environmental Allergies?
   c. Allergies to any Medication?

10. How are these allergies treated?

11. Do you have any special medical or dietary information for management in an emergency (medicine to keep on hand, people to call, etc.)?

12. Describe your child's schedule:
    a. Normal bedtime, waking time, nap time, and duration?
    b. Mealtimes?

13. Does your child have a different schedule at any other child care setting (babysitter, relative/ neighbor are, and/or school?

14. Regarding toilet habits, what words does your family use for bowel movements and urination?

15. Any special terminology for private parts?

16. Is your child toilet trained?

17. Does your child need to be reminded to go to the toilet during waking hours?

18. Other required DPW (or other agency) required forms and signatures will be used in conjunction with some of these questions. Is there any other information that will help us make the first few days in our program easier for your child?

19. Is there other information you would like to share?

Soans Christian Academy
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Email-soanschristianacademy7912@gmail.com
Kristen L. Domico, Director

Permission Form for Use of Student Participation on Center Website

This letter is to both inform you and request for your child's picture, voice, video, and/or name to be published on the center's website.

Center images are used on the internet to promote student activities and celebrate your child's work and participation. The website is meant to serve as an interactive resource for the entire Trinity Christian Academy community to stay better connected.

Rest assured, the center will safeguard all content and will not share/release any information without prior written consent from you the parent or legal guardian. Furthermore, you may withdraw your consent at any time by sending a written notice, along with a new form, to the director.

Please return this form to your child's teacher or the center's director to indicate if your child's participation may be used on the website. Thank you for your cooperation.

Check one of the following options:

☐ I/We GRANT permission for use of picture, voice, video, name, work and participation of this child/student to be published on the center's website.*

☐ I/We DO NOT GRANT permission for use of picture, voice, video, name, work and participation of this child/student to be published on the center's website.

Student Name:_____

Printed Name of Parent/Legal Guardian_____

Signature of Parent/Legal Guardian: (sign)_____ Date:_____

*Permission will be applicable until consent is withdrawn and, in addition, I agree to release and hold harmless all center personnel from and against any and all claims, demands, actions, complaints, suits or other forms of liability that may arise out usage of my child's picture, voice, name, work or participation on the internet.

THE SCHOOL DISTRICT OF PHILADELPHIA

PARENTAL PERMISSION

TRIP INFORMATION

School	School Phone	Grade/Room	Date Prepared

Teacher	Destination

Educational Purpose of Trip

Date of Trip	Leave Time	Return Time	Trip Itinerary (summary)

Method of Transportation	Cost to Student	Student Lunch
	☐ Free $____	☐ Bring ☐ Buy ☐ Provided ☐ Not Needed

Please complete and detach the bottom part of this form and return to teacher

STUDENT INFORMATION

Name of student: _____ I.D.#: _____ Date of Birth: _____

PARENT/GUARDIAN INFORMATION

1. Parent/Guardian: _____ Home Address: _____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Parent/Guardian: _____ Home Address: _____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____

Student lives with (check all that applies): ☐ Father ☐ Mother ☐ Guardian

EMERGENCY CONTACTS

If the parents/guardians cannot be reached, the school will call the people listed below. The people listed below should be responsible individuals who can: 1) give permission to administer health care; 2) pick up your child if your child is ill; 3) have the authority to speak on behalf of the parents or legal guardians.

Name: _____ Name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

HEALTH INFORMATION

If permission is granted, please provide the following medical information or if your child does not have any of the health conditions listed below, please write *"none"*.

Medication/s being taken by student: _____

Allergies to foods, drinks, insect bites, medications, other: _____

Other medical information: _____

Physician's Name: _____ Phone: _____

Medical/Hospital Insurance: _____ Group: _____ Type: _____

I have read the trip information to: _____ on _____.

Check one: my child ☐ may ☐ may not go on this trip

I understand that in case of any emergency requiring medical treatment, every effort will be made to reach one of the people listed above. If none of these people can be contacted, I authorize the school to give consent to treatment as deemed necessary by emergency responders.

Print Name of Parent/s or Guardian/s: _____

Signature of Parent/s or Guardian/s: _____ Date: _____

A copy of this form is to be kept on file until the end of the school year.

Volunteering Ideas

Taking your Child to:

- Stores/Malls
- Banks
- The Movies
- Parks / Playground
- A relative's house for events
- For a walk/biking/skate boarding/swimming
- Bowling
- Museum/theme parks
- Library

Having your child:

- Set the table at home
- Clean their room
- Help with cooking / baking

Activities with your child:

- Arts and crafts projects
- Counting things at home
- Playing games
- Reading
- Writing

The Head Start Home Visit

Adrianne Brigmon, Special Services Branch, Head Start Bureau

The home visit is a basic part of a Head Start program. For the family to gain the most from the home visit, component staff of the center-based program option should coordinate as a team to serve families in the home or in the center.

Why Home Visits Should be Made?

In addition to fulfilling the Performance Standards requirements, home visits provide program staff with greater insight into the children and their families, give the families a greater opportunity to get to know staff, show how important families are to the program, and add a personal touch. Finally, it may be easier for staff to travel to the parent's home than for the parent to get to the program.

Who Should Make Home Visits?

In center-based programming, home visits must be made by the education staff. The social service, parent involvement, and health staff may also make home visits to improve relationships with families, to find out or follow up on family needs, or assist with crisis situations.

Education Staff: The education staff visits the family to assess the development and instructional needs of the children; to gain insight into the child's likes, dislikes, and strengths; and to gain insight about the whole family. The education staff person can help reinforce the parent's skills as their child's prime educator by planning home activities in which the parent assists with the child's progress.

Social Service Staff: The social service staff will make family contacts to assess and re-assess family needs. They may also need to contact the family about irregular participation or absences and in a family crisis situation.

Parent Involvement Staff: Parent involvement staff can encourage parents to become volunteers for the program or attend Head Start activities, help parents become aware of parenting skills, and provide parent education information.

Health Staff: A health visitor promotes preventive health services and encourages early intervention, makes sure there are no health or safety hazards in the home, and assists with food and nutrition questions. The health staff person can also provide the family with information to ensure that the child continues receiving comprehensive health care after leaving Head Start.

What Makes a Successful Home Visit?

Before any home visit takes place, the Head Start program staff should establish the program rationale for going into the home. Established policies should be available for who will make the visit, how information will be shared with other staff while maintaining confidentiality, and how often visits will be made. Staff should be thoroughly trained in how to prepare for and conduct a home visit.

To prepare for the visit, staff should review available child and family files, let other staff know they are going to visit the family, and make sure there have not been too many other recent visits.

During the home visit Head Start staff should be friendly and cordial, and not overly official. The visitor should tell the parents what he/she expects to accomplish, observe what is going on in the home, and provide the parents with resources. Home visits should not be too lengthy and staff should be willing to return if another session is needed. Close the visit by reviewing what has been discussed and future plans. Leave contact information for the parent.

Head Start staff must remember that developing a trusting relationship with the family and constantly helping parents set goals are the purposes of the home visit. Above all, Head Start staff must always treat the family members with respect.

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HOME VISIT - PURPOSE AND PROCEDURE

1. Some teachers begin to make home visits immediately after the beginning of the operating year. The procedure for making home visits is:

    a. Parent is telephoned. (If there is no phone in the home, center staff is expected to make arrangements when the parent visits the center or through the emergency contact number).

    b. Purpose of the home visit is stated (program orientation, identify student goals, conduct ASQ, etc...).

    c. A time is set convenient to both parties.

    d. Two center staff persons or center staff with supportive staff make the home visit.

    e. Record all information on the Home Visit Form.

    f. Parent should sign the form at the conclusion of the home visit.

2. If the <u>first</u> home visit is not in September, the stated purpose could be :

    a. To obtain information about the child and determine parent priorities and needs concerning the child.

    b. To encourage parents to use their talents and skills in the classroom, thereby contributing to their child's self image.

    c. To share child outcome and progress.

3. The following home visit should be made in the spring. The purpose of this visit should be:

    a. To discuss the Center's program/activities.

    b. To encourage at-home activities that will establish continuity between home and school.

    c. To give the parent an opportunity to voice any concerns.

    d. To exchange information.

It should be remembered that the above items are just suggestions for making home visits. Ultimately, the purpose of the home visit will depend on the particular needs of a child.

The School District of Philadelphia
Prekindergarten Head Start

Pupil Name: _____ Birth Date: _____

PLANS/PROGRESS NOTES

(EACH ENTRY REQUIRES A SIGNATURE)

DATE	NOTES