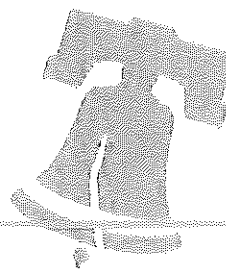




FreePhillyPreK

from
the School District of Philadelphia
and the City of Philadelphia



Thank you for your interest in Free Philly PreK from the School District of Philadelphia and the City of Philadelphia. Submission of a completed application does not ensure acceptance. The items below are needed for verification before enrollment can be confirmed.

Required Documents:

An application is not complete until the following documents are submitted (See page 2 for list of all acceptable documentation):

- ☐ Child's Age: Proof that the child will be 3 or 4 on or by September 1, 2025
- ☐ Family's Residency: Proof that the family resides in Philadelphia County (Document must be current and/or dated within the last 12 months)
- ☐ Household Income: Documentation of Household Income
- ☐ Picture identification of parent/guardian (Current State, Federal Photo ID, or Municipal ID)

The following additional documents may be needed before your child starts PreK:

- ☐ Child's health insurance card or proof of medical assistance
- ☐ Child's most up to date Immunization record
- ☐ Wellness Exam Form
- ☐ Dental Exam Form
- ☐ Copy of child's IEP
- ☐ Custody Order
- ☐ Documentation of Medical Assistance
- ☐ Med-1 form if staff will need to administer medication to your child or use any medical equipment
- ☐ Copy of Foster Care Placement Letter
- ☐ Copy of McKinney Vento Letter
- ☐ Child and Adult Care Food Program (CACFP) Enrollment Forms
- ☐ Emergency Contact Form
- ☐ Parent Fee Agreement
- ☐ Child Care Works (CCW) Application (if applicable)

**The School District of Philadelphia aligns policies and practices with the McKinney-Vento Homeless Assistance Act. Foster/Kinship care, Refugees, Asylum Seekers, and families in temporary living situations are not required to submit all documentation when applying. These families have 90 days after enrollment to submit the necessary documentation. For more details, call 215-400-4270.*

School Year 2025-2026 Philly PreK Application

Acceptable Verification Documents

- ☐ **Child's Age:** Proof that the child will be 3 or 4 on or by September 1, 2025.

(Provide one of the following):

<input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Valid US Passport
<input type="checkbox"/> Hospital record of child's birth	<input type="checkbox"/> Visa or Green Card
<input type="checkbox"/> Baptismal certificate indicating the child's date of birth	<input type="checkbox"/> Department of Human Services (DHS) letter on DHS letterhead
<input type="checkbox"/> Child's health insurance card	<input type="checkbox"/> Clinic/doctor/hospital records
<input type="checkbox"/> Official medical exam print out with child's date of birth	<input type="checkbox"/> Government Issued Document with Child's Birthdate
<input type="checkbox"/> Social Security documentation showing birthdate	<input type="checkbox"/> Prior school or daycare records indicating the date of birth (previous preschool)
<input type="checkbox"/> Notarized statement* from the parents or another relative indicating the date of birth	<input type="checkbox"/> Court documents

- ☐ **Family's Residency:** Proof that the family resides in Philadelphia County.

(Document must be current and/or dated within the last 12 months) (Provide one of the following):

<input type="checkbox"/> State issued ID or driver's license	<input type="checkbox"/> Voter ID showing address
<input type="checkbox"/> Current lease/rental agreement or mortgage statement	<input type="checkbox"/> Social Security Documentation
<input type="checkbox"/> Current Utility Bill (PECO, PGW and/or Water)	<input type="checkbox"/> Recent Employer Pay Stub
<input type="checkbox"/> Wage statements (W2 tax form)	<input type="checkbox"/> Child Care Works award letter received by parent
<input type="checkbox"/> Mail/notice/award letter from County Assistance Office/DHS	<input type="checkbox"/> Statement from social services agency attesting to client's residence
<input type="checkbox"/> Foster Letter	<input type="checkbox"/> Compass print out
<input type="checkbox"/> Medical document, etc.	

- ☐ **Household Income:** Documentation of Household Income. (Provide one of the following):

<input type="checkbox"/> Proof of TANF cash/SSI	<input type="checkbox"/> W-2, paystub, 1099
<input type="checkbox"/> SNAP/food stamps	<input type="checkbox"/> Signed statement of unemployment

RECORD OF ACCESS

STUDENT NAME: _____

D.O.B: _____

[illegible]



Grace Neighborhood Academy
5221, Oxford Ave, Philadelphia 19124
Phone: 215 535 8200 Fax: 215 535 8300

EMERGENCY CONTACT / PARENTAL CONSENT FORM

55 PA CODE CHAPTERS 3270.124 (a) (b), 3270.101 & 102; 3280.124 (a) (b), 3280.101 & .102; 3290.124 (a) (b), 3290.101 & .102

CHILD'S NAME (As it APPEARS on Child's state/government issued Birth Certificate)		DATE OF BIRTH
ADDRESS		
PARENT'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER ()
ADDRESS		E-MAIL ADDRESS
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
PARENT'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER
ADDRESS		
BUSINESS NAME		BUSINESS TELEPHONE NUMBER
ADDRESS		
EMERGENCY CONTACT PERSON(S) NAME		TELEPHONE NUMBER WHEN CHILD IS IN CARE
PERSON(S) TO WHOM CHILD MAY BE RELEASED		NAME ADDRESS TELEPHONE NUMBER WHEN CHILD IS IN CARE
NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER		TELEPHONE NUMBER
ADDRESS		
SPECIAL DISABILITIES (IF ANY)		ALLERGIES (INCLUDING MEDICATION REACTION)
MEDICAL or DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION, SPECIAL SITUATION
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD		
HEALTH INSURANCE COVERAGE FOR CHILD or MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)
PARENT'S SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE PARENTAL CONSENT		
OBTAINING EMERGENCY MEDICAL CARE		ADMIN. OF MINOR FIRST-AID PROCEDURES
WALKS AND TRIPS		SWIMMING / WADING / Sprinkler
TRANSPORTATION BY THE FACILITY		I allow Photos/ Videos used for classroom ONLY

SIGNATURE OF PARENT or GUARDIAN

DATE

SIGNATURE OF PARENT or GUARDIAN

DATE

School Year 2025-2026 Philly PreK Application

SECTION ONE: PRIMARY CAREGIVER

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

First Name:		Last Name:	
Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> non-Binary	
Primary Language:		Secondary Language(s):	
Street Address:		Apt./Unit#:	
City:	State:	Zip Code:	
Phone:		Email Address:	

Custody Agreement: The program will presume that there are no restrictions regarding a parent/guardian's right to be kept informed of his/her student's school progress and participate in school activities. A parent/guardian will only be prevented from participating in his/her student's education if a signed court order (e.g., divorce decree, custody order, or restraining order) specifically restricts the parent/guardian's access to the student. If restrictions are in place, the parent/guardian with legal custody must submit a signed copy of the court order describing the rights restricted.

Is there a custody agreement for this child that we need to be aware of? (Select one) ☐ Yes ☐ No
If yes, you must provide a copy of the Custody Agreement prior to attending the program.

Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated/Divorced	<input type="checkbox"/> Other
Relationship to Child Select one	<input type="checkbox"/> Parent/Step-Parent		<input type="checkbox"/> Grandparent		
	<input type="checkbox"/> Foster/Kinship Parent, related to child		<input type="checkbox"/> Foster Parent, not related to child		
	<input type="checkbox"/> Guardian, related to child		<input type="checkbox"/> Guardian, not related to child		
	<input type="checkbox"/> Teen Parent – parent was under the age of 18 when child		<input type="checkbox"/> Other (specify):		
Race/Ethnicity Select all that apply	<input type="checkbox"/> Hispanic or Latino/a		<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian	
	<input type="checkbox"/> Black or African American		<input type="checkbox"/> Multi-Racial or Bi-Racial	<input type="checkbox"/> Native Hawaiian	
	<input type="checkbox"/> Pacific Islander		<input type="checkbox"/> White	<input type="checkbox"/> Other (specify):	
Education Select highest Diploma/Degree earned or Grade Level completed	<input type="checkbox"/> High School Diploma		<input type="checkbox"/> GED		
	<input type="checkbox"/> ESL -English as a Second		<input type="checkbox"/> Some College/Vocational/Associate Degree		
	<input type="checkbox"/> Bachelors/Advanced Degree		<input type="checkbox"/> 11 th Grade		
	<input type="checkbox"/> 10 th Grade		<input type="checkbox"/> 9 th Grade or lower		
Employment School, Job Training Select all that apply	<input type="checkbox"/> Employed/Self-Employed		<input type="checkbox"/> Unemployed/Not Employed	<input type="checkbox"/> Disabled	
	<input type="checkbox"/> Member of the U.S. military on active duty		<input type="checkbox"/> Veteran of the U.S. military		
Health Insurance	Do you have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes,' name of health insurance provider:				
Do you receive benefits?	<input type="checkbox"/> WIC	<input type="checkbox"/> SNAP	<input type="checkbox"/> Medical	<input type="checkbox"/> SSI/TANF CASH	<input type="checkbox"/> No

School Year 2025-2026 Philly PreK Application

SECTION TWO: SECONDARY CAREGIVER

An adult who shares in the care of the child.

First Name:		Last Name:	
Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> non-Binary	
Primary Language:		Secondary Language(s):	
Street Address:		Apt./Unit#:	
City:	State:	Zip Code:	
Phone:		Email Address:	
Employment School, Job Training Select all that applies	<input type="checkbox"/> Employed/Self-Employed	<input type="checkbox"/> Unemployed/Not Employed	<input type="checkbox"/> Disabled
	<input type="checkbox"/> Member of the U.S. military on active duty		<input type="checkbox"/> Veteran of the U.S. military

SECTION THREE: LOCATION

Please indicate the name and address of the location for which you wish to apply for placement. To select more than one location, complete application online. Do not put a location that you are not willing or able to take your child regularly and on time. Transportation is not provided.

Center Name/Address:

SECTION FOUR: PREK CHILD

To enroll more than one child, please complete application online. A separate paper application is required for each child.

First Name:		Last Name:	
Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> non-Binary	
Race/Ethnicity Select all that apply	<input type="checkbox"/> Hispanic or Latino/a	<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Multi-Racial or Bi-Racial	<input type="checkbox"/> Native Hawaiian
	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other (specify):
Primary Language:		Secondary Language(s):	
Does your child have a current Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP)? (Select one) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Suspected			
If yes, mark which of the following services your child receives: (Select all that apply)			
<input type="checkbox"/> Special Instruction (SI) <input type="checkbox"/> Speech/Vision/Hearing Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Behavioral Health Services (e.g., PCA) <input type="checkbox"/> Other: _____			

School Year 2025-2026 Philly PreK Application

SECTION FIVE: HOUSING

Housing Information Select your current situation	<input type="checkbox"/> Own	<input type="checkbox"/> Rent	<input type="checkbox"/> Transitional housing
	<input type="checkbox"/> Living with relatives or others to due to lack of alternative, adequate housing or due to the loss of housing.	<input type="checkbox"/> Temporary housing situation due to emergency: eviction, flood, fire, hurricane, etc.	<input type="checkbox"/> Train or bus station, park or in car
	<input type="checkbox"/> Shelter	<input type="checkbox"/> Hotel/Motel, camping ground or other similar situation due to loss or lack of alternative, adequate housing.	<input type="checkbox"/> Apartment or house lacking utilities (water, heat, electricity, etc.)
	Does the Secondary Care Giver live with Family? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide income in Section Six below.		
	Is there another person over the age of 18 living in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	# of People in the family:		
Optional Information	Are you new to the country? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to disclose		
	Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to disclose		
	Is one of the child's parents currently incarcerated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to disclose		

SECTION SIX: FAMILY INCOME

Primary Caregiver Income			Secondary Caregiver Income		
Employment Type	Amount	Frequency	Employment Type	Amount	Frequency
Employment			Employment		
SSI/TANF CASH			SSI/TANF CASH		
Unemployment			Unemployment		
Other:			Other:		
<input type="checkbox"/> Primary Caregiver has no income. (Please note you will be required to provide a signed statement)			<input type="checkbox"/> Secondary Caregiver has no income. (Please note you will be required to provide a signed statement)		

SECTION SEVEN: SERVICE INFORMATION

PreK only covers a traditional school day, school year. Times vary by location. May be subject to parent fee.

I am seeking additional information about: (Select all that apply)

☐ Before School Care ☐ After School Care ☐ Summer Care

School Year 2025-2026 Philly PreK Application

Family Attestation

I understand that this information will be used to create my Parent Portal account, and I will receive an email with my sign-in information at the email given on this form. I understand that my application is not complete until I sign in and upload all supporting documentation.

By signing this form, I attest that my child is a resident of Philadelphia, is 3 or 4 years old on or by September 1, 2024 (and not of kindergarten entry age on September 1, 2025), and that I have provided proof of age and residency and income. I am aware if I move out of Philadelphia County that I will no longer be eligible for this PreK program.

Parent/Guardian Signature:	Date:
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Provider Eligibility Attestation

As the PreK provider, I attest that this child is a resident of Philadelphia, is 3 or 4 years old on or by September 1, 2025 (and not of kindergarten entry age on September 1, 2025). I confirm that all verification documentation (birthdate, residency, and income) has been uploaded and verified in the child management system account and/or maintained on file at the site location.

Name of Staff (Print):	Title:	Date:
Staff Signature:	Name of Program:	

School Year 2025-2026 Philly PreK Application

AGREEMENT FORM:

SCREENING, ASSESSMENT, AND FAMILY ENGAGEMENT SERVICES

Purpose: This document summarizes the services that will be provided to your child during the 2025-2026 school year. The provider will review this document with you and share the results of screenings, assessments, and any referrals made that occur during the school year. The provider will also be able to answer any question you may have during the review of this document.

Child's Name:	
Child's DOB:	
Parent/Guardian Name:	
Provider (Site Location) Name/Address:	

Developmental Screenings – I agree for my child to receive developmental screenings which will determine whether my child's development corresponds to what is typically expected for a child at his or her age. I understand that the classroom teachers will administer this screening utilizing the Ages and Stages Questionnaire (3 and SE) to assess what skills my child has achieved and identify areas which may need additional support. Results of the screenings will be shared with me and if needed a referral to the appropriate Early Learning Agency will be provided and I will be informed and guided through the process. ☐ Yes ☐ No

Outcomes Assessments - I agree for my child to receive outcomes assessments which are completed (2 times a year at minimum). I understand that this assessment is completed through an on-line database, which keeps my child's information confidential and secure. Assessment results are shared with me as they are completed throughout the program year as this assessment is used to determine what teachers need to focus on to support learning objectives for school readiness through their lesson planning. ☐ Yes ☐ No

By signing and initialing this document, you acknowledge that you have been informed of these services and are aware that PHLpreK will complete the screenings, outcomes assessment, allow data sharing with the Local Education Agency if a referral is made or the child has an active IEP.

Parent/Guardian Signature

Date

VERIFICATION of INFORMATION FORM

Read the following statements and sign where indicated.

My signature(s) below indicate that:

1. The information I have provided on all of the forms in my child's *Preschool Application* is accurate and complete. I have signed all application forms where indicated and have included copies of all required supporting documents. Deliberate misrepresentation of my information may subject me/us to prosecution under applicable Federal and/or State laws and that if enrolled, my child's participation in the preschool program may end.
2. I understand that:
 - a. The information contained in my child's *Preschool Application* 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 (FERPA) with legitimate educational interests as part of The School District of Philadelphia's preschool program.
 - b. Completing and submitting a *Preschool Application* does not guarantee that my child will be accepted to a preschool program.
 - c. Before my child's first day in preschool:
 - i. I will attend an orientation meeting and an individual conference with my child's teacher and will receive a Parent Handbook;
 - ii. If my child's physical and/or dental exam dates are more than twelve (12) months old, I will be required to submit an up-to-date *Child Health Assessment/Physical Exam Form*, including a current immunization record and/or *Child Dental Health/Dental Exam Form*;
 - iii. I may be required to re-verify my Philadelphia, PA address, family income and/or monthly benefits;
 - iv. I will be notified if additional forms and/or documents are needed, and will submit them as necessary.
3. During the time my child is enrolled in preschool:
 - a. S/He will attend every school day, his/her health permitting;
 - b. S/He will be escorted to and from school by an individual who is at least eighteen (18) years old;
 - c. Some locations cannot accommodate children in diapers, and S/He will be required to use the toilet with little adult assistance;
 - d. I will abide by all program policies stated in the Parent Handbook and will adhere to the scheduled arrival and departure times for his/her location;
 - e. S/He may be removed from enrollment and placed on the waiting list due to excessive absences, chronic late arrival to school and/or chronic late pick-up from school;
 - f. I will keep my child's information current and inform his/her teacher and the Office of Early Childhood Education of any changes;
 - g. I will always make sure my child's teacher has an active telephone number from within the Philadelphia calling area for me/us so that I can be contacted should the need arise.

Child's Name

Date of Birth

Signature of Primary Parent/Guardian

Date

Signature of Secondary Parent/Guardian

Date

Family Size List

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 Definition:

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 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.
- A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
- 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.

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
440 N. Broad St.
Philadelphia, Pennsylvania 19180

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 School District of Philadelphia 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: _____ Grace Neighborhood Academy _____

Signature of Early Childhood Staff: _____ Date: _____

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
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			<input type="radio"/> Type I <input type="radio"/> 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 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

CHILD'S MEDICAL/ CHILD'S DIETARY or FOOD RESTRICTIONS 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 answer and complete as necessary – use additional paper if needed:

Does your child have a medical condition?	<input type="radio"/> Yes	<input type="radio"/> No
If 'Yes', please list diagnosis or medical condition:		
If medication is required, please list medication:	<input type="radio"/> Daily	<input type="radio"/> As Needed

*School District of Philadelphia school-based sites will ONLY administer emergency as needed medication.

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.

Does your child have a dietary or food restriction?		<input type="radio"/> Yes	<input type="radio"/> No
If 'Yes', Name of restricted food:			
Reason for restriction:	<input type="radio"/> Medical – please indicate reaction and treatment:	<input type="radio"/> Religious	<input type="radio"/> Other
If 'Yes', Name of restricted food:			
Reason for restriction:	<input type="radio"/> Medical – please indicate reaction and treatment:	<input type="radio"/> Religious	<input type="radio"/> Other

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 _____

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

#4 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 _____

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

#5 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, SUITE 170 | PHILADELPHIA, PENNSYLVANIA 19130

#6 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									

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

Child's Name: _____

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 the following through on the Family Engagement Contract:

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

_____ (Parent Initials) **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.

FAMILY GOALS & 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 goal you develop.

PLEASE CHOOSE ONE OF THE FOLLOWING CATEGORIES

Check here _____ if you want to decline this questionnaire

Please describe your selection	
1. Family well-being	
1.1 Asset financial education, debt counseling	
1.2 Housing assistance: (subsidies, utilities, repairs)	
1.3 Food assistance: (Education & Nutrition)	
1.4 Transportation	
1.5 Health: (Mental health services, preventive medical & oral health, education on prenatal & postpartum care)	
2. Positive parent-child Relationships (education & research assistance)	
3. Families as Lifelong Educators (Involve in child's screening & assessment progress)	
4. Families as Learners	
4.1 Assistance with (ELS) English as second Language Training	
4.2 Assistance in enrolling into an education or job training program	
5. Family Engagement in Transitions (Supporting transitions between programs)	
6. Family Connections to Peers & Community	
6.1 Assistance with Family Safety, Custody Order & Protection from Abuse	
6.2 Assistance with community partner plans (DHS, TANF, etc.)	
6.3 Assistance with education on relationship / marriage	
7. Families as Advocates & Leaders: Parent committee, Head Start Program, etc.)	

Parent Name: _____ Parent Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____ Date: _____

The School District of Philadelphia
Prekindergarten Head Start

Child's Name: _____

Birth Date: _____

PLAN / PROGRESS NOTES

(EACH ENTRY REQUIRES A SIGNATURE)

DATE _____

NOTES

[illegible]



Grace Neighborhood Academy
5221, Oxford Ave, Philadelphia 19124
Phone: 215 535 8200 Fax: 215 535 8300

GENERAL INFORMATION

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

Admissions Date: _____ Withdrawal Date: _____

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

(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. Agree to update the Emergency Contact/ Parental Consent Form information whenever changes occur or every six (6) months at a minimum.
4. 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.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. I understand that my child will only be released to the following individuals: _____
11. 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 my part thereof, he/she remains.
12. 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.
13. I understand the Center is opened all year, except for holidays declared by the Center Director.
14. I do _____ do not _____ give permission for my child to be *photographed/ videotaped and the photos/tape to be displayed in the school.*
15. I/We _____ Grant 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. (Center images are used on the Internet to promote student activities and celebrate your child's work and participation. Rest assured, the center will safeguard all content and will not share/release any information without prior consent from you the parent/ guardian.)
16. 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.
17. 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 Name)

Sherwonda Rios

Director's (Signature & Date)

Parent / Guardian (Signature & Date)

Periodic Review (Parent/ Guardian Signature & Date)



Grace Neighborhood Academy
5221, Oxford Ave, Philadelphia 19124
Phone: 215 535 8200 Fax: 215 535 8300

EMERGENCY CHILD RELEASE

I, _____ AUTHORIZE Grace Neighborhood Academy to release my child(ren) to the person(s) designated. This is consonance with the Grace Neighborhood 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



Grace Neighborhood Academy
5221, Oxford Ave, Philadelphia 19124
Phone: 215 535 8200 Fax: 215 535 8300

"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 special needs require special care by our teachers?
7. Does your child have an IEP (Individualized Education Plan) or ISFP (Individualized Family Service Plan)?
(Note: If yes, we would like a copy of the plan, so we can provide the best possible learning experience for your child.)
8. What program or individuals work with your child in regards 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?
10. How are your child's allergies treated?
11. Do you have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.)?
12. Any other medical or special needs?



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 in 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: _____

Director Signature

Date

Grace Neighborhood Academy
5221, Oxford Ave, Philadelphia 19124
Phone: 215 535 8200 Fax: 215 535 8300



PARENT/GUARDIAN HANDBOOK

PARENT / GUARDIAN AGREEMENT FORM

1. I/We agree to comply with the rules and regulations of Grace Neighborhood Academy
2. I/We will immediately notify the Grace Neighborhood Academy if my child/children will be absent or lateness.
3. I/We agree to give two weeks written notice to Grace Neighborhood 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 Grace Neighborhood Academy staff to ensure that my child/children will have a rewarding learning experience.
7. 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 Grace Neighborhood Academy

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.

ACKNOWLEDGMENT OF HANDBOOK

I acknowledge by my signature that I have received a copy of the Grace Neighborhood 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.

Child's Name: _____

Date: _____

Parent/ Guardian Signature

Parent/ Guardian Signature



Grace Neighborhood Academy
5221, Oxford Ave, Philadelphia 19124
Phone: 215 535 8200 Fax: 215 535 8300

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 complaint 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:

Grace Neighborhood Academy
Sherwonda Rios, Director
5331, Oxford Ave Philadelphia, 19124

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

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

Office of Civil Rights
U.S Department of Health & Human Services
Suite 872, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-9111

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

Child's Name: _____

Parent / Guardian Signature

Date

Sherwonda Rios

Director Signature

Date

THE SCHOOL DISTRICT OF PHILADELPHIA
PARENTAL PERMISSION

TRIP INFORMATION

School <i>Grace Neighborhood Academy</i>	School Phone 215 535 8200	Grade/ Room	Date Prepared
Teacher		Destination Neighborhood walk, Playground, trips	
Educational Purpose of the Trip Gross motor, social studies, science			
Date of Trip	Leave Time	Return Time	Trip Itinerary (Summary)
Method of transportation	Cost to Student ___ Free \$ ___	Student Lunch ___ 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 with (Check all that applies): ___ Father ___ Mother ___ Guardian

EMERGENCY CONTACTS

If the parent / 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: _____	Phone Number: _____
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".

Medications/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 contacts.

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.



INFLUENZA (FLU) IMMUNIZATION
YOUR CHILD'S ANNUAL FLU SHOT

CHILD'S NAME: _____ **DOB:** _____

Regulation: Influenza (Flu) Shot

Children 6 months – 5 years old who attend any group childcare/daycare facility in Philadelphia must receive a dose of flu vaccine between **September 1 and December 31 every year**. You may be asked by your childcare facility to provide documentation of your child receiving their flu shot.

The Office of Child Development and Early Learning (OCDEL) permits written exemptions for part or all immunizations.

Please Check One:

☐

My child received an Influenza (flu) vaccine this year.

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

☐

My child has not received an Influenza (flu) vaccine **YET** this year but will by: _____

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

☐

My child did not and will not receive an Influenza immunization this year.

Written exemption as to why not:

PARENT/GUARDIAN NAME (Print): _____

PARENT/GUARDIAN NAME (Signature): _____

DATE: _____

VERIFICATION OF ENROLLMENT IN A HEAD START/EARLY HEAD START

PLEASE PRINT

Name of Child in Head Start/Early Head Start:	Parent/Guardian's Name:
Parent/Guardian's Address:	City, State, Zip:
Date Child Enrolled in Head Start: _____	Child's Date of Birth: _____

I give permission to the Head Start/Early Head Start Program to release this information to the Early Learning Resource Center (ELRC) to verify enrollment and the additional need for child care services.

Parent Signature: _____ Date: _____

HEAD START (HS) / EARLY HEAD START (EHS) PROGRAM INFORMATION

- Name of HS/EHS Program child attends: Grace Neighborhood Academy
- Address: 5221, Oxford ave
- City: Philadelphia State: PA Zip: 19124 County: Philadelphia
- HS/EHS Program Days and Hours: Monday – Friday 9 am to 6 pm
- Total number of HS/EHS Program Days per year: 180
- HS Program Begin Date: 8/25/2025 HS Program End Date: 6/12/2026
- Head Start/Early Head Start Enrollment Coordinator: Jayanthi Moses
- Phone Number: 215-535-8200 Fax Number: 215-535-8300

VERIFICATION

This form provides verification from the Head Start/Early Head Start Program to the Early Learning Resource Center (ELRC) that this child is enrolled in the above-named Head Start/Early Head Start program. The child care program referenced above meets applicable Head Start standards.

ONLY ONE SIGNATURE IS NEEDED TO VERIFY THAT THE ABOVE INFORMATION IS CORRECT

Head Start Coordinator	Day Care Director
Signature: _____	Signature: _____
Print Name: <u>Jayanthi Moses</u>	Print Name: <u>Sherwonda Rios</u>
Date: _____	Date: _____

#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 847/750-0551 (document #5555 and #5007). Print copies provided by CRNP have the schedule on the back of this form.					
Health history and medical information pertinent to routine care and emergencies (describe, if any): <input type="checkbox"/> NONE				DATE OF MOST RECENT WELL-CHILD/PHYSICAL EXAM:	
Allergies to food or medicine (describe, if any): <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO - IF NO, PLEASE EXPLAIN YOUR ANSWER:					
LENGTH/HEIGHT		WEIGHT		BLOOD PRESSURE	
IN/CM %ILE		LB/KG %ILE		(BEGINNING AT AGE 3)	
PHYSICAL EXAMINATION		<input checked="" type="checkbox"/> = NORMAL		IF ABNORMAL - COMMENTS	
HEAD/EYES/EARS/NOSE/THROAT					
TEETH					
CARDIORESPIRATORY					
ABDOMEN/GI					
GENITALIA/BREASTS					
EXTREMITIES/JOINTS/BACK/CHEST					
SKIN/LYMPH NODES					
NEUROLOGIC & DEVELOPMENTAL					
IMMUNIZATIONS	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) <input type="checkbox"/> NONE					
MEDICAL CARE PROVIDER: ADDRESS:				SIGNATURE OF PHYSICIAN OR CRNP:	
ZIP CODE:		PHONE:		LICENSE NUMBER:	
				DATE FORM SIGNED:	

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 _____