



PRE-K COUNTS ENROLLMENT CHECKLIST

- Enrollment & Getting to Know You Meeting
- Application for Admission of Child to School
- Application for Pre-K Counts/Headstart Funding
- Emergency Contact Form
- Agreement Form
- Residency Affidavit
- Dental Assessment
- Health Assessment (with date of exam)
- Proof of Income
- Photo ID of Primary caregiver
- Insurance Card of Child
- Birth Certificate
- Received Shirt
- Supply List
- Parent Handbook
- Permission for Photos
- IEP letter
- Child Pick-up Authorization
- Emergency Operation Plan Letter
- Transfer Letter
- Transition Letter
- Holiday Closing Schedule
- C.B.S. State Food Program Application
- Ages & Stages Questionnaires

Parent Signature _____ Date _____

Director/ Assistant Signature _____ Date _____

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		BIRTH DATE	
ADDRESS			
MOTHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER	
E-MAIL ADDRESS		MOBILE TELEPHONE NUMBER	
ADDRESS			
BUSINESS NAME		BUSINESS TELEPHONE NUMBER	
ADDRESS			
FATHER'S NAME/LEGAL GUARDIAN		HOME TELEPHONE NUMBER	
E-MAIL ADDRESS		MOBILE 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 REACTIONS)	
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION		MEDICATION. SPECIAL CONDITIONS	
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD			
HEALTH INSURANCE COVERAGE FOR CHILD OR MEDICAL ASSISTANCE BENEFITS		POLICY NUMBER (REQUIRED)	
PARENTS 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	
TRANSPORTATION BY THE FACILITY		WADING	

PERIODIC REVIEW

SIGNATURE OF PARENT OR GUARDIAN

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE

CHILD PICK-UP AUTHORIZATION

I, _____, authorize Little Peoples Village to release my child(ren) to the person (s) designated. This is in consonance with Little Peoples Village Emergency Contact/Parental Consent Form.

**Student's
Name**

**Designated Custodian(s)
Name & Relationship**

Your Signature

Relationship

Date

Print Name

Address

Address

(Home Phone)

(Work)

(Cell)

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

PLEASE PRINT CLEARLY

PLEASE PUT YOUR INITIALS NEXT TO WHAT IS APPLICABLE FOR YOUR CHILD:

Date: _____ Parent Signature: _____

Orientation-

_____ I understand that I MUST attend a mandatory orientation before my child can start. The date and time will be scheduled by

LPV.

Date: _____ Time: _____

IEP/IFSP

Your 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.

_____ 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

PICTURE

Occasionally the Center staff or approved visitors take pictures of or videotape the children. You can be sure that we take precaution for our children and these pictures (still or moving) maybe used to publicize and promote Center activities or events. Pictures may appear in local newspapers, center brochures, or on television. No additional notice may be given of picture-taking sessions.

_____ I do _____ I do not give permission for my child to be photographed or videotaped while at the Center or on Center-sponsored field trips for purpose of promoting the Center and its activities.

LPV TRIP SHIRT

We also take the children out on trips to local parks or cites where there may be groups of people. For such occasions, at the time of registration, children are given a t-shirt that has our school logo and telephone number on it.

_____ I received _____ I did not receive my child's School shirt at time of registration

TRANSFERRING RECORDS

If you would like for your child's records to be transferred, we would need 72 hours' notice. We would also need a written letter or form stating which records, why you want them to be transferred, and where you would like them to go.

_____ I agree _____ I do not agree to give 72-hour notice.

Place a check mark next to each item below. For all YES responses, please explain in the comment's column.

My Child:	No	Yes	Comments
Wears Diapers or Pull-ups			
Wears Glasses or has a lazy eye, crossed eye, wandering eye or other eye condition			
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, trouble urinating, urinary tract infection or kidney disease			
Has a feeding tube			
Has diabetes (If yes, please indicate Type I or 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			
Has/had polio, chicken pox, measles, mumps, scarlet fever, whooping cough			
Experiences car sickness			



ENROLLMENT AND "GETTING TO KNOW YOU" MEETING GUIDLINE

Child's Name: _____

Names of Meeting Attendees: _____

Meeting Dates: Enrollment: _____ Getting to Know You: _____

If "Getting to Know You" meeting was refused: 1. Date of refused by parent: _____

2. Attach a list of the information that you shared in written form.

Questions that might be asked at enrollment.

Family Composition Questions

- Who lives with the child? (Names and relationship to child) _____
- Does your child have any parent that does not live in the home? Yes/No Does your child visit this parent? Yes/No Are there any custody issues that we should discuss? _____
- Does your child have any siblings? (Names and ages) _____
- Does your family have any pets? _____
- Is there any other information about your family's composition that you would like to share?

Child Information

- Has your child been in an early learning program or child care before? Yes/ No
- If yes, would you share some information with us? (Where? When? For how long?) _____
- What kind of care (family day care home, relative/neighbor care, group, or center)? _____
- Is there a reason for leaving that program that you would like to share with me? Yes/ No
- Do you have any of your child's records from that program? Yes/ No
- How did your child react to other children and adults? _____
- What do you think will happen the first day your leave your child with us? _____
- Does your child have any imaginary friends? Yes/ No
- Are there any special problems or fears that we should know about? Yes/ No
- Does your child do any of the following:
Nail biting? Yes/ No Thumb sucking? Yes/ No Stuttering? Yes/ No
- Any special needs (medical, developmental, social, or mental health)? _____
- Do any of these special needs require special care by our teachers? _____
- Does your child have any of the following allergies:
 - Food? _____
 - Environmental? _____
 - Medication? _____
- How are your child's allergies tested? _____

- Do you have any special medical or dietary information for management in an emergency situation (medicine to keep on hand, people to call, etc.)? _____
- Any other medical or special needs? _____
- Describe your child's schedule:
 - Normal bedtime, waking time, nap time and duration _____
 - Meal times _____
 - Does your child have a different schedule at any other child care setting (babysitter, relative/neighbor care, school)? _____
- Regarding toilet habits, what words does your family use for bowel movements and urination? _____
- Any terminology for private parts? _____
- Is your child toilet trained? Yes/ No
- Does your child need to be reminded to go to the toilet during waking hours? Yes/ No
- Is there information that will help us make the first few days in our program easier for your child? _____

"GETTING TO KNOW YOU" MEETING

Questions for the Parent

- What are your expectations of our program? _____
- Is any particular aspect of the education program especially important to your child/family? _____
- Is there any information about your family's culture, ethnicity, language, or religion that is important for us to know? Would you and/or your family like to be a resource for any cultural awareness activities? _____
- Are you willing to be a volunteer in our classroom? Yes/ No
 - Are there any other ways you would like to be involved? _____
 - Are there any other talents or interests you would like to share with us? _____
- What times are best for us to reach you and/or for you to come in for parent conferences? _____
- Tell me about your child's favorites (ex toy, games, food, etc.) _____
- Has your child talked to you about his or her experiences in our program so far? Yes/ No
 - Is he/she positive about the program, other children, and the teaching staff? Yes/ No
 - If not, how do you think we can make your child's experience better? _____
- Are there any ways that we can improve communication with you about your child's experiences? Yes/ No

Parent/Guardian
Handbook Acknowledgement

Please Print

I, _____ the parent/s of _____
Parent/legal guardian first and last name child's first and last name

Agree to abide by the Center's Policies and Procedures.

- ❖ Have read this handbook in its entirety.
- ❖ I agree to pick my child up on time.
- ❖ I understand that tuition is due every Monday or Tuesday of each week.
- ❖ I will keep my telephone and address information current at all times.
- ❖ I will keep my child's immunization record up to date at all times.
- ❖ Other _____

Parent Signature

Date

Witness Signature

Date



COVID-19 PUBLIC HEALTH EMERGENCY
SPECIAL PROGRAM ATTENDANCE
ACKNOWLEDGMENT AND DISCLOSURE

FAMILY/CHILD VERSION: This should be initialed and signed by BOTH parents.

Please read and initial each statement below.

1. ____ I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter the facility beyond the designated drop-off and pick-up area. I understand that this procedure change is for the safety of all persons present in the facility and to limit to the extent possible everyone's risk of exposure. I understand that it is my responsibility to inform any Emergency Contact persons of the information contained herein.
2. ____ I understand that to enter upon the facility premises my child must be free from COVID-19 symptoms. If, during the day, any of the following symptoms appear my child will be separated from the rest of the people in the center. I will be contacted, and my child MUST be pick-ed up from the facility within 30 minutes of being notified.

Symptoms include,

- fever of 100.4 degrees Fahrenheit or higher
- dry cough
- Shortness of Breath
- Chills
- Loss of taste or smell
- Sore Throat
- Muscle aches

While we understand that many of these symptoms can also be related to non-COVID-19 related issues we must proceed with an abundance of caution during this Public Health Emergency. These symptoms typically appear 2-7 days after being infected so please take them seriously. Your child will need to be symptom free without any medications for 72 hours before returning to the facility.

3. ____ I understand that my child's temperature will be taken every 2 hours throughout the day while on facility premises.

- 4.____ I understand that my child must wear a mask at all times while in the facility and on facility premises. (OPTIONAL, may be required by some states in order to operate.)
- 5.____ I understand that my child will be required to wash their hands using CDC recommended handwashing procedures throughout the day using warm running water and rubbing with soap for at least 20 seconds.
- 6.____ I understand that outside of care, in order to control my child's exposure in the community, I will comply with any and all state, county or local stay-at-home orders, will limit my child's contact outside of care to persons living in my household. I will not take my child out to stores unless it is absolutely necessary and then only to shop for essential items like food, medicines and toiletries. I will follow any recommendations from the CDC that limits my child's risk for exposure including wearing a mask in all public areas and remaining 6ft from all other people.
- 7.____ My child and I WILL NOT gather with anyone that does not live in our household. I will only have contact with persons at my place of employment, and there I will practice all recommended social distancing, exposure limiting practices recommended by the CDC and by my employer. My child and I WILL NOT go to any gym, movie theater, nail or hair salon, park, beach, or other community location that is not for the purpose of getting food, medicines, toiletries or other life sustaining necessities until such time as it is determined by state and local health officials that the COVID-19 Public Health Emergency is over.
- 8.____ I will immediately notify Little Peoples Village management if I become aware of any person with whom my child or I have had contact exhibits any of the symptoms listed in Number 1 above, is advised to self-isolate, quarantine, or has tested positive, or is presumed positive for COVID-19. Further, I will immediately notify Little Peoples Village management if anyone from my place of employment is presumed positive or tests positive for COVID-19 whether or not I have had direct contact with that person.
- 9.____ I understand that while present in the facility each day my child will be in contact with children, families and other employees who are also at risk of community exposure. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I understand that I play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined herein.

I, _____, certify that I have read, understand, and agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by Little Peoples Village will result in termination of services. I acknowledge that care for my child will be terminated if it is determined that my actions, or lack of action unnecessarily exposes another employee, child, or their family member to COVID-19.

Child's Name: _____

DOB: _____

Parent's Name: _____

Parent Signature

Date

Parent's Name: _____

Parent Signature

Date

Management Team Witness

Date

Re-Opening LPV

Due to restrictions still in place, we will reopen at 75% capacity in each room. When instructed to and all safe measures are taken, we will open with full operation hours. It's impossible to have the same staff care for the same kids throughout the day without mixing up children and teachers from other classes so changes were made for everyone's safety.

New Temporary hours

We will be reopening Monday -Friday 7:30am-5:30pm. With only serving children no longer than 9 hours a day.

Same staff and same classroom

To help minimize interactions throughout the building, we are having all classrooms open throughout the day from open to close. This will help isolate any spread if a child or staff get sick. We will not be mixing the children or staff in different classrooms at any time. Same staff with same kids! Due to this guideline. We had to lower our hours to accomplish this goal. We will be open from 7:30-5:30pm and children can not exceed a 9hr period in a day. We also put a third teacher in each classroom to make sure all hours are covered, with same teachers, for the duration of the day.

Lower enrollment

We will lower our enrollment to we feel it is safe per CDC guidelines to go to regular capacity. By limited capacity, we hope this will lower the chance of covid spreading.

Drop off/pick up and labeled Waiting Spots

Designated drop off/pick up for children will be in rear entrance yard. This will allow adequate space for social distancing. We will have markings 6 feet apart near entrances so families know where to stand safely from one another.

Only Students and Staff Allowed Inside

Each person who enters a facility increases the chances of COVID-19 transmission, so it is a good idea to keep families outside and not allow any visitors.

Designated Runner

Assign the same staff members the responsibility of greeting families and walking each child to their classroom.

Health Screening Questionnaire

Before a child is allowed inside, parents answer a questionnaire to ensure they do not have any signs of COVID-19. Here is a sample questionnaire you can use:

Do you or your child or any member of your household have any of the following symptoms?

Fever (37.8C 100.4F Or Higher)

New/Worsening Cough

Shortness of Breath

Sore Throat

Difficulty Swallowing

Loss of Taste or Smell

Nausea/Vomiting, Diarrhea, Abdominal Pain

Runny Nose, or Nasal Congestion (In the absence of underlying reasons such as Seasonal Allergies, Nasal Drip, Etc.)

Unexplained Fatigue/Malaise/Myalgia

Chills

Headache

Conjunctivitis (Pink Eye)
Lethargy/Difficulty Feeding in Infants

Have you had contact with anyone with acute respiratory illness or who travelled outside of (country) in the last 14 days?

Have you had close contact with someone who has been diagnosed with COVID-19?

If you answered YES to any of these, DO NOT enter. Your child cannot be permitted to enter to ensure the safety of everyone. Contact your health care provider.

Temperature Checks

Check each staff and child's temperature using an infrared contactless forehead thermometer to ensure they do not have a fever before entering the building. This will be done at least twice a day to ensure temperature doesn't go up during the day.

Wear Masks

Ensure that every adult is wearing a face mask. Children under 3 years old should not wear face masks. There are mixed opinions on whether older children should wear masks and so unless legally required it is up to your discretion whether children should be required to wear them.

Contactless Check-in

Our staff member will check in/out children in for attendance on our childcare app daily.

Hygiene Station

Hand sanitizing station at the entrance of the building for all staff, parents and children to use before interacting with one another. Frequently washing hands with soap and water.

Indoor and Outdoor Play

Gross Motor activities are still included in your child's daily schedule but have been modified. Toddlers will only use the indoor play space which will be sanitized between each classroom use. Preschoolers and School Age children will use the outdoor play yard and equipment which will also be sanitized after each class use.

Scheduled Appointments

We will only take scheduled meetings with the directors, teachers and management. You must contact the front desk to schedule a meeting if necessary, to discuss any concerns. We want to ensure your safety as well as ours.

Outside Food (12 months and up) and Personal Items

Little Peoples Village has had a NO OUTSIDE FOOD Policy since September 2019, this will be strictly enforced as we reopen. NO food from outside is allowed in the center at this time. All personal items to include "inside shoes", additional clothing, blankets and crib sheets are to be brought upon return and LEFT at the center. We will wash and sanitize all personal items weekly. INFANTS: You still must bring pre-made bottles and baby food daily if applicable.



Greetings Parents,

The following program policies are designed to ensure that all enrolled children receive a quality preschool education.

Attendance Policy

Regular attendance is important for your child to maintain steady progress and to enjoy the benefits of a high-quality early childhood experience. If your child is ill or unable to attend school, please send your child's teacher a note to report the absence. Excessive absences are unacceptable and your child's enrollment in the program may be jeopardized. This policy also includes extended vacations.

- **First Occurrence (3 absences):** Teacher will verbally remind parents about the importance of daily attendance.
- **Second Occurrence (5 absences):** Teacher will meet with the parent/guardian to discuss the reason for absences and strategies to be utilized to avoid absences in the future.
- **Third Occurrence (10 absences):** Program director will confer with the parent regarding excessive absences and develop a plan of action to ensure daily school attendance.
- **Fourth Occurrence (15 absences):** Parent receives written notification that continued absences will result in child's removal from the class list.
- **Fifth Occurrence (18 absences):** In consultation with the program director, the child is placed back on the waiting list and the slot will be filled by the next child on the waitlist.

Thank you for adhering to the program policies. Our goal is to support children and families whenever possible and it is never our wish for a child to be dismissed from our program. We hope that these policies and procedures will provide a foundation for a strong program that will meet the needs of students, parents, and staff.

Director, Little Peoples Village

I have received and understand ***Little Peoples Village Attendance Policy***. I agree to contact my child's teacher when my child will be absent and/or in advance if there will be any prolonged absences from school. I further understand that I will provide documentation (doctor, dentist, family notes) when my child is absent from school. I understand that excessive absences may make it impossible for my child to remain in the **PKC/Head Start** program.

Parent Name

Parent Signature

Date

Director Name

Director Signature

Date

Document ID No. 1	Title: Policy to Reduce and Ultimately Eliminate Suspension and Expulsion of Children	Date Prepared: 11/27/2017
Revision		Effective Date: 05/30/2018

Policy:

This policy depicts LPVs methodology of reducing and eliminating the suspension and expulsion of children

Purpose:

The purpose of this policy is to identify positive behavior support guidelines and tools to be used by teaching and non-teaching staff at LPV; to raise awareness about suspension, expulsion and excessive disciplinary practices at the early childhood level to our families; to provide support through parent partnerships to help families who are experiencing challenging behaviors in the home by providing clear, age appropriate and consistent expectations and consequences to address challenging behaviors in a fair and equitable manner.

Scope:

This procedure applies to all teaching and non-teaching staff; the guidelines are mandatory and must be practiced diligently prior to the advancement of the next tier level of addressing disciplinary action.

Authorities/Responsibilities:

It is the responsibilities of the Executive Director, Director, Assistant Director to ensure teachers are empowered to implement all positive behavior tools as outlined in this policy and to provide teachers and support staff with adequate training and resources to address challenging behaviors in the classroom. At the completion of training, all staff and support staff will be responsible to ensure are implemented.

Procedures:

Teachers will implement the following strategies on a consistent basis to reduce challenging behaviors exhibited by children. Teachers will consistently document the use of these strategies and the results, whether positive or negative, daily.

Positive Behavior Support Strategies
All Teaching and Non-Teaching Staff will implement the following procedures to curtail existing challenging behaviors exhibited by children in their care

Visual Supports

- Design and post at children's eye level, a visual schedule complete with both pictures and words
- The visual schedule is utilized consistently and adapted based on student needs

Expectations

- Design with children, and post 3-5 classroom rules with pictures
- Classroom rules are positive, specific and descriptive
- Classroom procedures, responsibilities, rules are explicitly taught and reviewed frequently

Praise and Positive Reinforcement

- Behavior specific praise is used to reinforce appropriate behaviors
- Praise is used when catching students make positive choices
- Using a calm, low, neutral tone voice to provide short simple directions when redirecting inappropriate behaviors
- A ratio of 4:1 (praise to behavior correction statements) is used
- A combination of verbal and physical praise is used (**e.g.**, thumbs up, high five, stickers, kiss your brain, tokens, etc.)

Transition Procedures

- A warning of "one more minute" or something similar is used to signal a transition
- A transition signal is used (ring bell, blow whistle, turn off lights, play a transitional song)
- Provide personal face-to-face warning to children who have difficulty with transitions
- Provide more than one reminder when possible (e.g., 5 minutes until... 2 minutes until...)
- Expected behaviors are clearly stated at transition times (**e.g.**, hands at side, quite mouths)

Provide Alternative Choices, if possible

- Provide an alternative activity that will avoid disrupting others if child is unable or unwilling to participate in current activity
- Permit child to sit in cozy corner to read; play with a puzzle, have writing center open and stocked with crayons, markers and paper to encourage writing or drawing; permit calming music to be played and/or any other calming activity
- When child is redirected to the alternate activity, the child should be quietly praised and never punished

Allow Opportunities for helping

- Develop and implement a job chart
- Allow children to engage in jobs (e.g., wipe tables, organize toys, books, cubbies)

Introduce Scripted Stories

Implement scripted stories such as "Tucker the Turtle," and "Super Friend." Other suggested scripted stories can be located on the Center on the Social and Emotional Foundations for Early Learning (<http://csefel.vanderbilt.edu/index.html>)

- Teach children how to identify their feelings (e.g., use visual feeling charts, games, puppets, etc.)

Practical Teacher Engagement with an aggressive or aggravated child

Teachers can sometimes help diminish and/or eliminate student's aggressive behaviors by implementing strategies listed above; as well as practicing the following step-by-step engagement procedures:

- When a child exhibits aggressive behaviors that jeopardizes the physical safety of self, classmates and others, avoid physically handling or restraining the child. Only restrain a child if the child is a danger to himself and others
- Never grab a child by the arms; if you need to remove a child from a dangerous situation, go behind him/her, and lift the child from under the armpits
- Quickly relocate the child to a safe spot (writing center, cozy corner, etc.)
- Give the child time to calm down; do not continue talking (badgering) the child during the calm down period. Let the child process and encourage child to take deep breaths.
- During conversations with the child, keep your voice calm and in a low tone
- Ask child what else can he/she do to calm down besides deep breathing. Listen and accommodate child with responses, if possible: count fingers, draw, exercise, etc.
- Eliminate calling out a child's name repeatedly- **It is bad press!** It causes the child to be put on the spot; it encourages bad behavior and it gives other children a name to blame.
- Once child has calmed down, revisit the discussion about what made the child upset and revisit alternative behaviors

If the above strategies fail to change inappropriate behaviors, advancement to the next level on the progressive disciplinary procedure will be implemented for the individual child.

- Design specific strategies for individual children
- Revisit the Tucker the Turtle Story daily and continue to have children practice the steps
- Tailor the Tucker story to fit individual students (e.g., include child's name, specific behaviors exhibited by child, add child's picture, etc.)
- Encourage and praise child for expressing his/her feelings
- Remind him/her of strategies to regulate him/herself (e.g., counting down from 10, taking a walk, deep breathing, etc.)

If the use of these additional intervention strategies fails to improve challenging behaviors exhibited by children, advancement to the next level on the progressive disciplinary procedure will incur.

If the use of these additional intervention strategies fails to improve challenging behaviors exhibited by children, advancement to the next level on the progressive disciplinary procedure will incur.

Required Parent Conferences

- Center director initiates a parent conference to discuss individual children's challenging behaviors
- Director and parent collaborate to develop and implement an individualized plan to address learning goals and behaviors. Discussion will be held with child to demonstrate the partnership between the school and home. Director and parent will set a time-line and meet again to discuss child's progress
- If behaviors continue, director will initiate another parent conference to revisit strategies implemented both at home and at school
- If behaviors continue to persist, director initiates another parent conference to discuss agency intervention

Implement Agency Intervention

- Director discusses with parents about agency intervention, if needed. Parents are provided contact information on our Mental Health Consultant and an appointment will be arranged.
- Parent meets with the Mental Health Consultant and if agency intervention is required, parent provides permission for child to be screened
- Director suggests parents take a dual-action approach in obtaining services; parent must contact outside services recommended by center as well as contact their individual insurance companies to get recommendations of other agencies to contact. Director provides recommended locations including:

Birth to 3 years of age:

- Community Behavioral Health (<http://dbhids.org/>) - 215-413-3100
- City of Philadelphia Early Intervention Intake (Childlink) - 215-685-4646

3 to 5 years of age:

- Child Crisis Treatment Center - 215-496-0707
 - Etwyn - 215-895-5500
 - Child Guidance Center- 267-713-4100
 - Community Council - 215-473-7033
 - Philadelphia Mental Health Clinic- 215-735-9379
 - NorthEast Treatment Center - 215-451-7000
 - Preschool Family Intervention Center through the Community Council - 215-473-7033
- Director provides 15 days for parent to contact suggested providers and insurance company to schedule an appointment for child evaluation.
 - Call and Retrieve Procedure: During the 15-day period, the parent will be called if the child continues to injure him or herself; another child, a teacher or a staff person, and the student must be picked up within one hour. If the parent does not pick up the child within one hour, the child will not be able to return the next day.
 - If the parent refuses to seek additional help within the required timeline of 15 days, and if the child continues to injure him or herself; another child, a teacher or a staff person, the parent will be called to retrieve the child for the day. The parent will be given one hour to pick up the child.

If the parent fails to pick up the child within one hour, the parent will have to keep the child home the following day.

- If parent fails to pick up their child within one hour after two consecutive occasions, the parent will incur a late fee of \$25.00 per hour until the child is picked up.
- If the child continues to be uncontrollable, and causes injury to him or herself, peers, teachers or staff persons; and/or child attempts to destroy center property, the parent will be called to retrieve the child, within one hour; and if behaviors persist for several days in a row, the parent will be required to keep the child home for a cool-down period of 1-3 days.
- Parents must provide an appointment card to demonstrate good faith in scheduling the appointment.
- The call and pick up procedure as described above will continue during scheduling of appointment and evaluation.
- If parents fail to complete an evaluation within the second 15-day extension, the parent will be informed their child will be placed back on the waiting list for 30 days until an evaluation has been completed. As an alternative, the parent can provide their own wrap-around service for their child.
- This extension will be the final opportunity for the parent to get child evaluated. During this holding period, parent is not responsible to make their copayments
- Failure of the parent to complete an evaluation within the timeframe will result in the child being placed back on the waiting list until such services have been provided, and the childcare slot will be opened to other parents seeking childcare.
- During the holding period, the call and retrieval of child for incidences of aggression that hurts child, teacher, peers or staff will continue until evaluation.
- This extension will be the final opportunity for the parent to get child evaluated. During this holding period, parent is not responsible to make their copayments. Failure of the parent to complete an evaluation within the timeframe will result in the child being placed back on the waiting list until child have been evaluated and/or center support has been provided by the parent.

Extreme Circumstances:

- If a child has demonstrated extreme aggression towards him or herself; teachers, staff and/or other children on a consistent basis, the above process will be eliminated, and the parent will be required to seek intervention on their own (resources provided in this policy) immediately prior to the child being able to return to the center. The parent must demonstrate good faith by submitting an intake appointment card with an upcoming date for the child to return and provide follow-up documentation indicating that the parent and child completed their intake services will be rendered to help support the child's aggressive behavior at the center and towards others. If the parent fails to keep the appointment, the child will be placed back on the waiting list until the services has been provided.
- Any child that has been extremely aggressive and has broken any of the classrooms items, the parent will be responsible for replacement and/or purchase of the broken item.

Director's Name and Title

Director, Little Peoples Village II

I have received and understand ***Little Peoples Village Suspension and Expulsion Policy***. I agree to adhere to the contents within.

Staff Name

Staff Signature

Date

Director Name

Director Signature

Date

Little People's Village

CHILD and FAMILY INFORMATION FORM

The information and documentation you provide will assist the Office of Early Childhood Education in determining your eligibility for The School District of Philadelphia's preschool program, You are obligated to provide accurate and complete information. Deliberate misrepresentation of your information may subject you to prosecution under applicable Federal and/or State laws. PLEASE PRINT CLEARLY and use BLUE or BLACK INK.

Section 1: LOCATIONS

CHOOSE THE LOCATION(S) WHERE YOU WOULD LIKE YOUR CHILD TO ATTEND: Review the 2017-2018 School-Based Preschool Locations on pages 5-6. Select 1, 2 or 3 locations in preference order. If your child is accepted to preschool, the locations you select and the availability of funding in those locations will determine which location is chosen for your child, BEFORE-SCHOOL, AFTER-SCHOOL and TRANSPORTATION ARE NOT PROVIDED. You must be able to bring your child to school and pick up your child from school on time.

Name of your 1st Location Choice:

Name of your 2nd Location Choice:

Name of your 3rd Location Choice:

Section 2: CHILD

First Name.		Last Name:	
Date of Birth:		Gender. <input type="radio"/> Male <input type="radio"/> Female	
Address:		Apt./Unit N:	Zip Code:
Race/Ethnicity Select all that applies	<input type="radio"/> Hispanic or Latino/a	<input type="radio"/> American Indian	<input type="radio"/> Asian
	<input type="radio"/> Black or African American	<input type="radio"/> Multi-Racial or Bi-Racial	<input type="radio"/> Native Hawaiian
	<input type="radio"/> Pacific Islander	<input type="radio"/> White	<input type="radio"/> Other (specify):
Primary language:		Other language(s);	
English is spoken in the home.			<input type="radio"/> Yes <input type="radio"/> No
Child's English skills: <input type="radio"/> Very well <input type="radio"/> Well <input type="radio"/> Not well <input type="radio"/> Does not speak English			
Primary Parent/Guardian:			Date of Birth:
Parent has an active custody arrangement for this child.			<input type="radio"/> Yes <input type="radio"/> No
Child lives with (select all that applies); <input type="radio"/> Mother <input type="radio"/> Step-Mother <input type="radio"/> Foster Parent/Kinship Parent <input type="radio"/> Father <input type="radio"/> Step-Father <input type="radio"/> Grandparent <input type="radio"/> Relative <input type="radio"/> Other			
Mother Complete if child does not live with his/her mother	Name:		
	Address:		
	Contact phone #:		
	Does the child's mother provide financial support to the child? <input type="radio"/> Yes <input type="radio"/> No		
Father Complete if child does not live with his/her father	Name:		
	Address:		
	Contact phone #:		
	Does the child's father provide financial support to the child? <input type="radio"/> Yes <input type="radio"/> No		

Little People's Village

#1 CHILD and FAMILY INFORMATION FORM

Child's Name:		Date of Birth:	
Section 2: CHILD. continued			
Child has a disability.		O Yes	O No
If 'Yes', list all disabilities:			
Child has an IEP (Individualized Education Plan), an IFSP (Individualized Family Service Plan) and/or an ER (Evaluation Report) and is receiving Early Intervention services from ChildLink, ELWYN or ELWYN Seeds.		O Yes	O No
If 'Yes', indicate which Early Intervention services your child is receiving (select all that applies): <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Special Instruction <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Other			
Child wears diapers and/or pull-ups.		O Yes	O No
If 'Yes', when (select all that applies): <input type="checkbox"/> Daytime <input type="checkbox"/> Naptime <input type="checkbox"/> Nighttime <input type="checkbox"/> Other (specify):			
'If 'Yes', will child be able to use the toilet with minimal adult assistance while in preschool?		O Yes	O No
Child is/was in preschool or daycare. <input type="checkbox"/> No <input type="checkbox"/> Yes — name:			
If 'Yes', is your child still attending preschool/daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No - last date of attendance:			
I/We have a medically fragile child (chronic illness, terminal illness, etc)		O Yes	O No
If 'Yes', name of child:			
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
Child's Doctor	Doctor/Clinic/Office Name:		
	Address:		
	City:		State:
	Zip Code:	Phone #:	
Child's Dentist	Doctor/Clinic/Office Name:		
	Address:		
	City:		State:
	Zip Code:	Phone #:	
How did you hear about The School District of Philadelphia's preschool program? (select all that applies): <input type="checkbox"/> Another child attended the program <input type="checkbox"/> Neighbor <input type="checkbox"/> Family Member <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Radio <input type="checkbox"/> Informational flyer <input type="checkbox"/> Library <input type="checkbox"/> Internet <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Other			
Please share any additional information about your child that you would like us to know.			



#1 CHILD and FAMILY INFORMATION FORM

Child's Name:		Date of Birth:	
Section 3: 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: <input type="radio"/> Male <input type="radio"/> Female	
Primary language:		Other language(s):	
Home Address:			
Apt./Unit #:	City:	State:	ZIP Code:
Home Phone#		Cell Phone #:	
Email Address (please print clearly):			
Alternate Phone #:		Alternate Phone # belongs to:	
Best way to reach you during the day: Select all that applies	<input type="radio"/> Home Phone	<input type="radio"/> Cell Phone	<input type="radio"/> Work Phone #
	<input type="radio"/> Alternate Phone #	<input type="radio"/> Email	<input type="radio"/> Other (specify):
Marital Status Select one	<input type="radio"/> Married	<input type="radio"/> Separated	<input type="radio"/> Divorced
	<input type="radio"/> Single	<input type="radio"/> Other (specify):	
Relationship to Child Select one	<input type="radio"/> Parent/Step-Parent		<input type="radio"/> Grandparent
	<input type="radio"/> Foster/Kinship Parent, related to child		<input type="radio"/> Foster Parent, not related to child
	<input type="radio"/> Guardian, related to child		<input type="radio"/> Guardian, not related to child
	<input type="radio"/> Other (specify):		
Race/Ethnicity Select all that applies	<input type="radio"/> Hispanic or Latino/a	<input type="radio"/> American Indian	<input type="radio"/> Asian
	<input type="radio"/> Black or African American	<input type="radio"/> Multi-Racial or Bi-Racial	<input type="radio"/> Native Hawaiian
	<input type="radio"/> Pacific Islander	<input type="radio"/> White	<input type="radio"/> Other (specify):
Status Select all that applies	<input type="radio"/> Single Parent — cares for the child without physical or financial assistance from the other parent		
	<input type="radio"/> Teen Parent — parent was under the age of 18 when child was born		<input type="radio"/> Migrant Parent — non-immigrant
Does your family receive welfare benefits?		<input type="radio"/> Yes	<input type="radio"/> No
If 'Yes', your record/case # (NOT the on your EBT card): 51/			
If 'Yes', which benefits are received?		<input type="radio"/> TANF Cash Assistance	<input type="radio"/> SNAP Food Stamps
		<input type="radio"/> Medical Assistance	
Does your family receive WIC?		<input type="radio"/> Yes	<input type="radio"/> No
Education Select highest Diploma/Degree earned or highest Grade Level completed	<input type="radio"/> High School Diploma	<input type="radio"/> GED	<input type="radio"/> Vocational Degree
	<input type="radio"/> Associates Degree	<input type="radio"/> Bachelors Degree	<input type="radio"/> Masters Degree
	<input type="radio"/> Doctorate Degree	<input type="radio"/> Some College	<input type="radio"/> ESL —English as a Second Language
	<input type="radio"/> 11 th Grade	<input type="radio"/> 10 th Grade	<input type="radio"/> 9 th Grade or lower
	<input type="radio"/> Other (specify):		



#1 CHILD and FAMILY INFORMATION FORM

Child's Name:			Date of Birth:		
Section 3: PRIMARY PARENT, continued					
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"/> In School/Job Training Program		<input type="checkbox"/> Stay-at-Home Parent		<input type="checkbox"/> Retired
	<input type="checkbox"/> Member of the U.S. military on active duty		<input type="checkbox"/> Veteran of the U.S. military		
Employer Information Complete if you are Employed/Self-Employed	Employer/Business/Company Name:				
	Address:				
	City:				State:
	Zip Code:		Phone Y:		
	What type of work do you do?				
	How often are you paid?	<input type="checkbox"/> Every week	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	
	<input type="checkbox"/> Once a month	<input type="checkbox"/> Other (specify);			
School/Job Training information Complete if you attend High School, College or a Job Training program	School/Job Training Name:				
	Address:				
	City:				State:
	Zip Code:		Phone #:		
	What are you studying?				
Do you have a disability or disabilities?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please list your disabilities:					
Do you have health insurance?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', name of health insurance provider:					
Housing Information Select your current situation	<input type="checkbox"/> Own	<input type="checkbox"/> Rent	<input type="checkbox"/> Transitional housing Since what date?		
	<input type="checkbox"/> Homeless — Since what date?			<input type="checkbox"/> Shelter — Since what date?	
	<input type="checkbox"/> Living with family - Since what date?			<input type="checkbox"/> Living with friends — Since what date?	
	<input type="checkbox"/> Living with family or friends due to a fire/flood/emergency in my home - Since what date?				
During the past 12 months, I/we have moved from temporary to permanent housing.					<input type="checkbox"/> Yes <input type="checkbox"/> No
During the past 2 years, t/we have moved into a new house.					<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a mental health concern?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a social concern (English language learner, eating disorder, custody issues. etc.)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please list your concerns:					
Please share any additional information about the Primary Parent that you would like us to know.					

Little People's Village

#1 CHILD and FAMILY INFORMATION FORM

Child's Name:			Date of Birth:		
<p align="center">Section 4: SECONDARY PARENT An adult who shares in the care of the child.</p>					
First Name:			Last Name:		
Date of Birth:			Gender: <input type="radio"/> Male <input type="radio"/> Female		
Primary language:			Other language(s):		
Home Address:					
Apt./Unit #:		City:		State:	
				Zip Code:	
Home Phone #:			Cell Phone #:		
Email Address (please print clearly):					
Alternate Phone N:			Alternate Phone # belongs to:		
Best way to reach you during the day Select all that applies	<input type="radio"/> Home Phone #	<input type="radio"/> Cell Phone	<input type="radio"/> Work Phone #	<input type="radio"/> School Phone	
	<input type="radio"/> Alternate Phone	<input type="radio"/> E mail	<input type="radio"/> Other (specify):		
Marital Status Select one	<input type="radio"/> Married	<input type="radio"/> Separated	<input type="radio"/> Divorced	<input type="radio"/> Widowed	
	<input type="radio"/> Single	<input type="radio"/> Other (specify):			
Relationship to Child Select one	<input type="radio"/> Parent/Step-Parent		<input type="radio"/> Grandparent		
	<input type="radio"/> Foster/Kinship Parent, related to child		<input type="radio"/> Foster Parent, not related to child		
	<input type="radio"/> Guardian, related to child		<input type="radio"/> Guardian, not related to child		
	<input type="radio"/> No Relation		<input type="radio"/> Other (specify):		
Relationship to Primary Parent Select one	<input type="radio"/> Spouse husband/wife		<input type="radio"/> Companion/Partner		
	<input type="radio"/> Other (specify):				
Race/Ethnicity Select all that applies	<input type="radio"/> Hispanic or Latino/a		<input type="radio"/> American Indian		<input type="radio"/> Asian
	<input type="radio"/> Black or African American		<input type="radio"/> Multi-Racial or Bi-Racial		<input type="radio"/> Native Hawaiian
	<input type="radio"/> Pacific Islander		<input type="radio"/> White	<input type="radio"/> Other (specify):	
Status Select all that applies	<input type="radio"/> lives with child		<input type="radio"/> Does not live with child		
	<input type="radio"/> Provides financial support to child's family			<input type="radio"/> Migrant Parent - non-immigrant	
	<input type="radio"/> Teen Parent — parent was under the age of 18 when child was born				
Education Select highest Diploma/Degree earned or highest Grade Level completed	<input type="radio"/> High School Diploma		<input type="radio"/> GED		<input type="radio"/> Vocational Degree
	<input type="radio"/> Associates Degree		<input type="radio"/> Bachelors Degree		<input type="radio"/> Masters Degree
	<input type="radio"/> Doctorate Degree		<input type="radio"/> Some College		<input type="radio"/> ESL — English as a Second language
	<input type="radio"/> 11 th Grade		<input type="radio"/> 10 th Grade		<input type="radio"/> 9 th Grade or lower
	<input type="radio"/> Other (specify):				

Little People's Village

#1 CHILD and FAMILY INFORMATION FORM

Child's Name:		Date of Birth	
Section 4: SECONDARY PARENT, continued			
Employment, School, Job Training Select all that applies	<input type="checkbox"/> Employed/Self-employed		<input type="checkbox"/> Unemployed/Not Employed
	<input type="checkbox"/> In School/Job Training Program		<input type="checkbox"/> Stay-at-Home Parent
	<input type="checkbox"/> Member of the U.S. military on active duty		<input type="checkbox"/> Veteran of the U.S. military
Employer Information Complete if you are Employed/Self-Employed	Employer/Business/Company Name:		
	Address:		
	City:		State:
	Zip Code:	Phone N:	
	What type of work do you do?		
	How often are you paid? <input type="checkbox"/> Every week <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Other (specify):		
School/Job Training Information Complete if you attend High School, College or a Job Training program	School/Job Training Name:		
	Address:		
	City:		State:
	Zip Code:	Phone W.	
	What are you studying?		
Do you have a disability or disabilities?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please list your disabilities:			
Do you have health insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', name of health insurance provider:			
Do you have a mental health concern?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a social concern (English language learner, eating disorder, custody issues, etc.)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes', please list your concerns:			
Please share any additional information about the Secondary Parent that you would like us to know.			
Please share any other additional information that you would like us to know.			

Little People's Village

#1 CHILD and FAMILY INFORMATION FORM

Child's Name:	Date of Birth:			
Section 5: FAMILY MEMBERS 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. Father Sister, Brother, Companion, Partner, Friend. etc.		
1.				
2.				
3.				
4.				
6.				
7.				
8.				
Section 6: FAMILY INCOME Indicate how you financially provide for your family. Select each source of income that the Primary Parent, Secondary Parent and all children receive.				
<input type="checkbox"/> Employment/Self-Employment	<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Social Security	<input type="checkbox"/> SSI	
<input type="checkbox"/> Child Support	<input type="checkbox"/> Alimony	<input type="checkbox"/> Workman's Compensation	<input type="checkbox"/> Commission	<input type="checkbox"/> Tips
<input type="checkbox"/> TANF Cash Assistance	<input type="checkbox"/> Foster Care/Kinship Care	<input type="checkbox"/> Scholarship, Grant, Stipend		
<input type="checkbox"/> Financial support from Family/Friend (a friend or family member regularly gives you money to help you support your family)				
<input type="checkbox"/> Pension/Retirement	<input type="checkbox"/> Rental Properties (you are a landlord: another person pays you rent)			
<input type="checkbox"/> Veteran's Benefits	<input type="checkbox"/> Strike Benefits	<input type="checkbox"/> Other (specify):		
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 if any of my/our information is false, my/our participation in the preschool program may be terminated and I/we may be subject to legal action. I/We have attached 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 being given 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 and the Commonwealth of Pennsylvania will have access to and may verify the information and supporting documentation submitted with my/our Child and Family Information Form. 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		

Little People's Village

#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 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 or medical dietary concern that restricts his/her diet, the enclosed Medical Plan of Care Form for the Child and Adult Care Food Program (Pages 33-34) must be completed by an appropriate health care professional and submitted with your child's Preschool Application.

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: _____

Little People's Village

#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
110 N BROAD STREET SUTIT 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 condition 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 _____

Little People's Village

#4 POLICIES and CONSENT for EMERGENCY MEDICAL CARE and SCREENINGS 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 and PREVENTIVE SCREENINGS

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.

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

Signature of Parent/Guardian

Date

Early Childhood Use Only

Name of Location: _____

Signature of Early Childhood Staff: _____ Date: _____

Little People's Village

#8 VERIFICATION of INFORMATION FORM

Read the following statements and sign where indicated.

My/Our signature(s) below indicate that:

1. The information I/we have provided on all of the forms in my/our child's Preschool Application is accurate and complete. I/we have signed all application forms where indicated and have included copies of all required supporting documents. If any of my/our information is false, my/our participation in the preschool program may be terminated and I/we may be subject to legal action.
2. I/We understand that:
 - a. The information contained in my/our 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 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/our child will be accepted to a preschool program.
 - c. Before my/our child's first day in preschool:
 - i. I/We will attend an orientation meeting and an individual conference with my/our child's teacher and will receive a Parent Handbook.
 - ii. If my/our child's physical and/or dental exam dates are more than twelve (12) months old, I/We 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/We may be required to re-verify my/our Philadelphia, PA address, family income and/or monthly benefits.
 - iv. I/We will be notified if additional forms and/or documents are needed and will submit them as necessary.
3. During the time my/our 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. S/He will be able to use the toilet with minimal adult assistance
 - d. I/We 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. I/We will keep my/our child's information current and inform his/her teacher and the Office of Early Childhood Education of any changes.
 - f. I/We will always make sure my/our child's teacher has an active telephone number from within the Philadelphia calling area for me/us so that I/we 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

2022-2023 PA Pre-K Counts Enrollment Form

(This information is confidential to the PA Pre-K Counts program)

Date Form Completed: _____

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

Street Address		County	
City	State PA	Zip Code	
School District of Residence			
Home Phone	Work Phone	Email Address	

Child's Date of Birth	Age 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
-----------------------	--	---

Race (optional)	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaskan Native
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Other
<input type="checkbox"/> Not Applicable	
Ethnicity (optional)	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> English
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Spanish
<input type="checkbox"/> Not Applicable	<input type="checkbox"/> Other _____ (please specify)

Name of Parent or Guardian completing this application	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
--	---

Relationship to Child	(Select)
<input type="checkbox"/> Father	<input type="checkbox"/> Biological
<input type="checkbox"/> Mother	<input type="checkbox"/> Foster
<input type="checkbox"/> Guardian	<input type="checkbox"/> Adoptive
<input type="checkbox"/> Other _____ (please specify)	<input type="checkbox"/> Other _____ (please specify)

Role	
<input type="checkbox"/> Primary Guardian <input type="checkbox"/> Secondary Guardian	<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other
_____ (please specify)	

List Household Members below for determination of family size (required):		
	Relationship to Child	Age
1	ENROLLING CHILD	
2		
3		
4		
5		
6		
7		
8		
<p>Per PKC Statute, Regulations, and Guidance, the following members of the household are included in family size:</p> <ul style="list-style-type: none"> Parent of the child (biological or adoptive mother or father, stepmother or stepfather, caretaker or spouse) 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 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 of the parent or caretaker. Others supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program. If counted toward family size, any applicable income of these persons must also be counted for eligibility purposes. <p>Note: A family size value of one (1) with an income of \$0 is entered when a foster child is applying for Pennsylvania Pre-K Counts.</p>		
DETERMINED FAMILY SIZE =		

Employment Status of parent/guardian <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____	Employment Status of 2 nd parent/guardian (if applicable) <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____
---	---

Household Income Sources (Must check all that apply):				
<input type="checkbox"/> Employment <input type="checkbox"/> Social Security	<input type="checkbox"/> Self-Employment <input type="checkbox"/> SSI	<input type="checkbox"/> Unemployment Compensation <input type="checkbox"/> Child Support	<input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Alimony	<input type="checkbox"/> TANF Cash payments <input type="checkbox"/> Other

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

<input type="checkbox"/>	Behavioral Supports: A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
<input type="checkbox"/>	Child Protective Services: A child who is a foster child, a kinship care child or receiving Children and Youth services.
<input type="checkbox"/>	Education Level of Guardian: Does not have high school diploma or GED or post-secondary degree.
<input type="checkbox"/>	English Language Learner: A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
<input type="checkbox"/>	Individualized Education Plan (IEP): A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
<input type="checkbox"/>	Incarcerated Parent: A child for whom one of the child's parents is currently in prison.
<input type="checkbox"/>	Homeless: A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following: A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.
<input type="checkbox"/>	Migrant (Non-Immigrant)/Seasonal Student: A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
<input type="checkbox"/>	Teen Mother: A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided in this application and the associated income documentation is accurate. I understand that I may be asked to verify or substantiate information provided.

Parent/Guardian (Signature)

Date

Parent/Guardian Name (Print Name)



IT'S TIME TO GO TO THE DENTIST!

PHILADELPHIA HEALTH CENTERS FOR DENTAL CARE

HC #2 : 1720 S. Broad Street, 19145 : 215-685-1822
 HC #3 : 555 S. 43rd Street, 19104 : 215-685-7506
 HC #4 : 4400 Haverford Avenue, 19104 : 215-685-7605
 HC #5 : 1920 N. 20th Street, 19121 : 215-685-2938
 HC #6 : 321 W. Girard Avenue, 19123 : 215-685-3816
 HC #9 : 131 E. Cheltenham Avenue, 19144 : 215-685-5738
 HC #10: 2230 Cottman Avenue, 19149 : 215-685-0608



HOSPITAL-BASED DENTAL CLINICS



ST. CHRISTOPHER'S
 Front & Erie Avenue
 Dental Office
 215-427-5065

EPISCOPAL
 Front & Lehigh Avenue
 Dental Office
 215-707-1030

TEMPLE
 3233 S. Broad Street
 School of Dentistry
 215-707-2863

"Walk-ins" available for emergencies
 Daily - 08:00am to 02:00pm

EINSTEIN
 York & Tabor Road
 Dental Office
 215-456-7130

UNIVERSITY OF PENNSYLVANIA
 40th & Spruce Street
 School of Dentistry
 215-898-8979

FEDERALLY FUNDED CLINICS

FAIRMOUNT HEALTH CENTER
 1412 Fairmount Avenue
 Dental Office
 215-684-5349

**MARIA DE LOS SANTOS
HEALTH CENTER**
 401 W. Allegheny Avenue
 215-291-2500



"Wow!"
 "THESE DENTISTS ARE
 CHILD FRIENDLY!"



DOUGLAS R. REICH, D.M.D.

7122 Rising Sun Avenue
 215-725-8300

JUAN I. ESPINOZA, D.M.D.

RAULA A. PEREIRA, D.M.D.

in ENGLISH & SPANISH

324 W. Roosevelt Blvd.
 215-455-5385

DENTAL DREAMS

2459 Aramingo Avenue
 215-427-2800

2107A Collman Avenue
 215-235-4060

5675 N. Front Street
 215-224-0440

KIDS SMILES

2821 Island Ave - Suite 210
 215-492-9291

5848 Market Street
 215-747-6901

DOC BRESLER'S

240 Galger Road
 215-677-0380

6801 Ridge Avenue
 215-483-6633

1430 Snyder Avenue
 215-467-6000

PEDIATRIC DENTAL ASSOCIATES

100 E. Lehigh Avenue
 215-707-1030

6404 Roosevelt Blvd.
 215-743-3700

1-800-DENTIST: TOLL-FREE INFORMATION (NATIONWIDE)

215-925-6050 : PHILADELPHIA COUNTY DENTAL SOCIETY
 (for private dentists in your area)

Completed by your child's dentist return this form with your child's application

THE SCHOOL DISTRICT OF PHILADELPHIA
REPORT OF PRIVATE DENTAL EXAMINATION

Name of School	Student ID	Date issued	
Name of Student	Date of Birth	Room/Section/Book	Grade
<p>TO THE DENTIST</p> <p>Pennsylvania law requires that students attending school in the Commonwealth receive periodic dental examinations at stated intervals (upon original entry, while in third grade, and while In seventh grade).</p> <p>These examinations are required for school attendance. Payment for these examinations is the responsibility of the parent/guardian. If the student/family does not have health insurance the school nurse will help the family apply for health insurance. Please attach a copy of the student's dental examination or record the data below.</p> <p>Thank you for your cooperation.</p>			
UNDER TREATMENT/WORK BEGUN		COMPLETION OF WORK/NO TREATMENT NECESSARY	
Date Work Begun		<input type="checkbox"/> No Treatment Required NOW	
Scheduled Follow-up Appointment		<input type="checkbox"/> All Necessary Dental Work Completed	
Date of Dental Examination		Expected Completion Date	
Date of Cleaning		Comments/Follow-up Treatment/Special Instructions to School	
Date of Fluoride Treatment			
Name of Dentist		Telephone	
Signature of Dentist		Date Signed	
Address		Fax Number	

CHILD HEALTH ASSESSMENT

Child's Name (Last):		Child's Name (First):		Child's Date of Birth:		
Parent/Guardian Name:		Address:		Contact Phone #:		
PA child care providers must document that enrolled children have 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): <input type="checkbox"/> NONE				DATE OF MOST RECENT WELLCHILD/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	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						
NEXT APPOINTMENT – MONTH/YEAR:						
MEDICAL CARE PROVIDER:			SIGNATURE OF PHYSICIAN OR CRNP:			
ADDRESS:						
ZIP CODE:		PHONE:	LICENSE NUMBER:		DATE FORM SIGNED:	

