THE SCHOOL DISTRICT OF PHILADELPHIA

Preschool Application

for Academic Year

2024-2025

Pre-Kindergarten Registration

- Free, full-day pre-kindergarten services for children ages 3-5.
- Rolling enrollment as a child turns three. Children who are five on or before September 1st must apply to Kindergarten.
- Registration can be completed online or in person.

Pre-Kindergarten Benefits

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

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

THE SCHOOL DISTRICT OF PHILADELPHIA

Thank you for your interest in the School District of Philadelphia's preschool program! Completing and submitting a Preschool Application does not guarantee that your child will be accepted to a preschool program.

Required Documentation: *Documentation of citizen status is NOT required. All families are welcome.*

1. Applications will be processed when documentation below is received.

- ☐ Completed application
- ☐ Proof of child's date of birth (Birth certificate, health insurance card, etc.)
- ☐ Proof of TANF cash, SNAP/food stamps, other documentation of family income (W-2, etc.), or signed statement of unemployment
- ☐ Proof of Philadelphia residency (bill, driver's license, lease, etc.)
- ☐ Child's health insurance card
- ☐ Picture identification of parent/guardian (Current State or Federal Photo ID)

2. Enrollment will be finalized when additional documentation below is received.

- ☐ Child's health insurance card or proof of medical assistance
- ☐ Child's most up to date immunization record.
- ☐ Wellness Exam Form
- ☐ Dental Exam Form

3. If applicable additional documents may be needed:

- ☐ 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
- ☐ Copy of McKinney Vento Letter
- ☐ CACFP Enrollment Forms

**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.*

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

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

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

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

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

☐ YES

☐ NO - IF NO, PLEASE EXPLAIN YOUR ANSWER:

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

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

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

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

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

☐ **NONE**

NEXT APPOINTMENT – MONTH/YEAR:

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

School District of Philadelphia
Office of Early Childhood Education
Prekindergarten Programs

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 _____

RECORD OF ACCESS

STUDENT NAME: ______________________________ D.O.B: ______________________

NAME	DATE	PURPOSE OF ACCESS	DATE RETURNED

SOANS CHRISTIAN ACADEMY

7912 Dungan Road, Philadelphia, PA 19111

Phone: (267) 388-7648 | Fax: (267) 731-1857

EMERGENCY CONTACT / PARENTAL CONSENT FORM

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

CHILD'S NAME (As it APPEARS on Child's state / government issued "Birth Certificate")	DATE OF BIRTH
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
TRANSPORTATION BY THE FACILITY	I allow Photos/ Videos used for classroom ONLY

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN _____ DATE _____

PRIMARY PARENT

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

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

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

Phone #:	**Email Address:**

# of People in household		**# of People in family**		**O A custody arrangement for this child?**

Marital Status	O Married	O Single	O Widowed	O Separated/Divorced

Relationship to Child Select one	O Parent/Step-Parent	O Grandparent
	O Foster/Kinship Parent, related to child	O Foster Parent, not related to child
	O Guardian, related to child	O Guardian, not related to child
	O Other (specify):	O Teen Parent – parent was under the age of 18 when child was born

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

Education Select highest Diploma/Degree earned or highest Grade Level completed	O High School Diploma	O GED	O ESL – English as a Second
	O Some college/Vocational/Associates Degree	O Bachelors/Advanced degree	
	O 11th Grade	O 10th Grade	O 9th Grade or lower
Employment, School, Job Training Select all that applies	O Employed/Self-Employed	O Unemployed/Not Employed	O Disabled
	O Member of the U.S. military on active duty	O Veteran of the U.S. military	

Do you have health insurance? *If 'Yes', name of health insurance provider:*					O Yes	O No
Are you pregnant?	O Yes	O No	**Are you receiving mental health treatment?**		O Yes	O No
Do you receive benefits?	O WIC	O SNAP	O Medical	O TANF Cash	O SSI	

SECONDARY PARENT

An adult who shares in the care of the child.

First Name:	**Last Name:**
Date of Birth:	**Gender:** O Male O Female O Non-Binary

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

LOCATIONS

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

1st Location Choice:	**2nd Location Choice:**

PREK CHILD

First Name:	**Last Name:**
Date of Birth:	**Gender:** O Male O Female O Non-Binary

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

Primary language:	**Other language(s):**

Child is receiving Early Intervention services:	O IEP	O EFSP	O ER	O Suspected

Child's mother and/or father is currently incarcerated:	O Yes	O No

HOUSING

Housing Information Select your current situation	O Own	O Living with relatives or others to due to lack of alternative, adequate housing or due to the loss of housing	O Transitional housing
	O Rent	O Temporary housing situation due to emergency: eviction, flood, fire, hurricane, etc.	O Train or bus station, park or in car
	O Shelter	O Hotel/Motel, camping ground or other similar situation due to loss or lack of alternative, adequate housing.	O Apartment or house lacking utilities (water, heat, electricity, etc.)

Secondary Care Giver lives with Family?	O Yes	O No
Another person over the age of 18 living in the household?	O Yes	O No

Optional Information	New to the country?	O Yes	O No
	Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you?	O Yes	O No

FAMILY INCOME

Primary Caregiver Income			Secondary Caregiver Income		
Employment Type	**Amount**	**Frequency**	**Employment Type**	**Amount**	**Frequency**
O Employment			O Employment		
O SSI/ TANF CASH			O SSI/ TANF CASH		
O Unemployment			O Unemployment		
O Other:_____			O Other:_____		

I understand that this information will be used to create my Parent Portal COPA 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 my all supporting documentation.

Completing a Parent Portal COPA Account and submitting and finalizing an application does NOT guarantee that my child will be accepted to a preschool program.

Parent Signature:_____ Date:_____

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

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. Broad St.
Philadelphia, Pennsylvania 19130

POLICIES AND CONSENT FOR EMERGENCY MEDICAL CARE AND SCREENINGS

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

Child's Name: _____

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

In the event your child becomes seriously ill or injured and requires immediate medical attention, he/she will be accompanied by a 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: SOANS CHRISTIAN ACADEMY – 7912 DUNGAN RD. PHILADELPHIA, PA 19111

Signature of Early Childhood Staff: Kristen Domico Date: _____

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. Broad St.
Philadelphia, Pennsylvania 19130

#2 CHILD'S MEDICAL CONCERNS & DIETARY OR FOOD RESTRICTIONS 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 Administrator 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: _____ medical condition

_____ dietary or food restriction

___ My child has the following medical condition(s) and/or dietary or food restriction
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. 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 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: _____

SOANS CHRISTIAN ACADEMY
7912 DUNGAN ROAD
PHILADELPHIA, PA
19111

Signature of Early Childhood Staff: _____ Date: _____

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

#3 CHILD'S MEDICAL HISTORY FORM

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

MY CHILD:	NO	YES	COMMENTS
Wears diapers and/or pull-ups			
Has/Had a seizure(s)			
Has/Had a serious accident or illness			
Had an emergency room visit			
Had an overnight hospital stay			
Had surgery			
Wears glasses			
Has a eye, crossed eye, wandering eye Dr o her 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			OType I O Type II
Has rashes, eczema, hives, boils			
Has neuropathy, muscle tics1 spina bifida, muscular dystrophy, cerebral palsy			
Wears Jeg braces			
Uses a cane walker or wheelchair on a daily basis			
Has/Had had polio, chicken pox, measles, mumps, scarlet fever, whooping cough			
Experiences car sickness			
Child's mother c1nd/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 farm is true to the best of my knowledge. I understand that it is my responsibility to immediately inform my child's teacher or Early Childhood Health Services if there is any change to the above information.

Signature of Parent / Guardian

Date

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

#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, t01iillas, 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: _____

THE SCHOOL DISTRICT OF PHILADELPHIA

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

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: _____

pennsylvania
PRE-K COUNTS

KEYSTONE STARS

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

Soans Christian Academy

7912 Dungan Rd. Philadelphia PA 19111 | Tel: (267) 388-7648 | Fax: (267) 731-1857

Email: soanschristianacademy@gmail.com

GENERAL INFORMATION

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

Admissions Date: _____ Withdraw 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 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) Parent / Guardian (Signature & Date)

Kristen Domico _____

Director's (Signature & Date) Periodic Review (Parent/ Guardian Signature & Date)

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Kristen Domico, Director

"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?

THE SCHOOL DISTRICT OF PHILADELPHIA
PARENTAL PERMISSION

TRIP INFORMATION

School	School Phone	Grade/ Room	Date Prepared
Teacher		Destination	
Educational Purpose of the Trip			
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.

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CIVIL RIGHTS COMPLIANCE

Parents / Guardians

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

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

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

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

Bethany Academy
Barbara Ortiz, Director
6537 Rising Sun Ave.
Philadelphia, PA 19111

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

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

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

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

Child's Name: _____

_____ _____
Parent / Guardia Signature Date

_____ _____
Director Signature Date

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EMERGENCY CHILD RELEASE

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

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

_____

Your Signature Relationship Date

_____

Print Name

_____

Street Address City State Zip Code

_____

(Home Phone) (Work) (Cell)

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

PLEASE PRINT CLEARLY

SOANS CHRISTIAN ACADEMY
PARENT/GUARDIAN HANDBOOK

PARENT / GUARDIAN AGREEMENT FORM

1. I/We agree to comply with the rules and regulations of the Soans Christian Academy.
2. I/We will immediately notify the Soans Christian Academy if my child/children will be absent or lateness.
3. I/We agree to give two weeks written notice to Soans Christian Academy if my child / children will be withdrawing from the program.
4. I/We agree to pick up my child at the agreed upon dismissal time designated on the enrollment form. Failure-to do so will result in late fee charges and possible termination from the program.
5. I/We understand that tuition payments can be paid in advance, on Thursday and no later than Friday by 5:00 p.m. for the following week of care. Tuition payments are due no later than Monday morning for the current week.
6. I/We agree to cooperate with Soans Christian Academy staff to ensure that my child/children will have a rewarding learning experience.
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 Soans Christian Academy

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

Child's Name: _____ Date: _____

_____ _____

Parent/ Guardian Signature Parent/ Guardian Signature

The School District of Philadelphia
Prekindergarten Head Start

Child's Name: _____ Birth Date: _____

PLAN / PROGRESS NOTES

(EACH ENTRY REQUIRES A SIGNATURE)

DATE	NOTES