

The School District of Philadelphia
Office of Early Childhood
Prekindergarten Head Start

[Phase I]

Dear Parent(s)/Guardian(s),

Thank you for your interest in pre- registering your child(ren) in the School District of Philadelphia's Head Start program. The Head Start Federal guidelines states that each family's eligibility must be determined and ranked by priority based on various family needs. In order for us to make an accurate and fair determination of your family eligibility status, please complete the form below and provide the necessary information to verify your income and child's age. **Please return in the enclosed envelope provided with the following information:**

- COPY OF INCOME VERIFICATION
- COPY OF CHILD'S BIRTH CERTIFICATE OR DOCUMENT THAT VERIFIES CHILD'S DATE OF BIRTH
- COPY OF CHILD'S SHOT RECORD and HEALTH ASSESSMENT and DENTAL EXAM
- COPY OF CHILD'S HEALTH INSURANCE CARD

You will be **contacted during this school year** to bring in the remainder of your application packet and complete your intake interview.

REMEMBER... Completing the application and meeting with the Family Service staff at the intake interview does not guarantee that your child will be enrolled in the Head Start program.

If you have any questions, please call 215-400-4270 (select option 2).

Center Choice #1 _____ Center Choice #2 _____

Center Choice #3 _____ Center Choice #4 _____

PRE-REGISTRATION CHECKLIST APPLICATION FOR ELIGIBILITY

Child(ren) and family information (List every child for whom Head Start is requested)

Child's Name _____ Birth date _____

Child's Name _____ Birth date _____

Parent/Guardian _____ Phone# _____

Address/Zip Code _____

Parent/Guardian _____ Phone# _____

Address/Zip Code _____

Please respond to the questions by placing an X next to your answer.

Are you currently living in shelter and/or transitional housing? Yes _____ No _____

Are you doubled up with relatives or friends due to a fire, flood, etc.? Yes _____ No _____

Have you received permanent housing in the last 12 months? Yes _____ No _____

Is this child in Foster care/kinship care? Yes _____ No _____

Is this a one or two Parent household? One _____ Two _____

Are you the child's Grandparent or other relative? Yes _____ No _____

Are you the legal guardian of the child? Yes _____ No _____

_____ Family size: Number of dependent children _____ Number of dependent Adults _____

[over]

Are you a United States Citizen Yes _____ No _____

If no, how long have you lived in the United States? Years in USA _____

Have you changed your residence in the last two years in order to work in farming/agriculture?

Yes _____ No _____

Is there a sibling enrolled in Head Start? Yes _____ No _____

Head Start Center _____

Does your child have health insurance? Yes _____ (Please provide a copy of the card) No _____

Has your child been diagnosed with a disability? (IEP/CER)? Yes _____ No _____

Do you have a medically fragile child? (You have a child that has a chronic or terminal illness)

Yes _____ No _____

Do you have any disabilities or Physical/Mental Health concerns? Yes _____ No _____

Does your family have other Social Concerns:[English Language learners, custody issues, etc.]

State concern: _____

Were you referred by a community agency? Yes _____ No _____

Agency Name _____

Are Parent(s) in a Training program or attending School? Yes _____ No _____

Has this child had any previous pre-school experience? Yes _____ No _____

What language is spoken at home? _____

Is your family receiving Public Assistance :

TANF (cash assistance) Yes _____ No _____

TANF(Food Stamps) Yes _____ No _____

TANF (Medical Assistance) Yes _____ No _____

Are you receiving SSI Yes _____ No _____

Are you receiving WIC Yes _____ No _____

FAMILY INCOME: Current income must be included and attached to this document.

1. What is frequency of Pay (How often do you get paid?) **Circle one**

Parent: Weekly-----Bi-weekly-----Bi-monthly-----Monthly

Parent: Weekly-----Bi-weekly-----Bi-monthly-----Monthly

(PLEASE INCLUDE A COPY of the documentation for gross income: TANF letter (Cash), SSI, self employment, paystubs, employer letter, unemployment letter, Foster care letter, support letter. Proof or verification of food stamps/medical, assistance benefits, etc. PLEASE INCLUDE THIS DOCUMENTATION!!!!

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Signature: _____ Date _____

OFFICIAL USE ONLY*****

Received by (signature) _____

Family Service Field Representative /Social Worker

_____ **Date Received**

2/2011

CHILD HEALTH ASSESSMENT

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN NAME:
DATE OF BIRTH:	PHONE:	ADDRESS:
CENTER NAME:		

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).

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> NONE	Date of most recent well-child exam:
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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.) Child care facility needs 2 copies.
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LENGTH/HEIGHT _____ IN/CM %ILE _____	WEIGHT _____ LB/HG %ILE _____	BLOOD PRESSURE (BEGINNING AT AGE 3) _____ / _____
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PHYSICAL EXAMINATION	<input checked="" type="checkbox"/> =NORMAL	IF ABNORMAL - COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIO/RESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS <small>(Complete Dates: Month, Day, Year)</small>
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TESTS	DATE TEST	<input checked="" type="checkbox"/> =NORMAL	IF ABNORMAL - COMMENTS
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

MEDICAL CARE PROVIDER:	NEXT APPOINTMENT - MONTH/YEAR:
ADDRESS:	SIGNATURE OF PHYSICIAN OR CRNP:
PHONE:	LICENSE NUMBER:
	DATE FORM SIGNED:

DENTAL HEALTH

Child's Name _____ Birth Date _____ Center _____

Dear Parent/Guardian,

♥ Please complete **Part I** to the best of your knowledge

♥ **Part II** is to be completed by your child's dentist

Part I ~ Completed by parent/guardian

1. Has your child been to the dentist? _____ No _____ Yes ~ If Yes, please complete the following:
Dentist Name _____ Address _____ Zip _____
Phone Number _____ 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? _____

Part II ~ 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 _____