Your Child's World Learning Center, Inc.

"Where your child will feel free to explore all possibilities."

5837 N. 2nd Street, Philadelphia, PA 19120 PHONE: (215) 924-4175 FAX: (215) 924-6632
7120 N. Broad Street, Philadelphia, PA 19126 PHONE: (215) 924-4195 FAX: (215) 924-6632
6595A Roosevelt Blvd, Philadelphia, PA 19149 PHONE: (215) 289-2026 FAX: (215) 924-6632
1052 Easton Rd., Abington, PA 19001 PHONE: (215)758-2487 FAX: (215) 924-6632
2406 S 71st Street, Philadelphia, PA 19146 PHONE: (267) 233-7031 FAX: (215) 924-6632

PreK Application

Thank you for your interest in our PreK programs, we are so excited to support you as you raise your child. We have lots of exciting hand-on learning experiences ready for your child and we give them numerous opportunities to explore the world around them. Please take a moment to complete the required registration process, it will be worth it.

A high quality PreK experience does make a difference!

To qualify:

1. Child must be at least 3 years old on or before September 1st of the enrollment year and not be age-eligible for kindergarten; and,
2. Child and family must live in Philadelphia, PA (for all Philadelphia sites; and PA for Roslyn and Elmwood sites),
3. Family must meet current Head Start or PA Pre-K Counts income guidelines; and,
4. Child's complete *PreK Application* [forms and required supporting documents] must be submitted to and received by the appropriate preschool program:

   - To apply for one of our PreK site, mail or hand deliver your child's application to:
     5837 N. 2nd Street, Philadelphia, PA 19120
     7120 N. Broad Street, Philadelphia, PA 19126
     6595A Roosevelt Blvd, Philadelphia, PA 19149
     1052 Easton Rd., Abington, PA 19001
     2406 S 71st Street, Philadelphia, PA 19146

PreK Information

1. A free preschool program, funded by Federal Head Start, PA Pre-K Counts and PHL PreK funds, for qualified children and families up to the maximum funded capacity.

2. Days and hours of operation
   - Late August to Mid-June – (180 days of instruction)
   - Monday – Friday: 8:00 AM – 2:00 PM PHL PreK program
   - Monday – Friday: 8:30 AM – 2:30 PM PreK Counts and Head Start programs

3. Before-school care, after-school care is available at an additional cost. CCIS is accepted (Transportation is not provided)

4. Enrolled children are brought to school on time and picked up from school on time by an individual who is at least eighteen (18) years old.

5. Breakfast, lunch and afternoon snack are provided to enrolled children at no cost to families.

6. Completing and submitting a *PreK Application* does not guarantee that a child will be accepted to a PreK program.

7. Children and families are determined eligible for Head Start or PA Pre-K Counts based on the maximum allowable income for Head Start or PA Pre-K Counts income eligibility and the following verified information: child's date of birth, family address, family size and family's total annual gross income. The maximum allowable income, determined by the Poverty Guideline and issued each January in the *Federal Register* by the Department of Health and Human
   Services, is available online at www.hhs.gov. As a guide, the below chart shows the 2017 Poverty Guideline for the 48 contiguous states and D.C. and the maximum allowable income for Head Start, Bright Futures and PA Pre-K Counts income eligibility.

8. PHL PreK is not an income-based program. All Philadelphia residents are eligible.

Family Size	2018 Poverty Guideline for the 48 Contiguous States and D.C. **Maximum Income for Head Start Eligibility**	300% of the 2018 Poverty Guideline **Maximum Income for PA Pre-K Counts and Bright Futures Eligibility**
2	$16,240	$48,720
3	$20,420	$61,260
4	$24,600	$73,800
5	$28,780	$86,340
6	$32,960	$98,880
7+	Add $4,180 for each person	Add $12,540 for each person

8. A child's *PreK Application* is valid for one program year.

9. Failure to inform Your Child's World Learning Center, Inc. of a change in your home address, email address and/or telephone number will negatively affect your child's acceptance, enrollment opportunity and/or continued enrollment in a preschool program.

10. Your Child's World Learning Center, Inc. reserves the right to request additional documentation as necessary.

11. The preschool application process, eligibility criteria, selection process and locations vary by program and may be subject to change.

Thank you for your interest in Your Child's World Learning Center, Inc.'s PreK program. The information and documentation you provide with your child's *PreK Application* will assist our office in determining your eligibility for the Head Start, PHL PreK and/or the PA Pre-K Counts program. Completing and submitting a *PreK Application* does not guarantee that your child will be accepted to a PreK program.

Please submit your child's complete application **by 7/1 of the enrolling year**.

To apply:

1. Complete and submit the enclosed application forms. All forms are completed by the parent/guardian, with the following exceptions:

   ☐ *Child Health Assessment/Physical Exam Form* – completed by your child's doctor – physical exam date must be within the past twelve (12) months – complete immunization record must be included

   ☐ *Dental Health/Dental Exam Form* (Page 31) – completed by your child's dentist – dental exam date must be within the past twelve (12) months

2. Make a copy of and submit the following five (5) required supporting documents:

   ☐ **1**. Proof of your child's date of birth (birth certificate, court document, passport)

   ☐ **2**. Your child's health insurance card

   ☐ **3**. Current proof of PA address in the primary parent's/guardian's name (utility bill, mortgage, deed, rental/lease agreement, property tax bill, notarized statement of current address)

   ☐ **4**. Current state or federal photo ID of the primary parent/guardian

   ☐ **5**. Eight (8) current and consecutive weeks of gross income received by the primary parent, secondary parent and all children. Income to submit includes, but is not limited to, gross earnings from the following income sources: employment, self-employment, Social Security, SSI, unemployment compensation, workmen's compensation, child support, alimony/spousal support, TANF Cash Assistance, financial support from a friend or family member, retirement/pension, commission, tips, strike benefits, veteran's benefits, scholarship/grant/stipend, military allotment, rental properties and all other sources of income;

   ☐ **If you are paid in cash or with a hand-written personal or business check**: submit an original notarized statement from your employment supervisor or business owner indicating: the date, the business name/address/telephone number; your name; your position; the number of hours you work per week or your time schedule from the past 8 weeks; your gross income for each time period; the signature/title/contact telephone number of the individual writing the statement; the notary's seal and notary's signature

   ☐ **If you are self-employed, receive a 1099 or are responsible for paying your own taxes**: submit your family's entire previous year Federal Income Tax Return (to validate, your hand-written signatures must be included);

☐ **If you receive financial support from a friend or family member** (a friend or family member regularly gives you money to help you support your family): submit an original notarized statement, completed by this individual, indicating: the date, the individual's name; your name; your child's name; the dollar amount and frequency of financial support they provide to you; the notary's seal and notary's signature;

NOTE: If 8 weeks of income is not available, submit the income that you have. We will evaluate your information and notify you if other income documents are needed.

3. Make a copy of and submit the following supporting documents (required, if the situation applies to you, your child and/or your family):

☐ Verification of SNAP Food Stamps and/or Medical Assistance benefits – submit your family's current and complete COMPASS Report from the welfare office;

☐ Current custody arrangement;

☐ Documentation of child's foster care or kinship care placement;

☐ Documentation of guardianship;

☐ Child's Individualized Education Plan (IEP), Evaluation Report (ER), Individualized Family Service Plan (IFSP) from an Early Intervention provider (Child Link, ELWYN, ELWYN Seeds); ☐ Early Head Start letter.

PRESCHOOL INFORMATION

1. Operation of Your Child's World Learning Center, Inc.'s PreK programs is contingent upon The Your Child's World Learning Center, Inc. receiving Federal Head Start, Pennsylvania Pre-K Counts and PHL PreK funds. If it becomes necessary to make changes to the program, or if changes occur to the eligibility requirements, applicants' families will be notified by mail.

2. A family is applying for all PreK programs at the applicable location. Your Child's World Learning Center, Inc. will determine which program a family qualifies for and will enroll based on the eligible programs availability
   a. An initial family meeting is required for all families applying to PreK programming.

3. Selection process for all PreK program:
   a. Eligible children are selected based on a child's age, family income and the family's need for preschool services, not to exceed the maximum capacity in each location.
   b. When a complete *PreK Application* is received:
      i. Eligible children are considered for acceptance during the initial selection process;
      ii. Eligible children are considered for acceptance to fill remaining vacancies after the initial school year selection process has concluded;
      iii. ii. Parents/Guardians are notified by mail, email or telephone call of their child's acceptance or wait-list status within six (6) weeks following the date that program eligibility is determined.
   c. Eligible children's names are placed on the *PreK Waiting List* when they are not accepted to a PreK and will be considered for acceptance when a vacancy occurs in a selected location.
4. Healthy eating habits contribute to a child's overall well-being and helps them to grow up strong and healthy. Your Child's World Learning Center, Inc. sponsors the Child and Adult Care Food Program (CACFP) to provide daily nutritious meals and snacks to enrolled PreK children, at no cost to families.

   To ensure the safety of our students with food allergies, children are not allowed to bring food and/or beverages to school.

   Foods containing pork, peanuts or tree nuts will never be offered to your child.

#1: CHILD and FAMILY INFORMATION FORM

The information and documentation you provide will assist in determining your eligibility for PreK programming. 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

*****All children must be dropped off to school and picked up from school on time. A Late fee of $1.00 per minute per child begin 2 mins after school end.*****

5837 N. 2nd Street, Philadelphia, PA 19120 – Head Start
7120 N. Broad Street, Philadelphia, PA 19126 – PreK Counts, PHL PreK
6595A Roosevelt Blvd, Philadelphia, PA 19149 – PreK Counts, PHL PreK, Head Start
1052 Easton Rd., Abington, PA 19001 – PreK Counts
2406 S 71st Street, Philadelphia, PA 19146 – PreK Counts, PHL PreK, Head Start

Section 2: CHILD

First Name:	Last Name:	
Date of Birth:	Gender: O Male O Female	
Address:	Apt./Unit #:	Zip Code:

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

Primary language:	Other language(s):	
English is spoken in the home.	O Yes	O No

Child's English skills: O Very well O Well O Not well O Does not speak English

Primary Parent/Guardian:	Date of Birth:	
Parent has an active custody arrangement for this child.	O Yes	O No

Child lives with (select all that applies): O Mother O Step-Mother O Foster Parent/Kinship Parent O Father O Step-Father O Grandparent O Relative O Other

Mother Complete if child does not live with his/her mother	Name:
	Address:
	Contact phone #:
Father Complete if child does not live with his/her father	Name:
	Address:
	Contact phone #:

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 or any-other agency.	O Yes	O No
If 'Yes', indicate which Early Intervention services your child is receiving (select all that applies): O Speech Therapy O Special Instruction O Physical Therapy O Occupational Therapy O Other		
Child wears diapers and/or pull-ups.	O Yes	O No
If 'Yes', when (select all that applies): O Daytime O Naptime O Nighttime O Other (specify):		
If 'Yes', will child be able to use the toilet with little adult assistance while in preschool?	O Yes	O No
Child is/was in preschool or daycare. O No O Yes – name:		
If 'Yes', is your child still attending preschool/daycare? O Yes O 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 Your Child's World Learning Center, Inc.'s PreK program? (select all that applies):

O Another child attended the program O Neighbor O Family Member O Doctor's Office O Radio
O Informational Flyer O Library O Facebook O Supermarket AD O Other

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: O Male O Female
Primary language:	Other language(s):

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

Home Phone#:	Cell Phone #:
Email Address (please print clearly):	
Alternate Phone #:	Alternate Phone # belongs to:

Best way to reach you during the day: Select all that applies	O Home Phone #	O Cell	O Work Phone #	O School Phone #
	O Alternate Phone #	Phone # O Email O	O Other (specify):	

Marital Status Select one	O Married	O Separated	O Divorced	O Widowed
	O Single	O Other (specify):		

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

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

Status Select all that applies	O Single Parent – cares for the child without physical or financial assistance from the other parent	O Teen Parent – parent was under the age of 18 when child was born	
	O Refugee - fleeing other country in order to escape war, persecution, or natural disaster, etc with granted asylum.	O Asylum Seeker - fleeing other country in order to escape war, persecution, or natural disaster, etc. awaiting asylum.	O Migrant – nonimmigrant

Does your family receive welfare benefits?	O Yes O No O Previously
If 'Yes', your record/case # (NOT the # on your EBT card):	**51/**_____ _____ _____ _____ _____ _____ _____
If 'Yes', which benefits are received?	O TANF Cash Assistance O SNAP Food Stamps O Medical Assistance
Does your family receive WIC?	O Yes O No O Previously

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

Child's Name:	Date of Birth:

Section 3: PRIMARY PARENT, continued

Does your family receive WIC?	O Yes	O No	O Previously

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

Employment, School, Job Training Select all that applies			
	O Employed/Self-Employed	O Unemployed/Not Employed	O Disabled
	O In School/Job Training Program	O Stay-at-Home Parent	O Retired
	O Member of the U.S. military on active duty	O 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 #:	
	What type of work do you do?		
	How often are you paid?	O Every week	O Every 2 weeks	O Twice a month
		O Once a month	O 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?	O Yes	O No
If 'Yes', please list your disabilities:		
Do you have health insurance?	O Yes	O No
If 'Yes', name of health insurance provider:		

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

During the past 12 months, I/we have moved from temporary to permanent housing.	O Yes	O No
During the past 2 years, I/we have moved into a new house.	O Yes	O No
Do you have a mental health concern?	O Yes	O No
Do you have a social concern (English language learner, eating disorder, custody issues, etc.)?	O Yes	O No
If 'Yes', please list your concerns:		

Child's Name:	Date of Birth:

Section 4: SECONDARY PARENT

An adult who shares in the care of the child.

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

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	O Home Phone #	O Cell Phone #	O Work Phone #	O School Phone #
	O Alternate Phone #	O Email	O Other (specify):	
Marital Status Select one	O Married	O Separated	O Divorced	O Widowed
	O Single	O Other (specify):		
Relationship to Child Select one	O Parent/Step-Parent		O Grandparent	
	O Foster/Kinship Parent, related to child		O Foster Parent, not related to child	
	O Guardian, related to child		O Guardian, not related to child	
	O No Relation	O Other (specify):		
Relationship to Primary Parent Select one	O Spouse – husband/wife	O Companion/Partner		
	O Other (specify):			
Race/Ethnicity Select all that applies	O Hispanic or Latino/a	O American Indian	O Asian	
	O Black or African American	O Multi-Racial or Bi-Racial	O Native Hawaiian	
	O Pacific Islander	O White	O Other (specify):	
Status Select all that applies	O Lives with child	O Provides financial support to child's family		
	O Does not live with child	O Teen Parent – parent was under the age of 18 when child was born		
	O Migrant Parent – non-immigrant	O Refugee Parent - fleeing other country in order to escape war, persecution, or natural disaster		
Education Select highest Diploma/Degree earned or highest Grade Level completed	O High School Diploma	O GED	O Vocational Degree	
	O Associates Degree	O Bachelors Degree	O Masters Degree	
	O Doctorate Degree	O Some College	O ESL – English as a Second Language	
	O 11th Grade	O 10th Grade	O 9th Grade or lower	
	O Other (specify):			

Child's Name:			Date of Birth:
Section 4: SECONDARY PARENT, continued			
Employment, School, Job Training Select all that applies	O Employed/Self-Employed	O Unemployed/Not Employed	O Disabled
	O In School/Job Training Program	O Stay-at-Home Parent	O Retired
	O Member of the U.S. military on active duty	O 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 #:	
	What type of work do you do?		
	How often are you paid?	O Every week / O Every 2 weeks	O Twice a month
		O Once a month / O 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?		

Question		
Do you have a disability or disabilities?	O Yes	O No
If 'Yes', please list your disabilities:		
Do you have health insurance?	O Yes	O No
If 'Yes', name of health insurance provider:		
Do you have a mental health concern?	O Yes	O No
Do you have a social concern (English language learner, eating disorder, custody issues, etc.)?	O Yes	O No
If 'Yes', please list your concerns:		

Please share any additional information about the Secondary Parent that you would like us to know.

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.		
5.		
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.

O Employment	O Self-Employment	O Unemployment Compensation	O Workmen's Compensation
O Social Security	O SSI	O Child Support	O Alimony
O TANF Cash Assistance	O Commission	O Foster Care/Kinship Care	O Tips
O Pension/Retirement	O Veteran's Benefits	O Strike Benefits	O Scholarship/Grant/Stipend
O Financial support from Family or Friend – a family member or friend gives you money on a regular basis to help you support your family			
O Military	O Rental Properties – someone pays you rent	O 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 deliberate misrepresentation of my/our information may subject me/us to prosecution under applicable Federal and/or State laws and that, if enrolled, my/our child's participation in the preschool program may end. I/We have attached a copy of my/our child's proof of date of birth, verification of my/our PA address and copies of all income and monthly benefits that I/we and my/our children receive. I/We understand that this information is required so that my/our eligibility can be determined for Your Child's World Learning Center, Inc.'s PreK program. I/We understand that officials from Your Child's World Learning Center, Inc. and affiliates will have access to and may verify the information and supporting documentation submitted with my/our *PreK Application*. I/We further understand that, if necessary, additional documents may be requested and I/we will comply with this request. I/We understand that my/our child's complete *PreK Application* is confidential and will be held in strict confidence within Your Child's World Learning Center, Inc. and affiliated Agencies that have been determined to be school officials under the Family Educational Rights and Privacy Act with legitimate educational interests as part of Your Child's World Learning Center, Inc.'s PreK program.

____ ________________
Signature of Primary Parent Date

____ ________________
Signature of Secondary Parent Date

Picture Consent

I, ____________________________________ give Your Child's World Learning Center, Inc. consent to take my child's picture and use the image in observation notes, YCW publications and its affiliates.

Signature: ____ Date: ________________

CHILD'S MEDICAL CONCERNS FORM

Child's Name ____ Date of Birth ____________

Dear Parent/Guardian,

Your Child's World Learning Center, Inc. recognizes the fact that some children have a medical condition that requires prescribed medication. When the prescribed medication is to be administered during PreK hours, a representative from YCW health consultant team, with written permission, will train the staff at your child's PreK location to administer the medication to your child. Written permission is given by submitting form 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 Request for Administration of Medication.**

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

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**

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

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to immediately inform the Center Director if there is any change to the above information.

____ _____________

Signature of Parent/Guardian Date

POLICIES and CONSENT for EMERGENCY MEDICAL CARE and OTHER HEALTH SERVICES FORM

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

Child's Name ____ Date of Birth _______________

EMERGENCY MEDICAL CARE POLICIES

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

In the event your child becomes seriously ill or injured and requires immediate medical attention, s/he will be accompanied by staff and taken to the nearest hospital emergency room in an emergency medical vehicle. We will attempt to notify you at once. Under the Medical Services/Minor Act, immediate emergency treatment will be initiated at the hospital. However, it is essential that your child's teacher and the hospital is able to locate you as soon as possible, to give either written or monitored verbal permission for comprehensive treatment. Please be sure to keep your child's teacher informed about how to reach you at all times.

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

A Doctor's note is required before your child can return to preschool if s/he has any of the following: an emergency room visit, certain cases of illness (contagious, serious, requires a long absence, surgery, etc.), or certain cases of injury (needing doctor's care, cast or brace, special activities, etc.). If you have any doubt, please obtain a Doctor's note whenever your child goes for medical care.

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

My signature below indicates that I understand the Emergency Medical Care Policies and give consent for:

1. The administration of minor first aid to my child by preschool classroom staff;
2. The emergency medical and/or dental care which may be necessary to preserve the life of my child or to prevent impairment of his/her health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for on-going care;
3. My child to participate in the 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 ALL in PreK programs receive screenings during the school year;
4. Mental Health Consultation Services to provide services on an as needed basis. These services may include:
    a. Observation of my/our child in the preschool setting and consult with teaching staff regarding strategies and techniques to support my/our child's healthy social/emotional development;
    b. Conduct assessments and behavioral/developmental screenings, using standardized tools, across all domains of my/our child's development;
    c. Provide behavioral health consultation services to my/our child and his/her teacher within the early childhood facility;
    d. My/Our invitation to participate in team meetings and action plan development for my/our child's social/emotional well-being, where I/we will be provided with information about child-related issues and resources within my/our community that could be helpful.

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

____ _______________

Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: ____

Signature of Early Childhood Staff: ____ Date: ___________

CHILD'S DIETARY or FOOD RESTRICTIONS FORM

Child's Name ____ Date of Birth _______

Dear Parent/Guardian,

The Child and Adult Care Food Program (CACFP) provides a daily nutritional breakfast, lunch and snack for your child while enrolled in preschool at no cost to families. A monthly menu, posted in each location, lists the foods and beverages that your child is offered at each meal. The Office of Early Childhood Education recognizes the fact that certain foods, due to medical, religious or other reasons, are restricted from some children's diets. Please tell us about your child. This information will be shared with your child's nutritional, health and instructional staff. If your child has a non-disabling dietary restriction, efforts will be made to provide your child with an allowable substitution.

If your child has a food allergy which requires the administration of an **EPI-PEN, Benadryl or other medication**, please let us know immediately so that we can begin the process required to train the preschool staff.

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

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

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

1. Name of restricted food:

Reason for restriction: ☐ Religious ☐ Other (please specify)___________________

☐ Medical – please indicate reaction and treatment: _____________________________

2. Name of restricted food:

Reason for restriction: ☐ Religious ☐ Other (please specify)___________________

☐ Medical – please indicate reaction and treatment: _____________________________

The information on this form is true to the best of my knowledge. I will inform my child's teacher if any of this information changes.

____ ____________

Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: ____

Signature of Early Childhood Staff: ____ Date: ______________

CHILD and ADULT CARE FOOD PROGRAM (CACFP) GENERAL INFORMATION

Please keep this page for your records.

Dear Parent/Guardian,

Your child's center participates in the Child and Adult Care Food Program (CACFP) under the sponsorship of Your Child's World Learning Center, Inc.

CACFP requires the completion of 2 forms: *Child Enrollment Form* and *Meal Benefit Income Eligibility Form*. Your cooperation in carefully and accurately completing these forms facilitates the SDP's participation in CACFP. This information is necessary so that SDP may receive reimbursement for the meals served to enrolled preschool children. If you need help completing these forms, please do not hesitate to contact our office for assistance. Your child will receive free meals and snacks on the days they attend preschool at no cost to you. All meals provided through CACFP must meet nutritional standards established by the United States Department of Agriculture (USDA).

Meal Benefit Income Eligibility Form: When completing the *Meal Benefit Income Eligibility Form,* please be aware that the USDA defines a household as a group of related or unrelated individuals who share living expenses. Therefore, the income reported on this form must include the gross income (before deductions for taxes) of all members of your household. The reported income must be the total gross income listed by each income source that each household member received last month. [For the self-employed (self-owned businesses, farm or rental income), report income after expenses (net income)]. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the chart below, SDP receives a higher level of reimbursement for the meals and snacks served to your child.

CACFP Income Eligibility Guidelines

Household Size	Yearly Income		Household size	Yearly Income		Household size	Yearly Income
2	$30,044		4	$45,510		6	$60,976
3	$37,777		5	$53,243		7	$68,709

Households currently receiving SNAP (Supplemental Nutrition Assistance Program; formerly Food Stamps) **or TANF** (Temporary Assistance for Needy Families): you may provide the nine-digit SNAP or TANF record number issued by the County Assistance Office and the name of the adult household member associated with this SNAP or TANF record number. **You cannot use the numbers on your Medical Assistance or EBT Access Cards.**

Households that do not receive SNAP or TANF, or who did not provide their nine-digit SNAP or TANF record number and household member's name: list the names of all household members, the gross income (before deduction of taxes) each household member received last month, how often and from what source the income was received. If a household member is in the military, please contact our office or guidance on reporting his/her allowances and income. An adult household member must sign and date the form and include the last four numbers of his/her Social Security Number, or indicate that s/he does not have a Social Security Number.

Foster Children: To be considered a foster child, the child's care and placement is the responsibility of the State. The child has been an adjudicated dependent by the court and placed in the custody of the county children & youth agency; the child is formally placed by the county agency or a court with a caretaker household. (Foster children formally placed in kinship care by the county agency or a court are included in this group. It does not apply to informal arrangements that may exist outside of State or courtbased systems.) When applicable, households providing foster care can include the foster child as a member of the household along with non-foster children in the household; please contact our office for specific guidance on how to handle this situation.

NONDISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(2) Fax: (202) 690-7442; or
(3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

PRIVACY ACT STATEMENT: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, Your Child's World Learning Center, Inc. might not have the opportunity to receive free or reduced-price Federal reimbursement for the meals and snacks we offer your child. The adult household member who signs this application must provide the last 4 digits of his/her Social Security Number. The Social Security Number is not required when you apply on behalf of a foster child; if a Food Stamp (SNAP) or a Temporary Assistance for Needy
Families (TANF) cash assistance record number is listed; or if the adult household member signing the application has indicated s/he does not have a Social Security Number. We will use your information for administration and enforcement of the CACFP Program and to determine the level of funding that will be received.

CHILD ENROLLMENT FORM
Child and Adult Care Food Program (CACFP)

Section 1: FAMILY INFORMATION

Child Name ____ Date of Birth _______________

Parent/Guardian Name(s) ____

Address ____ Apt/Unit # ______________ Zip _____________

Telephone (Home) ___________________________________ (Cell) ____________________________________

Section 2: PARENTAL CONTACT INFORMATION

A representative from Your Child's World Learning Center, Inc. and/or the State Agency may contact you to verify your child's participation in CACFP. Please place a check mark next to the time and method of contact you prefer and complete as necessary:

Telephone: ___ I prefer to be contacted by telephone. The best time to contact me is during the:

___ Day (9:00 AM – 5:00 PM) at this phone number _____________________________

___ Evening (6:00 PM – 9:00 PM) at this phone number ___________________________

U.S. Mail ___ I prefer to be contacted by U.S. mail at the address listed above.

Section 3: ORGANIZATION INFORMATION

Sponsoring Organization:
Your Child's World Learning Center, Inc.
2400 S. 71st Street
Philadelphia, PA 19149

Participating Location:
Your Child's World Learning Center, Inc.

Section 4: EXPECTED DAILY HOURS OF SERVICE (hours may vary slightly, depending on location)

- ☐ Monday to Friday: 8:00 AM – 2:00 PM PHL PreK
- ☐ Monday to Friday: 8:30 AM – 2:30 PM PreK Counts, Head Start

Section 5: EXPECTED DAILY MEAL SERVICE PARTICIPATION (times may vary slightly, depending on location)

Breakfast: Offered 8:00 AM – 9:00 AM
Lunch: Offered 11:00 AM – 12:30 PM
Afternoon Snack: Offered 1:00 PM – 2:00 PM

Section 6: SIGNATURE

The information provided on this *Child Enrollment Form* accurately represents my family's expected participation in the CACFP. When changes occur, I agree to inform the Office.

____ ___________________

Signature of Parent/Guardian Date

NONDISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

MEAL BENEFIT INCOME ELIGIBILITY FORM
Child and Adult Care Food Program (CACFP)

The information you provide on this form determines the level of reimbursement Your Child's World Learning Center, Inc. receives from the Child and Adult Care Food Program (CACFP). Regardless of the income information you provide, you will never be asked to pay for any breakfast, lunch or afternoon snack your child eats while attending preschool.

Section 1: CHILD INFORMATION

Full Name ____Date of Birth _______________

Gender ☐ Male ☐ Female Is this child a foster child? ☐ No ☐ Yes; if 'Yes', proceed to Section

Foster Child Information: To be considered a foster child, the child's care and placement is the responsibility of the State. The child has been an adjudicated dependent by the court and placed in the custody of the county children & youth agency; the child is formally placed by the county agency or a court with a caretaker household.

Section 2: HOUSEHOLDS RECEIVING SNAP [Supplemental Nutrition Assistance Program (Food Stamps)] or TANF [Temporary

Assistance for Needy Families (Cash Assistance)]: If an adult member of your household has an active SNAP (Food Stamps) or TANF (Cash Assistance) account, you may give his/her active SNAP or TANF record number. If you complete this Section, you are not required to complete Section 3, but must complete Section 4.

☐ Yes, an adult member of my household has an active SNAP (Food Stamps) or TANF (Cash Assistance) account.

Name of this adult household member (print) ____

SNAP or TANF Record Number _____ _____ /_____ ______ ______ ______ ______ ______ ______

Section 3: HOUSEHOLD MEMBERS and GROSS INCOME – For households that do not receive SNAP/TANF, or who did not provide their nine-digit SNAP/TANF record number and household member's name, CACFP requires you to tell us who lives with you, who receives income and how much income they receive. In the HOUSEHOLD MEMBERS column, clearly print your full name, your child's full name and the full name of every other adult and child who lives with you. For each household member who receives income, locate the column that best describes a source of income that is received. Enter the dollar amount received (before taxes are taken out) and how often the income is received – every week, every 2 weeks, twice a month, monthly, yearly. If income is received from more than one source, complete each appropriate income column. If a household member does not receive any income, place an 'X' in the NO INCOME RECEIVED column. Use additional paper if necessary.

NOTE: for self-employed individuals (own their own business/pay their own taxes) enter the NET income (gross receipts minus allowable expenses).

HOUSEHOLD MEMBERS First and Last Names	GROSS INCOME RECEIVED FROM: Employment (before deductions), Self-Employment	GROSS INCOME RECEIVED FROM: Welfare, Child Support, Alimony	GROSS INCOME RECEIVED FROM: Social Security, SSI, Pensions, Retirement, Veteran's benefits	GROSS INCOME RECEIVED FROM: Unemployment, Workmen's Comp, Strike benefits, Rental properties, Other	NO INCOME RECEIVED
	AMOUNT / HOW OFTEN	AMOUNT / HOW OFTEN	AMOUNT / HOW OFTEN	AMOUNT / HOW OFTEN	x
1.	$ /	$ /	$ /	$ /	
2.	$ /	$ /	$ /	$ /	
3.	$ /	$ /	$ /	$ /	
4.	$ /	$ /	$ /	$ /	
5.	$ /	$ /	$ /	$ /	
6.	$ /	$ /	$ /	$ /	
7.	$ /	$ /	$ /	$ /	

Section 4: SIGNATURE and LAST 4 NUMBERS of SOCIAL SECURITY NUMBER - An adult household member must sign this form and provide the last 4 numbers of his/her Social Security Number; however, if Section 2 on Page 23 was completed in full, the last 4 numbers of the Social Security Number are not needed. If the adult does not have a Social Security Number, mark the "I do not have a Social Security Number" box. (For additional information, see Privacy Act Statement)

I certify that all information on this form is true and that the SNAP/TANF record number/household member's name is correct or that all income is reported. I understand that Your Child's World Learning Center, Inc. will receive Federal funds based on the information I give. I understand that CACFP officials may verify the information on this form, and that deliberate misrepresentation of the information may cause the enrolled child to lose meal benefits and may subject me to prosecution. The information provided on this form accurately represents the child's family's expected participation in the CACFP. When changes occur, I agree to inform Your Child's World Learning Center, Inc.

____ ___________________

Signature of Adult **Date**

____

Printed Name of Adult

Last 4 numbers of your Social Security Number _____ _____ _____ _____ ☐ I do not have a Social Security Number.

Address ____ Apt/Unit # _____________________

Philadelphia, PA Zip Code: ____________ Is this address a homeless shelter? ☐ Yes ☐ No

Contact Phone # ____

Section 5: CHILD'S ETHNIC and RACIAL IDENTITIES: Providing this information is voluntary and does not affect your child's ability to receive free meals and snacks while attending preschool. This information will be used to determine whether or not Your Child's World Learning Center, Inc. is complying with applicable provisions of Title VI of the Civil Rights Act of 1964. If you do not provide this information, a representative of Your Child's World Learning Center, Inc. is required to visually identify the ethnic and racial identities of your child.

Mark ONE Ethnic Identity:

☐ Hispanic or Latino/a

☐ Not Hispanic or Latino/a

Mark ONE or MORE Racial Identities (in addition to an Ethnic Identity):

☐ Black or African American

☐ American Indian or Alaska Native

☐ White

☐ Native Hawaiian or Other Pacific Islander

☐ Asian

☐ Other ________________________________

Completed by a Your Child's World Learning Center, Inc. Representative

☐ Identified by Adult Household Member ☐ Visual Identification by a Your Child's World Learning Center, Inc. Representative

Section 6: NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
Fax: (202) 690-7442; or
E-mail: program.intake@usda.gov
Your Child's World Learning Center, Inc. is an equal care provider.

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, Your Child's World Learning Center, Inc. might not have the opportunity to receive free or reduced priced Federal reimbursement for the meals and snacks that are offered to your child. The adult household member who signs this application must provide the last 4 numbers of his/her Social Security Number. The Social Security Number is not required when you apply on behalf of a foster child; if a Food Stamp (SNAP) or a Temporary Assistance for Needy Families (TANF) cash assistance record number is listed; or if the adult household member signing the application has indicated that s/he does not have a Social Security Number. We will use your information for administration and enforcement of the CACFP Program and to determine the level of funding that will be received.

Section 7: REIMBURSEMENT INFORMATION

Your Child's World Learning Center, Inc. may receive reimbursement for free or reduced-priced meals if your household income falls within the limits on this chart:

CACFP Income Eligibility Guidelines

Effective July 1, 2017 – June 30, 2018

Household Size	Yearly Income		Household size	Yearly Income		Household size	Yearly Income
2	$30,044		4	$45,510		6	$60,976
3	$37,777		5	$53,243		7	$68,709

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 *PreK Application* is accurate and complete. I/we have signed all application forms where indicated and have included copies of all required supporting documents. Deliberate misrepresentation of my/our information may subject me/us to prosecution under applicable Federal and/or State laws and that if enrolled, my/our child's participation in the preschool program may end.
2. I/We understand that:
   a. The information contained in my/our child's *PreK Application* will be held in strict confidence within Your Child's World Learning Center, Inc. that have been determined under the Family Educational Rights and Privacy Act with legitimate educational interests as part of The PreK program.
   b. Completing and submitting a *PreK Application* does not guarantee that my/our child will be accepted to a PreK program.
   c. Before my/our child's first day in PreK:
      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 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 little 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. S/He may be removed from enrollment and placed on the waiting list due to excessive absences, chronic late arrival to school and/or chronic late pick-up from school;
   f. I/We will keep my/our child's information current and inform his/her teacher and the Office of Early
      Childhood Education of any changes;
   g. 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

Your Child's World Learning Center, Inc.

PreK Program Emergency Contact and Agreement

Child's Name		**Date of Birth:**	
Address:		____________________, PA _____________	
Mother's Name ○ **Foster Parent** ○ **Legal Guardian**		**Contact Numbers** **Cell:** _____________________________________ **Home:** _____________________________________ **Work:**	
Home Address:		____________________, PA _____________	
Work Address:		____________________, PA _____________	
Father's Name ○ **Foster Parent** ○ **Legal Guardian**		**Contact Numbers** **Cell:** _____________________________________ **Home:** _____________________________________ **Work:** _____________________________________	
Home Address:		____________________, PA _____________	
Work Address:		____________________, PA _____________	
Child's Physician		**Phone Number**	
Physician Address:			

EMERGENCY CONTACTS AND PERSONS AUTHORIZED TO PICK CHILD:

Each person you authorize to pick up your child **must be 18 years or older and have a valid ID.**

Contact/Escorts Name	**Address**	**Phone Number**	**Parent's Initial and date authorized**

Allergies:	**Medical Conditions/Disabilities:**
Medications taken at home:	**Medications given to school with physician request and medication log completed:**
Nutrition/Dietary Restrictions	**Health Insurance Name and Policy Number**

Child's Name: ___________________________ **Date of Birth:** ___________________________

SIGN FULL SIGNATURE IN EACH BOX BELOW TO GIVE CONSTENT:	
Daily Walks	**X**
Transportation by the facility	**X**
Obtaining Emergency Medical Care	**X**
Administration of Minor First Aid Procedures	**X**
Photos (To be use by YCW and Affiliates)	**X**

AGREEMENT

Services provided by Your Child's World Learning Center, Inc. for the below fee:	
($0.00 weekly fee)	
PLUS the cost of Trips/Activity Fee (Determined per trip and parent will be notified in advance.)	
Breakfast, Lunch, PM Snack (Must complete CACFP form application)	*All meals must be eaten at school and cannot be taken off school site excluding trips.
Families will receive information in regard to growth and development about their child.	
Parent Agrees to the following:	
Pay weekly fees on the Monday of the service week regardless of the number of days attended or vacation.	
If parent receives child care assistance, parent agrees to pay the total fees owed if CCIS, DHS, or any other funding agency fails to pay.	
Parent received the parent handbook and will review and adhere to all the information.	
Update Emergency Contact and Agreement every 6 months and whenever a change occurs.	
Inform the schools Adm. whenever changes occur and provide proof of change if necessary and when requested.	
Keep your child home if your child has any signs of illness and/or cannot complete regular daily activities for whatever reason.	
Update dental forms every 6 months	Update health assessment/report forms every 12 months
☐ **8:00AM PHL** ☐ **8:30AM PreK Counts, Head Start**	☐ **2:00PM PHL** ☐ **2:30PM PreK Counts, Head Start**
Ensure that no outside food is brought to school.	Label all items sent to school.
Call when child is absent.	If child is absent 2 or more days, provide a Dr. note prior to returning.

Parent's Full Signature: X ____

Print Name: X ____

Parent Email Address:
X

Date: X ______________________

Director's Full Signature: X ____

Print Name: X ____

START DATE:_____________________________________ **TERM DATE:** __________________________________

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): ❑ **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).

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:

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.

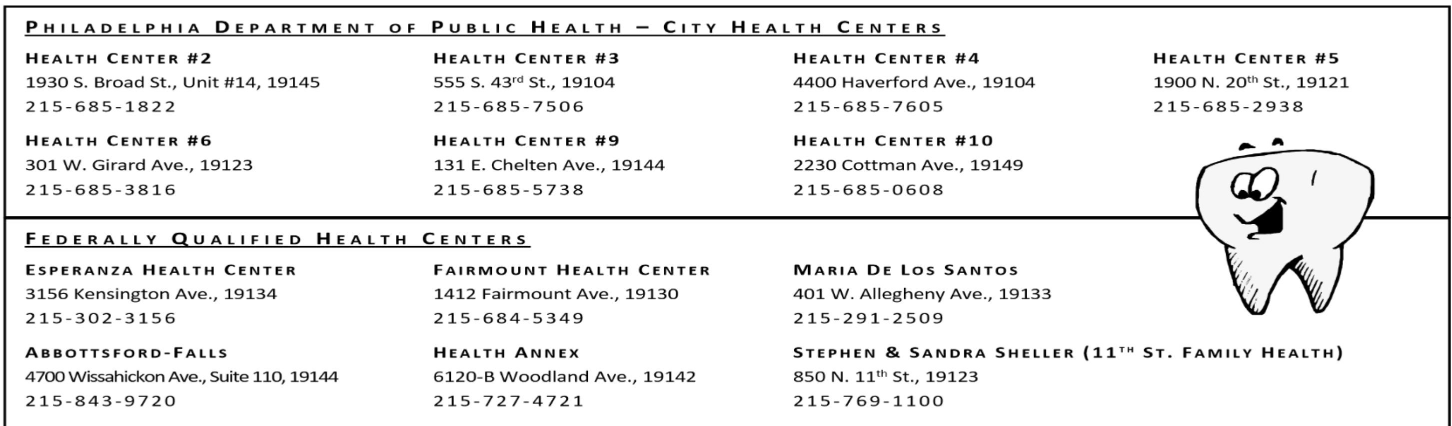
Dentist's Signature ____

Date _____________

IT'S TIME TO GO TO THE DENTIST!

Please Note:

- Addresses and phone numbers may change over time; call before visiting any of the providers listed below.
- For additional dental providers and/or information, please refer to the following: ○ 1-800-DENTIS (Toll-free, nationwide)
  - 215-925-6050 – Philadelphia County Dental Society (for private dentists in your area)
  - American Academy of Pediatric Dentistry - www.aapd.org ○ American Dental Association - www.mouthhealthy.org
  - PCCY (Public Citizens for Children and Youth) - 215-563-5848 - www.pccy.org/issues/child-health/dental ○ Philadelphia Department of Public Health - www.phila.gov/health/services/Serv_DentalCare.html



Philadelphia Department of Public Health – City Health Centers

Health Center #2	Health Center #3	Health Center #4	Health Center #5
1930 S. Broad St., Unit #14, 19145 215-685-1822	555 S. 43rd St., 19104 215-685-7506	4400 Haverford Ave., 19104 215-685-7605	1900 N. 20th St., 19121 215-685-2938
Health Center #6	**Health Center #9**	**Health Center #10**	
301 W. Girard Ave., 19123 215-685-3816	131 E. Chelten Ave., 19144 215-685-5738	2230 Cottman Ave., 19149 215-685-0608	

Federally Qualified Health Centers

Esperanza Health Center	Fairmount Health Center	Maria De Los Santos
3156 Kensington Ave., 19134 215-302-3156	1412 Fairmount Ave., 19130 215-684-5349	401 W. Allegheny Ave., 19133 215-291-2509
Abbottsford-Falls	**Health Annex**	**Stephen & Sandra Sheller (11th St. Family Health)**
4700 Wissahickon Ave., Suite 110, 19144 215-843-9720	6120-B Woodland Ave., 19142 215-727-4721	850 N. 11th St., 19123 215-769-1100

St. Christopher's
Pediatric Dentistry
3601 A. St., 19134
215-427-5065

TEMPLE
School of Dentistry
3223 N. Broad St., 19140
215-707-2863

Penn Dental Medicine
Pediatric Dentistry
240 S. 40th St., 19104
215-898-8965

Cavity Busters
- 240 Geiger Rd., 19115 — 215-677-0380
- 6801 Ridge Ave., 19128 — 215-483-6633
- 1430 Snyder Ave., 19145 — 215-467-6000

Pediatric Dental Associates
- 6404 E. Roosevelt Blvd., 19149 — 215-743-3700
- 2301 E. Allegheny Ave., 19134 — 215-282-8000
- 3509 N. Broad St., 19140 - within Temple Hospital, Boyer Pavilion, 6th Floor — 215-707-6411

Dental Dreams
- 2107-B Cottman Ave., 19149 — 215-235-4060
- 5675 N. Front St., 19120 — 215-224-0440
- 2459 Aramingo Ave., 19125 — 215-427-2800

Kids Smiles
- 5828 Market St., 19139, Entrance B — 215-747-6901
- 2821 Island Ave., 19153, Suite 210 — 215-492-9291

Douglas R. Reich, DMD
- 7122 Rising Sun Ave., 19111 — 215-725-8300