Your Child's World Learning Center, Inc.

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) 289-2026 FAX: (215) 924-6632
2406 S 71st Street, Philadelphia, PA 19146 PHONE: (215) 289-2026 FAX: (215) 924-6632

yourchildsworld@aol.com

Prekindergarten

Application

Return Completed Application

Your Child's World Learning Center, Inc.
Prekindergarten Program

Please Note: Completing and submitting an application does not guarantee enrollment.

In accordance with applicable Federal and State civil rights laws and regulatory requirements, you have the right to apply for services with the School District of Philadelphia and to be referred for services at other facilities without regard to your race, color, national origin, disability, age, sex and religion. You have the right to file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, national origin, disability, age, sex and/or religion. Complaints of discrimination may be filed with any of the following:

Bureau of Equal Opportunity
Southeast Regional Office
801 Market St. ~ Suite 5034
Philadelphia, PA 19107

Commonwealth of Pennsylvania
Human Relations Commission
110 N. 8th St
Philadelphia, PA 19107

Office of Civil Rights
U. S. Department of Health and
Human Services ~ Region III 150
S. Independence Mall West
Suite 436, Public Ledger Building
Philadelphia, PA 19106

Your Child's World Learning Center, Inc.
"Where Your Child Will Feel Free to Explore All Possibilities.
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Dear Parents and Guardians

Thank you for your interest in registering your child(ren) in Your Child's World Learning Center, Inc. Pre-Kindergarten program. Applications for the up-coming school year will be accepted on an ongoing basis.

Please complete the attached form, accompanied by supporting documentation to verify your income and child's age. Completed applications will take a minimum of two (2) weeks to be processed. Entry into the Head Start program is based on need, and applicants will be placed on a waiting list in order of need. All applicants will be notified by phone/mail whether their child has a space for the 2013-2014 school year or if their child will remain on the waiting list.

In order for us to determine your eligibility, we need to receive copies of the following information:

- Application: (Completed and signed)
- Proof of Child's age
- Proof of current income of Parent(s)/Guardian(s) of child (8 Weeks' Worth of Pay)
- Proof of Residency
- Child Custody information/documents (if applicable)
- An Individual Learning Plan (IEP) if your child has a disability (if applicable)
- Early Head Start Letter (if applicable)
- WIC ID (if applicable)
- Proof of food stamps (if applicable)
- Child's Health Insurance Card
- Picture ID of Parent/Guardian
- Health Assessment less than 1 yr. old.
- Dental Exam less than 6 months old
- Other Family/Health/Nutrition Information

Please see page 3, "Other Head Start Information" for more information on what documents can be used to meet these requirements.

These documents must be submitted to us before your application can be evaluated. Please submit COPIES only. Your child will not have the opportunity to be offered enrollment in the program nor have his/her name placed on the waiting list if his/her application is incomplete. To ensure that your application is complete, refer to the checklist at the end of your application.

Please submit your Head Start application and copies of all required documents by using the following methods:
Mail or Bring:

Your Child's World Learning Center, Inc.
Prekindergarten Location that you wish to enroll.

Your Child's World Learning Center, Inc.

ADDITIONAL PRE-KINDERGARTEN INFORMATION

1. Limited spaces are available. Completing and Submitting a Pre-Kindergarten application does not guarantee that your child will be accepted to the Pre-Kindergarten Program.
2. Head Start and Pre-K Counts are a FREE Prekindergarten program for children 3-5 years of age funded by the Federal Government or the State of Pennsylvania and the School District of Philadelphia.
3. Breakfast, Lunch, and PM Snack are provided to enrolled children at no cost to families.
4. Applications are reviewed using selection criteria to identify children and families with the greatest need for services in accordance with and guidance from the Federal Head Start Performance Standards and other regulations.
5. Parents will be notified if the centers selected are filled and their children's names will be placed on the waiting list. Parents will also be notified if their children are not eligible for the program along with the reasons for ineligibility.
6. Applications are valid only for the program year in which they are completed. If a child is age eligible for the next program year, parents will be notified to update all information for the new program year.
7. We determine whether you are eligible based on your family size and yearly gross income. We use the Federal Income Poverty Guideline issued each January in the Federal Register by the Department of Health and Human Services as our guide.
8. Your Child's World reserves the right to request additional documentation as necessary.
9. Failure to inform us 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 enrolled in the Pre-Kindergarten Program.

2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia:

Persons in Family	Head Start Income Maximum Guidelines	Pre-K Counts Income Maximum Guidelines
1	$11,770	$35,310
2	$15,930	$47,790
3	$20,090	$60,270
4	$24,250	$72,750
5	$28,410	$85,230
6	$32,570	$97,710
7+	add $4,160 for each additional person	add $12,480 for each additional person

Acceptable documents to process application:

Proof of Child's Age
Birth Certificate
Hospital record
Official document that verifies date of birth.

Proof of current income of Parent(s)/Guardian(s) of child	
Submit 8 weeks' worth of paystubs	Self-Employment-Tax Statement
1040 tax form (1st two pages)	Public Assistance letter or Compass Report
Social Security income letter	Unemployment verification
Written statement from employer or pay envelopes	Foster care letter from agency
Notarized letter of support from family member where you reside	Shelter placement letter for homeless students

Proof of Philadelphia Residency
Utility bill
Current voter's registration card
Rental agreement
WIC ID (If Applicable)
Proof of Food Stamps (If Applicable)
Child Custody Order (If Applicable)
Health Insurance Card

Note: In addition, other information (documentation) may be requested by the Social Service Coordinator, according to Federal regulations, in order to determine eligibility.

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #1: *FAMILY INFORMATION*

The information and documentation provided on this form will assist us in determining your eligibility for the Prekindergarten Head Start and/or the Pre-K Counts program. You are required to attach to this *Family Information* form copies of all income and monthly benefits that you, your husband/wife/companion/partner and all children receive. You are obligated to provide accurate and complete information.

Child's Name		**Date of Birth**	

SECTION 1: PRIMARY ADULT INFORMATION
(The Adult who is primarily responsible for the child)

First Name		**Last Name**	
Gender:	☐ Male ☐ Female	**Date of Birth**	
Is the Primary Adult Hispanic or Latino/a	☐ Yes	☐ No	
Primary Language			
Second Language			
Relationship to Child	☐ Parent	☐ Step-Parent	☐ Foster
	☐ Guardian	☐ No Relation	☐ Other (Specify)

Does your family receive benefits from the Department of Public Welfare (DPW)?	☐ Yes	☐ No
If Yes, your DPW Record/Case #: 51/____ ____ ____ ____ ____ ____ ____		
If Yes, which benefits? ☐ TANF Cash Assistance	☐ SNAP Food Stamps	☐ Medical Assistance
Does your family receive WIC?	☐ Yes	☐ No

Race (*check all that apply*): ☐ American Indian ☐ Asian ☐Black/African American ☐ Multi-Racial/Bi-Racial ☐ Native Hawaiian/Pacific Islander ☐ White ☐Other _____

Status (*check all that apply*):	☐ Single Parent	☐ Grandparent	☐ Lives with family	
	☐ Teen Parent	☐ Migrant Parent	☐ United States Citizen	
	☐ Married		☐ Not a United States Citizen	
Education (*Select highest level completed*):	☐ Doctoral	☐ Masters	☐ Some College	☐ 11th Grade
	☐ Bachelors	☐ Associates	☐ GED	☐ 10th Grade
	☐ Vocational	☐ ESL	☐ 12th Grade	☐ 9th Grade or

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #1: *FAMILY INFORMATION, continued*

Child's Name		**Date of Birth**	

SECTION 1: PRIMARY ADULT INFORMATION, continued

Employment, School, Job Training Select all that applies	□ Employed	□ In School	□ Unemployed
	□ Disabled	□ Homemaker	□ None
	□ Retired	□ Job Training	□ 12th Grade

Employer Information Complete if you are employed	Employer Name:			
	Address:			
	City:			State:
	Zip Code:		Phone#:	
	How often are you paid?	□ Every week	□ Every 2 weeks	□ Twice a month
		□ Once a month	□ Other (Specify)	

School/Job Training Complete if you attend school or a job training program	School/Job Training Name:	
	Address:	
	City:	State:
	Zip Code:	Phone#:

Home Address:				
Apt./Unit #:			Philadelphia, PA	Zip Code:
Home				
Home Phone#:				
Cell Phone#:				
Email Address:				
Alternate Phone#:				
Best way to reach you during the day:	□ Home Phone #	□ Cell Phone #	□ Work #	□ School Phone #
	□ Email	□ Other (Specify)		
Marital Status	□ Married	□ Single	□ Partner	□ Divorced
	□ Separated	□ Widowed	□ Other (Specify)	
Do you have a disability?			□ Yes	□ No
Do you have health insurance?			□ Yes	□ No
If 'Yes', name of health insurance company:				

Housing Information	□ Own	□ Rent	□ Transitional Housing
	□ Homeless	□ Shelter	□ Other (Specify)
	□ Living with friends/relatives		
	What date did you become homeless, or living in a shelter, transitional housing, or living with friends?		

During the past 12 months, I/We have moved from temporary to permanent	□ Yes	□ No
During the past 2 years, I/We have moved into a new house.	□ Yes	□ No
Do you have a mental health concern?	□ Yes	□ No
Do you have a social concern (English Language Learner, Eating Disorder, Custody Issues, Etc.)	□ Yes	□ No

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #1: *FAMILY INFORMATION*

Child's Name		**Date of Birth**	

SECTION 2: SECOND ADULT INFORMATION
(The husband, wife, companion or partner living with the Primary Adult)

First Name		**Last Name**	
Gender:	☐ Male ☐ Female	**Date of Birth**	
Is the Second Adult Hispanic or Latino/a	☐ Yes	☐ No	
Primary Language			
Second Language			
Relationship to Child	☐ Parent	☐ Step-Parent	☐ Foster
	☐ Guardian	☐ No Relation	☐ Other (Specify)
Relationship to Primary Adult	☐ Husband	☐ Wife	☐ Companion
	☐ Partner	☐ Other	(Specify)

Race (*check all that apply*): ☐ American Indian ☐ Asian ☐Black/African American ☐ Multi-Racial/Bi-Racial ☐ Native Hawaiian/Pacific Islander ☐ White ☐Other _____

Status (*check all that apply*):	☐ Migrant Parent	☐ Grandparent	☐ Lives with family
	☐ Single Parent	☐ Teen Parent	☐ United States Citizen
	☐ Married	☐	☐ Not a United States Citizen
Education (*Select highest level completed*):	☐ Doctoral Degree	☐ Grandparent	☐ Masters Degree
	☐ Bachelors Degree	☐ Associates	☐ Vocational Degree
	☐ ESL (English as a Second Language)	☐ GED	☐ Some College
	☐ 12th Grade	☐ 11th Grade	☐ 10th Grade
	☐ 9th Grade	☐ 8th Grade	

Employment, School, Job Training (*check all that apply*):	☐ Employed	☐ In School	☐ Job Training	☐ Unemployed
	☐ Disabled	☐ Homemaker	☐ Retired	☐ None
	☐ Member of the U.S. military on active duty			

Employer Information Complete if you are employed	Employer Name:			
	Address:			
	City:		State:	
	Zip Code:		Phone#:	
	How often are you paid?	☐ Every week	☐ Every 2	☐ Twice a
		☐ Once a month	☐ Other (Specify)	○

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #1: *FAMILY INFORMATION, continued*

Child's Name		**Date of Birth**	

SECTION 2: SECOND ADULT INFORMATION, continued

School/Job Training Complete if you attend school or a job training program	School/Job Training Name:			
	Address:			
	City:			State:
	Zip Code:	Phone#:		
Cell Phone#:				
Email Address:				
Alternate Phone#:				
Best way to reach you during the day:	☐ Home Phone #	☐ Cell Phone #	☐ Work #	☐ School Phone #
	☐ Email	☐ Other (Specify)		

Do you have a disability?	☐ Yes	☐ No
Do you have health insurance?	☐ Yes	☐ No
If 'Yes', name of health insurance company:		
During the past 12 months, I/We have moved from temporary to permanent	☐ Yes	☐ No
During the past 2 years, I/We have moved into a new house.	☐ Yes	☐ No
Do you have a mental health concern?	☐ Yes	☐ No
Do you have a social concern (English Language Learner, Eating Disorder, Custody Issues, Etc.)	☐ Yes	☐ No

SECTION 3: CHILD INFORMATION

First Name:				
Last Name:				
Gender:	☐ Male	☐ Female	Date of Birth:	
Is the Child Hispanic or Latino/a?			☐ Yes	☐ No
Mother's Name:				
Father's Name:				
Primary Language Spoken at home?				
2nd spoken language (If Applicable)				
Is English spoken in the home?			☐ Yes	☐ No
Child's English skills:	☐ Very Well	☐ Well	☐ Not Well	☐ Not at all

Race (***check all that apply***): ☐ American Indian ☐ Asian ☐ Black/African American ☐ Multi-Racial/Bi-Racial
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other _____

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #1: *FAMILY INFORMATION, continued*

Child's Name		**Date of Birth**	

SECTION 3: CHILD INFORMATION, continued

My child has a disability or disabilities	□ Yes	□ No
If 'Yes" type of disability/disabilities (list all):		
If 'Yes", does your child's disability/disabilities limit his/her ability to walk, run or climb stairs?	□ Yes	□ No
My child has an IEP (individualized Education Plan), an IFSP (Individualized Family Service Plan) and/or ER (Evaluation Report) from Childlink, ELWYN, or ELWYN SEEDS	□ Yes	□ No
My child is/will be receiving Early Intervention services from ChildLink, ELWYN	□ Yes	□ No
If 'Yes" indicate which Early Intervention services your child is/will be receiving (Select all that applies):		
□ Speech □ Special Instruction □ Physical □ Occupational □ Other		
My child is/was in a preschool or day care	□ Yes	□ No
If 'Yes", where?		
I/We have had other children who attend Head Start	□ Yes	□ No
If 'Yes", name or child/ren:		
If 'Yes", name of school(s)/location(s):		
I/We have had other children who attend Bright Futures/PreK Counts	□ Yes	□ No
If 'Yes", name or child/ren:		
If 'Yes", name of school(s)/location(s):		
I/We have a medically fragile child (Chronic Illness, Terminal Illness, Etc.)	□ Yes	□ No
If 'Yes", name or child/ren:		
Child's mother/father is currently incarcerated	□ Yes	□ No
My child was referred to a preschool program from a mental health provider	□ Yes	□ No

Child's Doctor's Information	Doctor/Clinic/Office Name:	
	Address:	
	City:	State:
	Zip Code:	Phone #:
Child's Dentist Information	Doctor/Clinic/Office Name:	
	Address:	
	City:	State:
	Zip Code:	Phone #:

Please share with us any social development concerns you have for your child: _____

_____

_____

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #1: *FAMILY INFORMATION, continued*

Child's Name		Date of Birth	

SECTION 4: FAMILY/HOUSEHOLD MEMBERS

List your name, the name(s) of your child(ren) and the names of all other adults and children who live in your home. Use additional paper if needed.

FIRST and LAST NAME	DATE of BIRTH MM/DD/YYYY	RELATIONSHIP to PRIMARY ADULT Self, Husband, Wife, Daughter, Son, Sister, Brother, Companion, Partner, Friend, etc.

SECTION 5: FAMILY INCOME INFORMATION

How you financially provide for your family – select each source of income that you, your husband/wife/companion/partner and all children receive

☐ Employment	☐ Unemployment	☐ Self-Employment	☐ Social Security	☐ SSI
☐ Child Support	☐ Alimony	☐ Worker's Compensation	☐ Commissions	☐ Tips
☐ TANF Cash Assistance	☐ Foster/Kinship Care	☐ Scholarship, Grant, Stipend		
☐ Pension	☐ Retirement	☐ Rental Properties	☐ Friend/Family	
☐ Other (Specify)				

SECTION 6: Signatures

Read the following statements and sign where indicated.

I/We have completed all sections on my/our *Family Information* form and certify the information is correct. I/We have attached copies of all income and monthly benefits that I/we and my/our children receive. I/We understandthis information is being given so that my/our eligibility can be determined for the Prekindergarten Head Start and/or the Bright Futures/Pre-K Counts program. I/We understand that officials from The School District of Philadelphia, the Department of Health and Human Services and/or the Commonwealth of Pennsylvania may verify the information and the supporting documentation submitted with my/our *Family Information* form.

I/We further understand that, if necessary, additional documents may be requested and I/we will comply with this request. I/We understand that my/our income documentation is confidential and will remain on file at Your Child's World Learning Center, Inc.

_____

Signature of Primary Adult Date

_____

Signature of Primary Adult Date

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #2: *Child's Medical Concerns*

Child's Name _____ Date of Birth_____

Dear Parent/Guardian,

The Office of Early Childhood recognizes the fact that some children have medical conditions. The health care provider may prescribe medications for these conditions. When the prescribed dose is to be administered during preschool hours, the Health Services division, with written permission, will train staff at your child's center to administer the medication to your child. Written permission is given by the submission of form MED-1: Request for Administration of Medication, completed by you and your child's health care provider for each medication. **At no time will medication be given to your child without a completed MED-1.**

Please check one box and complete as necessary:

☐ 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 your 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 Concern:

   ☐ 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 any change to the information indicated above.

_____ _____
Signature of Parent/Guardian Date

Early Childhood Use Only

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

Signature of Early Childhood Staff: _____ Date: _____

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #3: *Child's Health History*

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
Wear diapers/pull-ups			
Has (or had) seizures			
Has had a serious accident or illness			
Has had an emergency room visit			
Has had overnight hospital stay			
Had surgery			
Wear glasses			
Has a lazy eye, crossed eyes, wandering eyes, other eye conditions			
Have a history of ear infections, tubes in ears, hearing loss, wear hearing aid			
Have excessive colds, sore throats, coughing episodes, or snores loudly			
Have a history of asthma or bronchitis			
Have a heart murmur, a resolved heart murmur, rheumatic fever or other heart conditions			
Have a history of anemia, sickle cell disease, elevated lead level or other blood conditions such as G6PD, hemophilia,			
Has or had 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 (If Yes, please indicate Type I or Type II diabetes)			
Has rashes, eczema, hives, boils			
Have neuropathy, muscle tics, spina bifida, muscular dystrophy, cerebral palsy			
Wear leg braces			
Use a cane, walker or wheelchair			
Has (or had) polio, chicken pox, measles, mumps, scarlet fever, whooping cough			
Have car sickness			
Has food or medication allergies			
Has allergies due to seasonal changes, animals or other			
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:

Please share with us any health concerns you have for your child _____

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #11: *Information for Certification*

Read the following statements and sign where indicated.

My/Our signature(s) below indicate that:

1. The information I/we have provided on all of the forms in my/our child's *Preschool Application* is accurate and complete. I/we have signed all application forms where indicated and have included all required documents.

2. I/We understand that:
   a. Completing and submitting a *Preschool Application* does not guarantee that my/our child will be accepted to the Prekindergarten Head Start or the Bright Futures preschool program.
   b. Before my/our child's first day in the Prekindergarten Head Start or the Bright Futures preschool program:
      i. I/We will attend an orientation meeting and an individual conference with my/our child's teacher and, depending on which program my/our child is enrolled, will receive a *Prekindergarten Head Start Parent Handbook* or a *Bright Futures Parent Handbook;*
      ii. I/We will be required to submit an up-to-date *Child Health Assessment/Physical Exam* form and/or *Dental Health/Dental Exam* form if my/our child's physical and/or dental exam dates are more than twelve (12) months old;
      iii. I/We may be required to re-verify my/our Philadelphia, PA address, family income and/or monthly benefits;
      iv. I/We will be notified if additional forms are needed, and will submit them as necessary.

3. During the time my/our child is enrolled in a preschool program:
   a. S/He will attend every school day, his/her health permitting;
   b. S/He will be able to use the toilet with minimal assistance;
   c. I/We will abide by all program policies stated in the *Prekindergarten Head Start Parent Handbook* or the *Bright Futures Parent Handbook* and will adhere to the scheduled arrival and departure times for his/her location;
   d. 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;
   e. 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 Adult _____ Date _____

Signature of Second Adult (if applicable) _____ Date _____

AN INCOMPLETE APPLICATION WILL NOT BE PROCESSED

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #4: *Child's Dietary Restrictions*

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. A monthly menu, posted in each center, lists the foods and beverages that your child is offered at each meal component. The Office of Early Childhood recognizes the fact that certain foods, due to religious, medical 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. In order to ensure that your child is receiving an age appropriate, nutritionally sound diet, **requests for food restrictions must be verified by a note from your child's health care provider or religious leader**. If your child has a dietary restriction, efforts will be made to provide your child with an allowable substitution.

If your child has a significant 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 center staff.

Please check one box and complete as necessary:

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

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

1. Name of restricted food: _____

   Reason from restriction:

□ Religious	□ Other (Please Specify) _____
□ Medical – Please indicate reaction and treatment: _____	

2. Name of restricted food: _____

   Reason from restriction:

□ Religious	□ Other (Please Specify) _____
□ Medical – Please indicate reaction and treatment: _____	

3. Name of restricted food: _____

   Reason from 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 any change to the information indicated above.

_____ _____

Signature of Parent/Guardian Date

Early Childhood Use Only

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

Signature of Early Childhood Staff: _____ Date: _____

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #5: *Child's Nutrition History*

Parent/Guardian: Please complete both sides of this form to the best of your knowledge.

Child's Name _____ Date of Birth_____

1. What foods does your child like? _____
2. What foods does your child dislike? _____
3. Place a check mark in the No or Yes column next to each question:

	No	Yes
Does your child take vitamins?		
Do the vitamins contain iron?		
Do the vitamins contain fluoride?		
Are the vitamins prescribed by a doctor?		
Is your child on a special diet?		
Is the diet recommended by a doctor?		
Has there been a noticeable change in your child's appetite in the last month?		
Does your child drink from a bottle?		
Does your child eat or chew things that aren't food? (ex: dirt, clay, paint chips)		
Does your child have trouble chewing or swallowing?		
Does your child often have diarrhea?		
Does your child often have constipation?		
Do you have any concerns about what your child eats?		
Are you receiving WIC?		
Are you receiving Food Stamps?		

4. Place a check mark under the column that indicates the approximate number of times a week your child eats the following foods:

	0	1	2	3	4	5	6	7	7+
Milk ~ whole, skim, low fat, lactose free									
Cheese, yogurt									
Eggs									
Peanut butter									
Beans, peas, soy, tofu, lentils									
Nuts, seeds									
Beef, chicken, turkey									
Fish, shellfish									
Rice, noodles, bread, tortillas, crackers, cereal									
Green vegetables, spinach, collard greens									
Winter squash, pumpkin, sweet potatoes, carrots									
Oranges, grapefruit, tomatoes, broccoli, fruit juice									
Other fruits and vegetables									
Oil, butter, margarine, jams, jellies, olive oil									
Cakes, cookies, sodas, fruit drinks, candy									

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #6: 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 _____ Date of Birth_____

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: Your Child's World Learning Center, Inc.

Signature of Early Childhood Staff:_____Date: _____

Your Child's World Learning Center, Inc.
Pre---Kindergarten Program Application

Form #7: *Child's 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 bedtime routine?_____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 important 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	

Application for Preschool

Parent/Guardian ~ The Application for Preschool is 2 pages - please complete both pages to the best of your knowledge.

Child Information

Name_____Date of Birth_____Gender: Male Female

Address_____Apt._____Zip_____Phone # ___

_____ Does your child speak English? Yes_____No____Does your child understand English? Yes_____No _____ If you answered 'No' to either question, what language does your child speak and understand?

Parent/Guardian Information

Name_____Gender: M F Address_____Zip _____

Phone Numbers: Day_____Evening_____Cell _____

E-mail address _____

Are you a single parent? Yes_____No_____ Family Size: Number of adults _____Number of children ___

Do you receive: TANF_____Food Stamps_____Medical Assistance _ If 'Yes', welfare case # _____

Parent/Guardian Information

Name_____Gender: M F Address_____Zip _____

Phone Numbers: Day_____Evening_____Cell _____

E-mail address _____

Are you a single parent? Yes_____No_____Family Size: Number of adults _____Number of children _

Do you receive: TANF _ Food Stamps_____Medical Assistance _ If 'Yes', welfare case # _

Child's Health Care Information

Name of Doctor/Health Center/Clinic _____

Address_____Zip_____Phone Number _____

Type of Health Insurance: Medical Assistance_____ CHIP_ Private_____ Other _____

Name of Health Insurance Company_____Policy Number _____

Name of Dentist/Dental Clinic _____

Address_____Zip_____Phone Number_____

Child's Preschool Information (This information will be shared with the instructional staff to better assist your child while enrolled in preschool.)

Does your child have preschool experience?_____Is your child currently enrolled in a preschool? _____

If you answered 'Yes' to either question, name of preschool _

Please share with us any educational concerns you have for your child: _____

Application for Preschool

Child's Early Intervention Information (This information will be shared with the Special Needs Coordinators to better assist your child while enrolled in preschool.)

Has your child been referred for a developmental screening?_____ If Yes, has it been completed? _____

Does your child have an Individualized Education Plan (IEP)?_____ If Yes, name of Early Intervention agency: _____

Please share with us any developmental concerns you have for your child:_____

Emergency Contact Information (Adult individuals, other than the parent/guardian, who have agreed to be an emergency contact ~ Photo ID will be required)

1. Name_____Relationship to Child ____

   Phone Numbers: Day_____Evening_____Cell _____

   Approximately how long will it take for this individual to travel to your child's school? _

2. Name_____Relationship to Child ____

   Phone Numbers: Day_____Evening_____Cell _____

   Approximately how long will it take for this individual to travel to your child's school? _

Escort Information (Individuals other than the parent/guardian who have agreed to be an escort for your child ~ **Escorts must be at least 18 years old** ~ Photo ID will be required)

1. Name_____Relationship to Child _____

   Phone Numbers: Day_____Evening_____Cell _____

2. Name_____Relationship to Child _____

   Phone Numbers: Day_____Evening_____Cell _____

My signature below indicates that:

1. **I UNDERSTAND THAT COMPLETING and SUBMITTING AN APPLICATION FOR PRESCHOOL DOES NOT GUARANTEE THAT MY CHILD WILL BE ACCEPTED IN TO A PRESCHOOL PROGRAM;**
2. The information I have provided on both pages of the Application for Preschool is accurate;
3. I agree to inform my child's teacher when any of this information changes;
4. I understand that this information must be kept accurate so that I can be contacted in the event my child becomes ill or injured while attending preschool;
5. I understand that if my child is enrolled in preschool, I agree to abide by the program policies and to adhere to the scheduled arrival and departure times.

Parent/Guardian Signature_____Date _____

Parent/Guardian Signature_____Date _____

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

	CHILD DEVELOPMENT
	Ages 3-5
	Infants and toddlers
	Reading with children
	Potty training
	Discipline
	Other Child Development subjects:

	HEALTH & SAFETY
	Child-proofing your home
	Allergies & asthma
	Diabetes
	First Aid/CPR
	Poisons and look-alikes
	Over-the-counter medication
	Smoking cessation
	Signs of drug/a lcohol abuse
	Health insurance coverage
	Signs of lead poisoning
	The importance of dental health
	Women's health issues
	Men's health issues
	Other Health & Safety subjects:

	JUST FOR FUN
	Crafts/home decoration
	Aerobics
	Make-over tips (hair, make-up, etc.)
	Grou p sports (softball, bowling, etc.)
	Sewing
	Relaxation tips
	Free cultural activities
	Other Just for Fun subjects:

	NUTRITION
	Cooking & baking workshops
	Healthy snacks
	Understanding food labeling
	Cooking with children at home
	Healthy eating & weight control
	Exercising to good health
	Overweight child
	Underweight child
	Low-cost meal planning
	Other Nutrition subjects:

Comments or additional interests:

Child Care Survey

Do you need before and after school care for your child?

□ Yes □ No

Does /Will your child attend a child care facility or child care home after the Head Start day?

□ Yes □ No

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

Form #10: *FAM ILY INTEREST SURVEY*

The Office of Early Childhood is committed to providing workshops and training opportunities that meet the needs of parents and guardians. We want these opportunities to be interesting, informative, helpful and fun. During the school year, you will receive information about these workshops and training opportunities through many different resources such as informational flyers, workshops and parent meetings. Please complete the survey below to assist us in better serving you this school year.

Place a X next to each subject that interests you.

Family Name:_____ Child's Name:_____

How did you hear about The School District of Philadelphia's preschool programs?

O Family Member O Friend O Radio O Internet O Newspaper O Flyer

O Other (specify):

	MENTAL HEALTH			PARENTING/FAMILY LIFE
	Building relationships			Child support laws
	Building self-esteem			Peer pressure issues
	Stress management			Step-parenting & blended families
	Death, dying & grief support			Grandparents raising children
	Understanding anger			Childcare after school
	How to deal with fear			Divorce/separation
	Dealing with substance abuse (alcohol or drugs)			Sibling rivalry
	Domestic violence			Fatherhood
	Counseling resources			Caring for the elderly
	Bullying			Custody issues
	Time management			Co-parenting/communication
	Becoming trauma informed			Child abuse laws
	Other Mental Health subjects:			Other Parenting/Family life subjects:
	PERSONAL			HOME MANAGEMENT
	Expanding your education			Budgeting/money management
	Resume-writing/job readiness			Credit counseling
	Setting realistic goals		■	Law on Renters' rights
	GED			Cost saving household tips
	Computer classes			Furniture/appliances
	Financial aid for school			Housing repairs/weatherization
	SSI or Social Security guidelines			Energy assistance
	Obtaining a driver's license			Using coupons
	ESL			Housing
	Other Personal subjects:			Other Home Management subjects:

Your Child's World Learning Center, Inc.

Head Start/Pre-K Counts Program Emergency Contact and Agreement

Child's Name		**Date of Birth:**	
Address:		Philadelphia, PA _____	
Mother's's Name ○ **Foster Parent** ○ **Legal Guardian** **(Relationship to child)** _____		**Contact Numbers** **Cell:** _____ **Work:** _____ **Home:**	
Address:		Philadelphia, PA _____	
Father's Name ○ **Foster Parent** ○ **Legal Guardian** **(Relationship to child)** _____		**Contact Numbers** **Cell:** _____ **Work:** _____ **Home:** _____	
Address:		Philadelphia, PA _____	
Child's Physician		**Phone Number**	
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 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	X
AGREEMENT	
Services provided by Your Child's World Learning Center, Inc.:	
($0.00) Free Educational Program from 8:30AM-2:30PM, Monday-Friday during our current school calendar year. Excluding holidays, professional development days, early dismissal days, etc. SEE OUR SCHOOL CALENDAR	
Breakfast, Lunch, PM Snack	*All meals must be eaten at school and cannot be taken off school site excluding trips.
*Before and After School Services are available for an additional fee. Wrap around services begins 1 minute after dismissal.	
Parent Agrees to the following:	
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.	
Update dental forms every 6 months	Update health assessment/report forms every 12 months
Drop off child before 9:00AM on school days.	Pick up child by 2:30PM, Monday-Friday when school is open. ($2.00/minute/child late pick up fee begins at 2:01pm)
Volunteer a minimum of 2 hours a month.	Pick up child by the early dismissal/emergency early dismissal time when school closes early. ($2.00/minute/child late pick up fee begins 1 minute after dismissal)
Complete 2 Home Visits a year	Complete 2 Parent Conferences a year
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 _____	

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

DATE: August 23, 2014

SUBJECT: Nondiscrimination in Services

TO. Parents/Clients

FROM: Margaret Burden. Executive Director

Admissions, the provisions of services and referrals of clients shall be made without regard to race, color,religious creed, disability, ancestry,age, sex,national origin (including limited English proficiency),age or sex

Program services shall be made accessible to eligible persons with disabilities through themost practical and economically feasible methods available. These methods include. but are not limited to equipment redesign, the provision of aides, and the use of alternative service delivery locations Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/ student (and /or their guardian) who believes they have been discriminated against may file a complaint of discrimination with

Your Child's World Learning Center, Inc.
7 120 North Broad Street
Philadelphia, PA 19126

Department of Public Welfare Bureau
of Equal Opportunity
Room 223, Health and Welfare Building
P O Box 2675
Harrisburg, P A 17105-2675

Commonwealth of Pennsylvania
DPW-Bureau of Equal Opportunity
Southeast Regional Office
Suite 5034_5th floor
801 Market Street Philadelphia
PA 19107

U S. Department of Health & Human Services

Office of Civil Rights

Suite 372, Public: Ledger Building
150 S. Independence Mall West
Philadelphia, Pennsylvania 191Ofi-3499

PA Human Relations Commission

110 North 8th
Street
Suite 501
Philadelphia, Pennsylvania 19101

Parent's Signature: _____

Date: _____

5837 N. 2nd St, 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 19141 PHONE: (215) 289-2026 FAX: (215) 924-6632

Dear Parents and families

In an effort to get to know your child better an observation will be done on your child by his/her teacher in his/her room within 45 days of enrollment. Once that observation is complete the caregiver will arrange a meeting with you in order to share the information obtained from the observation. Your Child's World Learning Center also does Parent/Teacher conferences. At those times you will be invited to schedule a conference to discuss your child's progress.

Please sign below stating that you have read the above information and return to the office upon enrollment.

Thank You

I _____ have read and understand Your Child's World policy regarding

new enrollment observations.

_____	_____	_____
(Parents Signature)	(Child's Name)	(Date)

Your Child's World Learning Center, Inc.
"Where your child will feel free to explore all possibilities."
7120 N. Broad Street, Philadelphia, PA 19126 PHONE: (215) 924-4195 FAX: (215) 924-6632

Child's Name: _____ Date of Birth: _____

Parent's Name: _____

Permission for Field Trips

FIELD TRIPS: During t h e course of the school year, trips may be planned for the children. These trips are contingent upon if YCW Administration has enough parent volunteers during the year to ensure that we could have a least 2 responsible volunteers per classroom on the day of the trip. YCW Administration will invite only the parents who volunteer the most in the classroom to volunteer on the trips. It is imperative that all volunteers are very familiar with the children that they are chaperoning. In order for your child to go on these trips, you will receive a permission slip with the trip location at least 1 month in advance. You must sign, date, and return this form to your child's teacher at least 2 days prior to the trip. If your child needs a special chaperon due to their behavior, you will be notified at least 2 weeks in advance. All children requiring a special chaperon will not be allowed to attend the trip without their special chaperon appointed by the parent. All chaperons must be 18yrs of age or older with a valid ID, attend our chaperone training, and have a way of being contacted via phone during the trip.

_____

(SIGNATURE OFPARENT/GUARDIAN)

_____

(DATE)

Permission for Photographs

PHOTOGRAPHS: Recording events, celebrations, class progress, and individual students on film is a necessary part of camp life. We ask that you give your permission for your child, you and/or your family to be included in our Evergreen Camp photo collections, news releases and important YCW, School District of Philadelphia, and its affiliates on publications, etc.

_____

(SIGNATURE OF PARENT/GUARDIAN)

_____

(DATE)

Child and Adult Care Food Program

Sponsor/Center Name: Your Child's World Learning Center, Inc.

Agreement #:300-51-002-7

Child Enrollment Form

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK				MEALS RECEIVED
		TIME-IN	TIME OUT	TIME CHILD ATTENDS SCHOOL		
		AM	PM	LEAVES CENTER	RETURNS TO CENTER	
FIRST NAME	X Monday X Tuesday X Wednesday	8:30 AM	2:30 PM	N/A	N/A	X Breakfast X Lunch X PM Snack
Last NAME	X Thursday X Friday	☐ Yes ☒ No I work multiple shifts and child(ren) may be in care different days/hours				
BIRTH DATE	☐☐☐☐☐☐☐	Other:				☐☐☐☐☐
AGE		Enrollment Date:	Withdrawal Date:			

Signature _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Name of Enrolled Child(ren):

Names of all household members (First, Middle Initial, Last)	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless ☐ Migrant ☐ Runaway☐

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List only household members with income)	B. Gross income and how often it was received			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____

Date: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Last four digits of Social Security Number: * * * - * * - ___ ___ ___ ___ ☐ I do not have a Social Security Number

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ American Indian or Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islander
	☐ Black or African American	

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: _____

Categorical Eligibility: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: _____

Reason for Denied: _____

Temporary: Free_____ Reduced_____ Time Period: _____(expires after _____ days)

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household size	Yearly
1	$21,590
2	$29,101
3	$36,612
4	$44,123
5	$51,634
6	$59,145
7	$66,656
8	$74,167
Each additional person:	+$7,511

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, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

Your Child's World Learning Center, Inc.
"Where Your Child Will Feel Free to Explore All Possibilities."
5837 North Second Street, Philadelphia PA 19120 PHONE: (215) 924-4175
7120 North Broad Street, Philadelphia PA 19126 PHONE: (215) 924-4195
6595A Roosevelt Boulevard, Philadelphia PA 19149 PHONE: (215) 289-2026

Child Information Form

Child's Name: _____

D.O.B: _____

Mom/Guardian: _____

Address: _____

_____

Phone: (Cell) _____

(Work) _____

Email Address: _____

Dad/Guardian: _____

Address: _____

_____

Phone: (Cell) _____

(Work) _____

Email Address: _____

Who does child live with: _____

Does anyone have a custody order? _____

Date the order was issued: _____

***In order for us to enforce the order we must have a copy of the order in your child's file.**

Is this child a foster child? _____

***Provider a copy of the child's placement order**

If yes:

What is the name agency that child has direct care of the child? _____

Agency Social Worker: _____

Agency Social Worker Phone Number: _____

Agency Social Worker Email Address: _____

DHS Social Worker _____

DHS Social Worker Phone Number: _____

DHS Social Worker Email Address: _____

Names and Ages of Siblings living in the home: _____

_____

Name and relationship of other adults living in the home: _____

SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
CHILD HEALTH ASSESSMENT

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN NAME:
DATE OF BIRTH:	PHONE:	ADDRESS:
CENTER NAME: Your Child's World Learning Center, Inc.		

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): D NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): D 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.

LENGTH/HEIGHT	WEIGHT	BLOOD PRESSURE
_____IN/CM %ILE _____	_____LB/HG %ILE _____	(BEGINNING AT AGE 3)_____/_____

PHYSICAL EXAMINATION	☑☑=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 (Complete Dates: Month, Day, Year)
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TESTS	DATE TEST	☑☑=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)

D NONE

NEXT APPOINTMENT - MONTH/YEAR:

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN OR CRNP:
ADDRESS:	

	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

Your Child's World Learning Center, Inc.
6595A Roosevelt Boulevard,
Philadelphia PA 19149
PHONE: (215) 289-2026 FAX: (215) 924-6632

DENTAL HEALTH

Child's Name_____Birth Date_____Center Your Child's World Learning Center, Inc.

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 _____

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

Dental Office Stamp

IT'S TIME TO GO TO THE DENTIST!

Child's Name: _____ Date: _____

PHILADELPHIA HEALTH CENTERS FOR DENTAL CARE

HC #2	1720 S. Broad Street, 19145	215-685-1822
HC #3	555 S. 43rd Street, 19104	215-685-7506
HC #4	4400 Haverford Avenue, 19104	215-685-7605
HC #5	1920 N. 20th Street, 19121	215-685-2938
HC #6	321 W. Girard Avenue, 19123	215-685-3815
HC #9	131 E. Chelten Avenue, 19144	215-685-5738
HC #10	2230 Cottman Avenue, 19149	215-685-0608

HOSPITAL-BASED DENTAL CLINICS

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

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

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

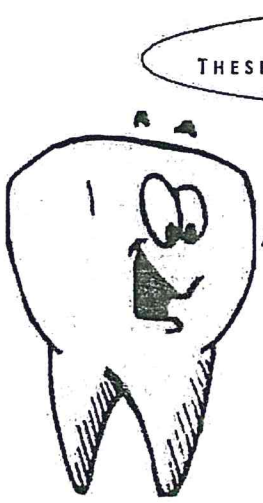
EINSTEIN
York & Tabor Road
Dental Office
215-456-7130

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

FEDERALLY FUNDED CLINICS

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

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



KIDS SMILES
2821 Island Avenue, Suite 210
215-492-9291

KIDS SMILES II
5848 Market Street
215-747-6901

DOC BRESLER'S
6801 Ridge Avenue
215-483-6633

DOC BRESLER'S
1430 Snyder Avenue
215-467-6000

DOUGLAS R. REICH, D.M.D.
7122 Rising Sun Avenue
215-725-8300

DENTAL DREAMS
2107A Cottman Avenue
215-235-4060

DENTAL DREAMS
5675 N. Front Street
215-224-0440

DENTAL DREAMS
2459 Aramingo Avenue
215-427-2800

PEDIATRIC DENTAL ASSOCIATES
6404 Roosevelt Boulevard
215-743-3700

PEDIATRIC DENTAL ASSOCIATES
100 E. Lehigh Avenue
215-707-1030

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

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

Job 08/10rev