Your Child's World Learning Center, Inc.
"Where your child will feel free to explore all possibilities."
6801 N. 16TH Street, Philadelphia, PA 19126 PHONE: (215) 224-3915 FAX: (215) 224-3780
6595A Roosevelt Blvd, Philadelphia, PA 19149 PHONE: (215) 289-2026 FAX: (215) 224-3780
2406 S 71st Street, Philadelphia, PA 19142 PHONE: (267) 233-7031 FAX: (215) 224-3780

Pre-Kindergarten Application

Head Start, PreK Counts, & PHL PreK
Full Day Pre-K!!!

Ages 3-5

(3 yrs. Old *before* Sept. 1st)
(5 yrs. Old *after* Sept. 1st)

Program Benefits:

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

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, sex, sexual orientation, disability, age, religion, ancestry, union membership or any other legally protected category. 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, sex, sexual orientation, disability, age, religion, ancestry, union membership or any other legally protected category. 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

Thank you for your interest in Your Child's World Learning Center's Pre-Kindergarten program! Completing and submitting a Pre-Kindergarten Application does not guarantee that your child will be accepted to our preschool program. For your best chance at acceptance, please submit your child's completed application to one of our centers that is convenient to you.

1. Complete ALL necessary steps below. As you collect each item, check off the box. *Applications will not be accepted without all supporting documentation.*

- ☐ **I have filled out the entire application**
- ☐ **I have proof of child's date of birth** (Birth certificate, health insurance card, etc.)
- ☐ **I have documentation of family income** (Tax forms, 4 consecutive paystubs, or financial support letter)
- ☐ **I have proof of Philadelphia residency** (bill, driver's license, lease, etc.)
- ☐ **I have my child's health insurance card**
- ☐ **I have my child's physical** (health assessment within the year) **and immunizations**
- ☐ **I have proof of child's dental visit (within the year)**
- ☐ **I have picture identification of parent/guardian** (Current State or Federal Photo ID)
- ☐ I have proof of TANF (DPW) cash, SNAP/food stamps, medical assistance *(if applies to you)*
- ☐ I have a custody order *(if applies to you)*
- ☐ I have a foster letter *(if applies to you)*
- ☐ I have a homeless verfication letter/shelter letter *(if applies to you)*

Child's Name:	Date of Birth:

#1: CHILD and FAMILY INFORMATION FORM

Section 1: 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):	
Emergency Contact:	Emergency Contact Phone #:

Best way to reach you during the day:	O Home Phone #	O Cell Phone #	O Email	O Emergency Contact

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

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

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

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):		

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

Name of Employer:	Name of Employer:		
How often are you paid?	O Monthly	O Twice a month	O Every Week
	O Every two weeks	O Other:	

Do you have a disability or disabilities? If 'Yes', please list your disabilities:	O Yes	O No
Do you have health insurance? If 'Yes', name of health insurance provider:	O Yes	O No

Child's Name:	Date of Birth:

Section 2: 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):

O Same as Primary Parent/Guardian	Home Address:		
Apt./Unit #:	City:	State:	Zip Code:

Home Phone #:	Cell Phone #:
Email Address (please print clearly):	
Emergency Contact:	Emergency Contact Phone #:

Best way to reach you during the day: Select all that applies	O Home Phone #	O Cell Phone #	O Email	O Emergency Contact
Marital Status Select one	O Married	O Single	O Widowed	O Separated/Divorced

Relationship to Child Select one		
	O Parent/Step-Parent	O Grandparent
	O Foster/Kinship Parent, related to child	O Foster Parent, not related to child
	O Guardian, related to child	O Guardian, not related to child
	O No Relation	O Other (specify):

Status Select all that applies			
	O Spouse – husband/wife	O Companion/Partner	O Teen Parent – parent was under the age of 18 when child was born
	O Lives with child	O Does not live with child	O Provides financial support to child's family

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

Education Select highest Diploma/Degree earned or highest Grade Level completed			
	O High School Diploma	O GED	O 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):		

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

Name of Employer:	Name of Employer:		
How often are you paid?	O Monthly	O Twice A month	O Every Week
	O Every two weeks	O Other:	

Do you have a disability or disabilities? If 'Yes', please list your disabilities:	O Yes	O No
Do you have health insurance? If 'Yes', name of health insurance provider:	O Yes	O No

Section 3: CHILD			
First Name:		Last Name:	
Date of Birth:		Gender: O Male O Female	
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			
There is 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			
Child has a disability. If 'Yes', list all disabilities:		O Yes	O No
Child has an **IEP**, an **IFSP** and/or an **ER** and is receiving Early Intervention services from ChildLink, ELWYN or ELWYN Seeds. If 'Yes', indicate below which Early Intervention services your child is receiving (select all that applies):		O Yes	O No
O Speech Therapy O Special Instruction O Physical Therapy O Occupational Therapy O Other			
Child wears diapers. (Some locations cannot accept children in diapers.)		O Yes	O No
Child wears pull-ups? O Daytime O Naptime O Nighttime O Other?		O Yes	O No
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:	
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
Please share any additional information about our child that you would like us to know.			

Child's Name:	Date of Birth:

Section 4: FAMILY MEMBERS AND HOUSING

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, etc.
1.		
2.		
3.		
4.		
5.		
6.		
7.		

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
We have a medically fragile child (chronic illness, terminal illness, etc.) Name of child:	O Yes	O No
Does someone in the home have a mental health concern?	O Yes	O No
Does someone in the home have a social concern (English language learner, eating disorder, custody issues, etc.)? If 'Yes', please list your concerns:	O Yes	O No
Optional Information New to the country?	O Yes	O No
Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you?	O Yes	O No

Section 5: FAMILY INCOME

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
O Social Security	O SSI	O Child Support	O Alimony
O Military/ Veteran's Benefits	O Commission	O Foster Care/Kinship Care	O Tips
O Pension/Retirement	O Strike Benefits	O Scholarship/Grant/Stipend	O Other (specify):
O Financial support from Family or Friend		O Rental Properties – someone pays you rent	

Does your family receive welfare benefits? O TANF Cash Assistance O SNAP Food Stamps O Medical Assistance

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

Please share any additional information about your family that you would like us to know.

Child's Name:	Date of Birth:

Section 6: 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 Philadelphia, PA address and copies of all income and monthly benefits that I/we and my/our children receive. I/We understand that this information is required so that my/our eligibility can be determined for The School District of Philadelphia's preschool program. I/We understand that officials from The School District of Philadelphia, the Department of Health and Human Services, the Commonwealth of Pennsylvania and the City of Philadelphia will have access to and may verify the information and supporting documentation submitted with my/our *Preschool 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 *Preschool Application* is confidential and will be held in strict confidence within The School District of Philadelphia and affiliated Community Nonprofit Partner Agencies that have been determined to be school officials under the Family Educational Rights and Privacy Act with legitimate educational interests as part of The School District of Philadelphia's preschool program.

_____ _____
Signature of Primary Parent Date

_____ _____
Signature of Secondary Parent Date

Section7: READY4K

Read by 4th and the Free Library of Philadelphia invite you to participate in Ready4K, a research-based text-messaging program for parents. Each week, you will receive approximately three (3) text messages with fun facts and easy tips to boost your child's learning – an approach that is scientifically proven to work. While there is absolutely no cost for enrolling in Ready4K, data and message rates may apply.

If your child is enrolled in a School District preschool program, would you like to receive helpful text messages with fun facts and easy tips on how to boost your child's learning?

☐ No, thank you.

☐ Yes, please send text messages to this number: _____

By opting to receive messages, you hereby agree to (i) the submission of this form to ParentPowered PBC, (ii) enroll in Ready4K ("the Program"), (iii) the ParentPowered PBC Terms of Use available at parentpowered.com/terms.html and Privacy Policy available at parentpowered.com/privacy.html, and (iv) receive approximately three Ready4K text messages per week from 70138. By providing us with your cell phone number above, you confirm that you want ParentPowered to send you information we think may be of interest to you, which involves ParentPowered using automated dialing technology to text you at the cell phone number you provided. While there is absolutely no cost for enrolling, data & message rates may apply. You can cancel your receipt of Ready4K text messages any time by texting STOP to 70138. For help with Ready4K text HELP to 70138 or email us at support@parentpowered.com.

Section 8: SURVEY

How did you hear about The School District of Philadelphia's preschool program? (select all that applies):

O Neighbor O Friend/Family Member O Doctor's Office O Radio O Newspaper O Dollar Tree
O Informational flyer O Library O Internet O Facebook O Instagram O Other

THIS PAGE WAS LEFT BLANK INTENTIONALLY

#4: 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 Office of Early Childhood Education's screening program which may include, but is not limited to: developmental screening, behavioral screening, vision screening, hearing screening and dental screening. I understand that as part of the preventative health program, children participating in preschool programs of The School District of Philadelphia receive screenings during the school year;
4. The School District of Philadelphia's Office of Early Childhood Education Program Mental Health Consultation Services to provide services on an as needed basis. These services may include:
    a. Observation of my child in the preschool setting and consultation with teaching staff regarding strategies and techniques to support my child's healthy social/emotional development;
    b. Conduct assessments and behavioral/developmental screenings, using standardized tools, across all domains of my child's development;
    c. Provide behavioral health consultation services to my child and his/her teacher within the early childhood facility;
    d. An invitation to participate in team meetings and action plan development for my child's social/emotional well-being, where I will be provided with information about child-related issues and resources within my 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

THIS PAGE WAS LEFT BLANK INTENTIONALLY

#5: CHILD'S MEDICAL HISTORY FORM

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

MY CHILD:	NO	YES	COMMENTS
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 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 my child's teacher or Early Childhood Health Services if there is any change to the above information.

_____ _____

Signature of Parent/Guardian Date

THIS PAGE WAS LEFT BLANK INTENTIONALLY

#6: CHILD'S MEDICAL/ CHILD'S DIETARY or FOOD RESTRICTIONS CONCERNS FORM

Child's Name _____ Date of Birth _____

Dear Parent/Guardian,

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

Please answer and complete as necessary – use additional paper if needed:

Does your child have a medical condition?	O Yes	O No
If 'Yes', please list diagnosis or medical condition:		
If medication is required, please list medication:	O Daily	O As Needed

*School District of Philadelphia school-based sites will ONLY administer emergency as needed medication.

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.

Does your child have a dietary or food restriction?		O Yes	O No
If 'Yes', Name of restricted food:			
Reason for restriction:	O Medical – please indicate reaction and treatment:	O Religious	O Other
If 'Yes', Name of restricted food:			
Reason for restriction:	O Medical – please indicate reaction and treatment:	O Religious	O Other

---

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

THIS PAGE WAS LEFT BLANK INTENTIONALLY

#7: VERIFICATION of INFORMATION FORM

Read the following statements and sign where indicated.

My signature(s) below indicate that:

1. The information I have provided on all of the forms in my child's *Preschool Application* is accurate and complete. I have signed all application forms where indicated and have included copies of all required supporting documents. Deliberate misrepresentation of my information may subject me/us to prosecution under applicable Federal and/or State laws and that if enrolled, my child's participation in the preschool program may end.
2. I understand that:
    a. The information contained in my child's *Preschool Application* will be held in strict confidence within Your Child's World and affiliated Agencies that have been determined to be school officials under the Family Educational Rights and Privacy Act (FERPA) with legitimate educational interests as part of The School District of Philadelphia's preschool program.
    b. Completing and submitting a *Preschool Application* does not guarantee that my child will be accepted to a preschool program.
    c. Before my child's first day in preschool:
        i. I will attend an orientation meeting and an individual conference with my child's teacher and will receive a Parent Handbook;
        ii. If my child's physical and/or dental exam dates are more than twelve (12) months old, I 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 may be required to re-verify my Philadelphia, PA address, family income and/or monthly benefits;
        iv. I will be notified if additional forms and/or documents are needed, and will submit them as necessary.
3. During the time my 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. Some locations cannot accommodate children in diapers, and S/He will be required to use the toilet with little adult assistance;
    d. I 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 will keep my child's information current and inform his/her teacher and the Office of Early Childhood Education of any changes;
    g. I will always make sure my child's teacher has an active telephone number from within the Philadelphia calling area for me/us so that I 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

THIS PAGE WAS LEFT BLANK INTENTIONALLY

#8 Child and Adult Care Food Program (CACFP) Enrollment Form

Section 1: Family Information

Child Name:			Date of Birth:
Parent/Guardian Name(s):			
Address:		Apt/Unit #:	Zip:
Telephone (Home):		(Cell):	
A representative from The School District of Philadelphia 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.			
I prefer contact by:	O Telephone	O Daytime: 9:00 AM – 5:00 PM	O U.S. Mail
	O E-Mail		

Section 2: Organization Information

Sponsoring Organization:

Your Child's World Learning Center
2406 S. 71st St.
Philadelphia, PA 19142

Section 3: Expected Daily Hours of Service

☒ Monday - Friday: 8:00 AM – 2:00 PM
OR
☒ Monday - Friday: 8:30 AM – 2:30 PM
OR
☒ Monday - Friday: 9:00 AM – 3:00 PM

Section 4: Expected Daily Meal Service Participation

☒ Breakfast: Offered 8:30 AM – 9:00 AM
☒ Lunch: Offered 11:45 AM – 12:30 PM
☒ Afternoon Snack: Offered 2:15 PM – 2:45 PM

Section 5: Signature

The Information provided on this Child Enrollment Form accurately represents my family's expected participation in CACFP. When changed occur, I agree to inform the Office of Early Childhood Education.

_____ _____

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:

(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 PAGE WAS LEFT BLANK INTENTIONALLY

#9 Meal Benefit Income Eligibility Form

Section 1: Child Information

Child Name:	Date of Birth:	
Gender:	O Male	O Female
Is this child a foster child?	O Yes	O No

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.**

An adult member of my household has an active SNAP (Food Stamps) or TANF (Cash Assistance) account.	O Yes	O No

If yes, Name of this adult household member (print):

SNAP or TANF Record Number **51** /_____ _____ _____ _____ _____ _____

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.	$ /	$ /	$ /	$ /	
8.	$ /	$ /	$ /	$ /	

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 The School District of Philadelphia 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 the Office of Early Childhood Education.

_____	_____	_____
Signature of Adult	**Printed Name of Adult**	**Date**

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

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 The School District of Philadelphia 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 The School District of Philadelphia 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

☐ White

☐ Asian

☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander

☐ Other _____

Completed by School District of Philadelphia Representative

☐ Identified by Adult Household Member ☐ Visual Identification by a School District of Philadelphia 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

(2) Fax: (202) 690-7442; or

(3) E-mail: program.intake@usda.gov

This institution is an equal opportunity provider.

Section 6, continued: 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, The School District of Philadelphia 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.

Your Child's World Learning Center, Inc. PHL AGREEMENT

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) PHL Pre-K program from 8:00am-2:00pm	
Breakfast, Lunch, PM Snack	*All meals must be eaten at school and cannot be taken off school site excluding trips.
PARNT WILL RECEIVE INFORMATION ON GROWTH AND DEVELOPMENT	
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.	
Sign Child In and Out Daily	
Drop off child before 9:00AM on school days.	Pick up child by 2:00PM, M-F when school is open. ($2.00/minute/child late pick up fee begins at 2:01pm) or 1min after early dismissal time.
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
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)
Call when child is absent.	If child is absent 2 or more days, provide a Dr. note prior to returning.
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.
Additional Services Available for a Fee – Before and After School Services – See Wrap Around Agreement	

Parent's Full Signature: **X** _____

Print Name: **X** _____ **Date:** **X** _____

Parent Email Address: **X**

YCW Staff's Full Signature: **X** _____

Print Name: **X** _____

THIS PAGE WAS LEFT BLANK INTENTIONALLY

PreK Counts/Head Start Pre-K 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**

PreK Program Emergency Contact and Agreement

Parent's Full Signature: X _____

Print Name: X _____ **Date: X** _____

Parent Email Address: X

THIS PAGE WAS LEFT BLANK INTENTIONALLY

Your Child's World Learning Center, Inc. PreK Counts/Head Start AGREEMENT

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) PHL Pre-K program from 8:00am-2:00pm or 8:30am-2:30pm (CHECK YOUR CLASS SCHEDULE)	
Breakfast, Lunch, PM Snack	*All meals must be eaten at school and cannot be taken off school site excluding trips.
PARNT WILL RECEIVE INFORMATION ON GROWTH AND DEVELOPMENT	
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.	
Sign Child In and Out Daily	
Drop off child before 9:00AM on school days.	Pick up child by 2:00PM OR 2:30PM, M-F when school is open. ($2.00/min/child late pick up fee begins at 2:01pm OR 2:31PM) CHECK YOUR CHILD'S SCHEDULE
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
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)
Call when child is absent.	If child is absent 2 or more days, provide a Dr. note prior to returning.
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.
Additional Services Available for a Fee – Before and After School Services – See Wrap Around Agreement	

Parent's Full Signature: X _____

Print Name: X _____

Parent Email Address:
X

Date: X _____

YCW Staff's Full Signature: X _____

Print Name: X _____

PreK Counts/Head Start AGREEMENT 2 Pgs. Total

Updated 8/2018

THIS PAGE WAS LEFT BLANK INTENTIONALLY

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

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

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

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

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:

THIS PAGE WAS LEFT BLANK INTENTIONALLY

#3: CHILD DENTAL HEALTH/DENTAL EXAM FORM

Child's Name _____ Date of Birth _____

SECTION 1: Completed by parent/guardian

1. Has your child been to the dentist? ☐ No ☐ Yes – if 'Yes', date of child's last dental visit _____
2. Does your child have (or had) cavities or caries? ☐ No ☐ Yes – If 'Yes', how many? _____
3. Does your child have any problems with his/her teeth, gums, or mouth? ☐ No ☐ Yes

   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth? _____

SECTION 2: Completed by child's Dentist

1. Date of child's most recent:

   Dental Examination _____ Teeth Cleaning _____ Fluoride Treatment _____
2. Has child ever needed dental treatment? ☐ No ☐ Yes

   If Yes, type of dental treatment _____

   Has dental treatment been completed? ☐ No ☐ Yes – if 'Yes', date of completion _____
3. Date of child's next dental visit _____

Dental Office Stamp

_____

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

_____

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-DENTIST (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
1930 S. Broad St., Unit #14, 19145
215-685-1822

HEALTH CENTER #3
555 S. 43rd St., 19104
215-685-7506

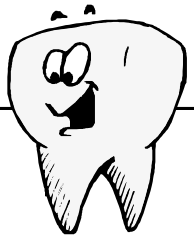
HEALTH CENTER #4
4400 Haverford Ave., 19104
215-685-7605

HEALTH CENTER #5
1900 N. 20th St., 19121
215-685-2938

HEALTH CENTER #6
301 W. Girard Ave., 19123
215-685-3816

HEALTH CENTER #9
131 E. Chelten Ave., 19144
215-685-5738

HEALTH CENTER #10
2230 Cottman Ave., 19149
215-685-0608



FEDERALLY QUALIFIED HEALTH CENTERS

ESPERANZA HEALTH CENTER
3156 Kensington Ave., 19134
215-302-3156

FAIRMOUNT HEALTH CENTER
1412 Fairmount Ave., 19130
215-684-5349

MARIA DE LOS SANTOS
401 W. Allegheny Ave., 19133
215-291-2509

ABBOTTSFORD-FALLS
4700 Wissahickon Ave., Suite 110, 19144
215-843-9720

HEALTH ANNEX
6120-B Woodland Ave., 19142
215-727-4721

STEPHEN & SANDRA SHELLER (11TH ST. FAMILY HEALTH)
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