THE SCHOOL DISTRICT OF

PHILADELPHIA

PRESCHOOL APPLICATION

FOR ACADEMIC YEAR

2021 - 2022

DISTRICT AND CHILDCARE PARTNERS

FULL DAY PRE-K

8:00AM TO 2:00PM

AGES 3-5

3YRS OLD BEFORE SEPT. 1ST, 2021

5YRS OLD AFTER SEPT. 1ST,2021

PROGRAM BENEFITS

FREE NUTRITIOUS MEALS

HIGH-QUALITY CURRICULUM

ACCESS TO NURSES

SPECIAL NEEDS SUPPORT

PARENT PARTICIPATION

A STEP AHEAD DAY CARE/PRE-SCHOOL

7802 CASTOR AVENUE

PHILADELPHIA, PA. 19152

215-722-4700

THE SCHOOL DISTRICT OF PHILADELPHIA

440 N. BROAD STREET

SUITE 170 – PRESCHOOL PROGRAM

PHILADELPHIA, PA. 19130-4015

APPLICATION PAPERWORK

1. ALL PAGES OF THIS APPLICATION **MUST** BE FILLED OUT IN ITS ENTIRETY.

2. ALL PAGES OF THIS APPLICATION **MUST** BE RETURNED TOGETHER.

3. ALL PROOF DOCUMENTS **MUST** BE INCLUDED WITH THE APPLICATION.

IF 1 THROUGH 3 IS COMPLETED **THEN** APPLICATION **WILL** BE PROCESSED.

REMEMBER, TO ENTER THIS PROGRAM IT WILL DEPEND ON WHEN YOUR APPLICATION IS **PROCESSED AND APPROVED.**

LIST OF REQUIRED DOCUMENTS NEEDED FOR ENROLLMENT

FOR PARENTS:

______Photo Id

______Proof of Philadelphia address

______Proof of income (2020 Income Tax, 6 weeks of pay stubs)

______Proof of TANF, SNAP/food stamps, medical assistance (if applies)

FOR CHILDREN:

______Birth Certificate

______Social Security Card

______Medical Insurance Card

______Updated Dental form (signed and filled out by dentist)

______Updated Health form (signed and filled out by doctor)

______Updated Immunizations

______Updated Influenza Record

______Updated full copy of IEP/IFS (if child has)

2020-2021 PA PRE-K COUNTS ENROLLMENT FORM

(THIS INFORMATION IS CONFIDENTIAL TO THE PRE-K COUNTS PROGRAM)

DATE FORM COMPLETED: ______________________________

Last Name (Child)	First Name (Child)	Middle Initial
Street Address	County	
City	State PA	Zip Code
School District of Residence		
Home Phone	Work Phone	Email Address
Child's Birth Date	Age ☐ 2 ☐ 3 ☐ 4 ☐ 5	Gender ☐ Male ☐ Female

Race
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific
- ☐ White
- ☐ American Indian or Alaskan
- ☐ Other

Ethnicity
- ☐ Hispanic
- ☐ Non-Hispanic

Primary Language
- ☐ English
- ☐ Spanish
- ☐ Other ______________________ *(please specify)*

Last Name (Legal Guardian)	First Name (Legal Guardian)	Gender ☐ Male ☐ Female

Relationship to Child
- ☐ Father
- ☐ Mother
- ☐ Guardian
- ☐ Other ______________ *(Please Specify)*

Select
- ☐ Biological
- ☐ Foster
- ☐ Adoptive
- ☐ Other ______________ *(Please Specify)*

Role in Child's Life
- ☐ Primary Guardian
- ☐ Secondary Guardian
- ☐ Legal Guardian
- ☐ Other ______________________ *(Please Specify)*

Household (Family) Size								
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ ____

Household Income *(required)* check box:

☐ Less Than $5,000	☐ $5,001 - $10,000	☐ $10,001 - $15,000
☐ $15,001 - $20,000	☐ $20,001 - $25,000	☐ $25,001 - $30,000
☐ $30,001 - $35,000	☐ $35,001 - $40,000	☐ $40,001 - $45,000
☐ $45,001 - $50,000	☐ $50,001 - $60,000	☐ $60,001 - $70,000
☐ $70,001 - $100,000	☐ More Than $100,000	

2017 Federal Poverty Level Guidelines

300%			
Family Size	**Annual**	**Monthly**	**Weekly**
1	$36,180	$3,015	$696
2	$48,720	$4,060	$937
3	$61,260	$5,105	$1,178
4	$73,800	$6,150	$1,419
5	$86,340	$7,195	$1,660
6	$98,880	$8,240	$1,901
7	$111,420	$9,285	$2,142
8	$123,960	$10,330	$2,383
Each Add'l	**$12,540**	**$1,045**	**$241**

Actual Annual Verified Gross Household (Family) Income: $ ____________________

(Attach copies of documents used to verify income prior to enrollment)

☐ Family income is at or below 300% of federal poverty level (required risk factor). Consider all sources of income. See *Federal Poverty Level Guidelines* relative to family size (must be verified prior to enrollment).

Other Child Eligibility Risk Factor Criterion *(Must check all that apply)*:

☐	**Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐	**Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services.
☐	**Education Level of Guardian:** Does not have high school diploma or GED or post-secondary degree.
☐	**English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
☐	**Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
☐	**Incarcerated Parent:** A child for whom one of the child's parents is currently in prison.

☐	**Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following: A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.
☐	**Migrant (Non-Immigrant)/Seasonal Student:** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
☐	**Teen Mother:** A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided is accurate. I understand that I may be asked to verify or substantiate information provided.

Parent/Guardian (Signature) **Date**

Parent/Guardian Name (Print Name)

Staff Verifying Income and Risk Factors (Signature) **Date**

Staff Verifying Income and Risk Factors (Print Name)

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: LOCATIONS

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

Name of your 1st Location Choice:
Name of your 2nd Location Choice:
Name of your 3rd Location Choice:

Section 4: 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		
Is your child fully potty trained? (Fully Potty Trained means – Child does not wear pull-ups or diapers and does not need any assistance from an adult when going to the bathroom.)	O Yes	O No
If 'Yes', child will be expected to use the toilet without adult assistance while in preschool. Answering falsely may slow down the enrollment process. (Some locations cannot accept children in diapers/pull -ups.)		
Child wears pull-ups/diapers? O Daytime O Naptime O Nighttime O Other? O pull-ups	O diapers	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 5: 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 6: 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 7: SIGNATURES

Read the following and sign where indicated.

I/We have completed all sections on my/our *Child and Family Information Form* and certify the information is correct. I/We understand that deliberate misrepresentation of my/our information may subject me/us to prosecution under applicable Federal and/or State laws and that, if enrolled, my/our child's participation in the preschool program may end. I/We have attached a copy of my/our child's proof of date of birth, verification of my/our 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 ________

Section 8: 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

Section 9: Family Well Being

Family Well Being is an important part of a child's educational success. Which aspects of Family Well Being are you interested in receiving workshops, training opportunities and other resources? (select all that applies):

O Adult Education O Employment O Food Assistance O Housing O Medical Home
O Mental Health O Physical Health O Safety O Substance Abuse

Section 10: 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 Informational flyer O Library O Internet O Facebook O Instagram O Other

THE SCHOOL DISTRICT OF PHILADELPHIA

APPLICATION FOR ADMISSION OF CHILD TO SCHOOL

(EH-40 Rev. 8/14 Comm. Code 61602445007)

PARENT/GUARDIAN MUST COMPLETE THIS FORM AND PROVIDE ALL NECESSARY DOCUMENTATION

STUDENT INFORMATION - PRINT ALL ENTRIES

LAST NAME	FIRST NAME	MIDDLE NAME OR INITIAL	DATE OF BIRTH MO DA YR	GENDER MALE FEMALE	STUDENT I.D. (SCHOOL USE ONLY)

HOUSE NO.	DIR	STREET NAME	ST., AVE.,ETC	APT.#	ZIP CODE	HOME PHONE

■ **CHECK ONE ONLY (√)**

RACE DESIGNATION (CHECK (√) ONE ONLY):

☐ 0. WHITE ☐ 1. BLACK / AFRICAN AMERICAN ☐ 2. HISPANIC / LATINO ☐ 3. AMERICAN INDIAN / ALASKA NATIVE

☐ 4. ASIAN ☐ 5. MULTI RACIAL / OTHER ☐ 6. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER

LANGUAGE SURVEY

	English	Other	Other Language (please specify)
1. What language does the family speak at home most of the time?	☐	☐	
2. What language does the parent(s) speak to her/his child most of the time?	☐	☐	
3. What language does the child speak to her/his parent(s) most of the time?*	☐	☐	
4. What language does the child speak to her/his brothers/sisters most of the time?*	☐	☐	
5. What language does the child speak to her/his friends most of the time?*	☐	☐	
6. What language does the child speak most frequently?*	☐	☐	
7. In what language would you like documents sent home? If other, which language? ______	☐ English Only		☐ English and Other

*If the answer to any of these questions is other than English, please contact the Enrollment Center for additional screening.

STUDENT EDUCATION: Complete this section if the child has ever attended school

■ **INDICATE CITY AND TYPE OF SCHOOL CHILD LAST ATTENDED**

☐ PHILADELPHIA CITY ☐ OTHER CITY ☐ PUBLIC SCHOOL ☐ NON-PUBLIC SCHOOL

DATE LAST ATTENDED	GRADE LAST ATTENDED	NAME OF SCHOOL	ADDRESS	CITY	STATE

■ If the student attended school Outside of the United States, do you have his/her school records?

☐ Yes* ☐ No

If yes, please provide a copy for the school

If no, please contact the school to obtain records

** High School students must have transcripts evaluated.*

■ Did child ever attend: ☐ Pre-Kindergarten and/or ☐ Kindergarten

1. Has child ever received Special Education services? ☐ Yes* ☐ No
2. Was child ever enrolled in an Early Intervention Program? ☐ Yes* ☐ No
3. Has child ever received ESOL/Billingual services? ☐ Yes* ☐ No

** If the answer is yes to any of the above 3 questions in this section, please ENROLL child in school and refer parent/guardian to the Principal, or Counselor or Special Education Liaison.*

■ Date child first enrolled in U.S. school: ______

CONTINUE ON REVERSE SIDE >>

PARENT/GUARDIAN INFORMATION - PRINT ALL ENTRIES

PARENT	"X" IF DECEASED	FULL NAME	CELL PHONE	E-MAIL	EMPLOYER PHONE
FATHER					
	NAME OF FATHER'S EMPLOYER:			EMPLOYER ADDRESS:	
MOTHER					
	NAME OF MOTHER'S EMPLOYER:			EMPLOYER ADDRESS:	
STEP PARENT GUARDIAN LEGAL CUSTODY					
		EMPLOYER:		ADDRESS:	

PROOF OF DATE OF BIRTH - MUST BE COMPLETED

1. OFFICIAL BIRTH CERTIFICATE	NUMBER	ISSUED BY (CITY AND STATE)
2. BAPTISMAL OR OTHER RELIGIOUS CERTIFICATE	ISSUED BY	NAME AND ADDRESS
3. OTHER	DESCRIBE	
4. COUNTRY OF BIRTH	NAME OF COUNTRY - IF BORN IN US, LIST NAME OF CITY AND STATE	

*Parent/Guardian Signature:*________________________________ *Date:* ____________________

OFFICIAL USE ONLY

SCHOOL PRINCIPAL/ADMINISTRATOR: It is the responsibility of the School Principal/Administrator to insure that this form is completed in its entirety and to verify all necessary documentation prior to signing.

VERIFICATION: THE PROOF OF DATE OF BIRTH IS BASED ON THE EXAMINATION OF DOCUMENT ABOVE

SIGNATURE OF SCHOOL OFFICIAL	DATE	POSITION

NAME OF SCHOOL/CENTER CHILD ADMITTED TO	SCHOOL NO.	DATE ENROLLED	GRADE	ROOM/SECT/BOOK NO

PRE-K ONLY		SIGNATURE OF SCHOOL PRINCIPAL / ADMINISTRATOR	DATE
SCHOOL GROUP	PROGRAM CODE		

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

#2: CHILD'S MEDICAL 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 check one box and complete as necessary – use additional paper if needed:

☐ At this time, my child does not have a medical condition.

☐ My child has the following medical condition(s):
A representative from Early Childhood Health Services may contact you for more information.

1. Diagnosis or medical condition: ______________________________
   - ☐ Does not require medication to be administered
   - ☐ Requires medication to be administered **DAILY**
     Medication name, dose and times ______________________________
   - ☐ Requires medication to be administered **AS NEEDED**
     Medication name and dose ______________________________

2. Diagnosis or medical condition: ______________________________
   - ☐ Does not require medication to be administered
   - ☐ Requires medication to be administered **DAILY**
     Medication name, dose and times ______________________________
   - ☐ Requires medication to be administered **AS NEEDED**
     Medication name and dose ______________________________

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to immediately inform my child's teacher or Early Childhood Health Services if there is a change to the information indicated above.

______________________________ ______________
Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: ______________________________

Signature of Early Childhood Staff: ______________________________ Date: ______________

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

#3: CHILD'S MEDICAL HISTORY FORM

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

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

The information on this form is true to the best of my knowledge. I understand that it is my responsibility to immediately inform my child's teacher or Early Childhood Health Services if there is any change to the above information.

Signature of Parent/Guardian ____________________ Date ____________

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

#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/our child in the preschool setting and consult with teaching staff regarding strategies and techniques to support my/our child's healthy social/emotional development;
    b. Conduct assessments and behavioral/developmental screenings, using standardized tools, across all domains of my/our child's development;
    c. Provide behavioral health consultation services to my/our child and his/her teacher within the early childhood facility;
    d. My/Our invitation to participate in team meetings and action plan development for my/our child's social/emotional well-being, where I/we will be provided with information about child-related issues and resources within my/our community that could be helpful.

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

______________________________ ____________
Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: ______________________________

Signature of Early Childhood Staff: ______________________ Date: ____________

THE SCHOOL DISTRICT OF PHILADELPHIA

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

INFLUENZA (Flu) IMMUNIZATION

YOUR CHILD'S ANNUAL FLU SHOT

Name: ____________________ **DOB:** ___/___/___ **Classroom:** _____________

Regulation: Influenza (Flu) Shot

- **The influenza (Flu) shot is now required for children in childcare and Preschool programs** unless there is a written exemption: medical, religious or personal.
- The Influenza (Flu) shot is typically given during a specified time frame, August 1st – December 31st, to afford the best protection against the Flu.
- The influenza (Flu) shot is on the recommended ACIP (Advisory Committee on Immunization Practices) schedule.
- **OCDEL (Office of Child Development and Early Learning) permits written exemptions for part or all immunizations.**

Parent's Name (printed): ________________________________

Parent's Name (signature): ________________________________ **Date:** ______________

My child received an influenza (flu) shot this year **YES / NO Date:** __________

I understand I have to provide a record of this immunization for my child's file annually.

My child has not received an influenza (Flu) shot **YET** this year but will by _______________.

I understand I have to provide a record of this immunization for my child's file annually.

My child did not and will not receive an influenza (Flu) shot this year.

Written Exemption as to why not:

____

____

PLEASE RETURN COMPLETED FORM TO YOUR CENTER BY: January 2, 2020

If you have questions contact the School Health Coordinator, Tracey Petty

215-400-5838/tpetty@philasd.org

Oct. 2019/tp

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

Parents may write immunization dates; health professional should verify and complete all data.

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG) ☐ YES ☐ NO	**NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.**	
	VISION (subjective until age 3)	
	HEARING (subjective until age 4)	
	LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

#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.

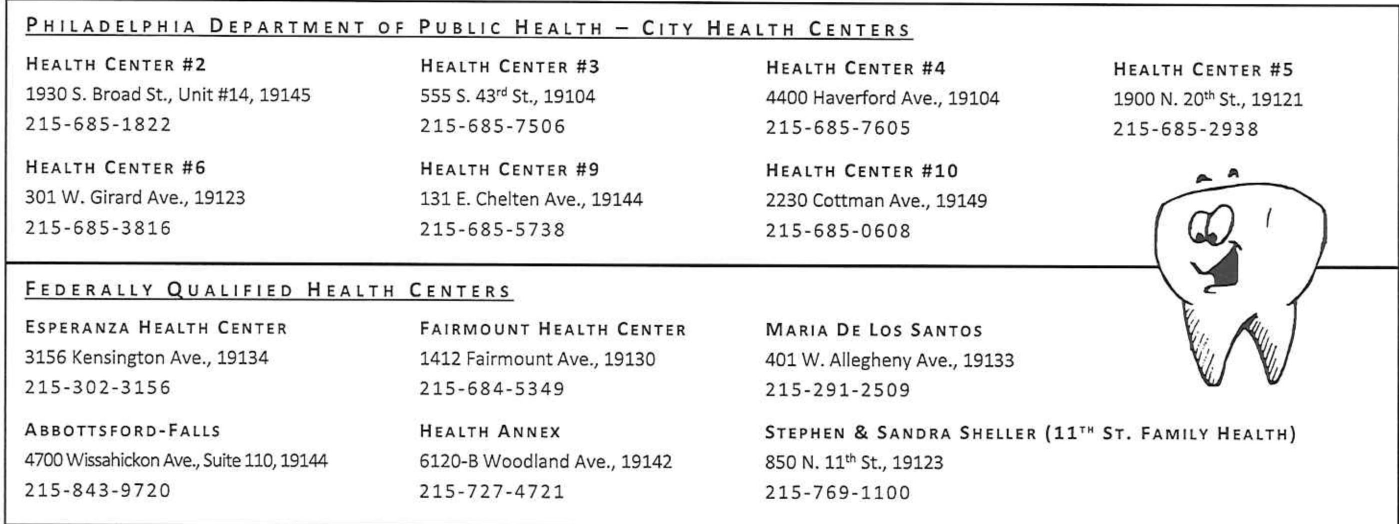
Dentist's Signature ____________________

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

job 08/2015 rev.

THE SCHOOL DISTRICT OF PHILADELPHIA

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

POLICIES AND CONSENT FOR EMERGENCY MEDICAL CARE AND SCREENINGS

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

Child's Name: ____

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

In the event your child becomes seriously ill or injured and requires immediate medical attention, he/she will be accompanied by a School District of Philadelphia staff person and taken to the nearest hospital emergency room in an emergency medical vehicle. We will attempt to notify the parent at once. Under the Medical Services/Minor Act, immediate emergency treatment will be initiated at the hospital. However, it is essential that both Early Childhood and the hospital be able to locate you as soon as possible, to give either written or monitored verbal permission for comprehensive treatment. Please be sure to keep your child's preschool teacher informed about how to reach you when you are not at home or at work/school.

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

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

CONSENT FOR EMERGENCY MEDICAL CARE AND PREVENTIVE SCREENINGS

My signature below indicates that I give consent for:

1. The administration of minor first aid to my child by preschool classroom staff
2. The emergency medical and/or dental care which may be necessary to preserve the life of my child or to prevent impairment of his/her health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for on-going care
3. My child to participate in the Office of Early Childhood screening program which may include, but is not limited to; developmental screening, behavioral screening, vision screening, hearing screening and dental screening. I understand that as part of the preventative health program, children participating in preschool programs of the School District of Philadelphia receive screenings during the school year.

Signature of Parent: ______________________________________ Date: ______________

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

Early Childhood Use Only

Name of Early Childhood Location: ____

Signature of Early Childhood Staff: ______________________________ Date: ______________

THE SCHOOL DISTRICT OF PHILADELPHIA
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440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

5. Where do you usually take your child for health care services (Medical Home)?

Name ____

Address ______________________________ Zip ______ Phone number __________

6. Where do you usually take your child for dental care services (Dental Home)?

Name ____

Address ______________________________ Zip ______ Phone number __________

THE SCHOOL DISTRICT OF PHILADELPHIA

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440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

CHILD'S HEALTH HISTORY

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

Child's Name ______________________________ Date of Birth ______________

Parent/Guardian Name ______________________________ Today's Date ______________

PREGNANCY and BIRTH INFORMATION

Did mother visit the physician fewer than 2 times during pregnancy? _____ No _____ Yes ~ If Yes, explain ______________

____

Did mother or child stay in the hospital for medical reasons longer than usual? _____ No _____ Yes ~ If Yes, explain ___________

____

Place of birth ______________________________ Birth weight _________ lbs. _________ oz.

Type of delivery: _____ Vaginal _____ C-Section (please explain why)

____

Was your child born more than 3 weeks before or after due date? ____ No ____ Yes ~ If Yes, please explain ______________

____

Were there any problems with the mother or child:

During pregnancy: _____ No _____ Yes ~ If Yes, explain ______________________

During delivery: _____ No _____ Yes ~ If Yes, explain ______________________

After delivery: _____ No _____ Yes ~ If Yes, explain ______________________

During pregnancy did the mother use: _______Cigarettes _______ Alcohol _______ Drugs _______ Prescription Medicine

Is this child's mother/guardian pregnant now? _______ No _______ Yes

CHILD'S HOSPITALIZATIONS and ILLNESSES

Overnight hospitalization: ______ No ______ Yes ~ If Yes, explain ______________________

Emergency Room Visit: ______ No ______ Yes ~ If Yes, explain ______________________

Serious Accident: ______ No ______ Yes ~ If Yes, explain ______________________

Serious Illness: ______ No ______ Yes ~ If Yes, explain ______________________

Surgery: ______ No ______ Yes

If Yes:
Type of surgery ______________________________

Date of surgery ______________ Name of Hospital ______________________

Problems or complications ______________________________

Seizures ______ No ______ Yes

If Yes:
Type of seizure ______________________________

Reaction ______________________________

Duration ______________________________

Medication ______________________________

THE SCHOOL DISTRICT OF PHILADELPHIA

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440 N. BROAD STREET, SUITE 170
PHILADELPHIA, PENNSYLVANIA 19130

Part I: Place a check mark in the **No** or **Yes** column next to each item. For all **Yes** responses, please explain in the **Comments** column.

DOES YOUR CHILD	NO	YES	COMMENTS
Wear glasses			
Have 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, etc.			
Have or had an umbilical or inguinal hernia			
Have reflux, stomach pain, diarrhea, constipation			
Have a feeding tube			
Have trouble urinating, urinary tract infection or kidney disease			
Wear diapers/pull-ups			
Have diabetes (If Yes, please indicate Type I or Type II diabetes)			
Have rashes, eczema, hives, boils			
Have neuropathy, muscle tics, spina bifida, muscular dystrophy, cerebral palsy			
Wear leg braces			
Use a cane, walker or wheelchair			
Have (or had) polio, chicken pox, measles, mumps, scarlet fever, whooping cough			
Have car sickness			
Have allergies due to medication or food			
Have allergies due to seasonal changes, animals or other			
Take medication daily or on an 'As Needed' basis			

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

____

____

THE SCHOOL DISTRICT OF PHILADELPHIA

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

Child Social Development

Parent/Guardian: Please complete both sides of this form to the best of your knowledge. Your answers will help us to better understand and assist your child while enrolled in preschool.

Child's Name ______________________ Date of Birth ____________

Parent/Guardian Name ______________________ Today's Date ____________

1. Please list the activities your child enjoys ______________________
2. Please list the activities your child does not enjoy ______________________
3. Does your child take a nap? _______ No _______ Yes ~ If Yes, when? __________ For how long? ________
4. What time does your child usually: Go to sleep at night? __________ Wake up in the morning? __________
5. Does your child sleep with a light on? _______ No _______ Yes
6. Does your child have bedtime routine? _______ No _______ Yes ~ If Yes, please describe ______________________
7. Does your child have trouble sleeping? _______ No _______ Yes ~ If Yes, please describe ______________________
8. a) What words or actions does your child use to indicate that s/he needs to use the bathroom? ______________________

   b) Does your child use diapers/pull ups? Yes____ No____ If yes, when?______________________
9. How does your child act with children s/he does not know? ______________________
10. How does your child act with adults s/he does not know? ______________________
11. Please tell us what your child is afraid of ______________________
12. How do you comfort your child? ______________________
13. Does your child have difficulty expressing what s/he wants? _______ No _______ Yes
14. Do you have difficulty understanding your child? _____ No _____ Yes ~ If Yes, please explain how you communicate: ______________________
15. Have there been big changes in your child's life within the last 6 months? _______ No _______ Yes ~ If Yes, please describe ______________________
16. Children learn to do things at different ages. So that we can better fit our program to meet your child's needs, please tell us, as best as you can remember, what age your child began the following tasks?

TASK	AGE		TASK	AGE
Sit up without help			Toilet trained	
Crawl			Respond to directions	
Walk			Play with toys	
Talk			Use crayons	
Feed and dress self			Understand what is said	

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

Child's Name ______________________ Today's Date __________

THE SCHOOL DISTRICT OF PHILADELPHIA

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

NUTRITION HISTORY

1. What foods does your child like? ____________________

2. What foods does your child dislike? ____________________

3. Place a check mark in the No or Yes column next to each question:

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

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

	0	1	2	3	4	5	6	7	7+
Milk ~ whole, skim, low fat, lactose free									
Cheese, yogurt									
Eggs									
Peanut butter									
Beans, peas, soy, tofu, lentils									
Nuts, seeds									
Beef, chicken, turkey									
Fish, shellfish									
Rice, noodles, bread, 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									

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

#5: CHILD'S DIETARY or FOOD RESTRICTIONS FORM

Child's Name ______________________________ Date of Birth ______________

Dear Parent/Guardian,

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

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

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

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

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

1. Name of restricted food: ______________________________
   Reason for restriction: ☐ Religious ☐ Other (please specify) ______________
   ☐ Medical – please indicate reaction and treatment: ______________
   ____

2. Name of restricted food: ______________________________
   Reason for restriction: ☐ Religious ☐ Other (please specify) ______________
   ☐ Medical – please indicate reaction and treatment: ______________
   ____

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

______________________________ ______________
Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: ______________________________

Signature of Early Childhood Staff: ______________________________ Date: ______________

Pre-K Counts

Consent for Preventive Screening

Center: A Step Ahead
7802 Castor Ave.
Philadelphia, Pa. 19152

Child's Name: ______________________________ Date of Birth: ______________

In partnership with the office of Early Childhood Screening Program, my child may participate in preventive screenings during the school year. Screenings will take place at the center by a Philadelphia School District nurse or by other qualified professionals.

I will be informed when screenings are being conducted and notified if any further evaluations are needed.

I give my permission for my child to receive the following health screenings and assessments;

- Hearing screening
- Vision screening
- Dental and oral hygiene screening
- Physical health assessment
- Height and weight tracking

Parent signature required,

Yes ____ Date ____________

No ____ Date ____________

Reasons:

____

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

CHILD and ADULT CARE FOOD PROGRAM (CACFP) GENERAL INFORMATION

Please keep this page for your records.

Dear Parent/Guardian,

Your child's center participates in the Child and Adult Care Food Program (CACFP) under the sponsorship of The School District of Philadelphia (SDP). SDP is grateful for the opportunity and privilege to partner with you and your child's center to bring the benefits of CACFP to your family.

CACFP requires the completion of 2 forms: *Child Enrollment Form* and *Meal Benefit Income Eligibility Form* (pages 21-25). Your cooperation in carefully and accurately completing these forms facilitates the SDP's participation in CACFP. This information is necessary so that SDP may receive reimbursement for the meals served to enrolled preschool children. If you need help completing these forms, please do not hesitate to contact our office for assistance at 215-400-4270. Your child will receive free meals and snacks on the days they attend preschool at no cost to you. All meals provided through CACFP must meet nutritional standards established by the United States Department of Agriculture (USDA).

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

CACFP Income Eligibility Guidelines
Effective July 1, 2017 – June 30, 2018

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

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

Households that do not receive SNAP or TANF, or who did not provide their nine-digit SNAP or TANF record number and household member's name: list the names of all household members, the gross income (before deduction of taxes) each household member received last month, how often and from what source the income was received. If a household member is in the military, please contact our office at 215-400-4270 for guidance on reporting his/her allowances and income. An adult household member must sign and date the form and include the last four numbers of his/her Social Security Number, or indicate that s/he does not have a Social Security Number.

Foster Children: To be considered a foster child, the child's care and placement is the responsibility of the State. The child has been an adjudicated dependent by the court and placed in the custody of the county children & youth agency; the child is formally placed by the county agency or a court with a caretaker household. (Foster children formally placed in kinship care by the county agency or a court are included in this group. It does not apply to informal arrangements that may exist outside of State or court-based systems.) When applicable, households providing foster care can include the foster child as a member of the household along with non-foster children in the household; please contact our office at 215-400-4270 for specific guidance on how to handle this situation.

Providing your child's Ethnic and Racial Identities is optional. If you elect not to provide this information, a representative of The School District of Philadelphia is required to visually identify your child. This information is used only to ensure that SDP and your center are in compliance with applicable provisions of Title VI of the Civil Rights Act of 1964.

FREQUENTLY ASKED QUESTIONS:

1. May I fill out a form if someone in my household is not a U.S. citizen? Yes. You or your child do not have to be U.S. citizens for your child to receive free meals and snacks on the days s/he attends preschool.

2. Will the information on my CACFP forms be verified? The information on your CACFP forms and your child's participation in CACFP may be checked during a CACFP Administrative Review.

3. What will happen to the information I provide on these forms? The information on your CACFP forms is confidential and will remain on file in The School District of Philadelphia, Office of Early Childhood Education, 440 N. Broad Street, Philadelphia, PA.

4. Can my child bring his/her own breakfast, lunch and/or snack to school? No. To ensure the safety of our students with food allergies, children are not allowed to bring food and/or beverages to school.

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

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

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

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

This institution is an equal opportunity provider.

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

info@annkidsfoodprogram.com
10100 Jamison Avenue,
Philadelphia PA 19116

Child and Adult Care Food Program

Child Enrollment Form

ANNKIDS
AnnKidsFoodProgram.com

Dear 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.

Section 1: Family information

Please print

Child First Name ☐☐☐☐☐☐☐☐☐☐☐☐ Child Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Child Date of Birth ☐☐/☐☐/☐☐☐☐ Age ☐☐

Parent/Guardian Full Name(s) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Address: ____________ City ____________ State ____ Zip ____

Tel. (Home) ☐☐☐-☐☐☐☐☐☐☐ (Cell) ☐☐☐-☐☐☐☐☐☐☐ (Work) ☐☐☐-☐☐☐☐☐☐☐

A representative from Ann Kids Food Program 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.

☐- During Day ☐- During Evening ☐- U.S. Mail ☐- Telephone (Home) ☐- (Cell) ☐- (Work)

Section 2: Organization Information

Agreement #

____

Sponsoring Organization:
Ann Kids Food Program
10100 Jamison Avenue
Philadelphia, PA 19116

Participating Location / Center:
A Step Ahead Day Care
7802 Castor Ave, 1st Floor
Philadelphia, PA, 19152

Section 3: Expected Daily Hours of Service

Please mark the times for each week day that your child is expected to attend the facility, please specify AM or PM.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Time In:							
Time Out:							

Section 4: Expected Daily Meal Service

☐ *AM Snack* ☐ *Lunch* ☐ *Supper*

Is the child of school age? ☐ Yes ☐ No

If yes, will additional meals be providedwhen school is not in session? If yes, please specify the meal:

☐ AM Snack ☐ Lunch ☐ Supper

Section 5: Signature of Parent/Guardian

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

____________________ ☐☐/☐☐/☐☐☐☐

Signature of Parent/Guardian *Date*

Section 6: For Child Care Representative Use Only

____________________ ☐☐/☐☐/☐☐☐☐ ☐☐/☐☐/☐☐☐☐

Signature Child Care Representative *Date* *Enrollment Date*

Section 7: For Ann Kids Food Program Use Only

____________________ ☐☐/☐☐/☐☐☐☐ ☐☐/☐☐/☐☐☐☐

Received by, Signature *Effective Date* *Withdrawal Date*

NONDISCRIMINATION STATEMENT: In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulation 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 using one of the following methods:

(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

Let's make this world a better place
And put a smile on every face!

CACFP Meal Benefit Income Eligibility (Child Care)

Complete o[illegible] application per household. Please use a pen (not a pencil).

ANKIDS

APPLY ONLINE:
Insert URL Here

STEP 1 List ALL children in day care (If more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals.

Child's First Name	MI	Child's Last Name	Foster Child	Migrant	Runaway	Homeless	Head Sta[rt]
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Check all that apply

STEP 2 Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

IF NO > Go to STEP 3 IF YES > Write case number here and proceed to STEP 4 (do not complete STEP 3)

CASE NUMBER:

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here? Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with All Adult Household Members section.

A. Child Income
Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child Income	How often? Weekly	Bi-Weekly	Monthly	Bi-Monthly
$	○	○	○	○

B. All Household Members that were not listed in STEP 1 (all persons living in your household not listed in STEP 1, for example: older children, grandparents, partners, etc.)
List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Full Name of a Household Member (even if does not receive income)	Earnings from Work	How often? Weekly	Bi-Weekly	Monthly	2x Month	Welfare/Child Support/Alimony	How often? Weekly	Bi-Weekly	Monthly	2x Month	Pensions/Retirement/ Social Security/SSI/ VA Benefits	How often? Weekly	Bi-Weekly	Monthly	2x Month
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or other Adult Household Member X X X - X X - _ _ _ _

Check if no SSN ☐

STEP 4 Contact information and adult signature. MAIL COMPLETED FORM TO YOUR SCHOOL AT:

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that CACFP officials may verify (check) the information. I am aware that if I purposely give false information, the participant/center may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City | State | Zip | Phone/Email

Source of Income for Children	
Sources of Child Income	**Examples**
Earnings from work	• A child has a regular full or part-time job where they earn a salary or wages
Social Security - Disability Payments - Survivors Benefits	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
Income from person outside of household	• A friend or extended family member regualry gives a child spending money
Income from any other source	• A child receives regular income from a private pension fund, annuity, or trust

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of Income**
• Salary, wages, cash bonuses • Net income from self-employment (farm or business) If you are in the U.S. Military: • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household

OPTIONAL Children's Ethnic and Racial Identities (Optional)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

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 funds your child care center/provider receives may be impacted. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of 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 or other FDPIR identifier for your child 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 the meal reimbursement for your child care center/provider. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

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:

MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (202) 690-7442; or
EMAIL: program.intake@usda.gov.

This institution is an equal opportunity provider.

*Only use this address if you are filing a complaint of discrimination.

DO NOT FILL OUT 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 ______

How often? ○ Weekly ○ Bi-Weekly ○ Monthly ○ 2x Month

Household size ______

Categorial Eligibility ☐

Eligibility: ○ Free ○ Reduced ○ Denied

Determining Official's Signature ______ Date ______ Confirming Official's Signature ______ Date ______ Follow-up Official's Signature ______ Date ______

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

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

Section 1: FAMILY INFORMATION

Child Name ______________________________ Date of Birth ____________

Parent/Guardian Name(s) ______________________________

Address ______________________________ Apt/Unit # __________ Zip ____________

Telephone (Home) ______________________________ (Cell) ______________________________

Section 2: PARENTAL CONTACT INFORMATION

A representative from 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:

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

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

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

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

Section 3: ORGANIZATION INFORMATION

Sponsoring Organization:
The School District of Philadelphia
440 N. Broad St.
Philadelphia, PA 19130

Participating Location:
Will be completed when your child begins preschool

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

☒ Monday, Tuesday, Wednesday, Thursday: 8:30 AM – 3:15 PM
☒ Friday: 8:30 AM – 12:45 PM

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

☒ 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 (Afternoon Snack is not offered on Friday)

Section 6: SIGNATURE

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

______________________________ ____________
Signature of Parent/Guardian Date

THE SCHOOL DISTRICT OF PHILADELPHIA

OFFICE OF EARLY CHILDHOOD EDUCATION

440 N. BROAD STREET

PHILADELPHIA, PA 19130-4015

#7: MEAL BENEFIT INCOME ELIGIBILITY FORM

Child and Adult Care Food Program (CACFP)

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

Section 1: CHILD INFORMATION

Full Name ____________________________ Date of Birth __________

Gender ☐ Male ☐ Female   Is this child a foster child? ☐ No ☐ Yes; if 'Yes', proceed to Section 4.

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

Section 2: HOUSEHOLDS RECEIVING SNAP [Supplemental Nutrition Assistance Program (Food Stamps)] or TANF [Temporary Assistance for Needy Families (Cash Assistance)]: If an adult member of your household has an active SNAP (Food Stamps) or TANF (Cash Assistance) account, you may give his/her active SNAP or TANF record number. If you complete this Section, you are not required to complete Section 3, but must complete Section 4.

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

Name of this adult household member (print) ____________________________

SNAP or TANF Record Number 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.	$ /	$ /	$ /	$ /	
9.	$ /	$ /	$ /	$ /	
10.	$ /	$ /	$ /	$ /	

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 ______________________ Date __________

Printed Name of Adult ______________________

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

Address ______________________ Apt/Unit # __________

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

Contact Phone # ______________________

Section 5: CHILD'S ETHNIC and RACIAL IDENTITIES: Providing this information is voluntary and does not affect your child's ability to receive free meals and snacks while attending preschool. This information will be used to determine whether or not 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

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(1) Mail: U.S. Department of Agriculture
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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.

Section 7: REIMBURSEMENT INFORMATION

The School District of Philadelphia may receive reimbursement for free or reduced-priced meals if your household income falls within the limits on this chart:

CACFP Income Eligibility Guidelines
Effective July 1, 2017 – June 30, 2018

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

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

#8: VERIFICATION of INFORMATION FORM

Read the following statements and sign where indicated.

My/Our signature(s) below indicate that:

1. The information I/we have provided on all of the forms in my/our child's *Preschool Application* is accurate and complete. I/we have signed all application forms where indicated and have included copies of all required supporting documents. Deliberate misrepresentation of my/our information may subject me/us to prosecution under applicable Federal and/or State laws and that if enrolled, my/our child's participation in the preschool program may end.
2. I/We understand that:
    a. The information contained in my/our child's *Preschool Application* 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.
    b. Completing and submitting a *Preschool Application* does not guarantee that my/our child will be accepted to a preschool program.
    c. Before my/our child's first day in preschool:
        i. I/We will attend an orientation meeting and an individual conference with my/our child's teacher and will receive a Parent Handbook;
        ii. If my/our child's physical and/or dental exam dates are more than twelve (12) months old, I/we will be required to submit an up-to-date *Child Health Assessment/Physical Exam Form,* including a current immunization record and/or *Child Dental Health/Dental Exam Form;*
        iii. I/We may be required to re-verify my/our Philadelphia, PA address, family income and/or monthly benefits;
        iv. I/We will be notified if additional forms and/or documents are needed, and will submit them as necessary.
3. During the time my/our child is enrolled in preschool:
    a. S/He will attend every school day, his/her health permitting;
    b. S/He will be escorted to and from school by an individual who is at least eighteen (18) years old;
    c. S/He will be able to use the toilet with little adult assistance;
    d. I/We will abide by all program policies stated in the Parent Handbook and will adhere to the scheduled arrival and departure times for his/her location;
    e. S/He may be removed from enrollment and placed on the waiting list due to excessive absences, chronic late arrival to school and/or chronic late pick-up from school;
    f. I/We will keep my/our child's information current and inform his/her teacher and the Office of Early Childhood Education of any changes;
    g. I/We will always make sure my/our child's teacher has an active telephone number from within the Philadelphia calling area for me/us so that I/we can be contacted should the need arise.

______________________________ ______________
Child's Name | Date of Birth

______________________________ ______________
Signature of Primary Parent/Guardian | Date

______________________________ ______________
Signature of Secondary Parent/Guardian | Date

A Step Ahead Day Care

Pre-K Counts

Academic School Year 2020/2021

7802 Castor Avenue

Philadelphia, PA 19152

Welcome Parents,

As the new school year approaches, we are excited to start a new year of learning for your child. It is our mission to offer a program to ensure that every child has the opportunity to develop skills to help them succeed in school.

It is extremely important that every child in this program attend school daily to insure they do not miss any of their planned lessons. We need your help in maintaining good attendance.

If a child misses **10 days** of class they can be placed back on the waiting list and may only return when here is an opening. If your child is out for any reason you must call your child's teacher at the school at 215-722-4700 by 9:00am and ask to speak with room 3 or 4. Please bring in a note stating why your child was absent for their file the day they return.

Together we can may this a wonderful learning experience for your child.

Child's Name____ Date________________

Parent/Guardian Signature____

Child's attendance review:

Date:______________________________ Number of absences to date______________

Comments: ____

____

Parent/Guardian Signature ________________________________ Date ______________

Authorized & Unauthorized Pick-up

For the safety of your child they will only be released to you or those persons you have listed as Emergency and Release Contacts. If you want a person who is not identified as an Emergency and Release Contact to pick-up your child, you must notify us in advance, in writing, including their full address. Your child will not be released without prior written authorization. In an emergency you may call using a verbal release form and you will be called back to verify the information. **The person picking up your child will be required to show a picture ID as verification and the full face must be visible to compare to the ID with the correct address. Please notify your pick-up person of our policy.**

If a child has not been picked up after closing and we have not heard from you, attempts will be made to contact you, and the contacts listed as Emergency and Release Contacts. Provisions will be made for someone to stay with your child as long as possible, but if after 1 hour we have not been able to reach you or a person listed as an Emergency and Release Contact, we will take your child to the 2nd police district, located at 2831 Levick Street (215-686-3020).

Right to Refuse Child Release

We may refuse to release children if we have reasonable cause to suspect that any person picking up a child is under the influence of drugs or alcohol, or is physically or emotionally impaired in any way that may endanger the child. To protect your child, we may request that another adult listed as an Emergency and Release Contact pick-up the child or we may call the police to prevent potential harm to your child. Reoccurring situations may result in the release of your child from the program.

Child's Name ______________________________ Date ______________

Parent/Guardian Signature ______________________________________

A STEP AHEAD DAY CARE/PRESCHOOL
BEFORE & AFTER PROGRAM

We have a Before & After program.

Hours: 7:00AM to 8:00AM

2:00PM to 6:00PM

Any ½ days: 12:00PM to 6:00PM
Rate: $95.00 per week, per child

Any full days: 7:00AM to 6:00PM
Rate: $95.00 with the option of bringing your child in for the day at an extra $12.00 per day, per child

If you are enrolled in our Before & After program, regardless if your child attends or not, tuition still must be paid.

Child's name: ___________________________________

___________ Yes, I do need Before & After care

___________ No, I do not need Before & After care

Signature ____

Date __________________

Revised 2/2021

A Step Ahead Day Care
7802 – 06 Castor Ave.
Phila., PA 19152

Parent & Caregiver Cell Phone Policy
September 1, 2019

The usage of cell phones creates a distraction and potential unsafe child care environment. Parents are restricted from use of personal cells during any time, at A Step Ahead. This includes taking pictures and videos with cell phones at any time in your child's classroom. Employees will ask anyone with a cell phone or blue tooth to leave the center until their call is completed. Your attention as a caregiver should be spent undistracted for communication between you, your child & your child's teachers.

Pictures and videos should not be taken in the classroom for the **safety** of all our children. Families may not have given permission for photos. When you are connected to our app, **"Classroom DOJO"**, you will be able to receive photos of your child in the classroom. Families that need translation may ask a teacher for the classroom I-pad for assistance.

Child's name ______________________________

Parent's signature ______________________________

Teacher's signature ______________________________

Date ____________

Original copy in child's file

Cc: Parent's copy

A Step Ahead Day Care
7802 – 06 Castor Ave.
Phila., PA 19152

Parent & Caregiver Cell Phone Policy
September 1, 2019

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Child's name ______________________________

Parent's signature ______________________________

Teacher's signature ______________________________

Date ________________

Original copy in child's file

Cc: Parent's copy

A Step Ahead Day Care/Pre-School/Before & After

Application for Enrollment

Please Print

Child's Name: ______________________________ Birthdate: ______________

Address: ______________________________ Philadelphia, PA. Zip Code ______________

Primary Language Spoken at Home: ______________________ Other Language: ______________________

Parent or Guardian #1: ______________________________

E-mail address: ______________________________

Phone: Home______________ Work ______________ Cell Phone ______________

Address ______________________________Philadelphia, PA. Zip Code______________

Parent or Guardian #2: ______________________________

E-mail address: ______________________________

Phone: Home______________ Work ______________ Cell Phone ______________

Emergency Person to release child other than parents:

Name: ______________________________ Relationship: ______________

Address ______________________________ Philadelphia, PA. Zip Code ______________

Telephone: Home______________ Work ______________ Cell Phone ______________

Identification must be on file for anyone other than a parent/guardian to pick up your child from the center

Child's Primary Medical Care

Physician's Name: ______________________________ Phone #: ______________

Address: ______________________________

In case of an emergency, hospital name to take your child: ______________________________

Child's Health Insurance

Name of Insurance Plan: ______________________________

Certificate Number (or ID) #: ______________________ Group #: ______________________

Policy Holder's Name: ______________________________

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations:

____

Does your child have an IEP/IFSP? Yes_______ No_______ IF your child has an IEP/IFSP, **please present a copy at time of enrollment.**

When would you like your child to start with us? Date ______________________

Parent/Legal Guardian Consent and Agreement for Emergencies

As parent/guardian, I give consent to have my child receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I agree to review and update this information whenever a change occurs and at least twice a year. If your child has an IEP/IFSP, please present a copy at time of enrollment.

Parent/Guardian Signature: ______________________________ Date: ______________

EMERGENCY CONTACT / PARENT CONSENT FORM

55 PA CODE CHAPTERS 3270.124(A)(B), 3270.181 & 182(A)(B), 3290.181 &182

CHILD'S NAME	BIRTHDAY
ADDRESS	
MOTHER'S NAME/LEGAL GARDIAN	PHONE NUMBER
ADDRESS	EMAIL
BUSINESS NAME	PHONE NUMBER
ADDRESS	
FATHER'S NAME/LEGAL GARDIAN	PHONE NUMBER
ADDRESS	EMAIL
BUSINESS NAME	PHONE
ADDRESS	

EMERGENCY CONTACT PERSON(S) NAME	PHONE NUMBER WHEN CHILD IS IN CARE

PERSON(S) TO WHOM CHILD MAY BE RELEASED NAME	ADDRESS	PHONE NUMBER

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER	PHONE NUMBER
ADDRESS	
SPECIAL DIABILITIES (IF ANY)	ALLERGIES INCLUDING MEDICATION REACTION
MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATIOIN	MEDICAL SPECIAL CONDITIONS
ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD	
HEALTH INSURANCE COVERAGE FOR CHILD /MEDICAL ASSISTANCE BENEFITS	POLICY NUMBER (REQUIRED)

PARENT'S SIGNATURE IS REQUIRED FOR EACHITEM BELOW TO INDICATE PARENTAL CONSENT	
OBTAING EMERGENCY MEDICAL CARE	ADMIN. OF MINOR FIRST AID PROCEDURES
WALKS & TRIPS	SWIMMING N/A
TRANSPORTATION BY THE FACILITY N/A	WADING N/A

PERIODIC REVIEW

SIGNATURE OF PARENT/GARDIAN ______________________ DATE ______________

SIGNATURE OF PARENT/GARDIAN ______________________ DATE ______________

AGREEMENT

55 PA CODE CHAPTERS 3270.123 &181(C); 3280.123 &181 (C); 3290.123 &181 (C)

NAME OF CHILD		DATE OF BIRTH
FEE AMOUNT? $	PER – DAY – WEEK? **PER WEEK, PER CHILD**	WHEN PAYMENT IS TO BE MADE? **MONDAY OF THE WEEK SERVED**

SERVICES TO BE PROVIDED AS PART OF THE DAY CARE FEE

*Pre-K Counts

8:00AM to 2:00PM (unless noted)

5 days weekly

breakfast, lunch and snacks

learning and fun activities

T.L.C.

CHILD'S ARRIVAL TIME	CHILD'S DEPARTURE TIME	PERSON DESIGNATED BY PARENT TO WHOM CHILD MAY BE RELEASED
LATE FEE AMOUNT $ 5.00	PER MIN.-HR. PER 5 MINUTES *(SEE BELOW)*	

EXTRA SERVICES TO BE PROVIDED AT AN ADDITIONAL FEES

LATE FEE WILL BE CHARGED PER CHILD, IF CHILD IS PICKED UP AFTER CLOSING TIME STARTING AT $5.00

EX: 6:00-6:05=$5.00, 6:06-6:10=$10.00, 6:11-6:15=$15.00, 6:16-6:20=$20.00, ETC.

I, THE PARENT/GUARDIAN:

☐ Received complete written program information at the time of enrollment – 3270.121, 3280.121, 3290.12.

☐ Agree to update the Emergency Contact/Parental Consent form information changes occur and every 6 months at a minimum. – 3270.121, 3280.121, 3290.121

Signature of operator Date Signature of parent/guardian Date

DATE OF CHILD'S ADMISSION	PERIODIC REVIEW- 6 MONTHS
DATE OF WITHDRAWL	SIGNATURE OF PARENT/GUARDIAN DATE

A Step Ahead Day Care
7802-7806 Castor Avenue
Philadelphia, Pa. 19152
215-722-4700

Photographs of Children

From time to time we photograph the children during special happenings here in our classroom. Photographs could be taken for birthdays with friends, an art project they made or maybe for an observation. Sometimes the local newspaper or news station may do a newsworthy piece on us. Children's pictures will also be posted on our website.

We are requiring your signature of permission for submission of these photos. Please sign below and return indicating your permission.

Child's name ____

I **DO** give permission to have my child's photographed and displayed and /or on television.

Signature ____ Date__________

I **DO NOT** give permission to have my child's photographed and displayed and /or on television.

Signature ____ Date__________

Civil Rights Compliance
Parent Awareness

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

> To be provided services at this agency and to be referred for services of other agencies without regard to your race, color, religious creed, disability, ancestry, national origin, age, or sex.
>
> To file a complaint of discrimination if you feel you have been discriminated against on the basis of your race, color, religions creed, disability, ancestry, national origin, age, or sex.

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

A Step Ahead Daycare
7802 Castor Avenue
Philadelphia, PA 19152

Department of Public Welfare
Bureau of Equal Opportunity
Health and Welfare Building
Room 521
P.O Box 2675
Harrisburg, PA 17105-2675

Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office
1105B State Office Building
1400 Spring Garden Street
Philadelphia, PA 19130

U.S Dept. of Health & Human Services
Office of Civil Rights
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19108

PA Human Relations Commission
711 Philadelphia State Office Bldg.
1400 Spring Garden Street
Philadelphia, PA 19130

Parent's Signature ______________________________ Date____________

Staff Signature ______________________________ Date____________

Nondiscrimination in Services

Subject: **Nondiscrimination in Services**

To: Parents and Guardians

From: Lynn Biddle

A Step Ahead Daycare

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, or English Limited Proficiency (ELP).

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

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

A Step Ahead Day Care
7802 Castor Avenue
Philadelphia, PA 19152

Department of Public Welfare
Bureau of Equal Opportunity
Health and Welfare Building
Room 521
P.O Box 2675
Harrisburg, PA 17105-2675

U.S Dept. of Health & Human Services
Office of Civil Rights
Suite 372, Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19108

Department of Public Welfare
Bureau of Equal Opportunity
Southeast Regional Office
1105B State Office Building
1400 Spring Garden Street
Philadelphia, PA 19130

PA Human Relations Commission
711 Philadelphia State Office Bldg.
1400 Spring Garden Street
Philadelphia, PA 19130

Parent's Signature ______________________________ Date__________

Staff Signature ______________________________ Date__________

A Step Ahead Day Care, Pre-School & After School Care

Getting to Know You Questionnaire

Dear Family,

We look forward to developing a partnership with your family in our program. You provided us with a lot of important medical and contact information during enrollment. We'd like to ask you a few more questions that will allow us to get to know your child and you a little better. Please let us know if you have special needs such as handicap access or translation services. Our goal is to do the best job we can do, welcoming your family into our program and creating a comfortable environment for your child. Would you kindly take a few minutes to complete this questionnaire and bring it with you to your "Getting to Know You" meeting with your child's teacher?

If your child has an IEP/IFSP, please present a copy at time of enrollment.

Thank you kindly,

Lynn Biddle, Director

Leona Kaminski, Director

Please turn over to complete information.

© 2012 CCA Global Partners, Inc.

Name of Child ______________________________ Child's DOB____________

1. Does your child have a nickname? Please provide it if you would like us to use it.

   ____

2. In what language do you and your child communicate at home?

   ____

3. Is there information about your family composition or household members that you would like to share?

   ____

4. What are some of your child's favorite things?

   ____

5. Are there cultural or religious holidays that your family observes that you would like to share with the program?

   ____

6. What are your child's toileting and napping behaviors?

   ____

7. Does your child have any special needs?

   ____

8. What are your child's favorite foods?

   ____

9. Is there anything else you can share with us about your child that will help us ease the transition for your child?

   ____

10. Is there anything else you would like to share about your child, you or your family?

   ____

Parent's Signature, ______________________________

© 2012 CCA Global Partners, Inc.

A STEP AHEAD DAY CARE, PRE-SCHOOL & BEFORE/AFTER

7802/06 Castor Avenue
Philadelphia, PA. 15192

Effective 06/05/2020

DROP OFF AND PICK UP POLICY / PROCEDURE

Family MAY NOT Enter Program

This pandemic has changed the way we look at early childhood education and our daily practices and procedures in a group setting. Changes in Procedures and Practices have been developed to support the health and safety of your children, your families, and our staff and to do all we can to remain open for families. The changes are meant to ward off Coronavirus and they are based on thorough research and guidance being recommended by experts such as the CDC. Thank you for your understanding and patience as we implement these new Policies and Procedures.

Drop Off and Pick Up Procedure and Child(ren)/Family Daily Health Screenings:

To reduce direct contact and limit the risk for coronavirus transmission, A Step Ahead Day Care *is restricting access to its facility to its essential staff and children enrolled in the program only. Accordingly, families WILL NOT be permitted to enter the building during drop off and pick up. Instead, a staff member will greet family at* ***the* street entry door** *and the subsequent procedures will be followed:*

- Families will be greeted at the entry door by a staff member.
- Families will be required to wear masks when interacting with Staff during drop off and pick up.
- There will be sterilized pens for you to sign in and out with. Please put in a designated bin to be sterilized.
- Daily Health Check Questionnaire:
  - Each morning before Drop Off, each family will be greeted at entry way by a staff member assigned to complete *****Daily Health Check Questionnaire***** with family before child(ren) will be admitted to the program.
  - Staff will ask family each question on the Health Check Questionnaire to avoid having the parent/family member touch the document.
  - Staff Member will take the family member's and child's/children's temperature.
  - If a family members answers 'yes' to any of the questions in the Questionnaire or if either child/children or family member fails the temperature check, their child/children may not enter the program.
  - If there are no issues with the Family Health Check, the Staff Member will:
    - Escort child into the program.
    - take the child to the nearest handwashing location.
    - direct/assist child in washing their hands.
    - No child will be accepted after **9:00am** and all children must pick up by **6:00pm**

Upon your arrival to pick up your child, you **must** call 215-722-4700 to announce your arrival and a staff member will bring your child out to you. You will also sign your child out the same way as you did when you signed them in.

**If family member answered "YES" to any of the above, the child and parent or family member may not enter the facility. Staff will direct families to the following CDC resource to determine their next steps. https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html

A Step Ahead Day Care, Pre-School, & Before/After

COVID-19 - Policy and Procedure Updates

TO: ALL FAMILIES

FROM: Lynn Biddle & Leona Kaminski

Effective 7/01/2020

We are preparing the center for operation. Our reopening date will be July 1st so we can provide a safe environment for children and teachers. The safety and well-being of your child is important to us! We realize, too, in this uncertain time, it is of great concern to you as parents and caregivers of young children. We recognize the importance of your entrusting the care and well-being of your young children in our program. Accordingly, we wanted to make sure that you are aware of all the practices we have implemented to keep our program clean and to minimize the spread of germs. The following list outlines our newly adopted practices:

Business Operations:

- We are **not** reducing our hours of operation. Our hours of operation are 7:00am to 6:00pm. If any changes to our hours of operation are needed in the future, we will provide you with as much notice as possible.
- All families and children in our care will have a daily health check and temperature screening during drop off and prior to entering the building. If child does not meet the health standards at the door, they will not be permitted into the center.
- Upon arriving at the program, all staff will have a daily health check and temperature screening prior to entering building. If staff does not meet health standards at the door they will not be permitted into center.
- Family members will not be permitted to enter the center.
- All children **must bring** a **second pair** of shoes for the center only. They will change into them when they come in & out of them when they leave for the day. The extra pair of shoes will be stored in center and will be disinfected at closing.
- Tuition will be put in an envelope labeled with,
  - Child's Name
  - Week of Payment
  - Amount of payment

  then placed in a locked box that will be available.

Classroom / Playground Practices:

- All classrooms will remain separated to reduce the number of children in one area and to reduce the possibility of viral transmission (even at drop off and pick up time).
- Large group activities will be eliminated.
- We will not share equipment and will clean equipment between uses.
- Time standing in line will be minimized (each child will be given a "spot" to stand or sit while waiting).

- Staff will have access to antibacterial hand sanitizers and disposable gloves and use them as needed.
- Staff will wash/scrub their hands and children's hands frequently at key transition times as this is recommended by the CDC as the most effective measure to reduce the spread of germs:
    - when arriving for the day
    - before and after meals
    - after toileting/diapering
    - after being outside
- We will minimize item sharing among children when possible, for example: give each child a set of his/her own markers, etc.
- We will refrain from sensory or water table activities including playdough unless each child is assigned their own container.
- The number of toys and other items in the classrooms will be reduced and rotated to permit washing and sanitizing frequently.
- Soft toys, blankets, dress-up clothing, stuffed animals will be removed for now to make cleaning and sanitizing easier and effective to reduce the spread of germs.
- Children will not be permitted to bring toys from home.
- We are increasing the amount of outside time while maintaining required smaller group sizes.
- Classrooms will stagger outdoor time so only one group is out at a time and allow 30 minutes between groups outside to allow for disinfection of playground equipment and toys.

Cleaning:

- Classrooms will have large bins for sanitizing toys at the end of the day.
- Daily, staff will disinfect high-touch surfaces, such as door handles, light switches, faucets, toys, and game that children play with at least twice daily.
- Nightly, after all children have left the building, we have implemented more extensive cleaning and disinfection of the entire program.

Communication:

- Families will receive communications on any changes in Family Handbook policies and procedures.
- The Directors will communicate with families via email, telephone, text, or other means of communications as needed.
- It is important for families and staff to communicate often and to be transparent with one another. Please voice concerns or questions you have with our Directors as soon as possible.
- If the current situation changes and it becomes necessary to update our policies and procedures or close our program temporarily, we will notify key family contact by Telephone and or Text immediately.

Meals & Service:

- We will not combine groups or classrooms of children during meals or snack time.
- Staff will allow for a minimum of 3 feet of space between children during mealtimes (6 feet is preferred).
- All surfaces will be disinfected before and after meal preparation and feedings using EPA-approved disinfectant products.
- All staff will wash hands before and after meal preparation, serving and feeding.
- Staff will guide and direct children to wash hands before each meal or snack.
- Each child's meal will be plated and served by staff, instead of served family-style.
- Teachers will distribute meals and snacks to children.
- Children will not share eating utensils.
- **School-Age children will bring their" single serve lunch" in a zip-lock bag only.**

Personal Protective Equipment (PPE):

- Staff will wear face coverings.
- Children under age 5 may not be expected to wear face coverings, this will be discussed with parents individually. Children under age 2 will not be permitted to wear face coverings.
- All staff will have access to PPE should a situation arise in which PPE is necessary.

Staff Training & Wellness:

- All staff have received training and education on COVID-19 symptoms, infection control, workplace disinfection and preventative measures including practices and procedures.
- Upon arriving at the program, all staff will answer a Daily Health Questionnaire and have their temperature taken to assure it is within acceptable limits.

We wanted to take this time to communicate all the changes to our practices which have been implemented so that you are aware of all the things we are doing to keep our program clean, minimize the spread of germs and support the health and wellbeing of children and staff. Please do not hesitate to reach out to Lynn Biddle or Leona Kaminski via email: astepaheaddc99@gmail.com or telephone: 215-722-4700 should you have a question or concern.

Please see attached Signature Page. You must bring this Signature Page (SIGNED) when we reopen & you arrive with your child. Your child cannot not start without it.

o

COVID-19 LETTER TO FAMILIES

POLICY AND PRECEDURE
SIGNATURE PAGE

I have read the Policy and Procedure letter and understand what is expected. If I have any additional questions, I will seek out the directors for answers.

Child/Children ____

Signatures:

Mother: ________________________________ Date ____________

Father: ________________________________ Date: ____________

COVID-19 PUBLIC HEALTH EMERGENCY
SPECIAL PROGRAM ATTENDANCE
ACKNOWLEDGMENT AND DISCLOSURE

A STEP AHEAD
FAMILY/CHILD: This should be initialed and signed by BOTH parents/ guardians.

Please read and initial each statement below.

1. ______ I understand that during this COVID-19 Public Health Emergency I will NOT be permitted to enter the facility beyond the designated drop-off and pick-up area. I understand that this procedure change is for the safety of all persons present in the facility and to limit to the extent possible everyone's risk of exposure. I understand that it is my responsibility to inform any Emergency Contact persons of the information contained herein.

2. ______ I understand that IF there is an emergency requiring me to enter the facility beyond the designated drop-off and pick-up area, I MUST wash my hands before entering, remove my shoes and wear a mask. While in the facility I must practice social distancing and remain 6ft from all other people, except for my own child.

3. ______ I understand that to enter upon the facility premises my child must be free from COVID-19 symptoms. If, during the day, any of the following symptoms appear my child will be separated from the rest of the people in the center. I will be contacted, and my child MUST be pick-ed up from the facility within 30 minutes of being notified.

   Symptoms include,

   - fever of 100.4 degrees Fahrenheit or higher
   - dry cough
   - Shortness of Breath
   - Chills
   - Loss of taste or smell
   - Sore Throat
   - Muscle aches

   While we understand that many of these symptoms can also be related to non-COVID-19 related issues we must proceed with an abundance of caution during this Public Health Emergency. These symptoms typically appear 2-7 days after being infected so please take them seriously. Your child will need to be symptom free without any medications for 72 hours before returning to the facility.

4. ______ I understand that my child's temperature will be taken every 2 hours throughout the day while on facility premises.

5. ______ I understand that my child can always wear a mask while in the facility and on facility premises.

6. ______ I understand that my child will be required to wash their hands using CDC recommended handwashing procedures throughout the day using warm running water and rubbing with soap for at least 20 seconds.

7. ______ I understand that I must bring my child a pair of shoes to the facility that will ONLY be worn inside this facility and will be left here each evening. I MUST remove my child's shoes at the entrance of the facility. Staff will have the child put on their "center only shoes" once the child washes their hands and goes into the classroom. At pick up, Staff will remove the child's "center only shoes" and the child will be brought to the entrance where I will put on my child's outside shoes prior to leaving the facility. The children's "center only shoes" will be sanitized by staff each night.

8. ______ I understand that outside of care, in order to control my child's exposure in the community, I will comply with any and all state, county or local stay-at-home orders, will limit my child's contact outside of care to persons living in my household. I will not take my child out to stores unless it is necessary and then only to shop for essential items like food, medicines, and toiletries. I will follow any recommendations from the CDC that limits my child's risk for exposure including wearing a mask in all public areas and remaining 6ft from all other people.

9. ______ My child and I WILL NOT gather with anyone that does not live in our household. I will only have contact with persons at my place of employment, and there I will practice all recommended social distancing, exposure limiting practices recommended by the CDC and by my employer. My child and I WILL NOT go to any gym, movie theater, nail or hair salon, park, beach, or other community location that is not for the purpose of getting food, medicines, toiletries or other life sustaining necessities until such time as it is determined by state and local health officials that the COVID-19 Public Health Emergency is over.

10. ______ I will immediately notify A STEP AHEAD management if I become aware of any person with whom my child or I have had contact exhibits any of the symptoms listed in Number 1 above, is advised to self-isolate, quarantine, or has tested positive, or is presumed positive for COVID-19. Further, I will immediately notify A STEP AHEAD management if anyone from my place of employment is presumed positive or tests positive for COVID-19 whether I have had direct contact with that person.

11. ______ I understand that while present in the facility each day my child will be in contact with children, families and other employees who are also at risk of community exposure. I understand that no list of restrictions, guidelines or practices will remove 100% of the risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I understand that I play a crucial role in keeping everyone in the facility safe and reducing the risk of exposure by following the practices outlined herein.

I, ______________________________ certify that I have read, understand, and agree to comply with the provisions listed herein. I acknowledge that failure to act in accordance with the provisions listed herein, or with any other policy or procedure outlined by A STEP AHEAD] will result in termination of services. I acknowledge that care for my child will be terminated if it is determined that my actions, or lack of action unnecessarily exposes another employee, child, or their family member to COVID-19.

Child's Name: ______________________________ DOB: ____________________

Parent's Name: ______________________________

______________________________ ____________________

Parent Signature Date

Parent's Name: ______________________________

______________________________ ____________________

Parent Signature Date

______________________________ ____________________

Management Team Witness Date

THE SCHOOL DISTRICT OF
PHILADELPHIA

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

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM