Kinder Academy, Inc.
2020-2021 Application Process

We are now accepting enrollment for the 2020-21 school year. **To enroll your child, you must submit a fully completed application, including copies of the following required documents.** Applications are available at the locations listed below and, on the days and times listed below. These documents are needed to determine program eligibility:

- Copy of child's birth certificate
- Copy of proof of address (copy of your utility bill - water, gas, or electric)
- Copy of proof of income:
  - The preferred proof of income is **last year's (2019) tax documentation**
  - If you do not have last year's tax documentation, please provide **4 consecutive weeks of paystubs**
  - **If unemployed, submit a copy of your unemployment determination letter, with the amount of payment**
  - Proof of SSI (Social Security)
  - Proof of child support (if applicable)
  - Proof of food stamps or cash assistance (SNAP or TANF)

PLEASE PROVIDE ONLY COPIES OF ALL REQUIRED DOCUMENTS. WE CANNOT ACCEPT ORIGINAL DOCUMENTS.

Completed applications will be processed in the order of receipt. You will be contacted within seven (7) business days to conduct the income verification via telephone. Please be sure that your contact information is correct. Upon review, eligible children will immediately be enrolled for the next available opening.

Applications may be dropped off (and picked up) at any Kinder Academy location on the following days and times:

Tuesdays and Wednesdays: 10:00AM - 12:00PM
Thursdays: 2:00PM - 4:00PM

Alternatively, completed applications can be mailed to the site of your choice. Addresses are listed below.

When dropping off, please be respectful of each other and follow all current social distancing requirements. There will be no face-to-face service available at this time. Please leave your application in the box provided outside and ring the bell to let the attendant know you have dropped off your application.

Kinder Academy @ Castor
7332 Elgin Street, Philadelphia, PA 19111 • Phone: 267.571.6800

Kinder Academy @ Oxford Circle CCDA
900 E. Howell Street, Philadelphia, PA 19149 • Phone: 267.571.5661

Kinder Academy @ Rhawnhurst
7922 Bustleton Avenue, Philadelphia, PA 19152 • Phone: 215.728.7700

Kinder Academy @ Parkwood
3001 Byberry Road, Philadelphia, PA 19154 • Phone: 215.612.1776

Kinder Academy @ Westminster Mayfair Presbyterian Church Child Care Center
6300 Harbison Avenue, Philadelphia, PA 19149 • Phone: 215.535.4424

At Kinder Academy, we are all Safe, Engaged, Respectful, Team Players

Kinder Academy is an equal opportunity care provider and employer

Kinder Academy, Inc Application

for Academic Year

2020 – 2021

To qualify:

1. Child must be at least 3 years old on or before September 1, 2020 and not be age-eligible for kindergarten; and,
2. Child and family must live in Philadelphia, PA; and,
3. Family must meet current Head Start or PA Pre-K Counts income guidelines; and,
4. Child's complete Preschool Application [forms and required supporting documents] must be submitted to and received by the appropriate preschool program:
    - To apply for a Kinder Academy preschool program hand-deliver your child's application to:

Kinder Academy - Castor
7332 Elgin Street
Philadelphia, PA 19111

Kinder Academy – Mayfair
6300 Harbison Avenue
Philadelphia, PA 19149

Kinder Academy – Oxford
900 E. Howell Street
Philadelphia, PA 19149

Kinder Academy – Rhawnhurst
7922 Bustleton Avenue
Philadelphia, PA 19152

Kinder Academy – Parkwood
3001 Byberry Road
Philadelphia, PA 19154

Kinder Academy, Inc Application for Academic Year 2020 – 2021

Thank you for your interest in our preschool program! Completing and submitting a Preschool Application does not guarantee that your child will be accepted to a preschool program. For your best chance at acceptance, please submit your child's completed application **as soon as possible**.

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

- ☐ I have filled out the entire application.
- ☐ I have proof of child's date of birth (Birth certificate, health insurance card, etc.).
- ☐ I have documentation of family income (Tax forms, 4 consecutive paystubs, or financial support letter. 1040 tax form is the preferred document).
- ☐ I have proof of Philadelphia residency (bill, driver's license, lease, etc.).
- ☐ I have my child's health insurance card.
- ☐ I have my child's physical (health assessment within the year) and immunizations.
- ☐ I have proof of child's dental visit (within the year).
- ☐ I have picture identification of parent/guardian (Current State or Federal Photo ID).
- ☐ I have proof of TANF (DPW) cash, SNAP/food stamps, medical assistance (if applies to you).
- ☐ I have a custody order (if applies to you).
- ☐ I have a foster letter (if applies to you).
- ☐ I have a homeless verification letter/shelter letter (if applies to you).

Child's Name:	Date of Birth:

#1: CHILD and FAMILY INFORMATION FORM

Section 1: PRIMARY PARENT
The adult who is primarily responsible for the care and well-being of the child.

First Name:		Last Name:	
Date of Birth:		Gender: O Male O Female	
Primary language:		Other language(s):	
Home Address:			
Apt./Unit #:	City:	State:	Zip Code:
Home Phone #:		Cell Phone #:	
Email Address (please print clearly):			
Emergency Contact:		Emergency Contact Phone #:	

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

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

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

Status Select all that applies	O Single Parent – cares for the child without physical or financial assistance from the other parent	O Teen Parent – parent was under the age of 18 when child was born

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

Employment, School, Job Training Select all that applies	O Employed/Self-Employed	O Unemployed/Not Employed	O Disabled
	O In School/Job Training	O Stay-at-Home Parent	O Retired
	O Member of the U.S. military on active duty	O Veteran of the U.S. military	
Name of Employer:	Name of Employer:		
How often are you paid?	O Monthly	O Twice a month	O Every Week
	O Every two weeks	O Other:	

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

Child's Name:	Date of Birth:

Section 2: SECONDARY PARENT
An adult who shares in the care of the child.

First Name:		Last Name:	
Date of Birth:		Gender: O Male O Female	
Primary language:		Other language(s):	
O Same as Primary Parent/Guardian		Home Address:	
Apt./Unit #:	City:	State:	Zip Code:
Home Phone #:		Cell Phone #:	
Email Address (please print clearly):			
Emergency Contact:		Emergency Contact Phone #:	

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

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

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

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

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

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

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

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

Section 3: 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

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 anytime by texting STOP to 70138. For help with Ready4K text HELP to 70138 or email us at support@parentpowered.com.

Section 9: 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

Kinder Academy, Inc.

7332 Elgin Street Philadelphia, PA 19111

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: _____

Kinder Academy, Inc.

7332 Elgin Street Philadelphia, PA 19111

CHILD'S MEDICAL HISTORY FORM

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

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

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

_____ _____

Signature of Parent/Guardian Date

Kinder Academy, Inc.

7332 Elgin Street Philadelphia, PA 19111

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: _____

Kinder Academy, Inc.

7332 Elgin Street Philadelphia, PA 19111

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

Kinder Academy, Inc.
7332 Elgin Street
Philadelphia, PA 19111

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 _____

Kinder Academy, Inc.

7332 Elgin Street
Philadelphia, PA 19111

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 _____

_____

_____

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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 <u>does not</u> 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 _____

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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									

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 _____

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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: _____

   ☐ Medical – please indicate reaction and treatment: _____

   _____

2. Name of restricted food: _____

   ☐ 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: _____

THE SCHOOL DISTRICT OF PHILADELPHIA

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

Child's Name: _____ Center: _____

Family Engagement Contract

By enrolling your child, you are joining us to achieve our program's mission: To bring a relentless focus on positive child and family outcomes to close the achievement gap and build a better future for children, families, and communities served by the Head Start program. To reach our ***shared mission,*** and recognizing your hopes and dreams for your child, ***we need to work together*** **as** ***equal partners***. Please officially join us in **partnership** by signing and following through on this Family Engagement Contract.

One hope or dream I have for my child is ...

Our program will do the following for you and your child:

- **Provide** an excellent education program -- every day-- for all of our students.
- **Guide** you through the process of learning and doing high quality parent child activities that support your child's learning at home.
- **Support** you to keep your child healthy and well.
- **Honor** your family's unique strengths, needs and circumstances.
- **Build** an environment that welcomes ALL families as partners in our program.
- **Welcome** your voice...and create opportunities for you to provide feedback and to be heard.
- **Offer** many ways for you to participate and volunteer at our program.

I _____ will do the following:

[parent or guardian's name]

- **Bring** my child to school **on time and every day.**
- **Participate** in **my child's learning** by completing **home learning activities.**
- **Read with my child daily or as often as possible.**
- **Attend** center activities to help build community and to advocate for my child and family.
- **Partner** with our program to keep my child healthy.

Partnership Agreement: We agree that we will work together as equal partners to achieve goals set for my child's school readiness and my family.

Parent/Guardian Signature**:** _____ Date:_____

Staff Signature:_____ Date: _____

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FAMILY INTEREST SURVEY

Head Start is committed to providing workshops and training opportunities that meet the needs of parents and caregivers. We want these opportunities to be interesting, informative, helpful and fun. Throughout the year you will receive information through many different resources such as information flyers, workshops and parent meetings. Please take a few minutes to complete the survey below to assist us in better serving you this year.

Family Name: _____Child's Name: _____

CHILD DEVELOPMENT

___ Ages 3-5
___ Infants and toddler's
___ Reading with children
___ Potty training
___ Discipline
___ Other_____

PARENTING/ FAMILY LIFE

___ Child support laws
___ Peer pressure issues
___ Step parenting & blended families
___ Grandparents raising children
___ Childcare after school
___ Divorce / separation
___ Sibling rivalry
___ Fatherhood
___ Caring for the elderly
___ Custody Issues
___ Co-parenting/communication
___ Child Abuse laws
___ Other_____

MENTAL HEALTH

___ Building relationships
___ Building self – esteem
___ Stress management
___ Death, dying & grief support
___ Understanding anger
___ How to deal with fear
___ Dealing with substance abuse (alcohol or drugs)
___ Domestic violence
___ Counseling resources
___ Bullying
___ Time management
___ Becoming trauma informed
___ Other_____

HOME MANAGEMENT

___ Budgeting / money management
___ Credit counseling
___ Law on Renters rights
___ Cost saving household tips
___ Furniture / appliances
___ Housing repairs / weatherization
___ Energy assistance
___ Using coupons
___ Housing
___Other_____

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PERSONAL

___ Expanding your education
___ Resume writing / job readiness
___ Setting realistic goals
___ GED
___ Financial aid for school
___ SSI or social security guidelines
___ Obtaining a driver's license
___ ESL
___ Other_____

JUST FOR FUN

___Crafts – home decorations
___ Aerobics
___ Make over tips (hair, make –up, etc.)
___ Group sports (softball, bowling, etc.)
___ Computer classes
___ Sewing
___ Relaxation tips
___ Free Cultural activities
___Other_____

HEALTH & SAFETY

___ Child proofing your home
___ Allergies & asthma
___ Diabetes
___ First Aid / CPR
___ Poisons and look-alikes/over the counter medication
___ Smoking cessation
___ Signs of drug /alcohol abuse
___ Health insurance coverage
___ Signs of lead poisoning
___ The importance of dental health
___ Women's health issues
___ Men's health issues
___ Other_____

NUTRITION

___ Cooking & baking workshops
___ Healthy snacks
___ Understanding food labeling
___ Cooking with children at home
___ Healthy eating & weight control
___ Exercising to good health
___ Overweight child
___ Underweight child
___ Low cost meal planning
___ Other_____

ADDITIONAL COMMENTS OR INTERESTS:

_____

_____

_____

Revised 8/13

CHILD HEALTH REPORT

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

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:

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

DIAPER CREAM AND ANY TYPE OF SUNSCREEN MAY BE APPLIED AS NEEDED:

○ YES ○ NO IF NO, PLEASE EXPLAIN YOUR ANSWER

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:

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#10: 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 _____