Child's Name:_____ Date Received: _____

Date of Birth: _____ First Preference:_____

# Jefferson County Pre-K Application Packet

____ Enrollment Form

____ Dental

____ Health Check

____ Immunizations

____ Birth Certificate

____ Preferences

Your completed application (all components) must be turned in at the Head Start/Pre-K TA Lowery site (the brick building located to the right of TA Lowery Elementary School) 221 Warm Springs Rd., Shenandoah Junction, WV. After receipt of your application you will be contacted by a Pre-K staff member to review the status of your application. If it is necessary to schedule a face to face appointment they will be held on Tuesdays at the Head Start/Pre-K TA Lowery site from 9:30AM to 2:30PM.

PLEASE NOTE: New age regulations for the 2018-2019 school year require potential students to expereince their fourth birthday by June 30 , 2018! This regulation is based on the WV Senate Bill 186. http://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=SB186%20SUB2%20enr.htm&yr=2017&sesstype=RS&i=186

# Jefferson County Pre-K/ Head Start Registration Preferences 2018-2019

221 Warm Springs Rd.
Shenandoah Junction, WV 25442
phone – 304-724-9942
fax – 304-725-7511

**Child's Name:** _____ **Date of Birth:** _____ **Gender:** _____

**Child's Social Security Number:** _____ **Foster Care: (Y/N)** _____ **TANF: (Y/N)** _____

**Parent or Guardian's name:** _____

**Street Address:** _____

**City/Town/Zip:** _____

**Main Phone number:** _____ **Other phone:** _____

**Email address:** _____

Please indicate 3 sites that you would prefer by placing a #1, 2, or 3 on the line next to the site name. Sites that have transportation are the HS/Pre-K sites listed in the box on the right. Sites that offer before and after childcare say; "wrap around care," next to the site name and they are listed in the box on your left. All sites are **Full Day** programs operating 5 to 6 hours per day depending on the location.

**_____ I do have transportation**
**(You may pick from either box)**

_____Blue Ridge Elementary Universal
_____Children First (wrap around)
_____Driswood Elementary Universal
_____North Jefferson Elementary Universal
_____Shepherdstown Daycare (wrap around)
_____TA Lowery Universal Pre-K/PSSN

**_____ I do not have transportation**
**(Sites below *may* have transportation available)**

_____ Blue Ridge Elementary HS/Pre-K
_____ Driswood Elementary HS/Pre-K
_____ South Jefferson HS/Pre-K
_____ TA Lowery HS/Pre-K

Reason for choice check all that apply:
1._____ JCS Employee 2._____Childcare location 3. _____Wrap around care needed

4._____Transportation 5._____ Same school sibling attends

6._____ Previously attended childcare/Head Start child

Yearly: _____ Monthly: _____Weekly: _____ SSI: (Y/N) _____
Approximate gross family income (required for data collection)

Total number in family: _____ # of Children under 4 :_____

Parent/Guardian Signature: _____ Date: _____

***Jefferson County Schools Universal Pre-K Programs are a non-discriminatory collaboration between Jefferson County Pre-K, Head Start, Child Care Centers and Office of Special Education.***

School Year_____
Student # _____

**Student Contact Information**
**Use Blue or Black Ink**

**2015-2016**
Please complete all blanks

**SOP 8.18a**

**Basic Student Information – Part I**

Last Name _____ First Name_____Middle_____ Other_____
Sex____ Date of Birth_____ Age_____ Birthplace (City and State)_____
School_____ Grade_____ Social Security Number_____
Transferred From_____Address_____

☐ NOT born in any state *
***(State refers to the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico)**

☐ Has NOT been attending one or more schools in any one or more states* for more than 3 full academic years.
If no, how many years at the point of enrollment. **CIRCLE 3 2 1 0**
***(State refers to the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico)**

**911 Address**_____
_____City_____State/Zip_____
**Mailing Address**
_____
_____City_____State/Zip_____
Student Home Phone #_____Listed or Unlisted
Transported by Bus _____Yes or _____No Bus # AM _____ PM _____ Special Medical Need_____
List siblings_____
Is the home language English _____Yes or _____No Native Language_____
Hispanic? (Y/N)_____ Race Options (check all that apply): White___ Black____ Asian___ Amerind___ Pacific____

**_____ Call Order*** **Parent/Guardian Information – Part II**

Last Name_____First Name_____Middle_____Relationship_____
**911 Address** Home Phone# _____Cell Phone# _____Pager #_____
_____City_____State/Zip_____
**Mailing Address**
_____
_____City_____State/Zip_____
Employer_____ Work Phone #_____ Ext_____
Occupation_____ Cell #_____ Ext_____
Pager #_____ Ext_____E-Mail _____
Is a translator needed to communicate with parent/guardian? _____Yes _____No

**_____ Call Order*** **2nd Parent/Guardian Information – Part III**

Last Name_____First Name_____Middle_____Relationship_____
**911 Address** Home Phone # _____Cell Phone #_____Pager #_____
_____City_____State/Zip_____
**Mailing Address**
_____City_____State/Zip_____
Employer_____ Work Phone #_____ Ext_____
Occupation_____ Cell #_____ Ext_____
Pager #_____ Ext_____E-Mail _____

**_____ Call Order*** **Emergency Contact Information – Other than a Parent/Guardian for Immediate Pickup from School – Part IV**

Last Name_____First Name_____Middle_____ Title_____Relationship_____
**911 Address**
_____City_____State/Zip_____
**Mailing Address**
_____City_____State/Zip_____
Day Time Phone #_____ Cell Phone #_____Pager #_____
E-Mail _____

***Call Order indicates the order in which to telephone contacts in the event of an emergency (1, 2, 3).**

This questionnaire in this section is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information will help determine the services the student may be eligible to receive.
1. Is your current address a temporary living arrangement? ____ Yes ____No
2. Is this temporary living arrangement due to loss of housing or economic hardship? ____Yes ____No

**– School Use Only –**
CR or
HR Teacher _____
Date entered into
the computer _____

_____ Print Name of Parent/Guardian

_____ Signature of Parent/Guardian

_____ Date

**Copies to: Principal – Teacher – Health Nurse – Transportation Department – Attendance Director**

School Year_____
Student # _____

**Student Contact Information**
**Use Blue or Black Ink**

**2015-2016**
Please complete all blanks

**SOP 8.18b**

Student_____ School _____

In case my child becomes seriously ill or injured at school take my child to _____. The physician and the hospital are hereby authorized to render such treatment as may be deemed necessary in an emergency for the health of my child.

_____ _____
Print Name of Parent/Guardian | Signature of Parent/Guardian

_____ _____ _____ _____ _____
Home Phone # | Work Phone # | Cell Phone # | Pager # | E-Mail Address

Name of Physician_____ Phone #_____
Physician's Address_____

Does the above student have any of the following?

| Description | Yes | No | Explanation | Medication/Dosage |
|---|---|---|---|---|
| 1. Heart Defect | | | | |
| 2. Diabetes | | | | |
| 3. Convulsive/Seizure Disorder | | | | |
| 4. Cerebral Palsy | | | | |
| 5. Visual Impairment | | | | |
| a. Corrective Glasses | | | | |
| 7. Hearing Impairment | | | | |
| a. Hearing Aid | | | | |
| 8. Orthopaedic Impairment | | | | |
| a. Wears Prosthesis | | | | |
| 9. Scoliosis | | | | |
| 10. Behavioral Disorders | | | | |
| 11. Urinary Tract Disorders | | | | |
| 12. Gastro/Intestinal Disorder | | | | |
| 13. Asthma | | | | |
| 14. Allergies | | | | |
| a. Seasonal | | | | |
| b. Food | | | | |
| c. Bee Sting | | | | |
| 15. Nasal/Respiratory Disorder | | | | |
| 16. Limited Activities | | | | |
| 17. Premature Birth | | | | |
| 18. Other | | | | |

**Special Instructions:**

**– School Use Only –**
HR Teacher _____

Date entered into the computer _____

_____ _____ _____
Print Name of Parent/Guardian | Signature of Parent/Legal Guardian | Date

**I AM 18 YEARS OF AGE OR WILL BE 18 YEARS OF AGE DURING THIS SCHOOL YEAR AND HEREBY GRANT MY CONSENT FOR JEFFERSON COUNTY SCHOOLS TO CONTACT MY LEGAL GUARDIAN IN CASE OF AN EMERGENCY.**

**STUDENT'S SIGNATURE**_____ **DATE**_____

**Copies to: Principal – Teacher – Health Nurse – Department Transportation**

_____ _____ _____
Print Name of Parent/Guardian | Signature of Parent/Guardian | Date

**Copies to: Principal – Teacher – Health Nurse – Transportation Department – Attendance Director**

# JEFFERSON COUNTY SCHOOLS

## Student Residency

*By completing this questionnaire, you help the county comply with the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. Your truthful and accurate answers help the county identify services that the student may be eligible to receive.*

School:_____ Last School Attended:_____

Student Name:_____ ☐ Male ☐ Female Age:_____ Grade:_____

Student WVEIS Number:_____ Date of Birth:_____

Parent(s)/Legal Guardian(s) Name:_____

Telephone: Work:_____ Home:_____ Cell:_____

*This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.*

1. Is your current address a temporary living arrangement? _____ YES _____NO

2. The student lives with: ☐ 1 parent ☐ 2 parents ☐ 1 parent & another adult ☐ a relative, friend(s), or other

3. Where is the student living now? (Check one box)

   ☐ In a shelter ☐ In a motel/hotel ☐ In a car ☐ In a camper or campsite

   ☐ With more than one family in a house or apartment

   ☐ With friends or family members (other than parent/guardian)

   ☐ A public or private place not ordinarily used as a regular sleeping accommodation.

   ☐ None of the above

4. Do you need help obtaining any of the following records:

   ☐ Birth Certificate ☐Immunization/Medical Records ☐ Academic Records

   ☐ Guardianship Records (If applicable) ☐ Evaluation for Special Services/Programs

5. Services received at "Last School Attended" (Check all that apply)

   ☐ Title I ☐ Free Lunch ☐ Social Services ☐ Special Education

6. List the student's siblings who also attending Jefferson County Schools below: (if applicable)

   Sibling Name: _____ School Attending: _____

   Sibling Name: _____ School Attending: _____

   Sibling Name: _____ School Attending: _____

Parent/Legal Guardian's Signature: _____ Date: _____

**Sheri L. Hoff, Ed. D.**

**Director of Attendance/Homeless Liaison**

**110 Mordington Avenue**

**Charles Town, WV 25414**

**Voice: 304-728-9249 Fax: 304-728-4574**

Jefferson County Schools

# HOME LANGUAGE SURVEY

Student Name_____ Birth Date_____ Sex: _____Male _____Female

Parent or Guardian Name_____

Address_____

Home Telephone _____ Work Telephone _____

School _____ Grade_____ Date_____

1. Was your child born in the United States? _____Yes _____No
   If yes, in which state?_____
   If no, in what other country? _____
2. Has your child attended any school in the United States for any three years during his/her lifetime?
   _____Yes _____No
   If yes, please provide school name(s), state(s), and date(s) attended:
   Name of School_____ State_____ Dates Attended _____
   Name of School_____ State_____ Dates Attended _____
   Name of School_____ State_____ Dates Attended _____
3. What language is spoken at home? _____
4. If available, in what language would you prefer to receive communication from the school?_____
   _____
5. Please check if your child is: A. _____Native American Indian B. ____Alaska Native
   C. _____Native Pacific Islander D. ____Native U. S. Virgin Islander
6. Is your child's first-learned or home language anything other than English? _____ Yes _____ No

**If you responded "Yes" to question number 6 above, please answer the following questions:**

7. What language did your child learn when he/she first began to talk? _____
8. What language does your child most frequently speak at home? _____
9. In what language do you most frequently speak to your child? Father_____
   Mother_____
10. What language can your child read fluently?_____
11. What language can your child write fluently?_____
12. Please describe the language <u>understood by your child</u>. (Check only one.)
    A._____Understands only the home language and no English.
    B._____Understands mostly the home language and some English.
    C._____Understands the home language and English equally.
    D._____Understands mostly English and some of the home language.
    E._____Understands only English.

_____ _____
Parent or Guardian's Signature Date

Please send all originals to the ESL teacher for processing.

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

4 Year Form

Name_____DOB_____Age_____Sex: M F Wt_____Ht_____BP_____Temp_____Pulse_____Screen Date_____

Allergies: ◻ NKDA _____ Current Meds: ◻ None _____

Accompanied by: ◻ Parent ◻ Grandparent ◻ Foster parent/organization ◻ Other _____

Health conditions that may require care at school:_____

◻ Vision Acuity Screen (obj) R_____ L_____
◻ Unable to obtain, re-screen in 4-6 month
Wears glasses ◻ Yes ◻ No

◻ Hearing Screen (obj)
25 db@ 20 db@
R ear:____500HZ R ear:____1000HZ ____2000HZ _____4000HZ
L ear:____500HZ L ear:____1000HZ ____2000HZ _____4000HZ
◻ Unable to obtain, re-screen in 4-6 months
Wears hearing aids ◻ Yes ◻ No

Oral Health Screen
Date of last dental visit_____
Water source: ◻ Public ◻ Well ◻ Tested
Fluoride ◻ Yes ◻ No
◻ Current dental problems:

◻ Developmental Surveillance: ✓_____
Gross Motor:
◻ Walks, climbs, runs ◻ Hops, jumps on 1 foot
◻ Up/down stairs alternating feet, without support
◻ Throws overhand ◻ Rides bicycle with training wheels
Fine Motor:
◻ Builds 10 block tower ◻ Uses utensils ◻ Has manual dexterity
◻ Draws 3 part person ◻ Puts on/removes clothes
Communication:
◻ Uses past tense ◻ Talks about daily experiences
◻ Speaks intelligibly ◻ Uses 4-5 word sentences
◻ Short paragraphs ◻ May show some lack of fluency
Cognitive: ◻ Names 4 colors ◻ Aware of gender (self and others)
◻ Knows difference between fantasy and reality
Social: ◻ Listens to stories ◻ Can sing a song
◻ Plays interactive games with peers ◻ Elaborate fantasy play

Immunizations: Attach current immunization record
◻ UTD ◻ Given, see vaccine record
Referrals: ◻ Developmental ◻ Dentist ◻ Vision
◻ Hearing ◻ Blood lead 10≥ug/dl ◻ CSHCN 1-800-642-9704
◻ Other:

◻ Risk indicators reviewed/screen complete

Please Print Name of Facility or Clinic

Signature of Clinician/Title

School Entry Requirements

---

History: ◻ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: ✓_____
◻ No change
◻ Family situation change

Caretaker(s) working outside home? ◻ Yes ◻ No
Child care? ◻ No ◻ Yes_____
Other changes since last visit:

Current Health Indicators: ✓_____
◻ No change
Changes since last visit:

School: Grade_____◻ Attends school regularly ◻ N/A
◻ Ability to separate from parents _____
◻ Gets along with other family members

◻ GROWTH PLOTTED ON GROWTH CHART
◻ BMI CALCULATED AND PLOTTED ON BMI CHART

◻ Normal elimination
◻ Normal sleep patterns
◻ Appropriate behavior

Nutrition: ◻ Normal eating habits
◻ Vitamins_____
◻ Passive smoking risk ◻ Yes ◻ No

✓_____
Hemoglobin/Hematocrit Risk: ◻ Low risk ◻ High risk

Dyslipidemia Risk: ◻ Low risk ◻ High risk

Tuberculosis Risk: ◻ Low risk ◻ High risk

Lead Risk: ◻ Low risk ◻ High risk
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
◻ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
◻ Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: ✓_____

| | | |
|---|---|---|
| ◻ General Appearance | | ◻ Skin |
| ◻ Neurological | | ◻ Reflexes |
| ◻ Head | | ◻ Neck |
| ◻ Eyes | ◻ Red Reflex | ◻ Ocular Alignment |
| ◻ Nose | ◻ Ears | ◻ Oral Cavity/Throat |
| ◻ Lungs | ◻ Heart | ◻ Pulses |
| ◻ Abdomen | | ◻ Genitalia |

Abnormal Findings and Comments:
Possible signs of abuse ◻ Yes ◻ No

Health Education:
◻ Discussed ◻ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction
Other:

Assessment: ◻ Well Child ◻ Other diagnosis

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

**HCT/HGB** _____

**Lead Blood Score** _____

Follow Up/Next Visit: ◻ 5 years of age ◻ Other

**Jefferson County Universal Pre-K/Head Start**
Jefferson County
Pre-K/Head Start
221 Warm Spring Ave.
Shenandoah Junction, WV. 25442
Phone: 304-724-9942
Fax: 304-725-7511

**CHILD - ORAL HEALTH**

Date exam completed: ___/___/___ Name: _____

**ORAL CONDITION**

KEY

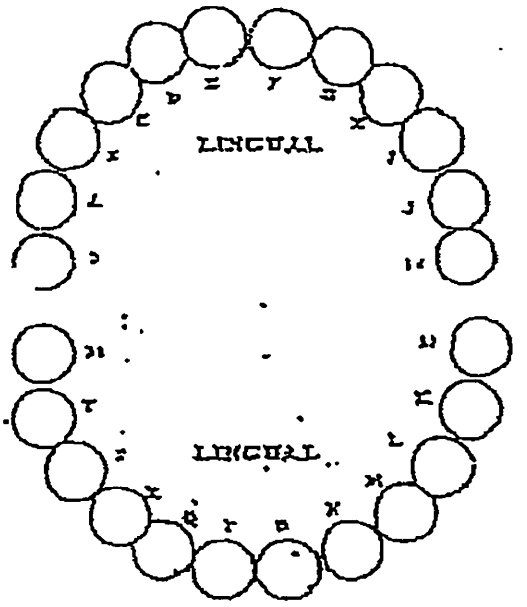
X Missing

Decayed

Filled

UPPER

RIGHT



LEFT

LOWER

Number of times per day child brushed teeth: |__|__|

Gum Condition:

☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Dental Needs:

☐ No Needs ☐ Treatment ☐ Cleaning
☐ Fluoride Supplement ☐ Oral Hygiene Instruction
☐ Other: Specify _____

Comments/Follow-up

Follow-up/6 months check-up date _____

D.D.S. Signature: _____ Date: _____

Stamp

phone #:

Address:

AK/2018