Date Received_____

Jefferson County Pre K Application Packet

Your completed application (all components) must be turned in at the Head Start/Pre-K TA Lowery Site (brick building located to the right of TA Lowery Elementary School) 221 Warm Springs Rd., Shenandoah Junction, WV 25442

____ **Enrollment Form**

____ **Dental**

____ **Health Check**

____ **Immunizations**

____ **Birth Certificate**

____ **Preferences**

You will be contacted by a Pre-K staff member to schedule a face-to-face registration appointment.

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 _____

Jefferson County Pre-K/ Head Start Registration Preferences 2017-2018

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/S) _____TANF: (Y/S) _____

Parent or Gaurdian's name: _____

Street Address: _____

City/Town/Zip: _____

Main Phone number: _____ Other phone: _____

Email addres: _____

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)
_____Small Scholars (wrap around)
_____TA Lowery Universal Pre-K/PSSN

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

_____ Blue Ridge Elementarty 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._____ Jefferson Co. Employee 2._____Childcare 3. _____Wrap around 4. _____Transportaion

4._____Same school sibling attends 5. _____ Previously attended childcare/ Returning Head Start child

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

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

Parent/Gaurdian 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.

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

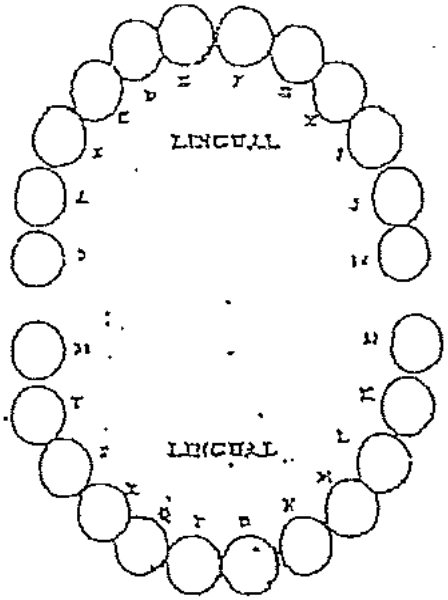
CHILD - ORAL HEALTH

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

ORAL CONDITION

KEY
X Missing
Decayed
Filled

UPPER

RIGHT  LEFT

LOWER

Number of times per day child brushed teeth: l__l__l

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/2017

Jefferson County Universal Pre-K/Head Start
PHYSICAL EXAM – CHILD

Jefferson County
Pre-K/Head Start
221 Warm Springs Rd.
Shenandoah Junction, WV 25442
phone – 304-724-9942
fax – 304-725-7511

Name: _____

Date exam completed: _____

PHYSICAL EXAM/ASSESSMENT	NORMAL	ABNORMAL	REFER	NOT EVAL
HCT/HGB _____ (Head Start requirement)	☐	☐	☐	☐
Height _____	☐	☐	☐	☐
Weight _____	☐	☐	☐	☐
Lead blood test score _____				
Lead risk assessment _____ (Head Start requirement)	☐	☐	☐	☐
TB Risk Assessment				
TB needed Yes No				
General Appearance	☐	☐	☐	☐
Posture, Gait	☐	☐	☐	☐
Speech	☐	☐	☐	☐
Head	☐	☐	☐	☐
Skin	☐	☐	☐	☐
Eyes External aspects	☐	☐	☐	☐
Optic fundoscopic	☐	☐	☐	☐
Cover test - screening	☐	☐	☐	☐
Ears External Canal	☐	☐	☐	☐
Hearing	☐	☐	☐	☐
Nose, Mouth, Pharynx	☐	☐	☐	☐
Teeth	☐	☐	☐	☐
Heart	☐	☐	☐	☐
Lungs	☐	☐	☐	☐
Abdomen (include hernia)	☐	☐	☐	☐
Genitalia	☐	☐	☐	☐
Bones, Joint, Muscles	☐	☐	☐	☐
Neurological/Social	☐	☐	☐	☐
Gross motor	☐	☐	☐	☐
Fine motor	☐	☐	☐	☐
Communication skills	☐	☐	☐	☐
Cognitive	☐	☐	☐	☐
Self-help skills	☐	☐	☐	☐
Social skills	☐	☐	☐	☐
Glands (Lymphatic/Thyroid)	☐	☐	☐	☐
Muscular Coordination	☐	☐	☐	☐
Other	☐	☐	☐	☐

Allergies_____

Current/prescribed medications_____

Follow-up	Doctor's Signature: _____ Date: _____ Printed Name of Dr: _____ Name/Stamp:_____ Phone: _____ Address:_____ _____

Screen Date _____

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_____ BMI_____ BP_____ Pulse_____ Temp_____

Allergies: ◻ NKDA _____ Current Meds: ◻ None_____

Accompanied by: ◻ Parent ◻ Grandparent ◻ Foster parent ◻ Foster 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
Wears hearing aids ◻ Yes ◻ No

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

Developmental

Developmental Surveillance: ✓ *Check those that apply*
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 ◻ Emotional ◻ Dentist ◻ Vision
◻ Hearing ◻ Blood lead 10≥ug/dl ◻ CSHCN **1-800-642-9704**

Provider signature required for validation
◻ **Risk indicators reviewed/screen complete**

_____
Please Print Name of Facility or Clinic

_____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: ◻ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations:

Social Emotional Health/Interpersonal Trauma[1]

Social/Family: ✓ *Check those that apply*
◻ Family situation change ◻ No change

_____
Has your child lived anywhere but with parent(s)/caretaker(s)?
◻ Yes ◻ No _____
Parent(s)/Caretaker(s) working outside home? ◻ Yes ◻ No
Child care? ◻ Yes ◻ No _____
Ability to separate from parent(s)/caretaker(s)? ◻ Yes ◻ No
Sibling(s) in the home? ◻ Yes ◻ No _____
Gets along with other family members? ◻ Yes ◻ No

Social Emotional/Stress Indicators: ✓ *Check those that apply*
Is there stress in the home? ◻ Yes ◻ No

_____
Has your child ever had a really scary or bad experience that they cannot forget? ◻ Yes ◻ No _____
Does your child have bad dreams or nightmares? ◻ Yes ◻ No

_____
Has your child experienced an emotional loss? ◻ Yes ◻ No

_____

Risk Indicators: ✓ *Check those that apply*
Exposure to: ◻ Passive Smoke ◻ Cigarettes ◻ E-Cigs ◻ Chew
◻ Alcohol ◻ Other drugs_____
◻ Access to weapon(s) ◻ Has a weapon(s)
Do you utilize a car/booster seat for your child ◻ Yes ◻ No
◻ Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____

Pre-school ◻ Yes ◻ No
◻ Attends school regularly _____ ◻ NA
◻ Special classes_____ ◻ NA
◻ Participates in extracurricular activities_____

Physical Health

Current Health Indicators: ✓ *Check those that apply*
◻ No change
Changes since last visit:

Nutrition: ◻ Normal eating habits ◻ Vitamins_____

◻ Normal elimination ◻ Normal sleep patterns

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?

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: ◻ Low risk ◻ High risk
Dyslipidemia Risk: ◻ Low risk ◻ High risk
Tuberculosis Risk: ◻ Low risk ◻ High risk

Physical Examination: ✓ = *Normal limits*

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

Assessment: ◻ **Well Child** ◻ **Other Diagnosis**

Labs: ◻ Blood lead, if needed or high risk

Referrals: *see above* ◻ Other

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

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

[1] Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian.
For assistance phone 844-HELP4WV (844-435-7498).