Preschool Application for

Academic Year 2019-2020

Full Day Pre-K!!!

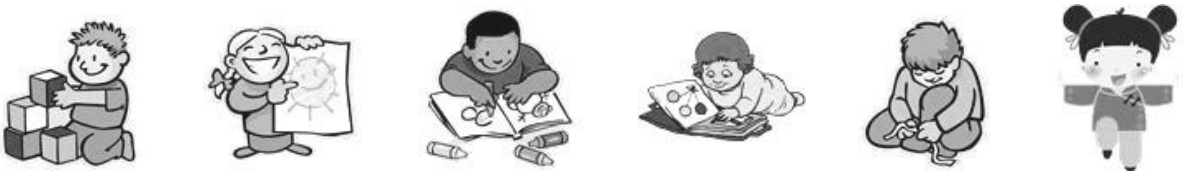
Ages 3-5

(3 yrs. Old *before* Sept. 1st. 2019)
(5 yrs. Old *after* Sept. 1st. 2019)

Program Benefits:

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

Precious Angels Preparatory Academy
6100 N Broad St
Philadelphia, PA 19141



Thank you for your interest in the Precious Angles Preparatory Academy 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 on or before February 28th, 2019.

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

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

Child's Name:	Date of Birth:

#1: CHILD and FAMILY INFORMATION FORM

Section 1: PRIMARY PARENT

The adult who is primarily responsible for the care and well-being of the child.

First Name:	Last Name:
Date of Birth:	Gender: ◯ Male ◯ 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:	◯ Home Phone #	◯ Cell Phone #	◯ Email	◯ Emergency Contact
Marital Status Select one	◯ Married	◯ Single	◯ Widowed	◯ Separated/Divorced

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

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

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

Education Select highest Diploma/Degree earned or highest Grade Level completed	◯ High School Diploma	◯ GED	◯ Vocational Degree
	◯ Associates Degree	◯ Bachelors Degree	◯ Masters Degree
	◯ Doctorate Degree	◯ Some College	◯ ESL – English as a Second Language
	◯ 11th Grade	◯ 10th Grade	◯ 9th Grade or lower
	◯ Other (specify):		
	◯ Employed/Self-Employed	◯ Unemployed/Not Employed	◯ Disabled

Employment, School, Job Training Select all that applies	◯ In School/Job Training	◯ Stay-at-Home Parent	◯ Retired
	Program ◯ Member of the U.S. military on active duty	◯ Veteran of the U.S. military	
Name of Employer:	Name of Employer:		
How often are you paid?	◯ Monthly	◯ Twice a month	◯ Every Week
	◯ Every two weeks	◯ Other:	

Do you have a disability or disabilities? If 'Yes', please list your disabilities:	◯ Yes	◯ No
Do you have health insurance? If 'Yes', name of health insurance provider:	◯ Yes	◯ 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: ◯ Male ◯ 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	◯ Home Phone #	Emergency Contact: ◯ Cell Phone #	◯ Email	◯ Emergency Contact
Marital Status Select one	◯ Married	◯ Single	◯ Widowed	◯ Separated/Divorced

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

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

Race/Ethnicity Select all that applies	◯ Hispanic or Latino/a	◯ American Indian	◯ Asian
	◯ Black or African American	◯ Multi-Racial or Bi-Racial	◯ Native Hawaiian
	◯ Pacific Islander	◯ White	◯ Other (specify):
Education Select highest Diploma/Degree earned or highest Grade Level completed	◯ High School Diploma	◯ GED	◯ Vocational Degree
	◯ Associates Degree	◯ Bachelors Degree	◯ Masters Degree
	◯ Doctorate Degree	◯ Some College	◯ ESL – English as a Second Language
	◯ 11th Grade	◯ 10th Grade	◯ 9th Grade or lower
	◯ Other (specify):		
Employment, School, Job Training Select all that applies	◯ Employed/Self-Employed	◯ Unemployed/Not Employed	◯ Disabled
	◯ In School/Job Training	◯ Stay-at-Home Parent	◯ Retired
	Program ◯ Member of the U.S. military on active duty	◯ Veteran of the U.S. military	
Name of Employer:	Name of Employer:		
How often are you paid?	◯ Monthly	◯ Twice A month	◯ Every Week
	◯ Every two weeks	◯ Other:	

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

1st Location Choice:
Precious Angels Preparatory Academy

Section 4: CHILD

First Name:		Last Name:	
Date of Birth:		Gender: ◯ Male ◯ Female	
Race/Ethnicity Select all that applies	◯ Hispanic or Latino/a	◯ American Indian	◯ Asian
	◯ Black or African American	◯ Multi-Racial or Bi-Racial	◯ Native Hawaiian
	◯ Pacific Islander	◯ White	◯ Other (specify):
Primary language:		Other language(s):	
English is spoken in the home.		◯ Yes	◯ No

Child's English skills: ◯ Very well ◯ Well ◯ Not well ◯ Does not speak English		
There is an active custody arrangement for this child.	◯ Yes	◯ No
Child lives with (select all that applies): ◯ Mother ◯ Step-Mother ◯ Foster Parent/Kinship Parent ◯ Father ◯ Step-Father ◯ Grandparent ◯ Relative ◯ Other		
Child has a disability. If 'Yes', list all disabilities:	◯ Yes	◯ 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):	◯ Yes	◯ No
◯ Speech Therapy ◯ Special Instruction ◯ Physical Therapy ◯ Occupational Therapy ◯ Other		
Child wears diapers. (Some locations cannot accept children in diapers.)	◯ Yes	◯ No
Child wears pull-ups? ◯ Daytime ◯ Naptime ◯ Nighttime ◯ Other?	◯ Yes	◯ No
If 'Yes', will child be able to use the toilet with little adult assistance while in preschool?	◯ Yes	◯ No
Child is/was in preschool or daycare. ◯ No ◯ Yes – name:		
Child's mother and/or father is currently incarcerated.	◯ Yes	◯ No
Child's mother and/or father is deceased.	◯ Yes	◯ No
There have been important changes in my child's life during the last 12 months.	◯ Yes	◯ No
If 'Yes', please explain:		
Child was referred to a preschool program from a mental health provider.	◯ Yes	◯ 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	◯ Own	◯ Rent	◯ Transitional housing – Since what date?
	◯ Shelter – Since what date?		◯ Train or bus station, park or in car – Since what date?
	◯ Living with relatives or others to due to lack of alternative, adequate housing or due to the loss of housing – Since what date?		◯ 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?
	◯ Temporary housing situation due to emergency: eviction, flood, fire, hurricane, etc.		◯ Abandoned apartment building
	◯ Other _____		

During the past 12 months, I/we have moved from temporary to permanent housing.	◯ Yes	◯ No
During the past 2 years, I/we have moved into a new house.	◯ Yes	◯ No
We have a medically fragile child (chronic illness, terminal illness, etc.) Name of child:	◯ Yes	◯ No
Does someone in the home have a mental health concern?	◯ Yes	◯ No
Does someone in the home have a social concern (English language learner, eating disorder, custody issues, etc.)? If 'Yes', please list your concerns:	◯ Yes	◯ No
Optional Information New to the country?	◯ Yes	◯ No
Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you?	◯ Yes	◯ No

Section 6: FAMILY INCOME

Select each source of income that the Primary Parent, Secondary Parent and all children receive.

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

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

Does your family receive WIC? ◯ Yes ◯ No ◯ 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 support@parentpowered.com.

Section 9: SURVEY

How did you hear about Precious Angels's preschool program? (select all that applies):

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

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

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

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

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

LENGTH/HEIGHT	**WEIGHT**	**BLOOD PRESSURE**
_____IN/CM %ILE_____	_____LB/KG %ILE_____	(BEGINNING AT AGE 3) _____ / _____

PHYSICAL EXAMINATION	**☑ = NORMAL**	**IF ABNORMAL - COMMENTS**
HEAD/EYES/EARS/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMETIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**COMMENTS**
DTap/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TESTS	**DATE OF TEST**	**NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL**
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		

PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (attach additional sheets if necessary)

❑ **NONE** **NEXT APPOINTMENT – MONTH/YEAR:**

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
ZIP CODE:	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

#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: o 1-800-DENTIST (Toll-free, nationwide)
  - o 215-925-6050 – Philadelphia County Dental Society (for private dentists in your area)
  - o American Academy of Pediatric Dentistry - www.aapd.org o American Dental Association - www.mouthhealthy.org
  - o PCCY (Public Citizens for Children and Youth) - 215-563-5848 - www.pccy.org/issues/child-health/dental o 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

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