Dr. Tanya Turner
Superintendent

Mr. James Bunch
Assistant Superintendent

Perquimans County Schools
P. O. Box 337
Hertford, North Carolina 27944

PQ Schools

Dear Parent / Guardian:

Thank you for completing the application packet for NC Pre-K.

All required documents will need to be turned in with the completed application **before** screeners are conducted. Scheduling of appointments for screening will be set up through the Perquimans County Central office. Mrs. Brickhouse and/or Mrs. Hall will contact parents to schedule a screening time. Again, only those who have a complete application with supporting documents will be contacted.

_____ **Verification of Income** (W-2s, paystubs for at least one month, etc.)

_____ **Birth Certificate** (Your child must be four years old on or before August 31)

_____ Proof **of Residency** (i.e., water bill, electric bill, lease agreement. etc.)

_____ Health **Assessment**

_____ Dental **Assessment**

_____ **Immunizations**

_____ **Emergency Contact** (pg.5)

_____ **Health Care Professional/Preferred Hospital information** (pg. 3 of application)

_____ **Categorical Eligibility** (Supporting documentation required pg. 2)

_____ **Other:** _____

Please submit this documentation as soon as possible. If materials are not received your child will not be screened for the NC Pre-K Program. If you have any questions, you may contact Trisha Brickhouse at 426-5741. Thank you for your prompt attention to this matter.

Sincerely,

Trisha Brickhouse, MSA NBCT
Chief Academic Officer of Curriculum and Instruction
NC Pre-K Director

PQ Schools

NORTH CAROLINA NC Pre-K Prekindergarten Program

Perquimans County Schools NC Pre-K Application

Perquimans Central School NC Pre-K
PO Box 129/181 Winfall Boulevard, Winfall, NC 27985
Phone: (252)426-5332 Fax: (252)426-5480

Please return completed application and required documentation to Perquimans Central School or Perquimans County Schools Central Office. This application is not complete without proper proof of the child's birthdate, proof of residency, and all sources of family income. You must also submit a current health assessment, dental screening, and immunization records.

Contact Trisha Brickhouse for questions at 252-426-5741 or trishabrickhouse@pqschools.org.

Child's Information

Child's First Name: Last Name: Date of Birth:

Gender: ☐ Male ☐ Female Hispanic: ☐ Yes ☐ No

Race *(Please check all that apply)*: ☐Native American Indian/Alaska Native ☐Asian ☐White ☐ Black/African American ☐Pacific Islander/Hawaiian

Is the child a US Citizen?: ☐ Yes ☐ No/Do not know

Is child a North Carolina resident?: ☐Yes ☐No

County of Residence: Application Date:

Family Information

Parent/Legal Custodian/Guardian:

Family Address: City: State: Zip:

Primary Phone Number: Alternate Phone Number:

Email where parent/custodian can be reached:

With whom does the child reside? ☐Mother only ☐Father only ☐ Both parents ☐Legal Custodian ☐Legal Guardian ☐Other, please specify: _____

Does the child live with an adult who has legal custody or guardianship? ☐ Yes ☐ No

If the child lives with an adult who has legal custody, is the adult a relative or non-relative who has legal custody or guardianship? ☐Relative: _____ ☐Non-relative ☐Unknown

Housing status: ☐Permanent ☐Homeless or Emergency Homeless Shelter ☐Hotel/Motel ☐ Battered Women and Children Shelter ☐Hospital for 30 days or under ☐ Lack of permanent nighttime address ☐Other:

Family Size *(List all family members in the household.)*

Name	Relationship to Child	Date of Birth	Provide details if the family member has special needs.

Total number of adults in the house: _____ Total number of children under the age of 18 in the house: ____

Total number of family members in house: _____

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NORTH CAROLINA NC Pre-K Prekindergarten Program

Income Documentation: ***Please submit check stubs for each employed parent to document pay for one month, child support, retirement, worker's compensation, statement from supervisor, IRS 1040, unemployment/social security benefits letters or copies of all W-2s.***

Mother/Stepmother/Guardian Information: ***(only if living in the home)***

Name:

Phone Number Home: Cell: Work:

Check all that apply: ☐Employed Number of hours worked per week: _____

☐Attending secondary education ☐Attending high school/GED ☐Attending job training

☐Seeking Employment ☐ Other Employment/Explain:

Wages Before Taxes	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Alimony	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Child Support	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Worker's Comp	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Unemployment	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSI/TANF/Work First	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Overtime	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly

Father/Stepfather/Guardian Information: ***(only if living in the home)***

Name:

Phone Number Home: Cell: Work:

Check all that apply: ☐Employed Number of hours worked per week: _____

☐Attending secondary education ☐Attending high school/GED ☐Attending job training

☐Seeking Employment ☐ Other Employment/Explain:

Wages Before Taxes	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Alimony	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Child Support	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Worker's Comp	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Unemployment	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSI/TANF/Work First	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Overtime	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSA	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSDI	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly

Home Language Survey

Is your child Limited English Proficient: ☐Yes ☐ No

What is the primary language spoken in the home?

In what language would you like for your child to be screened?

Military Involvement

Is at least one parent or legal guardian on this child an active duty member of the military? ☐Yes ☐No

Was a parent or legal guardian of this child seriously injured or killed while on active duty? ☐Yes ☐No

Additional Eligibility Categories *(Check all that apply. Please provide documentation.)*

☐Experiencing Homelessness ☐ In foster care ☐Receiving refugee services

Receiving Public Assistance *(for family sizes of 8 or less*)*

☐WIC* ☐ SNAP* ☐ Public Housing* ☐ TANF/Work First*

☐Medicaid ☐ SSI* ☐ Food and Nutrition Services (Food Stamps)*

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NORTH CAROLINA NC Pre-K Prekindergarten Program

Additional Health and Developmental Factors

Does your child have a chronic health condition?

☐ Yes *(Please indicate areas of concern with check below.)* ☐ No

If yes, include appropriate documentation or sign below to release records to the child care agency.

	Seizures		Allergies		Anemia
	Weight		Behavior/Emotional		Asthma
	Diabetes		High Lead Level		Hyperactivity
	Other:				

Has your child been diagnosed with a disability and have an active IEP?

☐ Yes *(Please indicate area of disabilities with check below.)* ☐ No

If yes, include appropriate documentation or sign below to release records to the child care agency.

	Autistic		Deaf/Blind		Hearing Impaired
	Multi-handicapped		Other Health Impaired		Developmental Delay
	Orthopedically Impaired		Speech/Language Impaired		Visually Impaired
	Traumatic Brain Injury		Other:		

I give permission for _____ to provide a copy of the IEP, developmental
(Doctor's Name / Facility / Testing Location)
screening, or other information pertaining to chronic health conditions, disabilities, or IEP to the Perquimans Central School NC Pre-K screening staff.

Parent signature: _____ Date: _____

Child's Prior Placement at the time of enrollment

	Child has never been served in any preschool or child care setting
	Child is currently unserved (at home now but may previously have been in child care or some other preschool program)
	Child is currently enrolled in Headstart
	Child is in unregulated child care
	Child is in a one or two-star facility
	Child is not receiving subsidy but is in some kid of regulated child care or preschool program
	Child is receiving subsidy and is in some kind of regulated child care or preschool program.

☐ Yes ☐ No Was the child previously served by Perquimans Central School as a three year old?
If yes, in what capacity?

Parent/Guardian Signature

I certify that all information provided is true, correct, and complete. I understand that demographic, medical, and financial information is provided to document eligibility for receipt of program funds. Program staff may verify information on this application. Deliberate misrepresentation may void the application and subject me to prosecution under applicable state laws.

Parent/Guardian Signature: _____ Date: _____

Relationship to child: _____
(**If guardian signs, attach documentation of guardianship.)*

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NORTH CAROLINA NC Pre-K Prekindergarten Program

Initial next to each statement:

_____ I understand that if my child is selected for participation, family involvement is expected. My family will cooperate with programs to submit necessary documentation and applications for services.

_____ I understand that transportation may be provided by a public school bus that will consist of students from Pre-K through second grade. I also understand that riding a bus is a privilege, not a right. Bus referrals or other incidents may result in a bus suspension.

_____ I understand that if there is a change in my child's address, phone number, or attendance it is my responsibility to notify the Pre-K Staff and inform them of changes.

_____ I understand that my child will need a current, updated health assessment before she/he attends a program, along with a current copy of immunization record.

_____ I understand that due to program guidelines and funding my child may be placed on a waiting list.

_____ I understand that the program follows Child Care Center guidelines as provided by the NC Division of Child Development and Early Education and through the Perquimans County Schools policies and procedures student/parent handbook.

_____ I understand that it is important that my child attend every day that he/she is able to attend.

_____ I have received and read the NC Child Care Laws and Rules Summary.

_____ I have received and read the Discipline and Behavior Management Policy.

_____ I have received and read the Policy for Prevention of Shaken Baby Syndrome and Abusive Head Trauma.

_____ My child has permission to play outside the fenced in play area with adult supervision. (Child care rule: #1322)

_____ _____

Parent / Guardian Signature Date

Will your child need to ride the bus, if available? Yes_____ No_____

Address for bus pick up and drop off: _____

PQ Schools NORTH CAROLINA NC Pre-K Prekindergarten Program

CHILD'S APPLICATION FOR ENROLLMENT

To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually.

CHILD INFORMATION: Date of Birth: _____

Full Name: _____

Last First Middle Nickname

Child's Physical Address: _____

FAMILY INFORMATION: Child lives with: _____

Father/Guardian's Name _____ Home Phone _____

Address (if different from child's) _____ Zip Code _____

Work Phone _____ Cell Phone _____

Mother/Guardian's Name _____ Home Phone _____

Address (if different from child's) _____ Zip Code _____

Work Phone _____ Cell Phone _____

CONTACTS:

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number
Name	Relationship	Address	Phone Number

HEALTH CARE NEEDS:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional.
Is there a medical action plan attached? Yes__ No__

List any allergies and the symptoms and type of response required for allergic reactions.

_____

_____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns.

_____

_____

List any particular fears or unique behavior characteristics the child has.

_____

_____

List any types of medication taken for health care needs _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child

_____

EMERGENCY MEDICAL CARE INFORMATION:

Name of health care professional _____ Office Phone _____

Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian _____ Date _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator _____ Date _____

Dental Screening Form

When the Health Assessment Transmittal Form issued by NCDPI is used to complete the NC Pre-K child's health assessment, a **separate dental screening** must also be completed due to it not being included on the NCDPI form. Per NC Child Care Rule 10A NCAC 09 .3005 Child Health Assessment, the child's health assessment must include a dental screening, which may be recorded on this form.

Child's Name: _____
Birth date: _____/_____/_____
Gender: ____ **Male** ____ **Female**
Parent or Guardian: _____
Address: _____
City: _____
Phone number: _____ **School/Pre-K:** _____

Screener's Name _____ Screening Date___/___/___

Organization/Practice Name _____

Phone number_____

Professional affiliation (please check one):

____Dentist
____Dental Hygienist
____Physician
____Physician Assistant
____Registered Nurse
____Other Health Professional: _____

Pattern of early childhood cavities:

- o No cavities/decay present or no obvious problem
- o Cavities/decay present or dental care needed (comment required)
- o Referral for Urgent Care (comment required)

Comments:

Signature_____ **Date**_____

January 2016rev

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name:

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

Public Health
HEALTH AND HUMAN SERVICES

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification
I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: _____ Date (m/d/yyyy):

Date of Exam (if Different):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here:

Public Health
HEALTH AND HUMAN SERVICES