

Child's Name: _____



To be completed by school nurse only:

_____ Date/time packet completed _____ Verification initials of nurse

- _____ State birth certificate received (4 years old BEFORE JULY 1)
- _____ Up to date immunization record with the required immunizations completed
- _____ Completed comprehensive physical form or completed health check form (Signed by a physician within last 365 days)
- _____ Income turned in if interested in Head Start _____ Yes _____ No
- _____ Documentation of recommended oral health examination signed by child's dentist _____ Yes _____ No

2024-2025 Marshall County WV Pre-K Registration

NO ASSIGNMENT TO A SITE CAN BE MADE UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED AND VERIFIED BY SCHOOL NURSE. A final review will be made by the Marshall County Pre-K Steering team at which time placement will be made as per policy 2525. Space is limited and completion of a packet **does not** guarantee placement at your first choice. Priority will be given based on the following:

Date of completed packet	Transportation Needs
School Residency District	Sibling enrollment at same location
Child Care Needs (Before/After School)	Social Service Needs

Income verification is not required to complete the packet, but is required to obtain services provided by Northern Panhandle Head Start.

INCOMPLETE PACKETS CANNOT BE CONSIDERED FOR PLACEMENT.

Parents,

To attend Marshall County Universal Pre-K, your child must be a resident of Marshall County. Please bring the entire application along with the information below to your child's screening: (Necessary forms are provided).

► **Required prior to Pre-K site assignment**

- **Certified Birth Certificate.** It must be an original, state birth certificate. (Certificates from the hospital or county court house **are not** acceptable) application can be made at: <http://www.wvdhhr.org/bph/hsc/vital/birthcert.asp>
- **Immunization Requirements.** Certificate of immunization must be from a physician or health department
- **Comprehensive Physical Form.** Physical or completed Health Check Form (must be dated within the last 365 days)
 - Dental Examination Certificate is requested as a part of the registration packet ► **Required**

for interest in Head Start □ **Income verification.** This is needed to determine eligibility for services provided by NPHS such as bussing if your child lives within their defined area.

Parents, please complete the following:

Please indicate 1st, 2nd or 3rd choice of Pre-K sites below

<i>School/Location</i>	<i>Choice 1st, 2nd, 3rd</i>	<u>Approximate start/end</u>	<i>NP Head Start Collaborative Services if Eligible</i>	<i>Before/After Care? (fees apply)</i>
**Cameron Elementary		8:25 – 1:45	Yes	No
Center McMechen		7:55 – 1:10	Yes	No
*PLAYS Child Care Center at St Francis School Building, Moundsville (600 Jefferson)		8:30 – 1:45	No	Yes
Glen Dale Elementary		8:00 – 1:15	Yes	No
McNinch Primary		7:50– 1:05	Yes	No
** McNinch-Stepping Stones (NPHS)		7:45 – 2:00	Yes	No
Hilltop Elementary		8:00 – 1:15	Yes	No
Washington Lands Elementary		8:00 – 1:15	Yes	No

Will your child require before or after care? _____ Yes _____ No

***Before/after care services only available at sites as listed above (Fees Apply)**

Head Start provides the same quality Pre-K experience with the added benefits of bus transportation services, enhanced family support services, child development services and family involvement opportunities.

**** Bus transportation may be available at:**

Cameron and McNinch/Stepping Stones if Head Start eligibility requirements are met and child lives within defined area and accepted into one of the Northern Panhandle WV Pre-K collaborative sites.

Please ask about Northern Panhandle Head Start income guidelines and services during the screening appointment. Many of our classes are Head Start Collaborative classes. This means that MCS and Head Start share in the delivery of instruction. Several classes are taught by Marshall County employees and the teacher assistant and bus driver (and related services) are provided by Head Start. Please note, the curriculum is the same and much can be gained by providing income information for Head Start eligibility.

If you are interested in placement in a Head Start location including transportation and extended services, please complete income information on page 5!

GENERAL INFORMATION

Student Legal Name: _____
(First) (Middle) (Last)

Nickname: _____

Age: _____ Birth Date: _____ / _____ / _____ Gender: _____ Male _____ Female
(Month) (Day) (Year)

Social Security Number: _____

With whom does the child reside? _____

Are you Hispanic/Latino? _____ Yes _____ No

Ethnic Group: _____ *Choose All That Apply

- A= Asian
- B =Black or African American
- H= Native Hawaiian or Other Pacific Islander
- I = American Indian or Alaskan Native
- W = White or Caucasian

Native Language: _____ *Choose from list

- EN=English;
- SP=Spanish;
- FR=French;
- JA=Japanese;
- GR=German;
- IT=Italian;
- PO=Polish;
- AR=Arabic;
- CA=Cambodian;
- CC=Chinese Cantonese;
- CM=Chinese Mandarin;
- CR=Creole (French);
- HI=Hindi;
- HM=Hmong;
- KO=Korean;
- LA=Laotian;
- NA=Navajo;
- PT=Portuguese;
- RU=Russian;
- TA=Tagalog;
- TH=Thai;
- VT=Vietnamese;
- OT=Other

(Circle relationship to child)

Biological Mother's/Foster Mother's/Female Legal Guardian's/Grandmother's Information:

Marital Status: _____

Name: _____ Birth Date: ____/____/____ Social Security # ____ - ____ - ____
(First) (Last) MO/DAY/YR

Home Telephone No.: (____) ____ - ____ Unlisted? ____ Cell Phone No: (____) ____ - ____

Home Address: _____

Employer's Name: _____ Employer's Phone No.: (____) ____ - ____

Employer's Address: _____

Occupation: _____ Full-Time Part-Time Seasonal

Highest Level of Education: High School Diploma/GED
 College (Degree Obtained): _____
 Special Certification

Health Problems/Disabilities: Yes No (If yes, explain: _____)

(Circle relationship to child)

Biological Father's/Foster Father's/Male Legal Guardian's/Grandfather's Information:

Marital status: _____

Name: _____ Birth Date: ____/____/____ Social Security # ____ - ____ - ____
(First) (Last) MO/DAY/YR

Home Address: _____

Home Telephone No.: (____) ____ - ____ Unlisted? ____ Cell Phone No: (____) ____ - ____

Employer's Name: _____ Employer's Phone No.: (____) ____ - ____

Employer's Address: _____

Occupation: _____ Full-Time Part-Time Seasonal

Highest Level of Education: High School Diploma/GED Equivalency
 College (Degree Obtained): _____
 Special Certification

Health Problems/Disabilities: Yes No (If yes, explain: _____)

Are you interested in Head Start? _____ Yes _____ No

If "yes", complete page 5 (many of our classrooms at school sites are Head Start Collaborative classes)

If "no", go to page 6

HEAD START

NOTE: If verification of income is not provided, application for Northern Panhandle Head Start will only be considered after all children have been placed whose parents have provided the income information.

INCOME INFORMATION

Income information required for all **biological** parents residing in the child's home (Please write below, no copies needed)

Gross Taxable Income:	Mother	Father
W-2 (for previous 12 months) or current paystubs		
1040 Tax Form (for previous 12 months)		
Non-Taxable Income:	Mother	Father
Veteran's Benefits		
Social Security Benefits (retirement, death benefits)		
Unemployment Compensation		
TANF/WV Works or SSI		
Other (child support, foster, custodial stipend)		
Total Gross Family Income:		

OTHER INCOME INFORMATION

- Medical Card YES / NO
- CHIP YES / NO
- Private Insurance YES / NO
- Food Stamps YES / NO
- TANF YES / NO
- WIC YES / NO

Name/Birth Date/Gender of other people in household:

Name	Birth Date	Gender

Have you been homeless in the past 12 months? YES / NO

Currently resides in: Owns home _____ Rents house _____ Rents Apartment _____ Trailer/RV _____

Emergency Contact: Person other than parent or guardian who could be contacted in case of emergency.

1. **Name:** (Last, First, Middle) _____

Relationship to student: _____ **Address:** _____

Mailing Address: (if different) _____

Phone: Home: (____)____-____ **Unlisted?**____ **Cell:** (____)____-____

e-mail: _____

Employer: _____ **Work:**(____)____ - _____ **EXT:** _____

2. **Name:** (Last, First, Middle) _____

Relationship to student: _____ **Address:** _____

Mailing Address: (if different) _____

Phone: Home: (____)____-____ **Unlisted?**____ **Cell:** (____)____-____

EXT____ **e-mail:** _____

Employer: _____ **Work:**(____)____ - _____ **EXT:** _____

OTHER INFORMATION

Did any agency refer your child? Yes No (Contact Person & Phone):_____

Is your child presently enrolled in a day care/Head Start/preschool program? Yes _____ No _____

If yes, where?

Has any other agency worked with your child, e.g., RESA, WV Birth to Three, Pre-School Special Needs, Starting Points, Parents as Teachers, etc.?

Yes _____ No _____ If yes, who? _____

Do you suspect your child to have a disability? (Y/N) _____

Describe: _____

**PRE-K MARSHALL COUNTY SCHOOLS
STUDENT HEALTH/EMERGENCY CARE UPDATE**

Date: _____

Pupil's Name _____
(Last) (First) (Middle)

Phone (____) _____ - _____
Cell Phone (____) _____ - _____

Physician's Name _____ Phone (____) _____ - _____

Dentist's Name _____ Phone (____) _____ - _____

Emergency Contact: *Person other than parent or guardian who could be contacted in case of emergency.

Name: _____ **Phone (____)** _____ - _____

Diseases and Health History as diagnosed by a physician. Check if any of the following apply to your child:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Emotional Problem | <input type="checkbox"/> Renal Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Hyperactive/ADHD/ADD | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intestinal Problem | <input type="checkbox"/> Stomach Problem |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tourette's |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Orthopedic Problem | <input type="checkbox"/> Urinary Tract |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prosthesis | |

Describe further any health problem checked above or any health problems not listed above:

Operations (kind, age, date):

Food Allergies (list foods): _____

If special diet is required, please request special dietary needs form which must be completed by a physician.

Drug(s) Allergies:

Bee/Insect Allergies: Does your child have a severe reaction requiring an immediate injection of medication (Epi Pen)?

No ____ Yes ____ If yes, list medication _____

Is oral medication for insect sting required? No ____ Yes ____ List Medication _____

Comments on Allergies:

List any activity restrictions:

List daily medications (long term): _____

Will student need to take any medications (including inhaler) at school? No ____ Yes ____

If yes, list medications _____

A doctor's order is necessary to have all medications, inhalers, and/or Epi Pens at school. Parents are responsible for transporting medication to school, and all medications must be in a container with the prescription label from the pharmacy.

Will student need special medical treatment at school? No ____ Yes ____

If yes, special instructions:

Physical defects (deformities, speech defect, poor eyesight, impaired hearing, bad teeth): _____

Vision: glasses ____ contacts ____ color blind ____ other _____

SPECIAL NEEDS / DIAGNOSED DISABILITIES:

My child currently has an IFSP IEP (Please attach copy of document)

I have concerns or my child is currently being treated for Speech Hearing Visual Physical

The following areas of concern: Medical Psychological/Behavioral Issues

PARENT/GUARDIAN PERMISSION

Student Name _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	My child may participate in all activities scheduled in the WV Pre-K Program, which may include field trips and other program events.
<input type="checkbox"/>	<input type="checkbox"/>	My child and/or other family members may have their pictures taken to be used for in-house programs, literature/presentations, newspapers, public relations advertisements, displays, bulletin boards, or in other types of educational publications.
<input type="checkbox"/>	<input type="checkbox"/>	During the first few years of school we would like to administer a series of screening tests to your child. These tests include speech, vision, hearing and dental. Today, please ask any questions you might have regarding these screening tests and the fluoride brush-in program.
<input type="checkbox"/>	<input type="checkbox"/>	I give permission for my child to participate in these screening tests and fluoride brush-in program.

The Marshall County Schools Pre-K Program is operated collaboratively between the Marshall County Board of Education, Northern Panhandle Head Start Inc. and child care centers. As a result, confidential student information pertaining to your child may be made available to the Head Start staff or local child care director. The information which may be disclosed is that information contained on the application for the Pre-K program. The purpose for disclosing this information is to enable the coordinator and team to make eligibility determinations.

By turning in this application, you give Marshall County Board of Education permission to share confidential information pertaining to your child to Northern Panhandle Head Start Inc. and /or participating child care centers. If eligible for Head Start family support services, you will be contacted for additional information.

I understand that incomplete packets will not be considered. I understand that all information within the Pre-K application packet is protected by state and federal laws and give my permission to the Marshall County Universal Preschool Program partners to verify all information within and assign my child to a Pre-K center. I give permission for my packet of information to be sent to the assigned center at which time the information will be used to complete the Pre-K registration process for that center.

To the best of my ability and knowledge, the information on this form is correct. I understand that it is my responsibility to report any changes to this information immediately. I understand that all of this information may be shared with appropriate staff for the health and safety of my child.

In the event of serious accident or illness, emergency medical services will be called. The student will then be transported to the nearest hospital. I give the school personnel my permission to render such treatment as may be deemed necessary in an emergency for the health of my child.

Signature _____
(Parent or guardian)

(Date)

Signature _____
(STAFF MEMBER)

(Date)

MARSHALL COUNTY SCHOOLS

PRE-K ATTENDANCE & WITHDRAWAL

By enrolling your child in Marshall County Pre-K, he or she becomes a part of a preschool classroom and a friend and learning partner to each of the other children in that room. Each school day is a valuable opportunity to learn and be a part of the class. When your child is absent, he/she misses out on the day's activities and also loses time interacting and learning with their classmates, their teacher, and the other children and adults in the school. This learning is what WV Pre-K is all about. So often, absences at an early age put students behind. Students who miss frequently, are more likely to experience difficulties in school by grade 3. Your child is an important part of our program and his/her class. Due to limits on class size we are sometimes forced to have a waiting list of children wanting Pre-K services. In order to best serve each child, the following procedures must be observed.

Marshall County Pre-K is dedicated to providing appropriate family support in cases of absenteeism and will adhere to the WV Policy 2525 regarding attendance:

Enrollment in an approved participating WV Pre-K program is voluntary; however, once the child is enrolled, attendance must follow WV Code 18-8-1, et seq., which allows the program administrator (i.e. principal, director, executive director) teacher and parent/guardian to pursue disenrollment of the child. Once a child is dis-enrolled, re-enrollment is not guaranteed.

When a child misses five (5) days, a letter from the school site will be sent to parents. A conference should be held by staff with parent/guardian to emphasize the benefits of regular attendance and allow communication between parents and the school staff regarding circumstances related to the absences. Conferences with parents must be held when a child misses ten (10) and fifteen (15) days, and a school issued letter is sent at those times as well. When a child has ten (10) unexcused absences within a thirty (30) day period, it shall be considered chronic absenteeism. As a **Chronic Absent** student, your child could be dropped from our program and another child would be given the opportunity to be a part of our preschool classroom.

ANYTIME YOUR CHILD IS ABSENT FROM THE PROGRAM, IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO CONTACT THE CENTER ON THE DAY OF THE ABSENCE. UPON RETURNING PLEASE PROVIDE A WRITTEN NOTE AS TO WHY THE CHILD WAS ABSENT.

The following absences shall be **EXCUSED**:

- The center is being temporarily closed due to weather or other unforeseen circumstances. Parents/guardians will be notified by phone when feasible.
- The child is ill, hospitalized or receiving medical treatment or therapy. Upon return, a medical excuse must be submitted.
- A parent may submit notes for a total of 10 days per school year when a child is ill.
- A family member is seriously ill, hospitalized, or receiving medical treatment or therapy. □ A death in the child's immediate family. □ Court ordered visitation.

If you do not notify the center of your child's absence, a contact by phone will be made to you to check the status of your child.

Signature of Parent/Guardian

Date

Marshall County Schools



Pre-K Family Dynamics Survey

Screening Site: _____

Student Name: _____

Parent/Guardian Name: _____

How many people live in your home? (Circle one):

1 2 3 4 5 6 7 8

What is your approximate family gross income?

_____ \$0 - \$10,000

_____ \$10,001 - \$20,000

_____ \$20,001 - \$30,000

_____ \$30,001 - \$40,000

_____ \$40,001 - \$50,000

_____ \$50,001 - \$60,000

_____ \$60,001 - \$70,000

_____ above \$70,001

School Entry Dental Examination Requirements for New Students Entering PreK or Kindergarten and Students in Grade 2

Dear Parent and/or Guardian,

Children with healthy teeth live longer, have more productive lives and higher self-esteem. The oral health of your child is important to ensure their school success, health and happiness. Please work with your Dentist and school to make sure your child has a healthy smile and great life!

Starting in the 2016/17 school year, new students entering PreK or Kindergarten and students entering grade 2 are required to show proof of a dental examination and HealthCheck/comprehensive health examination prior to entry into school. If your child is going into kindergarten and did not provide proof of a dental examination in PreK, proof will need to be provided for kindergarten enrollment.

The dental examination and HealthCheck/comprehensive health examination should:

- Be completed within one year of the date of pre-enrollment or at the time of enrollment. There will be a grace period of 45 days from enrollment (first day of class) for students to provide proof of the completed dental and HealthCheck examinations.
- Provide proof that the student completed a dental and HealthCheck examination within the last 12 months at the time of enrollment. Your school may provide a form to document a student dental examination or the Dentist may have their own form which should include at a minimum, the date when the exam was given and the Dentist's signature. Your child's medical provider will provide you with the HealthCheck/comprehensive well child exam from their office.

If your child is enrolled in Medicaid, CHIP, or a health plan that includes dental coverage, or a supplemental dental plan the exam will be paid. If your child needs insurance, please visit WVInRoads at <https://www.wvinroads.org/selfservice/> to see if you qualify for Medicaid or CHIP. Insurance coverage for families can also be found at <https://www.healthcare.gov/>.

If your child has already received their HealthCheck/comprehensive health examination and dental examination, please ask your child's Doctor and Dentist to provide you with proof. The dental exam should include the date when the exam was given and the signature of the Dentist completing the exam. In order for the school to assist with follow-up care coordination, it would be beneficial if the information indicated the need for additional dental work.

If you have any questions about the requirements, need assistance with finding a Medical Doctor and Dentist or coverage for the exam cost, please contact your school nurse.

For more information, please contact:

Casey Storm
Marshall County Schools
Director of Student Services
304-843-4400 ext 317

The attached forms may be completed by a Dentist and a Doctor. Please return the completed forms to the nurse at your school.



MARSHALL COUNTY SCHOOLS

214 Middle Grave Creek Road

Moundsville, WV 26041

Dental Certificate

*It is recommended that all students entering Marshall County Schools have a dental examination. However, it is not mandatory for enrollment purposes.

Student Name _____

School Attending _____

Date of Birth _____

Date of Exam _____

Is Historical? YES NO

Type of Service Provided _____

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? _____

Are there treatment needs? _____

Dentist/Public Health Hygienist Who Performed Service _____

Does the student have a return visit scheduled? YES NO

Dentist Signature _____

This form may be returned to the parent to take to school or fax to MCS 304-843-4863



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

Pre K
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: 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 Dentist Vision
 Hearing Blood lead 10₂ug/dl CSHCN 1-800-642-9704
 Other:

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, or visits to other providers:

Social/Family History: Check those that apply
 No change
 Family situation change

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

Current Health Indicators: Check those that apply
 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

Check those that apply
Hemoglobin/Hematocrit Risk: Low risk High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: Low risk High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: Low risk High risk
See Periodicity Schedule for risk indicators

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: Check those that apply
 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.

Labs: Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
 Other referral(s)

Follow Up/Next Visit: 5 years of age Other