

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

2025-2026 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	Yes
Sand Hill Elementary		8:30 – 1:45	Yes	No
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

HHS POVERTY GUIDELINES 2024

FAMILY SIZE	100%	130%
1	\$15,060	\$19,578
2	\$20,440	\$26,572
3	\$25,820	\$33,566
4	\$31,200	\$40,560
5	\$36,580	\$47,554
6	\$41,960	\$54,548
7	\$47,340	\$61,542
8	\$52,720	\$68,536
EACH ADDITIONAL MEMBER	\$5,380	\$6,994

Effective January 11, 2024
Released by the Dept of Health & Human Services

Student Oral Health Form

Patient Information

Child's Name (Last, First, MI) _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Guardian _____ Phone _____

Oral Health Service

Please provide date of service in applicable box below:

Date of service	School Entry	2nd Grade	7th Grade	12th Grade
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Current Oral Health Services:

Type of Services Provided? Examination

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? Yes No

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

Additional Information

Oral Health Provider's Contact Information and Signature

Provider Name (please print) _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Office Contact email _____