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

School/Location	*Choice 1st, 2nd, 3rd*	**Approximate start/end**	*NP Head Start Collaborative Services if Eligible*	*Before/After Care? (fees apply)*
**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:

____ Anorexia/Bulimia
____ Arthritis
____ Asthma
____ Bleeding Problem
____ Cancer
____ Cerebral Palsy
____ Chicken Pox
____ Cystic Fibrosis
____ Diabetes
____ Emotional Problem
____ Heart Problem
____ Hearing Problem
____ Hyperactive/ADHD/ADD
____ Intestinal Problem
____ Leukemia
____ Muscular Dystrophy
____ Orthopedic Problem
____ Prosthesis
____ Renal Problem
____ Scoliosis
____ Seizures
____ Spina Bifida
____ Stomach Problem
____ Tourette's
____ Tuberculosis
____ Urinary Tract

Describe further any health problem checked above or any health problems <u>not listed above</u>:

_____

_____

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 **<u>severe</u>** reaction requiring an **<u>immediate injection</u>** 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	
		My child may participate in all activities scheduled in the WV Pre-K Program, which may include field trips and other program events.
		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.
		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.
		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**

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_____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 10≥ug/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

School Entry Requirements

The information above this line is intended to be released to meet 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

Department of Health & Human Resources

Application for Certified Copy of West Virginia Birth Certificate

Please complete on-line, print, sign, and mail as instructed below or print except where signature is required.

The following pertains to information that would be found on the certificate being requested.

Name of person on the certificate

_____
First Middle Last

Date of Birth

_____
Month/Day/Year

Mother's Maiden Name

_____
First Middle Last

Sex:

☐ Male ☐ Female

Father's Name

_____
First Middle Last

Place of Birth

City _____ County _____ State _____

Hospital _____

Requestor's Relationship:

Parent/Grandparent ☐ Guardian or agent ☐ Child/Grandchild ☐

Certificate of my own birth ☐ Spouse ☐ Brother/Sister ☐

Making false statements and misuse of vital records will result in criminal and civil penalties pursuant to WV Code §16-5-38.

_____
Signature (Required)

_____
Printed Name (Required)

Requesting _____ copies at $12.00 per copy and enclosing $_____.

Please send check or money order. Please do not send cash.
Make checks payable to: Vital Registration

Send copies to: Print your address below.

_____

_____

_____

_____

_____
City State Zip

( ) _____
Area Code Your daytime telephone number:

_____
E-Mail address

Submit form with check or money order to:

Vital Registration
Room 165
350 Capitol Street
Charleston, WV 25301-3701

Telephone: (304) 558-2931

Last Revised 1/8/09

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:

	School Entry	2nd Grade	7th Grade	12th Grade
Date of service				

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 _____