Early Learning Academy Registration Packet 2020-2021

INTERBORO SCHOOL DISTRICT

Registration Office Hours beginning February 26, 2020: M-Th 9am-1pm, Wednesdays 4-7pm, closed Fridays

If you have any questions regarding necessary residency documents, please call Patti O'Shea

610-461-6700 ext. 1279

ISD will begin to accept PreK applications on February 26th. Applicants will be informed of acceptance beginning on April 22, 2020. Slots will be filled based on prioritized need. A prioritized waiting list will be maintained once the District's 51 PKC slots are filled.

Interboro Learning Academy Registration
PreK Counts Checklist for the 2020 – 2021 School Year

In order to register for Interboro's PreK Counts Program, the following documentation is required:

☐	Completed Interboro Early Learning Academy Registration Packet
☐	Student's State Issued Birth Certificate (student must be 4 by Sept. 1, 2020)
☐	Student's Immunization Records
☐	Proof of Residency ***If you are an ISD homeowner, please bring in 1 of the following:*** • Current Property/School Tax Bill • Current Mortgage Statement ***If you are renting within the ISD:*** • Current Lease (Must list ALL Tenants including children. If you have a month to month lease, you will need to provide a letter from your landlord stating your lease is current and list all tenants including children. • Lease Verification Form completed in its entirety (Found on page 17 of the registration packet) • Please be advised that all leases are verified by landlords/owners, prior to the completion of the registration process. ***If you are living with an ISD homeowner:*** • Multiple Occupancy (MO) Packet (Print this from our Forms section of the Registration Page or pick up one at the Registration Office)
☐	Proof of financial eligibility for PreK Counts program– Documentation that your family income is at or below 300 percent of the Federal Poverty Guidelines (W2, current tax forms, and/or one month's pay stubs for all members of the household)
☐	Picture ID with correct name/address (PA driver's license or PA ID) • *Update Card and Picture ID together is acceptable* • *Internet Address Change Receipt with Picture ID is acceptable*
☐	1 Current Utility Bill (Water Bill; Gas Bill; Phone Bill; Electric Bill; Cable Bill) • *Can be a printed bill from an online account; can be a confirmation letter from the utility*

Additional documentation that families may submit *as applicable*.

☐	Zero Income Declaration (to be completed if family is declaring no income from any source) found on page 18 of the registration packet
☐	Student's IEP, 504 (if applicable)
☐	**If you are a single parent without custody papers, you will need to complete the Affidavit of Custody and have it notarized. This form can be found on page 17 of the registration packet.** Please bring with you any Custody, Guardianship, or Foster Papers (if applicable)
☐	**Any applicable documentation to substantiate risk factors**

Early screenings are important. As a PKC provider, Interboro shall ensure all children have had the opportunity to receive the recommended vision, hearing, and health screenings. By August 26, 2020, families are requested to submit the following documentation. If the child's screening is not current (within 180 days of the start of the school year), Interboro SD will provide these services during the school year. Examinations must be dated between February 16, 2020 and August 26, 2020.

☐	Student's Physical Form (See Form on Early Learning Academy Registration Website)
☐	Student's Dental Form (See Form on Early Learning Academy Registration Website)

STUDENT INFORMATION:

Full First Name: _____ Full Middle Name: _____Full Last Name: _____ Gender: Male / Female/non-Binary Grade: **PRE K**

Hispanic? Yes / No Race (circle all that apply): Native American Indian/Alaskan Native Native Hawaiian/Pacific Islander Black/AA White Asian

DOB: _____ / _____ / _____ City of Birth: _____ State of Birth: _____ Country of Birth: _____

Date of PA Residence: _____ / _____ / _____ *OR* _____Born in PA_____New Citizen to US

Previous Schooling:_____No formal schooling/home with parent _____Approved Day Care _____Home Day Care/Babysitter

Address of Student: _____

Home Phone Number: _____ - _____ - _____ Student resides with (circle one): Mother & Father Mother Only Father Only Guardian Foster Parent

Previous Address: _____

_____

Does your student have an IEP? Yes / No Does your student have a 504? Yes / No

Has your student ever received Early Intervention Services? Yes/No If yes, through which Intermediate Unit/County_____if exited, date_____

Please circle any additional services your student is receiving: ESL (English Second Language) Title I Services Other: _____

PARENT / GUARDIAN INFORMATION:

Primary Parent / Guardian is the adult who registered the student, will be the first contact, will receive all communications, and be assigned the Parent Portal Access Information for the student

Primary Parent / Guardian (who student lives with) Full Name: _____Relationship to Student: _____

Status (Circle One): Single Married Separated Divorced Guardian Foster Parent If Married… Name of Spouse: _____

Address of Primary Parent / Guardian: _____

_____

Home Phone Number: _____ - _____ - _____ Work Phone Number: _____ - _____ - _____ Cell Phone Number: _____ - _____ - _____

Primary Parent / Guardian Email Address: _____

Other Parent / Guardian: This parent will be listed as a 2nd parent, granting them Education Access (HAC, mailings & attend educational meeting).

Other Parent / Guardian Full Name: _____ Relationship to Student: _____

Address of Other Parent / Guardian: _____

_____

Home Phone Number: _____ - _____ - _____ Work Phone Number: _____ - _____ - _____ Cell Phone Number: _____ - _____ - _____

Other Parent / Guardian Email Address: _____

OTHER PEOPLE LIVING WITH STUDENT:

Name	Age	Relationship to Student	Do they attend a school in Interboro SD?	If "Yes"… what school?
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	

PRIMARY PARENT / GUARDIAN SIGNATURE: _____ Date: _____ / _____ / _____

REGISTRATION COORDINATOR SIGNATURE: _____ Date: _____ / _____ / _____

OFFICIAL USE ONLY **OFFICIAL USE ONLY** **OFFICIAL USE ONLY** **OFFICIAL USE ONLY** **OFFICIAL USE ONLY** **OFFICIAL USE ONLY**

Residency Status: ☐ Resident ☐ MO (Not Homeless) ☐ Homeless Family ☐ Military Family ☐ Foster Child

Student Status: ☐ Regular ☐ Guardianship (COURT) ☐ Guardianship (Superintendent)

Student Registration Item Checklist:

☐ Birth Certificate

☐ Current Immunizations

☐ Former ISD Student

Parent Registration Item Checklist: Homeowner Renter MO

☐ Proof of Residency: Lease & LVF Settlement Paperwork Mortgage Statement Tax Bill

☐ Photo ID with Correct Address (or with Update Card / Internet Receipt)

☐ Utility Bill ☐ Add'l mail ☐ 30 days to turn in the ** documents- date:_____

Notes:_____

_____

Additional Documents: ☐ Multiple Occupancy Packet ☐ Guardianship Packet approved by Superintendent ☐ IEP/504/GIEP Paperwork

☐ Lease Verification Form/Landlord Letter ☐ Foster Paperwork/Fact Sheet ☐ Homeless Paperwork/Fact Sheet

☐ Custody Order/CYS Paperwork ☐ Other Items: _____

_____Scanned to Bldg/Nurse_____Daily Sheet _____entered in Eschool _____Scanned ELL _____Scanned Spec Ed _____Scanned Foster/Homeless/Military

_____Uploaded to Eschool _____lease verified _____check residency if applicable_____send 30 day letter

First Day of School: _____ / _____ / _____ District Enrollment Date: _____ / _____ / _____ SIS Student Number:_____

To be completed by Curriculum Office:

Grade: PRE K Building Assigned: ____HIGH SCHOOL (1600) ___KA(900)

INTERBORO SCHOOL DISTRICT

900 WASHINGTON AVENUE

PROSPECT PARK, PA

MAINTAINED BY THE BOROUGHS OF GLENOLDEN, NORWOOD, PROSPECT PARK AND TINICUM

REGISTRATION OFFICE **PHONE: 610-461-6700|FAX: 610-583-1678**

PUPIL SERVICES OFFICE

_____ PreK
Student's Name Grade

1. Does your child currently receive any Special Services?

   My child _____DOES _____DOES NOT receive any special services. If no, please skip questions 2-8 and sign below.

2. Does he/she have a current Individualized Education Plan (IEP) ____Yes ____No

3. Special Education and/or related services:
   IEP includes:
   _____Speech/Language Therapy ____Physical Therapy
   _____Occupational Therapy ____Positive Support Plan

4. Does he/she have a current Evaluation or Reevaluation Report (ER/RR) ____Yes _____No

5. Does your child have a current 504 Service Agreement _____Yes ____No

6. Does your child have a current Gifted Individualized Education Plan ____Yes ____No

7. Has your student ever received Early Intervention Services? _____Yes ____No

   If yes, through which Intermediate Unit/County_____
   if exited, date_____

8. Did he/she receive either of the below services at their former school:

   ESL (English Second Language) ___Yes ___No Title I Services_____Yes ___ No

Please provide the Registrar with of copy of all documents pertaining to your child's special services prior to his/her 1st day of school. Requests for records will also be made and program determination and location will be made once received.

(All registrants must sign and acknowledge that they have read this document)

I _____, the Parent/Guardian of _____, acknowledge that the questions above are answered to the best of my knowledge and understanding.

_____ _____ _____
Parent's Signature Print Name Date

_____ _____
Reviewed with Registration Coordinator Date

INTERBORO SCHOOL DISTRICT

900 WASHINGTON AVENUE

PROSPECT PARK, PA

MAINTAINED BY THE BOROUGHS OF GLENOLDEN, NORWOOD, PROSPECT PARK AND TINICUM

REGISTRATION OFFICE **PHONE: 610-461-6700|FAX: 610-583-1678**

CUSTODY AGREEMENT/COURT ORDER REGISTRATION FORM

_____ _____

Student's Name **Student's Grade**

1. Is the student living full-time with both parents/guardian in the Interboro School District?
_____Yes _____No If yes, skip questions 2-5 and sign below.

If no, please explain in detail:

2. Is there a custody agreement or court order? _____Yes _____No

3. Who has physical custody? ___Mother ____Father ____Joint _____Guardian

4. Who has legal custody? ___Mother ___Father _____Joint_____Guardian

5. Who has educational rights? ___Mother ___Father _____Joint _____Guardian

Any single parent who does not have a Legal Court Order will need to provide a notarized letter, signed by both parents explaining the living/visitation arrangements.

The attached Affidavit of Custody is to be used when the paternal parent is registering the child but is not listed on the birth certificate and there are no court documents. This form is to be notarized.

Please provide the Registrar with a copy of all notarized documents pertaining to custody and court orders **prior** to his/her 1st day of school in order to start on the agreed start date.

Sign below acknowledging that the above information is correct.

I _____, the Parent/Guardian of _____,

acknowledge that the questions above are answered to the best of my knowledge and understanding.

_____ _____ _____

Parent's Signature **Print Name** **Date**

_____ _____

Reviewed with Registration Coordinator **Date**

INTERBORO SCHOOL DISTRICT

Health History Form

DATE___ GRADE_____ DATE OF BIRTH___

FULL NAME_____ Male____ Female____

ADDRESS _____

_____

Guardian's / Mother's Name: _____

Guardian's / Father's Name: _____

Home Phone Number_____ Emergency Phone Number_____

Doctor's Name_____ Phone Number_____

DOES YOUR CHILD HAVE:

Frequent Colds	yes	no
Frequent sore throats	yes	no
Allergies (list)……	yes	no
.....		
Asthma	yes	no
Speech Difficulties	yes	no
Earaches	yes	no
Frequent Nightmares	yes	no
Vision/Hearing Loss	yes	no
Poor Eating Habits	yes	no
Emotional Problems	yes	no
Frequent Bed-wetting	yes	no
Epilepsy	yes	no
Diabetes	yes	no
Difficulty Sleeping	yes	no

HAS YOUR CHILD HAD:

Tonsillectomy & Adenoidectomy	yes	no
Head injury (unconscious)……	yes	no
Convulsions……	yes	no
Chicken Pox……	yes	no
Scarlet Fever……	yes	no
Tuberculosis (self or family)……	yes	no
Rheumatic Fever……	yes	no
Pneumonia……	yes	no

DEVELOPMENTAL PATTERNS

Did your child crawl……	yes	no
Does your child stumble, fall or bump into things frequently……	yes	no
Easily understood by others……	yes	no

Age child spoke words _____

Age child spoke in sentences _____

Age child walked _____

1. List hospitalizations, operations, serious accidents: _____
   _____
2. Is your child currently under medical treatment or on medication? Yes____ No____
   If yes, please explain or list medications: _____
   _____
3. Is there any information concerning your child's health that you or your child's doctor feel should be known by the school? Yes____ No____
   If yes, please explain:_____

INTERBORO SCHOOL DISTRICT

Registration, Enrollment, & Residency Office

900 Washington Avenue Prospect Park, PA 19076

Phone: 610-461-6700 Ext. 1279

Family Dentist Report

Child's Name _____Grade_____

Dentist Must Sign This Section:

The above child visited my office on _____

All dental corrections have been made_____

No corrections were necessary _____

This child is in need of care _____

Office Address _____

Office Phone _____

Dentist Signature_____

Thank you for completing this form as it is a state requirement for state funded Pre K and the Kindergarten Academy.

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student...*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student...*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student...*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student...*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student...*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT NAME:

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address_____ Phone_____

Signature of examiner_____ MD ☐ DO ☐ PAC ☐ CRNP ☐

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Reason: _____ Date Rescinded:_____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

HOME LANGUAGE SURVEY*

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

School District: INTERBORO SCHOOL DISTRICT Date: _____

School: _____

Student's Name: _____ Grade: _____

1. **What is/was the student's first language? _____**

2. **Does the student speak a language(s) other than English?**
   (Do not include languages learned in school.)

   ☐ Yes ☐ No

   If yes, specify the language(s): _____

3. **What language(s) is/are spoken in your home? _____**

4. **Has the student attended any United States school in any 3 years during his/her lifetime?**

   ☐ Yes ☐ No

   If yes, complete the following:

   Name of School State Dates Attended

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

Person completing this form (if other than parent/guardian):

Parent/Guardian signature: _____

*The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school/full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school/full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the school district/charter school/full day AVTS in the future.

2020 PA Pre-K Counts Enrollment Form

(This information is confidential to the PA Pre-K Counts program)

Date Form Completed: _____ / _____ / _____
MM **DD** **YY**

Last Name (Child)	**First Name (Child)**	**Middle Initial**

Street Address	**County**	
City	**State** PA	**Zip Code**
School District of Residence		
Home Phone	**Work Phone**	**Email Address**

Child's Date of Birth	**Current Age (must be 4 by 9/1/2020)**	**Gender**
	☐ 3 ☐ 4	☐ Male ☐ Female

Race *(optional)*

- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific
- ☐ Not Applicable
- ☐ American Indian or Alaskan
- ☐ White
- ☐ Other

Ethnicity *(optional)*

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Not Applicable

Primary Language

- ☐ English
- ☐ Spanish
- ☐ Other _____ (please specify)

Last Name (Legal Guardian)	**First Name (Legal Guardian)**	**Gender**
		☐ Male ☐ Female

Relationship to Child

- ☐ Father
- ☐ Mother
- ☐ Guardian
- ☐ Other _____ (please specify)

(Select)

- ☐ Biological
- ☐ Foster
- ☐ Adoptive
- ☐ Other _____ (please specify)

Role

- ☐ Primary Guardian
- ☐ Secondary Guardian
- ☐ Legal Guardian
- ☐ Other _____ (please specify)

Household/Family Size *(required)* list all members of the household (including the child) and relationship to child

☐ 1_____ ☐ 4_____ ☐ 7_____

☐ 2_____ ☐ 5_____ ☐ 8_____

☐ 3_____ ☐ 6_____ ☐ __ _____

Household Income *(required)* check box:(must submit W2, current tax forms, and/or one month's pay stubs for all members of the household)

☐ Less Than $5,000	☐ $5,001-$10,000	☐ $10,001-$15,000
☐ $15,001-$20,000	☐ $20,001-$25,000	☐ $25,001-$30,000
☐ $30,001-$35,000	☐ $35,001-$40,000	☐ $40,001-$45,000
☐ $45,001-$50,000	☐ $50,001-$60,000	☐ $60,001-$70,000
☐ $70,001-$100,000	☐ More Than $100,000	

Note: If a family is at or below 100% of federal poverty level, the child is eligible for Head Start. Head Start may better serve the needs of some children and families due to the additional services they can offer. Interboro School District will notifiy you if you are eligible for Headstart and require a sign off to acknowledge receipt of this information.
https://www.dciu.org/HeadStart

2020 Federal Poverty Level Guidelines

300%			
Family Size	**Annual**	**Monthly**	**Weekly**
1	$38,280	$3,190	$736
2	$51,720	$4,310	$995
3	$65,160	$5,530	$1,253
4	$78,600	$6,550	$1,512
5	$92,040	$7,6,70	$1,770
6	$105,480	$8,790	$2,028
7	$118,920	$9,910	$2,287
8	$132,360	$11,030	$2,545
Each Additional	**$13,440**	**$1,120**	**$258**

Other Child Eligibility Risk Factor Criterion *(Must check all that apply):*

☐	**Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐	**Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services.
☐	**Education Level of Guardian:** Does not have high school diploma or GED or post-secondary degree.
☐	**English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
☐	**Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
☐	**Incarcerated Parent:** A child for whom one of the child's parents is currently in prison.
☐	**Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following: A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.
☐	**Migrant (Non-Immigrant)/Seasonal Student:** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
☐	**Teen Mother:** A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided is accurate. I understand that I may be asked to verify or substantiate information provided.

Parent/Guardian (Signature) **Date**

Parent/Guardian Name (Print Name)

OFFICIAL USE ONLY TO BE COMPLETED BY INTERBORO SD BUSINESS OFFICE OFFICIAL USE ONLY

Actual Annual Verified Gross Household (Family) Income: $ _____

*Attach copies of documents used to verify income prior to enrollment

☐ Family income is at or below 300% of federal poverty level (required risk factor). Consider all sources of income. See ***Federal Poverty Level Guidelines*** relative to family size (must be verified prior to enrollment).

Staff Verifying Income and Risk Factors (Signature) **Date**

Interboro Early Learning Academy
Parent Input Packet ~ 2020-2021

Child's Name_____ Please Circle: Male Female

Date of Birth_____ Current Age_____

Name you would like your child to be called in school_____

How old will your child be when she/he starts Pre K : _____ Years _____ Months

Person completing this checklist _____Relationship to Child_____

Student's Address _____Town_____

Parent/Guardian email address (Home)_____

Parent/Guardian phone (Home) _____ (Cell) _____ (Work) _____

Please take the time to answer these questions carefully and accurately. The information that you provide will help the school staff plan for your child's strengths and needs.

Developmental Stages:

At what age (approx.) did your child: Attempts to zip coat_____
Walk_____ Talk_____
Independently zips coat_____
Toilet Train_____ Dress Self_____
Attempts to tie shoes_____
Does your child wear a pull-up or diaper?_____
Independently ties shoes_____

Pre- School Experience:

1. My child **attends/has attended** a **pre-school program:** Yes____ No_____ How many years?_____
   a. Name of Program_____ Days per Week _____ Full Day or Half Day
2. My child **attends** a **day care program.** Yes_____ No _____
   a. In a private home b. Day care center Days per Week _____ Full Day or Half Day

Please describe your child's preschool experience:

_____

_____

_____

_____

3. My child has been evaluated by the DCIU Early Intervention Program? Yes _____ No _____

(If you responded yes, please complete questions 5 and 6)

4. My child is receiving services from the DCIU Early Intervention Program? Yes ____ No _____

5. My child received services from the DCIU Early Intervention Program in the past? Yes___ No___

6. Has your child ever received or participated in the following:

Check	Services	Current	In the Past	Age	DCIU	Private
	Speech Therapy					
	Occupational Therapy					
	Physical Therapy					
	Learning Support					
	Social Skills /Play Therapy					
	Behavior Counseling					
	Psychological Evaluation					

Exposure to Literature

7. How often do you read to your child? _____

8. My child has approximately _____ books in her/his personal library?

9. What is your child's favorite book? _____

10. My child visits the library in our community? Yes _____ No _____

11. Does your child enjoy playing outside ? ___ Yes ___No
What types of physical activities does he/she like to play?

_____

12. How much time does your child watch television/play video games each day?

30 minutes _____ 30 minutes to 3 hours _____ More than 3 hours _____

13. List any educational experiences your child has had outside your home? Ex. Library programs, museums, family trips, zoo, plays, etc.

_____

_____

Medical Information:

13. My child has the following medical issues: _____

_____

14. My child has had the following childhood illnesses?
Respiratory (RSV) Yes _____ No _____ Chronic Ear Infections Yes _____ No _____

Whooping Cough Yes _____ No _____ Asthma Yes _____ No _____

Food Allergies? Peanuts_____, Tree Nuts _____ , Milk/Dairy_____, Fruits_____

Other:_____
_____

15. My child is taking the following medication prescribed by a pediatrician?

Medication _____ Dosage _____

Medication _____ Dosage _____

Medication _____ Dosage _____

16. Has your child ever been exposed to toxic substances such as lead, pesticides, inhalants etc?
No _____Yes _____ Please Explain _____

17. My child was born premature? No _____ Yes _____ , How many weeks? _____
Indicate any complications that might impact learning or school
performance?_____
_____
_____

Related Services Information:

18. Are you concerned about any of the following areas pertaining to your child?

Speech and Language No _____ Yes_____ why? _____
Hearing No _____ Yes _____ why? _____
Vision No _____ Yes _____ why? _____

Primary Language spoken by student_____

Primary Language spoke in home by parents_____

Behavioral Observations:

19. How would you best describe your child?

___Quiet ___Outgoing ____Attentive ____Social ____Persistent

___Shy ___Curious ____Playful ____ Assertive ____Independent

20. Does your child exhibit any of the following behaviors? Please provide as accurate a picture of your child as possible.

- Defiance towards adults? No _____
  Yes _____ Please Explain? _____
- Aggressive or violent behavior toward others? No _____
  Yes _____ Please Explain? _____
- Frequent uncontrolled outbursts? No _____
  Yes _____ Please Explain? _____
- Withdrawal or inability to relate to others? No _____
  Yes _____ Please Explain? _____
- Difficulty separating from you for a short period of time? No _____
  Yes _____ Please Explain? _____
- Difficulty interacting/ playing well with other children? No _____
  Yes _____ Please Explain? _____

AdditionalComments/Observations:_____

_____

_____

Listening Skills:

21. Can your child:

Listen to a complete story: Yes _____ No _____

Complete a single step direction or request (Please pick up your toys):
Yes _____No _____

Complete two step directions or request (Please get your bicycle and put it in the garage):
Yes _____ No _____

Complete three step directions or request (Please bring me the newspaper, turn on the light, and feed the dog) Yes _____No _____

Explain further, if

necessary_____

_____

22. If applicable, please list **first and last names** and ***ages*** of other children living in your home.

_____ _____

_____ _____

_____ _____

23. If applicable, please list ***first and last names*** and ***ages*** of child's siblings that reside in another home.

_____ _____

_____ _____

_____ _____

24. Please use the space below to tell us anything else that you believe would help the school team better meet your child's educational strengths and needs:

_____

_____

_____

_____

INTERBORO SCHOOL DISTRICT
STUDENT INFORMATION

Student's Name _____ Home Phone _____
Address _____ Birth Date _____
_____ Grade _____
Homeroom/Teacher _____

Parent or Guardian Information (Circle one)
Name _____ Cell Phone _____
Place of Employment _____ Business Phone _____
City _____ State _____

Parent or Guardian Information (Circle one)
Name _____ Cell Phone _____
Place of Employment _____ Business Phone _____
City _____ State _____
Parent/Guardian E-mail Address _____

Person with whom child lives if other than parent (specify) _____

Will someone usually be home during the day? Yes No (Circle one)

If unable to reach parent/guardian in case of emergency/illness contact (Neighbor, relative with transportation)
Name _____ Relationship _____ Phone# _____
Address _____ Cell/Work _____
Name _____ Relationship _____ Phone# _____
Address _____ Cell/Work _____

****Change of address must be verified with documentation at the administration building****
(Over)

Medical conditions **(check all that apply)**
__Asthma
__Medication allergy (If yes please name) _____
__Seizures
__Diabetes

Family Doctor _____
Phone _____
Family Dentist _____
Phone _____
Does Your Child Have? Health Insurance Y__ N__
Dental Insurance Y__ N__

__Other, please explain _____

__Food Allergy? (If yes, please name), _____
Requires EpiPen? Yes / No (please circle)
Requires Benadryl? Yes / No (please circle)

Bee Sting Allergy? Yes / No (please circle)
Requires EpiPen? Yes / No (please circle)
Requires Benadryl? Yes / No (please circle)

****If yes, please supply to school nurse with Doctor's orders as per school policy.**

List any medications your child takes on a daily basis with dose & time. **(Please contact the school nurse if it will be necessary to take medication at school)** _____

Do we have permission to give your child the following?: **PLEASE INITIAL EACH CHOICE**

__Tylenol __Chloraseptic (throat) Spray __Anbesol __Visine __Sting Kill (Bee Sting Relief)
__Tums __Topical Antibiotic Ointment __Caladryl __Burn Spray

Signature of Parent/Guardian _____ **Date** _____

*** **SPECIFIC MEDICAL INFORMATION WILL BE SHARED WITH SCHOOL PERSONNEL WHO HAVE CONTACT WITH YOUR CHILD IF IT IS DEEMED NECESSARY FOR THE SAFETY OF YOUR CHILD OR IF A MEDICAL CONDITION IMPACTS YOUR CHILD'S EDUCATION*****

THE FOLLOWING PAGES ARE TO BE COMPLETED ONLY IF APPLICABLE

- *Affidavit of Authority/Custody*
- *Zero Income Declaration*
- *Lease Verification Form*

INTERBORO SCHOOL DISTRICT

Affidavit of Authority / Custody

(This form is to be used by Single Parents / Guardian with no Custody Paperwork or for Parent whose name is not listed on Birth Certificate)

Student's Full Name: _____

Student's Date of Birth: _____ **Student's Grade:** _____

BE IT KNOWN, that on this _____ day of _____ _____
(Day) (Month) (Year)

I, _____ hereby state and declare that I am the
(Parent's/Guardian's Name)

Parent/Guardian and claim to have custody of
_____.
(Student's Full Name stated above)

Parent/ Guardian Signature:

_____

Address: _____

_____

Home Phone Number: _____ **Cell Phone Number:** _____

Sworn to and subscribed before me, a Notary Public, on this day _____ of _____, 20_____

_____
Notary Public

Zero Income Declaration Letter

To be completed only if the family does not receive income from any source.

Name (Parent/Guardian) _____

Name (Child) _____

Program Name _____

Program Year _____

I am signing this letter to declare that I currently do not have any income from any source. My financial support comes from (please describe):

☐ I agree to notify the above program about changes in my income within 30 days of the change.

☐ I certify that the information submitted is accurate and true to the best of my knowledge. I understand that by completing, signing, and dating this form, I declare I have no household income and that the information I am providing is correct. I understand that providing false information may result in denial of services.

_____ _____

Parent Signature Date

_____ _____

Reviewer Signature Date

INTERBORO SCHOOL DISTRICT
Lease Verification Form

ONLY REQUIRED TO BE COMPLETED BY RENTERS

Student Name:_____School_____Grade_____

Residing at:_____

Name of Property Management,
Complex, or Landlord: _____

Phone # of Property Management,
Complex, or Landlord: _____

Term of Lease: Start on ___ / ___ / ___ End on ___ / ___ / ___
Please note that if you are presenting a lease that is month to month, you may be required to supply the school district with a copy of a current utility bill each month.

Names of All Occupants (Should include your student(s) and that match the Lease)

1. _____
2. _____
3. _____
4. _____
5. _____

I am aware that all information will be confirmed by the Landlord and/or Management Company and I affirm that the above information is accurate.

Guardian Signature:_____Date_____

OFFICE USE ONLY

____Attached Public Access County Sheet

____Verified by_____title:_____

Cleared? ☐ YES ☐ NO

ISD Contact: _____Residency Office Initial:_____