PRE-K STUDENT REGISTRATION

2023-2024

Families interested in registering a student in the JCS Pre-K program may submit applications beginning on April 1, 2023. Bring a completed registration packet to the Head Start/Pre-K site on the T.A. Lowery Elementary School campus (*brick building to the right*) at 221 Warm Springs Rd., Shenandoah Junction. You will receive an email confirmation from a member of our placement team that has been assigned to your file. Placement letters will be mailed by end of May. Packets received after the first window will be handled on an individual basis.

Student's name: _____

Date received: _____

Date of birth: _____

PLEASE NOTE:

- Age regulations for 2023-2024 school year require children to be 4 years old by **June 30, 2023**. According to state law policy 2419, all classrooms are inclusive.
- Jefferson County Schools does NOT provide transportation for Pre-K; however, the Head Start Program has limited transportation available for qualifying families.

___ Registration Form

___ Preferences

___ Immunizations

___ State Certified Birth Certificate

___ Health Check Physical Exam *(completed by Physician)*

___ JCS Student Contact Information Form

___ JCS Home Language Survey

___ JCS Student Residency

___ Dental Screening *(completed by Dentist)*

– – – – – – – – – – OFFICE USE ONLY – – – – – – – – – –

Date received:	Initials:	Assigned to:	Initials:
Date email confirmation:	Initials:	Screening appt.:	Initials:
Date letter mailed:	Initials:	Classroom asgmt.:	Initials:

Pre-K / Head Start Registration Preferences 2023-2024

Contact Information

Child's Name: _____ **Date of Birth:** _____ **Gender:** _____

Child's Social Security Number: _____ **Foster Care: (Y/N)** _____ **TANF: (Y/N)** _____

Parent/Guardian's Name: _____

Street Address: _____

City/Town/Zip: _____

Primary Phone Number (w/voice mail): _____ Is this a cell phone? ☐ Yes ☐ No

Backup Phone: _____ Is this a cell phone? ☐ Yes ☐ No

Email Address: _____

Site Selection

Please indicate three (3) sites that you would prefer by placing a 1, 2, *and* 3 on the line next to the site name. *This section MUST be completed to process your application.*

All sites are **Full Day** programs, operating five (5) to six (6) hours per day depending on the location.

Locations:

___ Blue Ridge
___ Driswood
___ North Jefferson
___ Page Jackson
___ Shepherdstown Day Care
___ South Jefferson
___ T. A. Lowery

Reason for choices: (*check all that apply*)

☐ JCS Employee

☐ Location/Close to home

☐Other: (p*lease list reason on the line below)*

_____

_____

Transportation/Wrap Around Care

Does the student have transportation available? ☐ Yes ☐ No (*if no, please provide a brief description):*

_____

Does the student require wrap around care? ☐ Yes ☐ No (*You will be contacted with available options*)

Yearly: _____ Monthly: _____ Weekly: _____ SSI: ☐ Yes ☐ No

Approximate gross family income (required for data collection)

Total number of family members: _____ # of Children under 4: _____

Parent/Guardian Signature: _____ Date: _____

Jefferson County Schools Universal Pre-K Program is a non-discriminatory collaboration between Jefferson County Schools, Head Start, Child Care Centers, and the JCS Department of Special Programs

School Year: _____
Student #: _____

Student Contact Information

Type, or use blue or black ink

JEFFERSON COUNTY SCHOOLS

Part I – Basic Student Information

SOP 8.18a

Last Name: _____ First Name: _____ Middle: _____ Name Suffix: _____
Gender: ____ Date of Birth: ___/___/_____ Age: ____ Birthplace (City and State): _____
Former School: _____ Grade: ____ Social Security Number: _____
Transferred From: _____
Former School Address: _____
☐ NOT born in any state *
☐ Has NOT been attending one or more schools in any one or more states* for more than 3 full academic years. If no, how many years at the point of enrollment. _____
**(State refers to the 50 U.S. States, the District of Columbia, and the Commonwealth of Puerto Rico)*
Phone # _____ (*phone number that receives calls for school closures, attendance, etc.*)
Transported by Bus: ☐**Yes** ☐**No** Bus # ☐**AM** / ☐**PM** Does the student have an IEP or 504 Plan: ☐**Yes** ☐**No**
Special Medical Need: _____
List siblings in JCS at same address: _____
Is the home language English: ☐**Yes** ☐**No** Native Language: _____ Hispanic: ☐**Yes** ☐**No**
Race Options *(check all that apply)*: ☐White ☐Black or African American ☐Asian ☐ Hispanic
☐American Indian/Alaskan Native ☐Pacific Islander/Native Hawaiian

Part II – Parent Guardian

This contact will receive all official communications including lunch bills and legal documents.

Last Name: _____ First Name: _____ Middle: _____ Relationship: _____
Home Phone # _____
Cell Phone # _____ Email: _____
911 Address: _____ City: _____
State/Zip: _____
Mailing Address: _____ City: _____
State/Zip: _____
Employer: _____ Work Phone #: _____ Ext. ____
Occupation: _____
Is a translator needed to communicate with parent/guardian? ☐**Yes** ☐**No**

Part III – Parent Guardian 2

Last Name: _____ First Name: _____ Middle: _____ Relationship: _____
Home Phone # _____
Cell Phone # _____ Email: _____
911 Address: _____ City: _____
State/Zip: _____
Mailing Address: _____ City: _____
State/Zip: _____
Employer: _____ Work Phone #: _____ Ext. ____
Occupation: _____
Is a translator needed to communicate with parent/guardian? ☐**Yes** ☐**No**

Part IV – Emergency Contact – other than parent/guardian

Last Name: _____ First Name: _____ Middle: _____ Relationship: _____
Home Phone # _____ Cell Phone # _____ Email: _____
911 Address: _____ City: _____
State/Zip: _____
Mailing Address: _____ City: _____
State/Zip: _____
Day: _____ Work Phone #: _____ Ext. ____
Occupation: _____
Is a translator needed to communicate? ☐**Yes** ☐**No**

School Year: _____
Student #: _____

Student Medical Information
Type, or use blue or black ink

JEFFERSON COUNTY SCHOOLS

SOP 8.18b

Student: _____ School: _____

In case of serious illness or injury at school, take the student to _____.
The physician and the hospital are hereby authorized to render such treatment as may be deemed necessary in an emergency for the health of my child.

_____ _____
Print Name Parent/Guardian *Signature of Parent/Guardian*

_____ _____ _____ _____
Primary Phone # *Cell Phone #* *Work Phone #* *Email*

Name of Physician _____ Phone # _____
Physician's Address _____

Does the above student have ANY of the following?

Description	YES	NO	Explanation	Medication/Dosage
Heart Defect	☐	☐		
Diabetes	☐	☐		
Convulsive/Seizure Disorder	☐	☐		
Cerebral Palsy	☐	☐		
Visual Impairment	☐	☐		
a. Corrective Glasses	☐	☐		
Hearing Impairment	☐	☐		
a. Hearing Aid	☐	☐		
Orthopedic Impairment	☐	☐		
a. Wears Prosthesis	☐	☐		
Scoliosis	☐	☐		
Behavioral Disorders	☐	☐		
Urinary Tract Disorder	☐	☐		
Asthma	☐	☐		
Allergies	☐	☐		
a. Seasonal	☐	☐		
b. Food	☐	☐		
c. Bee Sting	☐	☐		
Nasal/Respiratory Disorder	☐	☐		
Limited Activities	☐	☐		
Premature Birth	☐	☐		
Other	☐	☐		

Special Instruction:	**-School Use Only-** HR Teacher _____ Date Information Entered _____

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

I AM 18 YEARS OF AGE OR WILL BE 18 YEARS OF AGE DURING THIS SCHOOL YEAR AND HEREBY GRANT MY CONSENT FOR JEFFERSON COUNTY SCHOOLS TO CONTACT MY LEGAL GUARDIAN IN CASE OF AN EMERGENCY.

STUDENT'S SIGNATURE _____ **DATE** _____

Copies to: Principal – Teacher – Health Nurse – Dept. of Transportation

Student Residency Form

By completing this form, you help Jefferson County Schools comply with the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. Your truthful and accurate answers help the county identify services that the student may be eligible to receive.

School: _____ Last school attended: _____

Student name: _____ Gender: ☐ Male ☐ Female Age: _____

Grade level: _____ Student date of birth: _____ WVEIS number: _____

Parent/guardian name: _____

Telephone numbers: Primary: _____ Cell: _____ Work: _____

This section of the form is intended to address the McKinney-Vento Act 42 U.S.C. 11434a(2). The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? ☐ YES* ☐ NO

**If you answered NO to this question, please stop here and sign the form below. If you answered YES, please complete the remainder of the form below and sign to complete.*

2. The student lives with: ☐ One (1) parent ☐ Two (2) parents ☐One (1) parent and another adult ☐ A relative, friend(s), or other

3. Where is the student living now? (Check any that apply)

☐ In a transitional shelter ☐ In a motel/hotel ☐ In a car ☐ In a camper or campsite ☐ In substandard housing

☐ With more than one (1) family in a house or apartment ☐ With friends or family members (other than parent/guardian)

☐ A public or private place NOT ordinarily used as a regular sleeping accommodation

☐ None of the above

4. List the student's siblings who also attend a Jefferson County School below: (*if applicable*)

Sibling Name: _____ School Attending: _____

Sibling Name: _____ School Attending: _____

Sibling Name: _____ School Attending: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Director of Attendance/Homeless Liaison

110 Mordington Ave. Charles Town, WV 25414

Voice: 304-728-9249 Fax: 304-728-4574

JEFFERSON COUNTY SCHOOLS

SOP 7.19a

Home Language Survey

ENCUESTA del IDIOMA en el HOGAR

Student Name:_____ Birth Date: _____ Sex: ____Male ____Female
Nombre del estudiante *Fecha de nacimiento* *Sexo* *Masculino* *Femenino*

Parent or Guardian Name: _____
Nombre del padre o tutor

School: _____ Grade: _____ Date: _____
Escuela *Grado* *Fecha*

1. What is the primary language spoken in the home, regardless of the language spoken by the student?
   ¿Cuál es el idioma primordial utilizado en el hogar, independientemente del idioma hablado por el estudiante?

   _____

2. What is the language most often spoken by the student?
   ¿Cuál es el idioma más usado por el estudiante?

   _____

3. What is the language that the student first acquired?
   ¿Cuál es el idioma que el estudiante adquirió como primera lengua?

   _____

Parent or Guardian Signature: _____ Date: _____
Firma del padre o tutor *Fecha*

Please call 304-728-9224 for assistance with completing this form. Thank you.
Para asistirle a completar este formulario, llame al 304-728-9224. Gracias.

Universal Pre-K/ Head Start

Child – Oral Health Exam

Child's name: _____ Date exam completed: _____

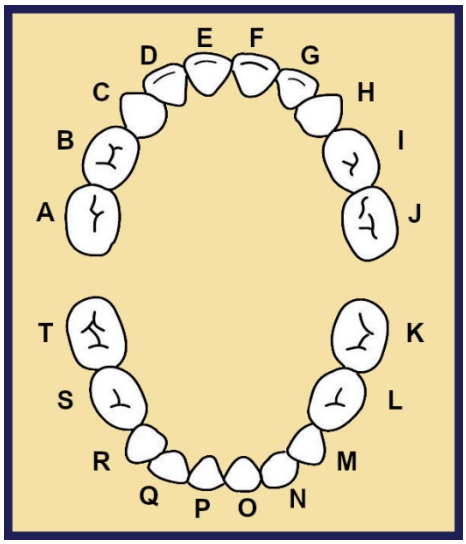
Child's date of birth: _____

Oral Condition

UPPER

Key
X Missing
Decayed
Filled

LEFT



RIGHT

LOWER

Number of times per day child brushed teeth: _____

Gum Conditions:

☐ Normal ☐ Swollen ☐ Bleeds easily ☐ Infected

Dental Needs:

☐ None ☐ Treatment ☐ Cleaning ☐ Fluoride supplement ☐ Oral hygiene instruction

Follow-up Needed: ☐ Yes ☐ No Reason: _____

Signature: _____ Stamp:
Printed: _____
Address:_____
Phone: _____

Return to: Jefferson County Schools Pre-K/Head Start (Fax) 304-725-7511

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Requirements for Pre-Kindergarten Program Enterers

All children entering an approved pre-kindergarten ("Pre-K") classroom must have age appropriate immunizations[1] upon enrollment as mandated by state law.[2] The following chart shows the **minimum** number of doses for each vaccine required for entry.[2]

Hepatitis B **3 doses** Final dose at age 24 weeks or older
Diphtheria, tetanus, and acellular pertussis vaccine (DTaP) **4 doses** Booster dose after 4th birthday is not required
Varicella **1 dose** **After** child's 1st birthday
Inactivated polio virus (IPV) **3 doses** Booster dose after 4th birthday is not required
Measles, mumps, and rubella (MMR) **1 dose** **After** child's 1st birthday

Students may be provisionally enrolled in Pre-K with at least one dose of each required vaccine and allowed up to eight months, if necessary for minimum intervals, to obtain up-to-date status. The WVDHHR, Bureau for Public Health recommends that vaccine doses administered 4 days or fewer before the minimum interval or age be considered valid.

For questions, contact the Division of Immunization Services at 1-800-642-3634.

[1]Applicable immunization schedules can be found at http://www.cdc.gov by searching "Immunization Schedules." [2] West Virginia Code § 16-3-4 and WVDHHR interpretative rule 64CSR95.

Screen 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

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____☐ Child with special health care needs_____☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____ ☐ UTO *(retest in 6 months)*
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@ ☐ UTO *(retest in 6 months)*
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can enter bathroom and have a bowel movement by himself/ herself ☐ Child can brush his/her teeth ☐ Child can dress and undress without much help ☐ Child can engage in well-developed imaginative play ☐ Child can answer simple questions ☐ Child can speak in words that are 100% understandable to strangers ☐ Child can draw pictures that you recognize ☐ Child can follow simple rules when playing games ☐ Child can tell you a story from a book ☐ Child can skip on 1 foot ☐ Child can climb stairs, alternating feet, without support ☐ Child can draw a person with at least 3 body parts ☐ Child can draw a simple cross ☐ Child can unbutton and button medium sized buttons ☐ Child can grasp pencil with thumb and fingers instead of fist
☐ Concerns about child's behavior, speech, learning, social or motor skills_____
_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma- **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704
☐ Women, Infants and Children (WIC) **1-304-558-0030**

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____
_____
_____
☐ **Family health history reviewed** _____
_____
Concerns and/or questions_____
_____

Social/Psychosocial History

What is your family living situation_____
_____
Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____
_____
Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care/after school care _____
_____
How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____
_____

Is your child in school? ☐ Yes ☐ No _____
Favorite thing about school_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____
_____
Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

HCT/HGB _____

Lead Blood Score _____

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/Vegetables/Lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Red Reflex	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____
_____
_____
_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Living situation and food security
- ☐ Tobacco, alcohol, and drugs
- ☐ Intimate partner violence
- ☐ Safety in the community
- ☐ Engagement in the community

School Readiness
- ☐ Language understanding and fluency
- ☐ Feelings
- ☐ Opportunities to socialize with other children
- ☐ Readiness for structured learning experiences
- ☐ Early childhood programs and preschool

Developing Healthy Nutrition and Personal Habits
- ☐ Milk, water, and juice
- ☐ Nutritious foods
- ☐ Daily routines that promote health

Media Use
- ☐ Limits on use
- ☐ Promoting physical activity and safe play

Safety
- ☐ Belt-positioning car booster seats
- ☐ Outdoor safety
- ☐ Water safety
- ☐ Sun protection
- ☐ Pets
- ☐ Firearm safety

☐ **Other**
_____
_____
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
☐ TB skin test *(if high risk)*
☐ Lipid profile *(if high risk)*
☐ Other _____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 5 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

See page 1, school requirements for required signature