Clay County Schools Collaborative Pre-K Application

School:_____ Program:_____ 3 yr. _____ 4 yr.

1st Choice:_____ 2nd Choice:_____ 3rd Choice:_____

Child's Name: (last)_____ (first)_____ (middle)_____

Birth Date:_____ Age:_____ Gender: M _____F

(Office Use) Age Eligible:_____Yes _____No

Physical Address:_____
Street City State Zip Code

Mail Address: (If different from Physical)_____
P.O. Box City State Zip Code

Email Address:_____ County of Residence:_____

Parent/Guardian Names:_____

Home Phone #:_____ Cell Phone #:_____

Place of Employment:_____ Work Phone #:_____

Ethnicity: *Please circle one*
White Asian Black/African Hispanic American Indian/Alaska Native
Native Hawaiian/Pacific Islander Other

Does your child speak a language other than English? _____ Yes No
If Yes, please specify the language:_____

Please provide directions to your home:_____

Transported by Parent: _____Yes _____No If no, provide Bus #_____

Name & Address	Emergency Contact/Pick-up Relationship to child	Phone #	Contact Yes/No	Pick-up Yes/No

Signature of Parent/Guardian: _____ Date:_____

Signature Verifying Staff Member:_____ Date:_____

Family information

CACEP Status: Free or Reduce CACEP Date: _____ CACEP Income: _____

Foster Care: _____ Child Support: _____ WIC: Yes or No SNAPS: Yes or No

TANF: Yes or No SSI: Yes or No

Name of Member	Date	Source	Amount	Per	Annual Amount	Type	Desc. Code	Verification Code

Type Code	Description Codes	Verification Codes
ERN	PEN= Pension	CS= Check Stub
SUB= Subsidized	SSI= Supplemental Social Security	W2=W2
	Social Security	EL=Employer Letter
		TANF= TANF

Household Members

First and Last name of everyone in your household	Status	Birth Date	Gender	Relationship To Child	Language	Lives with Family	Provides Financial Support	Highest Grade	Employment Status/Subsi
			M or F						
			M or F						
			M or F						
			M or F						
			M or F						
			M or F						
			M or F						
			M or F						
			M or F						

Signature of Parent or Guardian: _____ Date: _____

Verifying Staff Member: _____ Date: _____

Medical Information and Health History

Does your child have any of the following conditions? *Please circle all that apply.*

Bee Stings	Hearing Problems	Hyperactive/ADHD	Severe Acne
Bladder Infection	High Blood Pressure	Seizure/Epilepsy	Spina Bifida
Cerebral Palsy	Cancer	Sinus Problems	Thyroid Disease
Allergies	Chicken Pox	Intestinal Problems	Tuberculosis
Arthritis	Depression	Multiple Sclerosis	Ulcers/GERD
Anorexia/Bulimia	Cystic Fibrosis	Leukemia	Vision Problems
Asthma	Diabetes	Prosthesis	Weight Problems
Autism	Ear Infections	Scoliosis	Other:

If you circle any of the above please explain: _____

_____

Is your child on any medication at this time? ___**Yes** ___ **No**
If yes will your child require any medication during school hours? ___ **Yes** ___ **No**

List daily medications: _____

Does your child have any activity restrictions? _____

Will students need special health care procedure at school? _____Yes _____**No**

What type of procedure? _____

Other Health Information/Special Education: _____

Name of Insurance: _____ Policy Number: _____

Family Physician	Address	Phone Number
Dentist	Address	Phone Number
Hospital	Address	Phone Number

Please Note: In the event of serious accident or illness, emergency medical services will be called. The student may be transported to the nearest hospital at the parent's expense.

This information, along with my child's immunization record, may be shared with school personnel, wellness center personnel, and other health professionals pertinent to my child's health. My child's immunization record can be shared with the West Virginia Statewide Immunization Information System.

Signature of Parent or Guardian: _____ Date: _____
Verifying Staff Member: _____ Date: _____

STUDENT RESIDENCY QUESTIONNAIRE/AFFIDAVIT

This document is intended to address the McKinney-Vento Assistance Act. Your answers will help determine documents necessary to enroll your child quickly.

Student:_____ (Male_____ Female_____)

Birthdate:_____ Grade:_____

1. Do you and your student live in a fixed, regular, adequate nighttime residence? **Yes**_____ **No**_____
   (If you circled "Yes" stop here. You must provide a gas or electric bill in your name as proof or residence.
   If you circled "NO", please continue with this form.)

2. Do you and the student live in:
   - ☐ Shelter
   - ☐ Motel/hotel
   - ☐ Temporarily with another family in a house, mobile home, or apartment
   - ☐ In a Car or RV
   - ☐ At a campsite
   - ☐ Transitional housing
   - ☐ Other location_____

3. The student lives with:
   - ☐ One parent
   - ☐ Two parents
   - ☐ A qualified relative
   - ☐ Friend(s)
   - ☐ An adult that is not the legal guardian
   - ☐ Alone with no adult(s)

4. I am:
   - ☐ The parent/legal guardian of the above-named student
   - ☐ A qualified adult relative of the above-named student (Relationship:_____

Parent/
Legal Guardian Signature:_____ Date:_____

Print Your Name:_____

Residence:_____
Street City Zip

Mailing Address:_____
Street City Zip

Telephone (____)_____ Cell Phone: (____)_____

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Sample Income Calculation Sheet

Parent/Legal Guardian Name:_____

Child's Name:_____

To calculate family's income, use the formula below. Income is calculated by earnings from previous calendar year or past 12 months.

***Number of months worked:_____ *Number in family:_____**
****Note: In the Monthly Earnings Section, multiple the monthly earnings by number of months worked or how long the parent has been employed for less than year.**

Documents Verified –Circle all that apply:

- ◯ TANF
- ◯ SSI
- ◯ Foster/Kinship Care Income
- ◯ Income Tax Form
- ◯ W-2 Form
- ◯ Pay Stubs
- ◯ Self Employed Income
- ◯ Employer letter or declaration
- ◯ Unemployment compensation
- ◯ Other (specify),_____

_____

	Hourly Rate	Hourly Rate	Weekly Earnings	Monthly Earnings	Yearly Earnings
Parent 1	X	X	X	X	X
Parent 2	X	X	X	X	X
Annual Income					
Total					

Family Is:

Income Eligible:_____ Over Income:_____ Automically Eligible:_____

Staff Signature:_ _____ Date:_____

Parent Signature:_____ Date:_____

Family Services/ERSEA Specialist:_____ Date:_____

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