

Child's Name: _____

Date: _____



Pre-K Application

2018-2019

1. Please mail applications by **April 30, 2018** to:

WCS Federal Programs- Pre-K Program
117 Tarboro St. N.E.
Wilson, NC 27893

2. After you complete your application and send to WCS Federal Programs, please attend Pre-K Registration at Vick Elementary:
May 22nd We will contact you to set up an appointment for your child's screening.
3. Applications **MUST** have the following to be complete:
 - Proof of Birth Certificate and Immunization Records
 - Proof of Residency
 - Proof of Income (Ex. Copy of 1040, W2 from 2016, Court-Ordered Child Support, SSI, SSA, Unemployment Benefits, Workers Comp, Public Assistance/Work First Benefits or three (3) consecutive paystubs.)
 - If applicable, documentation of chronic health and/or developmental or educational needs and/or IEP.
4. This application is for children who will be 4 years old by August 31, 2018.
5. This is an application for services offered and **DOES NOT** constitute enrollment into the program. Eligibility for the Pre-K program is based on educational need.
6. Parent/Guardian must be able to provide transportation.
7. Your child must have a health assessment within the first 30 days of attendance.

Child's Name: _____

Date: _____



*Child's Information: *Child must be 4 years old on or before August 31, 2018. Eligibility is based on educational need. Pre-K is available to students residing within Wilson County. Classrooms are located at Vick Elementary School. Please note, a limited number of slots are available at Vick Elementary School due to funding.*

Child's Name: _____

Date of Birth: _____/MM/DD/YYYY

Child's Address: _____

Street City State Zip County

Mailing Address: _____

(If different from above) Street City State Zip County

Email address: _____

Ethnicity/Race:

- Hispanic/Latino
- Native American Indian or Alaska Native
- White or European American
- Black or African American
- Native Hawaiian or Pacific Islander
- Asian

Gender:

- Male
- Female

Child's Name: _____

Date: _____

Family Information:

Who does your child live with? Documentation is required if child does not reside with parents.

- Mother and Father
- Single Mother
- Single Father
- Parent & Step Parent
- Grandparent(s)
- Foster parent(s)
- Legal Guardian
- 50/50 Custody
-

Mother/Stepmother/Guardian Name: _____

Resides with child: YES or NO

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Father/Stepfather/Guardian Name: _____

Resides with child: YES or NO

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Child's Name: _____

Date: _____

FAMILY INCOME INFORMATION:

NOTE: Documentation of each applicable source of family's income is required.

| | Mother/Stepmother/Guardian | Father/Stepfather/Guardian |
|-----------------------------|--|--|
| Please Check ALL that Apply | <input type="checkbox"/> Employed (If employed, please list average hours worked per week): _____ <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Attending Secondary Education <input type="checkbox"/> Attending Job Training <input type="checkbox"/> Not Employed | <input type="checkbox"/> Employed (If employed, please list average hours worked per week): _____ <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Attending Secondary Education <input type="checkbox"/> Attending Job Training <input type="checkbox"/> Not Employed |
| Current Wages BEFORE Taxes | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly |
| Alimony | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly |
| Court-Ordered Child Support | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly |
| Worker's Comp | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly |
| Unemployment | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly |
| SSI/TANF/Work First | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly |
| Overtime | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly | \$_____ This amount is (please circle below) Yearly Monthly Twice Monthly Bi- Weekly Weekly |

Child's Name: _____

Date: _____

***My signature certifies that I am currently unemployed and have no income of any kind. The person or source that provides basic living expenses for family:**

_____ I certify this information is true. If any part is false, I understand my child's participation in the program will be terminated.

Parent/Guardian Signature: _____

Date: _____

Language:

What is the language spoken with the child at home? _____

In what language would you like your child to be screened? _____

Health:

Does your child have a chronic health condition identified by a medical professional?

- Yes
- No

If Yes, what is the health condition? _____

***Documentation of chronic condition**

(Official documentation from a medical provider indicating child's chronic condition is required.)

Developmental and /or Educational Need

Has your child been diagnosed with a developmental or educational need by a medical professional?

- Yes
- No

If yes, please explain _____

Has this child been referred for evaluation or identified with a disability by a medical professional?

- Yes
- No

Is date of referral known: YES NO

Child's Name: _____

Date: _____

Date of referral for evaluation of disability(ies): _____

What was the decision from the disability evaluation for this child?

Does this child have an active Individualized Education Plan (IEP)?

- Yes
- No

Is this child receiving services related to disability?

- Yes
- No

If yes, please specify type of disability services:

***Documentation indicating developmental or educational need is required, if applicable.
*Please provide a copy of child's IEP, if applicable.**

Type of identified disabilities for this child (Check all that apply)

| | | | |
|---|--|--|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Deaf-Blind | <input type="checkbox"/> Behaviorally/ Emotionally Disabled | <input type="checkbox"/> Educable Mentally Disabled |
| <input type="checkbox"/> Preschool Development Delayed | <input type="checkbox"/> Specific Learned Disabled | <input type="checkbox"/> Orthopedically Impaired | <input type="checkbox"/> Speech Language Impaired |
| <input type="checkbox"/> Severe Profound Mentally Disabled | <input type="checkbox"/> Visual Impaired | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Traumatic Brain Injured |
| <input type="checkbox"/> Other: Please define: | | | |

Child's Name: _____

Date: _____

Parent/Guardian Responsibility and Participation (Please initial for each statement)

_____ I understand this is an application for services offered and DOES NOT constitute enrollment into any program.

_____ I certify that the information given on this application is true and accurate and all income has been reported.

_____ I understand this information is being given for receipt of federal funding. Program staff may verify information on this application. Deliberate misrepresentation of the information may subject me to prosecution under applicable federal and or state laws.

_____ I give permission for my child to receive developmental hearing, vision, dental and/or speech and language screening and for the results of these screenings to be shared with Wilson County Schools.

_____ I understand that if my child is selected to participate in the Wilson County Schools Pre-K program, parent involvement will be critical to the success of my child and I/we commit to participate as required by the program criteria.

_____ I understand that Wilson County Schools Pre-K is designed to serve at-risk children and that every effort shall be made by me to maintain my child's enrollment and participation.

_____ I understand that I will need to provide transportation for my child.

_____ I understand that my child will need a current, updated health assessment and immunizations before he/she attends a program.

Parent/Guardian

Signature: _____ **Date:** _____

Relationship to Child: _____

**If guardian signs, please attach documentation of guardianship.*

Return this completed original application by mail by April 30, 2018 to:

**WCS Federal Programs- Pre-K Program
117 Tarboro St. N.E.
Wilson, NC 27893**

****FAXED applications will not be accepted.**

| ****WCS Federal Programs Office Use Only**** | | |
|--|----------------|-----------------|
| Received by: | Date Received: | Date Processed: |
| | | |

Child's Name: _____

Date: _____

Release of Information Consent Form

I _____, parent/guardian of
(Parent/Guardian First and Last Name)

(Child's First and Last Name)

consent to the release of my child's contact information, demographic information, assessment scores, parent survey information, enrollment and attendance information, and which school your child attends after Pre-K to Wilson County Schools. The release of this information requires your consent. If you agree to the release of this information, please sign and return this form.

Parent's Signature (Consent): _____

Date: _____

Which school does your child plan to attend after Pre-K?
