Date Application Received: _____

Cuddle Zone Learning Center

445 Allentown Dr Allentown PA 18109 (610) 434-2644

PREK COUNTS APPLICATION FORM

2024-2025 SCHOOL YEAR

Child's First Name: _____ Child's Last Name:_____

DOB: ___/___/___ Gender ___M___F Social Sec # _____-____-_____

Street Address: _____County: _____

City_____ State_____ Zip Code_____

School District of residence: _____ Phone No. _____

Email: _____ Household Size: _____

List Household Members below for determination of family size (required):		
	Name	Relationship to child
1	Enrolling Child	----------
2		
3		
4		
5		
6		

Primary Language: ☐ English ☐ Spanish ☐ Other _____
(please specify)

Name of Parent/Guardian Completing this Form:_____

Relationship to child: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____
(please specify)

Family Type: ☐ One Parent ☐ Two Parent ☐ Adoptive
☐ Foster ☐ Relative/Guardianship ☐ Other _____
(please specify)

Race (optional): ☐ Black or African American ☐ White ☐ Other _____
(please specify)
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaskan Naive

Ethnicity (Optional): ☐ Hispanic ☐ Non-Hispanic ☐ Non-Applicable

Household Information

Income Sources: (Must Check all that apply)

☐ Employment ☐ Self-Employment ☐ Unemployment Compensation ☐ Worker's Compensation ☐ TANF Cash payments

☐ Social Security ☐ SSI ☐ Child Support ☐ Alimony ☐ Other _____ (please specify)

Household Income check box: Attach a copy of 2023 1040 page 1 (required) for verification of income for eligibility

☐ 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 -$75,300
☐ $70,001 - $72,900	☐ $72,901 - $85,320	☐ OVER $75,300

Other Child Eligibility Risk Factor Criterion (Check all that apply):

- ☐ Disability or developmental delay (verified with copy of IEP or other source of documentation from the parent or EI provider) and/or participation in one of the Early Intervention programs. Specify which one: _____
- ☐ English Language Learner: A child whose first language is not English and who is the process of learning English is considered an English Language Learner
- ☐ Behavioral Supports (A child who is receiving mental health treatment or who was referred from a health practitioner)
- ☐ Child Protective Services: A child who is a foster child, a kinship care child or receiving Children and Youth Services
- ☐ Migrant (Non-Immigrant)/Seasonal Student
- ☐ Education level of Guardian: does not have a high school diploma or GED
- ☐ Homeless: A child who lacks a fixed, regular and adequate nighttime residence
- ☐ Incarcerated Parent: A child for whom one of the child's parents is currently in prison
- ☐ 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 Printed Name: _____

For Office Use Only: 2023 Federal Poverty Level Guidelines

Family Size	100% (Head Start Eligible)	300% (PreK Counts Eligible)
1	$14,580	$43,740
2	$19,720	$59,160
3	$24,860	$74,580
4	$30,000	$90,000
5	$35,140	$105,420
6	$40,280	$120,840
7	$45,420	$136,260
8	$50,560	$151,680
Each additional family member	+$5,140	+$15,420

Verified Household Size:_____

Actual Annual Verified Gross Household (Family) Income: _____

☐ Family Income is at or below 300% of federal poverty level

☐ Family Income is at or below 100% of federal poverty level and Head Start eligible (made referral to Head Start ___)

_____ _____

Staff Verifying Income and Risk Factors Signature/Title Date

☐ PreK Counts Only ☐ Summer Care needed

☐ Wraparound Care needed ☐ Title XX funding

For Head Start Eligible families (100% of FPL or below) ☐ **Check if not applicable**

I have been informed of my child's eligibility for Head Start and given the following:

☐Contact information for the following Head Start location:
Head Start of the Lehigh Valley 1520 Hanover Ave, Allentown PA 18109
P: 610 437-6000 www.CSCinc.org

My signature below indicates that I have been informed about my options but may still choose to enroll in the Cuddle Zone Pre-K Counts program.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Staff Signature **Date**

"Getting to Know You" Notes

(To be completed by the child's Parent/Guardian prior to enrollment)

Parents: Please complete this form to allow us to get to know a little more about your child so that we can best be prepared to help them transition into their new classroom!

Childs' Name:_____Date of Birth:___/___/___ Anticipated Start Date:___/___/___

Any Nicknames:_____ *Parent Email:_____

Does your child have any pets?_____ Siblings Names and Ages:_____

Other important family members living at home? Examples: Parents, Step Parents, Grandparents, Aunts, Uncles

_____

Does your child have any fears? Examples: the dark, water, spiders, loud noises, heights

_____

Please list some of your child's likes and dislikes:

Likes: examples: legos, playground, dinosaurs, books, water play, painting, play-doh,

_____

Dislikes: examples: sensory materials, dirty hands, water, foods/beverages

_____

Previous child care experience? Where and How long?_____

Is your child able to use the bathroom and change their clothes with minimal assistance? ___yes ___no

Please explain:_____

Helpful hints/special information about your child including allergies/diet restrictions:

_____

____(initial here) I am aware that in addition to completing this form, a "Getting to Know You" Meeting is available for me and my child with management as well as the classroom teachers at my request within 60 days of enrollment or at anytime thereafter at parent request.

*Parent Signature:_____*Date:_____

(bottom portion to be completed by school staff)

Teacher Initials:_____ _____ _____ _____ _____

Classroom Assigned:_____ PreK Counts? __yes __no Wrap around care? __yes __no

(This form is to be reviewed by all classroom teachers and kept in the child's classroom file)

INDIVIDUALIZED EDUCATION PLANS (IEP) AND INDIVIDUALIZED FAMILY SERVICE PLANS (IFSP) INFORMATION SHEET

Child's Name_____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so that we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

_____ I am providing a copy of my child's IEP or IFSP

_____ I am not providing a copy of my child's IEP or IFSP

_____ Not applicable to my child

I have applied for services for my child:

_____
Name of agency

My child is currently receiving services from: _____

_____

SIGNATURE:_____DATE:_____

PRINT NAME:_____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Return to:
Cuddle Zone Learning Center
445 Allentown Dr, Allentown PA 18109
FAX 610 434-3005

ALLENTOWN HEALTH BUREAU
245 North 6th St
Allentown, PA 18102
Ph. 610.437.7760 Fax 610.437.8799

TUBERCULOSIS ASSESSMENT REPORT FOR CHILD CARE FACILITIES

Please return to the child's daycare provider, not the Health Bureau

Age-appropriate tuberculosis assessment should be performed by the healthcare provider as part of the physical exam that is required by the City of Allentown Codified Ordinance for admission *to licensed Child Care Facilities.* Age-appropriate tuberculosis assessment may be performed **yearly**, in conjunction with the physical assessment.

Name of Child: _____ Date of Birth: _____
NAME of DAY CARE FACILITY Cuddle Zone Learning Center _____

To determine the risk of acquiring Tuberculosis infection, the following questions should be asked of the parent/guardian.

____yes ____no 1. Have you or your child been exposed or had any household contact with someone who has or is suspected to have active tuberculosis?
____yes ____no 2. Are you or your child from a foreign country or have you been outside the U.S. in the last six months?
____yes ____no 3. Are you or your child a household contact with someone who has been in jail or homeless in the last five years?
____yes ____no 4. Do you or your child have cancer, chemotherapy treatments, HIV infection, chronic asthma, or long-term steroid use?
____yes ____no 5. Has your child had household contact with someone with a positive Tuberculosis Test?

If "yes" to any of these questions, a tuberculosis test is required according to the guidelines and recommendations as follows: For children under the age of 2 years, a PPD skin test is required. For children over 2 years, a QuantiFERON Gold test is recommended but a PPD test is acceptable. Testing must be interpreted by a healthcare provider. Frequency of testing should be done accordingly to the degree of risk of acquiring Tuberculosis infection.

Date: _____
_____ Tuberculosis assessment completed – No need for TB Testing at this time.
_____ Tuberculosis testing completed by: _____

PPD METHOD (5TU) (CHILDREN UNDER 2)
DATE PPD APPLIED: _____
GIVEN BY: _____
RESULTS IN 48-72 HOURS: _____MM
INTERPRETED BY: _____
DATE: _____

QUANTIFERON TB GOLD PLUS TEST
DATE OF TESTING: _____
RESULTS: _____
POSITIVE NEGATIVE
INTERPRETED BY: _____
DATE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____