Clay County Schools Pre-K Application Form

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

Child's Name: (Last) _____ (First) _____ (Middle) _____

Birth Date: _____ Age: _____ Gender: M or F

Physical Address: _____
Street Address City State Zip code

Mail Address: (if different from physical) _____
P.O. Box City State Zip code

Email Address: _____ County: _____

Name of Parent or Guardian: _____Telephone Number: _____

Place of Employment: _____ Work Number: _____

Ethnicity: *Please Circle One*

White Asian Black/African American 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 other language: _____

Please provide us with directions to your home:

Transportation: Bus Number _____ Transported by Parent: _____ yes _____ No

Emergency Contact/ Pick-Up

Name/Address	Relationship to Child	Phone Number	Contact (yes or no)	Pick-up (yes or no)

Signature of Parent or Guardian: _____ Date: _____
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 SUB= Subsidized	PEN= Pension SSI= Supplemental Social Security Social Security	CS= Check Stub W2=W2 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: _____