2022-2023 NC Pre-K Application Parent Reminders

☆ All **completed** NC Pre-K Applications should be returned to the nearest elementary school in your attendance zone **for processing only.**

☆ Student placement will be determined based on eligibility ranking and is **not necessarily guaranteed** at the location where the application is received and/or returned.

Tips for completing your NC Pre-K Application

☆ Complete each section of the application in its entirety.

☆ List **all** household members, to include the student when providing the names of persons living in the home.

☆ Provide the **most current** tax information or provide two (2) consecutive paystubs.

Following these tips will reduce the delay in your application's entry and processing time

2022-2023
NC Pre-K Applications
Parent Checklist

Keep This Form Attached & Return with the following items:	DETACH YELLOW, BLUE & GREEN COPIES Child's doctor/dentist must complete the Blue and Green Copies
☐ Application Completed ☐ Statement of Residency ☐ Current electric bill or ☐ Signed Lease Agreement ☐ Birth Certificate (Child will be 4 on or before Aug. 31st, 2022) ☐ Social Security Card ☐ Proof of Income ☐ All Household members (Two consecutive pay stubs or the most current tax information; i.e. W2, 1099 or Tax Return)	☐ Health Assessment (Due within the first 30 Days in attendance) ☐ Date of Appointment_____ ☐ Dental Screening (Due within the first 30 Days in attendance) ☐ Date of Appointment_____ ☐ Immunizations (Due within the first 30 Days in attendance) ☐ Date of Appointment _____ Date turned in to the school_____

Office Checklist (To be completed by the School Data Manager)

☐ Application Completed ☐ Statement of Residency ☐ Current electric bill or ☐ Signed Lease Agreement ☐ Birth Certificate (Child will be 4 on or before Aug. 31st, 2022) ☐ Social Security Card ☐ Proof of Income ☐ All Household members (Two consecutive pay stubs or the most current tax information; i.e. W2, 1099 or Tax Return)	☐ Health Assessment (Due within the first 30 Days in attendance) ☐ Date of Appointment_____ ☐ Dental Screening (Due within the first 30 Days in attendance) ☐ Date of Appointment_____ ☐ Immunizations (Due within the first 30 Days in attendance) ☐ Date of Appointment _____ ☐ Brigance Testing ☐ Date of Appointment _____ Date Complete Packet was Received _____ Date entered in NC Pre-K_____

2022-2023 NC Pre-Kindergarten Application

Scotland County Schools
322 South Main Street, Laurinburg, NC 28352
Phone 910-276-1138 or Fax 910-277-4310

The NC Pre-K Program is available to children in Scotland County who will be **4 years of age on or before August 31, 2022 and who MAY BE ELIGIBLE** for the program. You must provide your child's birth certificate, current immunization record, current health assessment & dental screening, proof of income and proof of residence, including street address along with this completed application. After the application process is completed, you will be notified **by mail prior to August 24, 2022** of your child's eligibility status. **Regular attendance is very important to the NC Pre-K students' success.**

CHILDREN ARE NOT ASSURED PLACEMENT WHERE ASSESSED AND MAY BE PLACED AT ANOTHER NC PRE-KINDERGARTEN SITE.

Please answer all questions as accurately as possible. Your answers to the following questions will help us to determine your child's eligibility and will be kept strictly confidential.

Child's Name _____
First Middle Last

Child's Gender: ___ Male ___ Female Date of Birth ____/____/____ Birthplace _____
Month Day Year

Child's Ethnicity *(check one)*: ☐ Child is Hispanic or Latino or of Spanish origin
☐ Child is **not** Hispanic or Latino or of Spanish origin

Child's Race: (*check at least one and all that apply*) _____American Indian/Alaska Native; _____Asian; _____Black/African American; _____Native Hawaiian/other Pacific Islander; _____White/European American

Is your child a U. S. Citizen? _____ Yes _____ No Is your child a N.C. Resident? _____ Yes _____No

County of Residence: _____ Application date: _____

Email: _____

Family Information

***If legal Guardian/Custodian, court ordered custody documents must accompany this application before it can be processed.**

Name of Parent(s), Legal Guardian(s) or Legal Custodian(s) who lives in the home:

_____, Phone #_____
First Middle Last
Alt. phone #_____

_____, Phone#_____
First Middle Last
Alt. phone #_____

Home Address_____
Street City State Zip Code

Mailing Address (if different) _____
Street City State Zip Code

Child lives with: ☐ Both parents in same home ☐ Single Mother ☐ Single Father ☐ Parent and Step-Parent
☐ Legal Guardian(s) ☐ Legal Custodian(s) ☐ Other: (specify) _____

Check (**one**) of the following statements: ☐ I consider my family to be homeless
☐ I consider my family to have adequate housing

***Income verification will be required –*W-2's from the prior year (if at all possible), two (2)* current consecutive pay stubs & all other income verification documents as noted below.**

Mother's/Stepmother's/Guardian's/Custodian's Name: _____

Please check all that apply: *Employed?* Yes _____ No_____ (If **not** employed, please complete our **"No Income" statement below**)

Place of employment and work telephone number: _____

Income BEFORE Taxes	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Alimony	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Child Support	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Worker's Comp	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Unemployment	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
SSI/TANF/Work First	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Overtime	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly

☐Seeking Employment ☐Attending secondary education ☐Attending high school/GED ☐Attending job training ☐Other

Unemployed/Zero Income Statement

(Adults in the home must complete ONLY if receiving NO Income)

I, _____, verify that I am NOT employed and receive NO Income.

Signed _____ Date _____

Father's/Stepfather's/Guardian's/Custodian's Name: _____

Please check all that apply: *Employed?* Yes_____ No_____ (If **not** employed, please complete our **"No Income" statement below**)

Place of employment and work telephone number: _____

Income BEFORE Taxes	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Alimony	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Child Support	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Worker's Comp	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Unemployment	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
SSI/TANF/Work First	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly
Overtime	$_____	This amount is	□yearly	□monthly	□twice monthly	□bi-weekly	□weekly

☐Seeking Employment ☐Attending secondary education ☐Attending high school/GED ☐Attending job training ☐Other

Unemployed/Zero Income Statement

(Adults in the home must complete ONLY if receiving NO Income)

I, _____, verify that I am NOT employed and receive NO Income.

Signed _____ Date _____

*****INCOME FOR ANYONE ELSE LISTED IN THE HOME*****

Name of Person Receiving Income	Source of Income	Amount	How Often?

Falsification on any part of this form may forfeit your child's space in the program.

List parents, step-parents, legal guardians, legal custodians, brothers, sisters, half-brothers, half-sisters, step brothers, step sisters, grandparents, aunts, uncles and anyone else living in the home with the child.

Name	Age	Relationship to the Pre-K Child
1.		**Pre-K Child**
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

The language spoken most often in our home is: English _____ Other *(specify)* _____

Does your child have a chronic health condition? Yes_____ No_____
If yes, submit note from doctor.

Military Status of Parent/Legal Guardian: *(if applicable, provide documentation)*

- □ Active duty in US armed forces
- □ Active duty in NC National Guard Reserve Unit of armed forces and ordered to active duty in the past or next 18 months
- □ One parent or legal guardian of this child was seriously injured or killed while on active duty
- □ Not Applicable

Who currently cares for your child when you are at work or school?

_____ Child Care Center; Name of Center _____
_____ Parent/Home
_____ Relative
_____ Head Start; Name of Head Start _____
_____ Other – Please Specify _____

If your child is not in child care now, has he/she ever been in a child care program? _____Yes _____No
If yes, where did he/she attend? _____
Name of child care center

Does your child receive any type of voucher to assist with the cost of day care? _____

Does your child have an active IEP (Individualized Education Program)? _____ Yes _____ No
If yes, submit copy of the child's IEP

Has your child been referred for evaluation for or identified with a disability? _____Yes _____ No
If so, date of referral: _____

Is your child currently receiving services or been referred for a special need or disability? _____Yes _____ No
If yes, please check all that apply and provide documentation of services:

_____ Speech Therapy
_____ Educational Services
_____ Mental Health Services
_____ Physical Therapy
_____ Other Please Specify _____

Who provides these services? _____

Family Responsibilities

Please read carefully and initial each box

	I give **permission** for my child to receive developmental, hearing, vision, dental and/or speech and language **screenings** and for the results of these screenings to be shared with partnering Pre-K Programs.
	I understand that if my child is selected for participation, family involvement is expected. My family will cooperate with programs to submit necessary documentation and applications for additional services.
	I understand that it is my (parent/guardian or designee) responsibility to be in place to receive my child from the Pre-K Program as scheduled daily.
	I understand that if there is a change in my child's address, phone number or attendance in any type of licensed care, or if there is a change in family income, it is my responsibility to notify Scotland County's NC Pre-K Department at 322 South Main Street, Laurinburg, NC 28352 and inform them of any changes.
	I understand that my child will be required to have a current immunization record, updated health assessment and dental screening before or within the first 30 days of attending the NC Pre-K Program.
	I understand that my child **may be placed on a waiting list.**

I certify that all information provided is true, correct and complete. I understand that information is provided to document eligibility for receipt of program funds. Program staff may verify information on this application. Deliberate misrepresentation may subject me to prosecution under applicable North Carolina state laws.

_____

Parent/Guardian/Custodian Signature Date

Relationship to child _____

Site Preference may be considered; however, placement is not guaranteed

Preference Location 1:_____

Preference Location 2:_____

Dear Parent(s) and/or Guardian(s),

As you register your child for school, there are some health requirements he/she will need.

For **Pre-Kindergarten (Pre-K)**, if selected for the program, your child will need the following:

- A completed North Carolina Health Assessment Transmittal Form
- An up-to-date immunization record
- A completed Dental Screening Form

For students entering North Carolina schools for the first time, as required by North Carolina law (G.S. 130A-440, G.S. 130A-441, G.S. 130A-152, and G.S. 130-90), your child will need:

- A completed North Carolina Health Assessment Transmittal Form
- A complete immunization record

Once school begins, you will have **30 calendar days** to submit this information to the school. If not submitted after 30 days, your child will be excluded from school. Please schedule appointments as soon as possible. We do not want your child to miss school days.

If your child has a medical condition (asthma, diabetes, severe allergies to food/insect stings, etc.) in which medication will be needed during school hours, your medical provider will need to complete a Medication or Procedure Order Form for any prescription or over the counter medications. These forms are located in the school office. Medications should be brought in the original pharmacy container or box labeled with your child's name. If your child has any health conditions where specialized healthcare is needed, please notify the school so we can help plan the care of your child during the school day.

If you have any questions or concerns about what you will need to have your child ready for school, please contact your school nurse. We look forward to working with you and your child.

Sincerely,
Scotland County School Nurses

January 2016rev

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT TO COMPLETE THS SECTION

Student Name:

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION AND BACK PAGE

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

NC Public Health
HEALTH AND HUMAN SERVICES

January 2016rev

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification
I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: _____ Date (m/d/yyyy):

Date of Exam (if Different):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here:

NC Public Health
HEALTH AND HUMAN SERVICES

Dental Screening Form

Parent To Complete

When the Health Assessment Transmittal Form issued by NCDPI is used to complete the NC Pre-K child's health assessment, a **separate dental screening** must also be completed due to it not being included on the NCDPI form. Per NC Child Care Rule 10A NCAC 09 .3005 Child Health Assessment, the child's health assessment must include a dental screening, which may be recorded on this form.

Child's Name: _____
Birth date: _____/_____/_____
Gender: ____ **Male** ____ **Female**
Parent or Guardian: _____
Address: _____
City: _____
Phone number: _____ **School/Pre-K:**_____

Health Care Provider To Complete

Screener's Name _____ Screening Date___ /___/___

Organization/Practice Name _____

Phone number_____

Professional affiliation (please check one):

____Dentist
____Dental Hygienist
____Physician
____Physician Assistant
____Registered Nurse
____Other Health Professional: _____

Pattern of early childhood cavities:

- o No cavities/decay present or no obvious problem
- o Cavities/decay present or dental care needed (comment required)
- o Referral for Urgent Care (comment required)

Comments:

Signature_____ **Date**_____

Scotland County Schools
322 South Main Street
Laurinburg, NC 28352
Telephone: 910-276-1138
Fax: 910-277-4367

Statement of Residency

Under penalty of law, I _____,
Name of Homeowner/resident/parent/guardian

hereby certify that _____ resides at
Name of student presented for enrollment

_____
Street Address City State Zip Code

and that _____ does not reside at any
Name of student presented for enrollment

other address in the County of Scotland. I further certify that attached hereto and

incorporated herein by reference is a true and authentic (check both and attach document):

_____ Current, recently dated electric bill for the residence described above; **and**

_____ Signed lease agreement for the residence or residential tax bill.

I understand that if false information is provided in this Statement and that it is subsequently determined that the child identified above is not eligible to attend Scotland County Schools, the child will be required to re-enroll elsewhere, and I may be held responsible for the cost of educating the child during the period of enrollment, not to include state funds.

_____
Signature of Homeowner/resident/parent/guardian

Date: _____