3-5 Enrollment Packet

220 North Grant Avenue, Fort Collins, CO 80521
Phone: (970) 490-3204 Fax: (970) 490-3134 Email: psdece@psdschools.org bit.ly/PSDpreschool

Emergency Contact Information

Child's name:______________________ DOB: ______________ Child+: ____________

Emergency contact name (other than parent):____________________ Relationship to child: ____________

Phone (Home): ____________________ Phone (Cell): ____________________

Check all that apply: ☐ Emergency contact ☐ Release child to

Is this person at least 16 years old with a valid ID? ☐ Yes ☐ No

Emergency contact name (other than parent):____________________ Relationship to child: ____________

Phone (Home): ____________________ Phone (Cell): ____________________

Check all that apply: ☐ Emergency contact ☐ Release child to

Is this person at least 16 years old with a valid ID? ☐ Yes ☐ No

Emergency contact name (other than parent):____________________ Relationship to child: ____________

Phone (Home): ____________________ Phone (Cell): ____________________

Check all that apply: ☐ Emergency contact ☐ Release child to

Is this person at least 16 years old with a valid ID? ☐ Yes ☐ No

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Phone (Home): ____________________ Phone (Cell): ____________________

Check all that apply: ☐ Emergency contact ☐ Release child to

Is this person at least 16 years old with a valid ID? ☐ Yes ☐ No

Department of Language, Culture & Equity
POUDRE SCHOOL DISTRICT

HOME LANGUAGE AND RESIDENCY (HOUSING) FORM

This box MUST be completed by school registrar before giving to site ELD and/or McKinney representative as appropriate.
Intake School:_____Intake Date: _____
Enrolling School:_____Date Enrolled: _____
Student ID #:_____Grade: _____

State and federal regulations require that schools determine eligibility for English Language Development, immigrant, migrant, refugee, or McKinney-Vento education services and supports. This information is used to ensure that the educational rights of each child are met. This **confidential information** is for school use only.

Student's Last Name	Student's First Name	Student's Middle Name
Date of Birth	Place of Birth	Address
Date Student Entered Colorado	Date Student Entered US (if applicable)	
Parent/Guardian Name(s)	Phone Numbers	

Home Language Survey

Does your child understand a language other than English? If yes, what other languages does your child know?	
What language did your child first learn?	
What language do you most frequently speak with your child?	
What language does your child most frequently **speak** with you?	
Is your child able to **read** and **write** in this language?	
List any other languages used in the home.	
Which language do you prefer for communication to and from school?	

Educational History

Please complete the following educational history as accurately as possible.

Grade and Date(s)	School Name	School Location	Language of Instruction

If you came to the US from another country, did your child attend school inthat country? ☐Yes ☐No
If yes, please complete the following:

How many total years did your child attend school in another country? Which country?	
Did your child receive any specialized instruction (Gifted/Talented, Special Education, Interventions)?	

Have you been given Refugee Status Paperwork? ☐Yes ☐No

Health Conditions

Student Name:_____ Date of Birth:_____/_____/_____

Health Care Provider/Medical Clinic:_____ Last exam date: _____

Dentist/Dental Clinic:_____ Last exam date: _____

Are you enrolled in Supplemental Nutrition Assistance Program (SNAP) ☐ Yes ☐ No

Is your family currently on WIC ☐ Yes ☐ No

Medical Insurance:

☐ Medicaid/Health First ☐ Colorado Health Plan Plus (CHP+) ☐ None/Uninsured ☐ Other_____

Hospital Preference:

☐ Poudre Valley Hospital ☐ McKee Medical Center ☐ Medical Center of the Rockies ☐ Banner Health

Health Conditions:

Response		Health Condition	Response		Health Condition
YES	NO	Allergy- Environmental / Animal	YES	NO	Hearing Impairment- Devices worn? YES NO
YES	NO	Allergy – Food	YES	NO	Heart Condition
YES	NO	Allergy – Insect	YES	NO	Kidney /Urinary
YES	NO	Allergy - Medication	YES	NO	Mental Health
YES	NO	Asthma	YES	NO	Neurological
YES	NO	Autism Spectrum Disorder	YES	NO	Orthopedic
YES	NO	Brain / Head Injury	YES	NO	Physical limitation/restrictions
YES	NO	Cancer	YES	NO	Premature or significant birth history
YES	NO	Chewing or swallowing troubles	YES	NO	Seizures/ Epilepsy
YES	NO	Diabetes	YES	NO	Special Diet
YES	NO	G-Tube	Yes	NO	Vision Problem – Glasses worn? YES NO
YES	NO	Genetic Disorder	OTHER:		

Explain any health condition(s)above:_____

_____

_____

Does your child need medication at school? YES ☐ NO ☐

Name of Medication(s):_____

**Print or request an *Authorization to Administer Medication* form from your school or from the PSD health services website:

Please list any other daily medication(s) that your child is taking at home: _____

I voluntarily provide this information and understand I must provide the following health documents for my child's health file: Complete immunizations, current physical exam, dental exam, and lead blood test results

_____

Parent/Guardian Signature **Date**

Housing Information

The McKinney-Vento Assistance Act protects and supports the educational rights of students who do not have permanent housing. Your answers help to determine the support the student may be eligible for.
*This **confidential information** is for school use only.*

A. Please check which of the following situations the student resides in (you can choose more than one): (Choose all that apply or None of the Above.)

____Living with extended family members, non-family members, or friends
____Motel, car, campsite, or park
____Shelter (emergency, safehouse) or transitional housing program
____Inadequate housing (lacks proper kitchen, bathroom facilities, water or electricity, and/or infestations, mold, or other dangers)
____None of the above
____Other (Please Explain)

B. Please check all the following reasons that apply to the students living situation (you can choose more than one): (Choose all that apply or None of the Above.)

____Loss of housing
____Economic hardship
____Temporarily waiting for house or apartment
____Providing care for a family member
____Living with boyfriend/girlfriend/significant other/friend
____Loss of employment
____Parent/Guardian deployed
____None of the above
____Other (Please explain)

C. I am a student living apart from my parents or guardians. ☐ Yes ☐ No

For students **without** a fixed, regular and adequate nighttime residence the following rights apply:

Educational Rights

1. Go to school no matter where they live or how long they have lived there
2. Choose between the local school where they are living, the school they attended before they lost their housing, or the school where they were last enrolled
3. Enroll in school without proof of address, immunizations, school records, or other documents
4. Have access to extracurricular activities
5. Get transportation to their school of origin (if feasible and in their educational best interest)
6. Get all the school services they need (including free breakfast/lunch, fees waived)
7. Be free from harassment and isolation
8. Have disagreements with the schools settled quickly

Any questions about these rights can be directed to the local McKinney-Vento Program Specialist at 970-490-3242.

By signing below, I acknowledge that I have read and understand the above rights.

Signature of either parent, guardian, or unaccompanied youth Date

Please complete these last three pages only if you have concerns.

Child's Name:_____Child's Date of Birth: _____

Pregnancy & Birth		
Birth weight: _____lbs._____oz.	Child Born at:	☐ 40+ weeks ☐ Preterm at_____weeks due to _____

7. Please share any difficulties during pregnancy, labor, or delivery:

8. Did your baby experience any difficulties after delivery (ie: seizures, trouble breathing):

9. Any medications used during pregnancy: ☐ Yes ☐ No - List medications and reason:

10. Describe how your child was as a baby:

Health & Developmental History

Toileting

☐ Training started	☐ Diapered during the day
☐ Needs help toileting	☐ Toilet trained

Soiling or wetting concerns:

Sleeping Habits

Do you feel like your child gets enough sleep? ☐ Yes ☐ No

Is your child easily soothed? ☐ Yes ☐ No Concerns:

Family Considerations

Have there been any changes in the child's life such as a new sibling, divorce, marriage or death in the family?

Please describe the child's reaction, if any. _____

Current Child Development

Does your child have an: ☐ IEP ☐ IFSP ☐ Private Therapy: _____

If so, please provide us a copy or request to sign a Release of Information form so we can access a copy.

Do you have concerns about your child in any of the following areas?

☐ Yes	☐ No	MOTOR SKILLS (walking, drawing)	☐ Yes	☐ No	ADAPTIVE SKILLS (feeding and dressing self)
☐ Yes	☐ No	SOCIAL – EMOTIONAL (behavior, social skills)	☐ Yes	☐ No	EARLY LEARNING (engaging in play, early concepts)
☐ Yes	☐ No	COMMUNICATION (speech intelligibility, language comprehension)			

-- Developmental Inventory --

Thinking about the skills your child demonstrates consistently, does he or she:

Motor Skills

Does your child:	Yes	Not yet	N/A
Use crayons and/or markers to scribble, draw, or "write"			
Use scissors to snip the edge of a piece of paper			
Use one hand for most activities			
Run, walk, and jump			
Throw and kick a ball; try to catch a ball with both hands			

Social-Emotional

Does your child:	Yes	Not yet	N/A
Show an awareness of feeling, his/her own and those of others			
Want independence, but stills needs security of parents			
Enjoys playing with other children similar in age			
Verbally express what he/she wants or needs			
Show empathy toward familiar adults and friends			

Communication

Does your child:	Yes	Not yet	N/A
Listen and remember details of simple stories			
Understand simple 1-2 step directions			
Put 3-5 words together to speak in short sentences ("want more milk")			
Ask lots of questions			
Speak clearly so that most family members and friends understand him/her			

Adaptive Skills

Does your child:	Yes	Not yet	N/A
Feed himself/herself using a fork and/or spoon			
Wash and dry his/her own hands			
Help with dressing and undressing			
Drink from a cup			
Open doors and cupboards			

Early Learning

Does your child:	Yes	Not yet	N/A
Enjoy looking at books with an adult or independently			
Play with toys in expected way (drive and crash cars, take care of a doll)			
Name and match colors			
Sing along with familiar songs			
Ask for help with difficult activities			

Your specific concerns:

When did you first notice concerns in this area?

Have you pursued private services through your child's doctor?

Previous or Current Home-Based or Childcare/Preschool Provider

Name of Childcare or Preschool:	Month/Year Attending:
Street Address:	
City/State/ZIP:	Phone Number: ( )
Days/Hours:	☐ I agree to allow PSD to contact for further information
Your Child:	
Describe your child's personality:	
Share your child's favorite activities?	

Does your child have the opportunity to play with other children?	☐ Yes	☐ No	Explain (@ the park, with her cousins, etc.):	
My child attends to an engaging play activity (non-screen related) for:	☐ < 5 mins	☐ 5-10 mins	☐ 10-30 mins	☐ 30+ mins

How much time a day does your child spendwatching/using screens?_____hours _____minutes
Does this concern you? ☐ Yes ☐ No

Behavior

N/A	Yes	No	
			Do you have behavior concerns at home?
			Does your childcare provider have behavior concerns at childcare?
			Has anyone else (family or friend) expressed concerns about your child's behavior?
			Has your child ever been asked to leave a childcare setting due to behavior?

Anything else you would like us to know about your child?

What do you hope your child will learn from the PSD Early Childhood Education Program?