

2020-2021 3-5 Enrollment Packet

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

Please complete the following boxes with Parent/Guardian's current contact information and employer information. This information is necessary so that we can contact you in the case of an emergency. Primary and Secondary Guardians will be contacted first. Additional emergency contacts may be added on the following page.

Primary Guardian:			
Street Address:			
City, State, Zip:			
Primary's Phone(s):	()	<input type="checkbox"/> Home	<input type="checkbox"/> Cell
	()	<input type="checkbox"/> Home	<input type="checkbox"/> Cell Texting Ok? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:			
Employer:			
Street Address:			
City, State, Zip:			
Work Phone:	()		

Secondary Guardian:			
Street Address:			
City, State, Zip:			
Secondary's Phone(s):	()	<input type="checkbox"/> Home	<input type="checkbox"/> Cell
	()	<input type="checkbox"/> Home	<input type="checkbox"/> Cell Texting Ok? <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address:			
Employer:			
Street Address:			
City, State, Zip:			
Work Phone:	()		

Emergency Contact Information

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

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	() <input type="checkbox"/> Home <input type="checkbox"/> Cell	Check all that apply <input type="checkbox"/> Emergency contact <input type="checkbox"/> Release child to Is this person at least 16 years old with a valid ID? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
	() <input type="checkbox"/> Home <input type="checkbox"/> Cell		

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	() <input type="checkbox"/> Home <input type="checkbox"/> Cell	Check all that apply <input type="checkbox"/> Emergency contact <input type="checkbox"/> Release child to Is this person at least 16 years old with a valid ID? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
	() <input type="checkbox"/> Home <input type="checkbox"/> Cell		

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	() <input type="checkbox"/> Home <input type="checkbox"/> Cell	Check all that apply <input type="checkbox"/> Emergency contact <input type="checkbox"/> Release child to Is this person at least 16 years old with a valid ID? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
	() <input type="checkbox"/> Home <input type="checkbox"/> Cell		

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Street Address: City, State, Zip:			
Phone #'s:	() <input type="checkbox"/> Home <input type="checkbox"/> Cell	Check all that apply <input type="checkbox"/> Emergency contact <input type="checkbox"/> Release child to Is this person at least 16 years old with a valid ID? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
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Phone #'s:	() <input type="checkbox"/> Home <input type="checkbox"/> Cell	Check all that apply <input type="checkbox"/> Emergency contact <input type="checkbox"/> Release child to Is this person at least 16 years old with a valid ID? <input type="checkbox"/> Yes <input type="checkbox"/> NO	
	() <input type="checkbox"/> Home <input type="checkbox"/> Cell		

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

Please read each box, initial and check Agree or Disagree

	Permission Contract	Initial or Check
Release of Information	I authorize the Poudre School District Early Childhood Education Program to release information to Partnering Community agencies/providers, contracted service providers, and to providers identified by the parent/guardian.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
Specific Information Shared	I understand that following PSD policy, I will need to complete a records release form every time I want to access copies of my child's records.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
Field Trips (3-5 year olds only)	I understand that my child will ride a Poudre School District bus when they go on supervised field trips as part of the program. Permission slips must be signed for each trip for my child to be able to participate.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
Sunscreen/hand lotion	I understand that sunscreen and lotion may be used on my child and in classroom activities. Product information for classroom sunscreen is available in the classroom.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
Telephone Contact	I give my permission for the program staff to give my telephone number to another parent for the purpose of program/classroom events and parent involvement only.	<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
Emergency Medical Care	In an emergency the Poudre School District Early Childhood Education Program will call 911 and access medical assistance for my child. I understand that all reasonable attempts will be made to contact myself and/or my emergency contacts. In the case that I cannot be reached, I give permission for Poudre School District Early Childhood Education Program to arrange emergency medical care for my child.	
Data Collection	I understand that the Poudre School District Early Childhood Education Program collects non-identifiable statistical information to be used for documentation, Program Information Report and funding purposes.	
Home Visits and Conferences	I understand that there will be six home visits (for Head Start funded families) and Parent/Teacher Conferences (for all families) during the school year. Home visits and/or teacher conferences may include support from Teacher & Education, Health and Family Mentor staff. If I am unable to make a scheduled visit, I must reschedule. I understand that lack of attendance at home visits will lead to a review of my child's enrollment and may lead to disenrollment.	
Quality Assurance	I understand that there may be a supervisor who comes into my home during a scheduled home visit with one of the staff members mentioned above for the purpose of quality assurance.	
Screenings	I understand that my child will be screened throughout the school year for the purpose of assessment in vision, hearing, dental, speech, growth and developmental needs.	
Poudre School District Cumulative File	I understand that if my child is enrolled in a Poudre School District Early Childhood Education Program my child's records will be transferred to his/her Poudre School District cumulative file.	
Custody and Court Order	I understand that I must provide Custody and Court Orders that pertain to my child to the Early Childhood Education Program for the school to be aware of and follow special instructions.	
Preschool Attendance Area	I understand that for my child to attend preschool in the Poudre School District our permanent home address must be in the Poudre School District boundaries. I verify that I have provided my child's actual home address.	
Attendance Policy	I understand that if my child is enrolled in the Poudre School District Early Childhood Education Program my child will be subject to the program's attendance policy. I understand that attendance issues will lead to a review of my child's enrollment and possible disenrollment. I understand that this is not drop-in care.	

This form is valid for the 2020-2021 school year.

Parent/Guardian Signature

Print Name

Date

Early Childhood HOME LANGUAGE AND STUDENT RESIDENCY FORM



State and federal regulations **require** that schools identify and report the language(s) spoken and heard by each child in the home, and determine eligibility for immigrant, migrant, refugee or McKinney education services. This information is used to ensure that the educational rights of each child are met. Please take a few minutes to complete this questionnaire. **This confidential information is for school use only.**

Student's Last Name	Student's First Name	Student's Middle Name
Student's Date of Birth	Country of Birth	Address:
Date Student Entered Colorado	Date Student Entered USA	
Parent or Guardian Name(s)		Home Phone #: _____
		Work Phone #: _____

Home Language Information:

Was the language first spoken by the student a language other than English?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Language: _____
Does the student speak a language other than English?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Language: _____
Is a language other than English used in the home?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Language: _____
Will you need an interpreter for conferences, phone calls and other verbal communication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Language: _____

Residency Information:

Have you been given "Refugee Status" paperwork? No Yes

Did you move to Colorado with the intent of working in agriculture, farming or fishing? No Yes

Do you work in agriculture, farming or fishing? No Yes

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):

- 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):

- 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. My student is living apart from his/her parents or guardians. Yes No

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

Signature of parent or guardian

Date

2020-2021 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

Dental Screening – Early Childhood Permission Form

Children who are enrolled in the Poudre School District’s Early Childhood Program have the opportunity to have their teeth examined by a local dentist from the community. This is a free service and is performed right in your child’s classroom. This is a fun classroom activity that children really enjoy. With parent permission, a fluoride varnish will be applied to your child’s teeth as well, in both the fall and spring of the 2020/2021 school year. This satisfies the program requirement for a dental exam. Written results of the exam will be sent home with each child. Parents will be informed if a child has cavities or needs further evaluation.

Yes No **I give permission for a dental exam and evaluation.**

Yes No **I give permission for fluoride varnish to be applied.**

For a copy of the Health District of Larimer County’s Notice of Privacy Practices please visit their website at:
<http://www.healthdistrict.org/sites/default/files/health-district-notice-of-privacy-practices-english-02-17.pdf>

Parent/Guardian: _____ **Date:** _____
(Signature required for children age 17 or under)

(Please print your information)

Student’s Last Name:	Student’s First Name:	Student’s Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Student’s Date of Birth:	Parent/Guardian Name:	Relationship to Student:
Address:	City, State, Zip:	Phone:
Type of dental insurance? <input type="checkbox"/> Medicaid / DentaQuest <input type="checkbox"/> CHP+	<input type="checkbox"/> None <input type="checkbox"/> Private Dental Insurance <input type="checkbox"/> Other: _____	

Has your student seen a dentist before? No Yes: Date of child’s last appointment: _____
 Are your child’s gums/teeth brushed at least once a day? No Yes
 Does your child have any trouble with teeth, gums, or mouth that you know about? No Yes
 Does your child have any cavities? No Yes
 Does your child have trouble chewing or swallowing? No Yes

Child’s dentist is at:

- | | |
|--|---|
| <input type="checkbox"/> FoCo Kids | <input type="checkbox"/> Mountain Kids |
| <input type="checkbox"/> Toothzone | <input type="checkbox"/> Big Grins |
| <input type="checkbox"/> KidsFirst Dental | <input type="checkbox"/> Kindergrins |
| <input type="checkbox"/> Jennifer Hargleroad | <input type="checkbox"/> Health District |
| <input type="checkbox"/> Keith Van Tassell (Ped. Dent. Of Rockies) | <input type="checkbox"/> Drs. Gerken & Galm (Ped Dent. Of Loveland) |
| <input type="checkbox"/> Salud Dental Clinic | <input type="checkbox"/> Other (please specify): _____ |

OFFICE USE ONLY:

Screening Date: ____/____/____
Number of cavities: _____
A ____ **B** ____ **C** ____ **D** ____ **E** ____ **F** ____ **G** ____ **H** ____ **I** ____ **J** ____
T ____ **S** ____ **R** ____ **Q** ____ **P** ____ **O** ____ **N** ____ **M** ____ **L** ____ **K** ____
Provider’s Signature _____
Print Name _____

Provider Comments



FREE Vision Screening Colorado Lions KidSight Program

The local Lions Club in your community, in conjunction with the Colorado Lions KidSight Program, will offer free vision screening to your child at his/her preschool or kindergarten. The screening uses state-of-the-art technology and is 85-90% effective in detecting the vision problems that could lead to lazy eye. No physical contact is made with your child and no eye drops or medications are used. **WHY VISION SCREENING?** 1 in 20 children has an undetected vision problem that could turn into lazy eye if left untreated. Early detection and treatment is essential to prevent lazy eye.

Parent/Guardian: Please fill out the following. All information is kept confidential and is not sold to third parties. PLEASE PRINT CLEARLY and ANSWER ALL QUESTIONS.

Child's full name: _____ Male _____ Female _____
First *Middle* *Last*

Child's date of birth: _____ Child's age: _____

Parent or Guardian: _____ Email: _____

Address: _____ City: _____ Zip code: _____

Phone (INCLUDING area code) _____

Is your child currently under the care of an eye doctor?

Yes _____ No _____ If yes, name of eye doctor: _____

I hereby give permission for my child to participate in the screening event. I have read and understood the following information regarding this program:

- The information obtained from this vision screening is preliminary only and does not constitute a diagnosis of vision problems.
- I may be communicated with by telephone or email if my child does not pass the vision screening.
- I understand that if my child does not pass the eye screening, I am responsible for arranging for an eye exam with an eye doctor of my choice. I understand that I am responsible for all costs of any eye exams.
- I will not hold the Lions organization, the Colorado Lions KidSight Program, their employees, agents, officers, and representatives liable for any injury which may accrue as a result of the vision screening, including but not limited to errors of commission, errors of omission, or other misdiagnosis.

Signature of Parent or Guardian _____ Date _____

RESULTS:

For Office Use Only

____ Pass We are unable to detect a vision problem at this time. The screening is not a substitute for a complete pediatric eye exam. Consult an eye care professional if a vision problem is suspected.

____ Unreadable We were unable to get reliable vision screening results for this child. This can happen occasionally if the child looks away from the equipment during the screening. Consult an eye care professional if a vision problem is suspected.

____ Refer Child should be examined by an eye care professional because he/she may have the following Condition:

____ Strabismus ____ Anisometropia ____ Astigmatism
 ____ High Farsightedness ____ High Myopia
 ____ Other _____

Authorization for Disclosure of Protected Health Information

Doctor

PARENT TO COMPLETE

I authorize _____
(Provider/Clinic Name)

_____ (Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name _____ DOB _____

Address _____

Phone Number _____ Parent Name _____

PSD HEALTH STAFF TO COMPLETE

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

**Poudre School District Early Childhood Health Staff
220 North Grant Fort Collins CO 80521 Fax 970-490-3134**

For the purpose of: PSD Early Childhood Health Requirements

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

- Entire medical record, from date _____ to date _____.
- Summary statement of diagnostic testing and treatment plan, from date _____ to date _____.
- Laboratory Result, from date _____ to date _____.
- Immunizations records, from date _____ to date _____.
- Well-child exam, from date _____ to date _____.
- Dental exam, from date _____ to date _____.
- Developmental reports and evaluations, from date _____ to date _____.
- Other: _____
- (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
- Verbal consultation as needed with _____

PARENT TO READ AND SIGN

I understand this authorization will expire, without my express revocation one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining the individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.

Signature of Patient, Parent or Authorized Personal Representative _____
Date

Printed Name of Patient, Parent or Authorized Personal Representative _____
Relationship to Patient



Authorization for Disclosure of Protected Health Information

Dentist

PARENT TO COMPLETE

I authorize _____
(Provider/Clinic Name)

(Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name _____ DOB _____

Address _____

Phone Number _____ Parent Name _____

PSD HEALTH STAFF TO COMPLETE

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Signature of Patient, Parent or Authorized Personal Representative **Date**

Printed Name of Patient, Parent or Authorized Personal Representative **Relationship** to Patient

This authorization reflects the requirements of HIPAA, 45 C.F.R.J 164.508.

**Partnership & Volunteer Program
1630 S. Stover
Fort Collins, CO 80525
(970) 490-3208**

Volunteer Agreement

Please carefully read each item governing terms and conditions of volunteer service in Poudre School District.

1. As a PSD volunteer, I have accepted the responsibility to be available as indicated on my Volunteer Application (which may be revised from time-to-time as necessary) and if unable to serve as scheduled, I will notify the school office as soon as possible.
2. I understand and agree that as a PSD volunteer, I will be subject to the direction and control of the Site Supervisor/Director or Principal of the school, or their designees.
3. I will wear my identification badge at all times when I am providing volunteer services for PSD schools.
4. For every child I interact with or observe as a volunteer, I understand that I am obligated to report any known or suspected child abuse to the Teacher, Counselor, Site Supervisor/Director, or Principal.
5. I WILL NOT transport children, staff or school guests in my own vehicle unless I have completed and submitted a Volunteer Field Trip Driver Application Form which is approved by the Site Administrator.
6. I understand and agree that I am not authorized to drive PSD vehicles.
7. I WILL NOT contact parents, guardians or emergency contact persons unless directed to do so by the Site Supervisor/Director or Principal or their designees.
8. I will conduct myself in a friendly, courteous manner and not show partiality toward any student, and will remain neutral in my speech and actions with respect or religion and politics at all times that I am engaged in volunteer activities with students.
9. I understand that it is my responsibility to inform the Site Supervisor/Director or Principal of any health/medical issues that may impair my ability to or prevent me from properly carrying out the duties and responsibilities of the volunteer service to which I have been assigned.
10. I understand and agree that as a PDS volunteer I am subject to all applicable PSD policies/regulations and to all directives from authorized PSD officials.
11. As a PSD volunteer, I understand I am covered by PSD liability insurance as long as I comply with applicable PSD policies/regulations and directives from authorized PSD officials, if I immediately notify the Site Supervisor/Director or Principal of any occurrence that may result in a claim.

Volunteer Confidentiality Agreement

1. As a volunteer in Poudre School District, I understand that I have been authorized by the Site Supervisor/Director or Principal to act as a "school official" subject to the directions and control of the school's administrators and teachers. As a school official, I may under limited circumstances, have access to student education records and other information in connection with my authorized duties. Student education records may include all records, files, documents and other materials that contain personally identifiable information on any student, as well as the personally identifiable information itself (including but not limited to student grades and test scores).
2. I will not discuss with others, while serving as a volunteer or when no longer in a volunteer role, the content of any specific student education records nor will I disclose student education records, personally identifiable student information in such records, or other information regarding any student that may reasonably be considered confidential.
3. While in the possession and control of student education records, and while handling, distributing, organizing mailing, or filing student education records, I understand and agree that I must protect those records from being viewed or obtained by non-authorized individuals.
4. I understand and agree that questions about the content of student education records must be directed to a PSD employee who is authorized to review the records and provide information regarding their content. As a volunteer, I understand and agree that I should state that I am not authorized to provide information regarding student records.
5. I will never take any student education records off campus unless authorized in writing by the Site Supervisor/Director or Principal, or his/her designee.
6. I must report any breach or suspected breach in the confidentiality of student education records immediately upon my discovery thereof to the Site Supervisor/Director or Principal, or his/her designee. I understand and agree that my failure to maintain the confidentiality of student education records and personally identifiable information to which I am given access may disqualify me from further services as a volunteer in Poudre School District.

I have read the above Volunteer Agreement and Volunteer Confidentiality Agreement, have been given the opportunity to ask questions to ensure that I understand them, and agree to abide by their terms.

Volunteer Name (please print) _____

Date _____

Signature _____

-OPTIONAL-

PARTNERSHIP CENTER, 1630 SOUTH STOVER, FORT COLLINS, CO 80525
(970) 490-3208 - WWW.PSDSCHOOLS.ORG

OFFICE USE ONLY	
<input type="checkbox"/>	Parent Refusal
<input type="checkbox"/>	Parent will complete at home
<input type="checkbox"/>	Already in the system
Child's Name _____	

VOLUNTEER APPLICATION
Please Print Clearly

Date: _____

Applicant's Name (Last, First): _____

Email: _____ Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

Emergency Contact: _____ Phone: _____

Applicant's Date of Birth (required**) _____

As required by Policy KJ, Poudre School District will conduct a background check of all volunteer applicants at its expense. **Your date of birth is required in order to perform the background check.

Volunteer service in the Poudre School District is a privilege that may be granted, denied or revoked at any time in the District's sole discretion.

Type of Volunteer (check only one):

- Parent Grandparent Business Senior Citizen Faith Community
- Community Member PSD Student

Preferred Opportunities for Volunteer Service:

- Reading Tutoring Library/Media Center Math
- Writing Data Entry/Analysis Mentoring Science
- Work from home Other: _____

Preferred School - PLEASE LIST SCHOOL NAME

- Early Childhood _____ Elementary _____
- Junior High _____ Senior High _____
- No Preference

I certify that the above information is true to the best of my knowledge. I have read the Volunteer Agreement and the Volunteer Confidentiality Agreement and agree to abide by their terms if my volunteer service is approved.

Volunteer Signature

Date



Media Opt-Out Form

This form is for parents who wish to designate that their child **SHOULD NOT** be in photos/video or articles published by PSD and/or its schools.

If this form is not completed and returned to the school by September 1 each year, PSD will assume that parent(s)/guardian(s) have given permission to publish their student’s photo, video and/or name as specified below.

Please note: This form does not apply to students participating in public events, like academic competitions, performances and athletic events. Student photos and names from these events may be published by news media.

Photos, Articles and Videos Featuring Students Published in Print and Electronic Media

Poudre School District staff often photograph, film and interview PSD students at events and school activities for promotional and publicity purposes.

This information is typically posted on the PSD website and featured on PSD social media channels including Facebook, Twitter, YouTube, Instagram and Snapchat.

Confidential student information is not shared, but information and photos may be published on websites, in social media and publications as follows:

- As a general rule, students are not identified in photos used on District website pages.
- Students’ first and last names may be included in news items on the District website when it relates to participation in curricular and school activities.
- School websites may identify students in photos and/or news items (it is a site-based decision).
- Articles about individual students may include a photo identifying the student.

Special Considerations

- This form does not cover publication of student photos or names in the news media.
- This form does not apply to yearbooks, student newspapers or other student publications.

If you DO NOT want your child to be interviewed, photographed or filmed, complete and sign the form and return it to your child’s school.

Do not include my child in any articles, photographs, or videos published on the PSD/school websites or in district/school publications.

Student Name _____ School _____

Grade _____ Student ID# _____

Parent or Guardian Signature

Date



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

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?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	MOTOR SKILLS (walking, drawing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ADAPTIVE SKILLS (feeding and dressing self)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	SOCIAL – EMOTIONAL (behavior, social skills)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	EARLY LEARNING (engaging in play, early concepts)
<input type="checkbox"/> Yes	<input type="checkbox"/> 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:	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain (@ the park, with her cousins, etc.):
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My child attends to an engaging play activity (non-screen related) for:	<input type="checkbox"/> < 5 mins	<input type="checkbox"/> 5-10 mins	<input type="checkbox"/> 10-30 mins	<input type="checkbox"/> 30+ mins
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How much time a day does your child spend watching/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?