EARLY CHILDHOOD CARE AND EDUCATION
RECRUITMENT/REFERRAL FORM

Please return form to:

Listed below are several high quality program options for which your child may be eligible. The goal of this form is to identify the best options for your child and family.

Please check all programs in which you are interested:

- ❑ Nash/Rocky Mount Pre-Kindergarten Program
- ❑ Edgecombe County Pre-Kindergarten Program
- ❑ NC Pre-K Program

} *To participate in these programs your child must be four years old on or before August 31.*

- ❑ Head Start
- ❑ Smart Start Scholarship Program/ Down East Partnership for Children
- ❑ Department of Social Services (DSS) Child Care Subsidy
- ❑ All programs in which I may qualify

} You must apply to DSS and/or Head Start using their application process. Checking these boxes does not mean your application has been sent to these agencies.

Please include the following attachments:

❑One child information form for each child that needs services

❑ Certified Birth Certificate

❑Two months of paystubs for the parents/guardians in the house of the child applied for or a wage form signed by the employer (Required for DSS, Smart Start Scholarship, NC Pre-K)

❑ Copy of most recent Health Assessment/Well-child Visit Report (Required for NC Pre-K)

❑ Copy of current Immunization Record (Required for NC Pre-K)

❑Written documentation of any other sources of income: WFFA, Social Security (SSA), SSI Disability, Child Support, etc. (Required for DSS, Smart Start Scholarship, NC Pre-K)

❑ Proof of Residence

❑Class schedules for any parent/guardian who is attending school

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Please review all information to ensure you have filled out the form completely. You must sign below.

The Early Care & Education Programs that may receive a copy of this form include:

- Department of Social Services Child Care Subsidy
- Edgecombe or Nash County Health Department
- NC Pre-Kindergarten Programs
- Public School Pre-Kindergarten Programs
- Head Start
- Smart Start Scholarship Program/Down East Partnership for Children

I give permission for my child to be assessed and referred to the Early Care & Education program(s) listed above, by forwarding to the appropriate program a copy of this form and any other necessary information. Representatives from any of the indicated Early Care & Education agencies have my permission to confirm all of the information on this form.

I understand that additional information may be requested after my eligibility for a particular program has been determined.

I certify that all of the information above is subject to verification, is true and correct and that all income is reported to the best of my ability.

Signature of Parent/ Guardian completing this form: _____Date:_____

**If guardian signs, official documentation of guardianship will be required.*

FOR AGENCY USE ONLY:

Wait List: _____Child's Name: _____Date of Application: ___/___/___ School Year: _____

Nash-Rocky Mount Public Schools
Nashville, North Carolina

Edgecombe County Public Schools

For Every Child the Down East Partnership for Children

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____

Parent/Guardian Relationship to Child:
❑ Mother
❑ Father
❑ Guardian
❑ Other:_____

Do the children you are applying for live with you?
❑ Yes
❑ No, the child lives with:
_____

Home Address: (Street, City, State, Zip Code)

Mailing Address: (Street or PO, City, State, Zip Code)
(If different than home)

How many addresses have you and your child had in the past year?
❑ 1 ❑ 2-3 ❑4-5 ❑ 6-7 ❑ 8 or more

Best phone number to reach you: _____
❑ Home
❑ Cell
❑ Work
❑ Other:_____

Second best phone number to reach you: _____
❑ Home
❑ Cell
❑ Work
❑ Other:_____

Email address: _____

County You Live In: ❑Nash ❑ Edgecombe
❑ Other _____

School District You Live In: ❑ ECPS ❑NRMPS
❑ Other _____

Your Date of Birth: _____

***Your Social Security Number:** _____
*Required for DSS only

Parent/Guardian Race/Ethnicity:
(please check all that apply)
❑ White ❑ Black ❑ Latino/Hispanic ❑ Asian ❑ Pacific Islander
❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____

Marital Status: ❑Single ❑ Married ❑Separated ❑ Divorced ❑ Widowed

Education Level:
❑ In High School ❑ Dropped Out of High School ❑ High School Diploma or GED
❑ In College ❑ College Graduate ❑ Masters Degree

SCHOOL INFORMATION – If you are attending school or training you must attach a class schedule to this form.

Are you currently in school, college, or enrolled in a GED or other training program? ❑ YES ❑ NO

If yes, Name of School or Program: _____

How many hours are you taking?
❑ Full-time Status (12 hours or more)
❑ Part-time Status (less than 12 hours)

If you are enrolled in college, is the program primarily online?
❑ YES
❑ NO

EMPLOYMENT/INCOME INFORMATION – If you are employed you must provide two months of pay stubs or have your employer complete the attached wage form.

Employer: _____
❑ Unemployed
❑ Seeking Employment

Employer's Phone Number: _____

Date You Were Hired: _____

Number of Hours Worked Each Week: _____

How often are you paid?
❑ Weekly
❑ Every Two Weeks
❑ Monthly
❑ Bi-Monthly

Does your family receive assistance from the Food and Nutrition Program (Food Stamps)?* ❑ YES ❑ NO
*For DSS Only

If yes, please provide FNS ID #: _____

SECOND PARENT/GUARDIAN INFORMATION

Is there another parent or guardian that lives in the home with the child/children? ❑ YES ❑NO

If yes, please complete the following information for that person:

Second Parent/Guardian Name: _____			
Relationship to Child:	❑ Mother ❑ Father ❑ Guardian ❑ Other:_____	**Second Parent/Guardian Date of Birth:**_____	***Second Parent/Guardian Social Security Number:** _____ *Required for DSS only
Marital Status:	❑Single ❑ Married ❑Separated ❑ Divorced ❑ Widowed		
Education Level:	❑ In High School ❑ Dropped Out of High School ❑High School Diploma or GED ❑ In College ❑ College Graduate ❑ Masters Degree		
Parent/Guardian Race/Ethnicity: *(please check all that apply)*	❑ White ❑ Black ❑ Latino/Hispanic ❑ Asian ❑ Pacific Islander ❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____		

SECOND PARENT/GUARDIAN SCHOOL INFORMATION – ***If you are attending school or training you must attach a class schedule to this form.***

Are you currently in school, college, or enrolled in a GED or other training program? ❑ YES ❑ NO **If yes, Name of School or Program:** _____	
How many hours are you taking? ❑ Full-time Status (12 hours or more) ❑ Part-time Status (less than 12 hours)	**If you are enrolled in college, is the program primarily online?** ❑ YES ❑ NO

SECOND PARENT/GUARDIAN EMPLOYMENT/INCOME INFORMATION – ***If you are employed you must provide two months of pay stubs or have your employer complete the attached wage form.***

Employer: _____	❑ Unemployed ❑ Seeking Employment
Employer's Phone Number: _____	**Date You Were Hired:** _____
Number of Hours Worked Each Week: _____ **How often are you paid?** ❑ Weekly ❑ Every Two Weeks ❑ Monthly ❑ Bi-Monthly	**Does your family receive assistance from the Food and Nutrition Program (Food Stamps)?*** ❑ YES ❑ NO *For DSS Only **If yes, please provide FNS ID #:** _____

ADDITIONAL INCOME INFORMATION

List the amounts of the following income sources that you receive - write in $0 if none is received.

	Amount Per Month	Parent/Guardian receiving	
WFFA (Work First)	$		
Social Security (SSA)	$		
SSI Disability	$		
Child Support ❑ Court Ordered ❑ Direct	$		
Unemployment Benefits	$		
Other: _____	$		

You must provide written documentation for all additional income sources.

HOUSEHOLD INFORMATION

Please list <u>ALL</u> individuals who live at the home address listed on the first page, including child:

Name	Date of Birth	Relationship to Child
Ex. Joe Smith	*01/01/1988*	*Father*

Total number of family members: _____

Do you have transportation to consistently take child to and from child care/pre-school? ❑ YES ❑ NO

Is a parent/guardian of the child actively serving in the military? ❑YES ❑ NO

What language is spoken in the home most of the time? _____

Does your family lack a fixed regular and adequate nighttime residence? ❑YES ❑ NO

This may include sharing the housing of other persons due to loss of housing, economic hardship or similar reason; living in hotels, motels or camping grounds; living in emergency or transitional shelters; or awaiting foster care placement.

Please check any of the following family challenges that you experienced in the last year:

- ❑ Work hours reduced or laid off from work
- ❑ Substance abuse
- ❑ Incarceration
- ❑ Reported child abuse and/or neglect
- ❑ Physical challenge or chronic illness
- ❑ Mental health services
- ❑ Domestic violence

CHILD #1 INFORMATION

Please complete one form for each child that needs services.

Child's Full Name: (*as on birth certificate*) _____	
Child's Date of Birth: _____	**Child's Social Security Number:** _____
Child's Gender: ❑ Male ❑ Female	
Child's Race/Ethnicity: *(please check all that apply)*	❑ White ❑ Black ❑ Latino/Hispanic ❑ Asian ❑ Pacific Islander ❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____
Child's Language:	If your child has started talking, what language is spoken? ❑ English ❑Spanish ❑ Other _____
Family Status: *(check only one box)*	This child lives with: ❑ Mother ❑ Father ❑ Mother & Father ❑ Guardian ❑ Other: _____

CHILD CARE INFORMATION

What is your child's current child care status?

❑ Enrolled in a child care facility (center or home)

Name of facility: _____

❑ Previously enrolled in a child care facility (center or home) but no longer attending

Name of facility: _____ Month/Year child last attended child care: _____

❑ Utilizing Family-Friend-Neighbor Network

Person caring for child (grandparent, neighbor, etc.): _____

❑ No child care being used at this time (parent cares for child)

Are you currently receiving financial assistance for child care? ❑ YES ❑ NO

If yes, name of agency: _____

SPECIAL NEEDS AND SERVICES

Has your child received any of the following services within the past year?

IFSP (Individualized Family Service Plan): ❑ YES ❑ NO ❑ Don't know
CDSA (Children's Developmental Services Agency): ❑ YES ❑NO ❑ Don't know
IEP (Individualized Education Plan): ❑ YES ❑ NO ❑ Don't know
Child welfare: ❑ YES ❑ NO ❑ Don't know
Foster care: ❑ YES ❑ NO ❑ Don't know

Does your child have health insurance? ❑ Medicaid ❑ Private Insurance ❑ No Insurance

Does your child have a developmental or educational challenge? ❑ YES ❑ NO ❑ Don't know

If yes, please explain: _____

Does your child have a physical challenge or chronic illness? (for example: cerebral palsy, asthma)

❑ YES ❑ NO ❑ Don't know If yes, please explain: _____

Has your child had a well-child visit or health assessment in the last 12 months? ❑ YES ❑ NO

CHILD #2 INFORMATION

Please complete one form for each child that needs services.

Child's Full Name: (*as on birth certificate*) _____	
Child's Date of Birth: _____	**Child's Social Security Number:** _____
Child's Gender: ❑ Male ❑ Female	
Child's Race/Ethnicity: *(please check all that apply)*	❑ White ❑ Black ❑ Latino/Hispanic ❑ Asian ❑ Pacific Islander ❑ Native American/Alaskan ❑ Middle Eastern ❑ Other _____
Child's Language:	If your child has started talking, what language is spoken? ❑ English ❑Spanish ❑ Other _____
Family Status: *(check only one box)*	This child lives with: ❑ Mother ❑ Father ❑ Mother & Father ❑ Guardian ❑ Other: _____

CHILD CARE INFORMATION

What is your child's current child care status?

❑ Enrolled in a child care facility (center or home)

Name of facility: _____

❑ Previously enrolled in a child care facility (center or home) but no longer attending

Name of facility: _____ Month/Year child last attended child care: _____

❑ Utilizing Family-Friend-Neighbor Network

Person caring for child (grandparent, neighbor, etc.): _____

❑ No child care being used at this time (parent cares for child)

Are you currently receiving financial assistance for child care? ❑ YES ❑ NO

If yes, name of agency: _____

SPECIAL NEEDS AND SERVICES

Has your child received any of the following services within the past year?

IFSP (Individualized Family Service Plan): ❑ YES ❑ NO ❑ Don't know
CDSA (Children's Developmental Services Agency): ❑ YES ❑NO ❑ Don't know
IEP (Individualized Education Plan): ❑ YES ❑ NO ❑ Don't know
Child welfare: ❑ YES ❑ NO ❑ Don't know
Foster care: ❑ YES ❑ NO ❑ Don't know

Does your child have health insurance? ❑ Medicaid ❑ Private Insurance ❑ No Insurance

Does your child have a developmental or educational challenge? ❑ YES ❑ NO ❑ Don't know

If yes, please explain: _____

Does your child have a physical challenge or chronic illness? (for example: cerebral palsy, asthma)

❑ YES ❑ NO ❑ Don't know If yes, please explain: _____

Has your child had a well-child visit or health assessment in the last 12 months? ❑ YES ❑ NO

WAGE FORM

Early Childhood Care and Education Recruitment/ Referral

In order to determine eligibility for DSS or the DEPC Smart Start Scholarship Program for child care assistance, it is necessary for you to provide proof of income.

If you do not have paystubs, please have your **current employer complete and sign** the following form. Please list gross wages for two months prior to the current month. Please complete for **each** parent/guardian.

Name Parent/Guardian #1: _____

Employer Name: _____ **Employer Phone #:** _____

Hire Date: _____ **Rate of Pay per hour: $**_____ **Hours worked per week** _____

How often paid: ❑Weekly ❑Every two weeks ❑ Monthly ❑Bi-Monthly

Please complete: (Use last 2 months pay periods) **INCLUDING OVERTIME**

Date of Pay (Received)	Gross Pay (before deductions)	# of hours worked (per pay period)	Regular Pay	Overtime Pay

Employer's Signature: _____ **Date:** _____

Employer/Company: _____

Name Parent/Guardian #2: _____

Employer Name: _____ **Employer Phone #:** _____

Hire Date: _____ **Rate of Pay per hour: $**_____ **Hours worked per week** _____

How often paid: ❑Weekly ❑Every two weeks ❑ Monthly ❑Bi-Monthly

Please complete: (Use last 2 months pay periods) **INCLUDING OVERTIME**

Date of Pay (Received)	Gross Pay (before deductions)	# of hours worked (per pay period)	Regular Pay	Overtime Pay

Employer's Signature: _____ **Date:** _____

Employer/Company: _____

VERIFICATION FORM FOR SELF-EMPLOYMENT – INCOME EARNED AND HOURS WORKED

This form is to record income earned and hours worked for parents who are self-employed. It is to be submitted with business records such as time cards, receipts, log books, etc. This form cannot be accepted without this additional documentation. The information provided must be for a **full two-month (8-week)** period.

I, _____, am providing this written statement of income earned and hours worked from my _____ business for the period beginning _____ and ending _____.

(Name/Type of Business)

INCOME: Make copies of this form as needed to capture the **full two-months (8-weeks)**. Do not forget to attach business records such as time cards, receipts, log books, etc.

Date	Source of Income (client, sale, project, etc.)	Amount Earned
		TOTAL _____

HOURS: Hours worked during the **full two-months (8-weeks)**.

Week Tracking	Number of Hours Worked
_____ through _____	
_____ through _____	
_____ through _____	
_____ through _____	
_____ through _____	
_____ through _____	
_____ through _____	
_____ through _____	
	TOTAL: _____

I certify that this is a true and correct record of income earned to the best of my knowledge.

_____ Signature

_____ Date

NASH/EDGECOMBE
PRE-KINDERGARTEN HEALTH ASSESSMENT REPORT

PARENT COMPLETE

Personal Data **Please bring your child's shot records with you to this visit**

Please Print Clearly – See other side for more required information. Please present completed form to your child's school.

Child's Name: _____ _____ _____ **Birth Date:** ____/____/ 20____ (mm/dd/yyyy)
(Last) (First) (Middle)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Yes	No	
☐	☐	Are you concerned about your child's health, weight, development, or behavior?
☐	☐	Does anyone in your family have a condition that has affected their health, weight, development, or behavior? **(Please explain in the comments section)**
☐	☐	Has your child been seen by a provider for any health, weight, development, or behavior concern?
☐	☐	Has your child had a dental exam by a dentist in the last 12 months?
☐	☐	Has your child had a well-child visit or check-up in the last 12 months?

Comments: _____

_____

Parent/Guardian Name: _____ **Phone:** _____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC. **Signature:** _____ **Date:** _____

HEALTH CARE PROVIDER COMPLETE

Recommendations to School Personnel Based on Health Assessment

☐ **No Recommendations, Concerns, or Needs** ☐ **Requesting School Follow Up**

☐ **Medication**

☐ Child takes medication for specific health conditions List Medications: 1. _____ 3. _____

☐ Medication must be given and/or available at school 2. _____ 4. _____

☐ **Allergy**

☐ Food: _____ ☐ Insect: _____ ☐ Medicine: _____ ☐ Other: _____

Type of allergic reaction: ☐ Anaphylaxis ☐ Local Reaction **Response Required:** ☐ Epinephrine Auto-Injector ☐ Other: _____ ☐ None

☐ **Developmental Concerns Identified –** Child needs referral to school support team for further evaluation. **(See comments below)**

☐ **Special Diet**

Guidance: _____

☐ **Health-Related Recommendations to Enhance School Performance (***For example: sitting near the front of classroom, special equipment needs).*

Please specify: _____

☐ **School Health Forms Attached**

☐ School Medication Authorization Form ☐ Diabetes Care Plan ☐ Asthma Action Plan ☐ Health Care Plan(s) List Condition _____

Comments: _____

_____

Was this assessment completed in the child's regular health care provider's office? ☐ ***Yes*** ☐ ***No***

<u>If no</u>, please provide a copy to the child's parent to give to the child's regular health care provider.

Health Care Professional's Certification – Attach a copy of the immunization record. Complete ALL screenings.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: _____

Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice Phone :_____ Fax: _____

<u>Provider Stamp Here</u>

PARENT COMPLETE

Personal Data

Child's Birth Date: ____/____/ 20____ (mm/dd/yyyy)

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

County of Residence: _____ **Zip Code:** _____

School your child will be attending: _____ **Sex:** ☐ 1 Male ☐ 2 Female **Hispanic or Latino Origin:** ☐ 1 Yes ☐ 2 No

Child has: ☐ 1 Medicaid ☐ 2 Private Insurance/HMO ☐ 3 No Insurance ☐ 4 Other: _____

Place where your child gets regular health care:
☐ 1 Health Department ☐ 2 Hospital Clinic ☐ 3 Community Health Center ☐ 4 Private Doctor/HMO ☐ 5 Other: _____ ☐ 6 No regular place

Doctor/Practice Name: _____ **Dentist Name:** _____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: ____/____/____ - Assessment must be completed no more than 12 months prior to child's first day of Pre-K

The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the state standards for Health Check Services.

Immunizations – Attach a copy of the immunization record.

Pertinent Illnesses, Risks or Developmental Problems: (Please check all that apply)

☐ Allergy
☐ Anemia ☐ At-Risk for Anemia
☐ Asthma
☐ Attention/Learning
☐ Bleeding Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Dental Conditions
☐ Diabetes
☐ Emotional/Behavioral
☐ Encopresis
☐ Enuresis (Daytime)
☐ Genetic Disorders
☐ Heart Conditions
☐ Hearing Disorders
☐ Kidney Disorders
☐ Lead (Hx of >10 mcg/dL) ☐ At-Risk ☐ Test Done
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other:_____
☐ None

Screening Results – Screenings MUST be completed and scored for ALL children who may be enrolling in an NC Pre-K program.

Developmental

Screening Tool(s) Used: ☐ 1 PEDS ☐ 4 PSC ☐ 2 ASQ ☐ 5 ASQ-SE

Developmental Domains:	Within Normal 1	Concern Identified 2	Referred to Specialist 3
Emotional/Social	☐	☐	☐
Problem Solving	☐	☐	☐
Language/Communication	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Gross Motor Skills	☐	☐	☐

Comments: _____

Hearing

Hearing	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.

Screening Tool Used: ☐ 1 OAE ☐ 2 Audiometry

☐ 1 Pass
☐ 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.
☐ 3 Referral to audiologist/ENT **(check if YES)**
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	Right	Left	Stereopsis ☐ Pass ☐ Fail
Far:	20/	20/	Acuity Test Used:
Was test performed with corrective lenses? ☐ Yes ☐ No			

☐ 1 Pass (Acuity, Stereopsis, & Symptoms)
☐ 2 Referral to eye doctor **(check if YES)** Refer if worse than 20/40 in either or both eyes, a two line difference between eyes, unable to test, failed stereopsis, or signs of disease.
☐ 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.

Physical Examination

Weight: _____ lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI) – for age: _____
☐ 1 Underweight (< 5%ile)
☐ 2 Healthy Weight (5%ile to < 85%ile)
☐ 3 Overweight (85%ile to < 95%ile)
☐ 4 Obese (>95%ile)

Blood Pressure: _____/_____
☐ 1 Within Normal Range
☐ 2 >90th percentile (_____%ile)

	Normal 1	Abnormal 2
HEENT	☐	☐
Dental/Oral	☐	☐
Lungs	☐	☐
Cardiac	☐	☐
Abdomen	☐	☐
Neurological	☐	☐
Back/Extremities	☐	☐
Genital	☐	☐
Skin	☐	☐

Comments: _____