Pre-K Required Documentation 2022-2023

(staff initial when received)

_____Application

_____Proof of Age (ex. certified birth certificate, passport)

_____Social Security Number

_____Physical

_____Shot Record

_____Proof of Income

_____Proof of Residence (electric or utility bill)

Dyer County School System
Voluntary Pre-K Application
2022-2023

For Office Use Only:

School Zoned:_____

Received By: _____

Date Received: _____

L1:_____ L2:_____ L3:_____

Please print clearly in Black or Blue ink.
All information on the application must be current and correct.

Student's Last Name _____ **First Name** _____ **Middle Initial**_____

Student's SSN _____ **Student's Birthdate:** _____ _____ _____
Month **Day** **Year**

Student's Gender: (circle one) **M** **F** **Race:** _____

Custody (circle): **Both Parents** ***Mother** ***Father** ***Other**_____
***Legal custodial papers may be required if student does not reside with his/her parents.**

Does this student participate in the Imagination Library? (Dolly Parton Initiative) (circle one) **Yes** **No**

Student's Address _____ **Apt.#** _____ **City** _____ **Zip**_____

Mother's Name_____

Mother's Address _____ **Mother's Home Phone**_____

Mother's Cell Phone_____ **Mother's Employment**_____

Mother's Employment Phone_____

Father's Name_____

Father's Home Phone_____

Fathers Address _____

Father's Cell Phone_____ **Father's Employment** _____

Father's Employment Phone_____

(If Applicable)
Guardian's Name:_____

Guardian's Address _____ **Guardian's Home Phone**_____

Guardian's Cell Phone:_____ **Guardian's Employment**_____

Guardian's Employment Phone:_____

Does this child have any food allergies or special medical conditions? (circle one) **Yes** **No**

If yes, please list:_____

NOTE: A medical statement from the doctor is required in order to honor any special requirements or to administer any prescribed medication.

Please list the full name, grade and school of any siblings:

	Name	Grade	School Attending
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Please answer the following questions:

What is the number of adults in the household? _____

Education level of Mother: GED/High School Graduate (circle one) Yes No

Education level of Father: GED/High School Graduate (circle one) Yes No

(If Applicable)
Education level of Guardian: GED/High School Graduate (circle one) Yes No

With whom does this child live? _____

Is a parent in active Military? (circle one) YES NO

Is a parent incarcerated? (circle one) YES NO

Has your child ever received TEIS services (circle one) YES NO

Has your child ever been in the EVEN START PROGRAM (circle one) YES NO

Does this child have speech or language difficulties? (circle one) YES NO
*If yes, documentation is required.

I have read and completed all of the information necessary to the best of my ability and verify that the information provided on this application is accurate. I do understand that the district will assign students based on selection criteria set forth by the district. Placement in a classroom is not guaranteed based upon application to the program.

_____ _____ _____

Parent/Guardian/Caregiver Signature Relationship to Student Date

Dyer County Schools Pre-K

CONFIDENTIAL: HEALTH HISTORY INFORMATION

ALERT TO PARENTS: If your child has a serious medical condition, it is vital that you discuss this with your School Nurse and teacher(s) immediately. It is very important to know of **LIFE THREATENING** conditions.

Name:_____ Birthdate:_____ Sex: M/ F
Last First MI (circle)
School:_____ Grade:_____ Teacher:_____

In order to provide a safe and healthy environment for your child, this information may be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

A. MEDICAL HISTORY: Check the ones that apply to your child and describe under the comment section.

_____ ADD/ADHD
_____ Anxiety/Panic attack
_____ Asthma
_____ Bee Sting allergy
_____ Bowel problem
_____ Cerebral Palsy
_____ Diabetes
_____ Color Blindness
_____ Epi-Pen
_____ Emotional Concerns
_____ Headaches
_____ Hearing Problem
_____ Heart Condition
_____ Kidney/urinary problems
_____ Muscle Disorder
_____ Neurological Concern
_____ Orthopedic problem
_____ Seizures
_____ Vision problems
_____ Other:_____ (explain)
_____
_____

Comments:_____
_____

B. MEDICATIONS: Please list any PRESCRIPTION medication your child is taking. (Home or School)

Name of Medication: _____ **Reason:** _____ **Home☐ School☐**
Name of Medication: _____ **Reason:** _____ **Home☐ School☐**
Name of Medication: _____ **Reason:** _____ **Home☐ School☐**
Name of Medication: _____ **Reason:** _____ **Home☐ School☐**

C. ALLERGIES: List allergies your child has that cause a problem at school:

Cause of the allergy: _____ Treatment: _____
Be specific: Ingestion☐ Exposure☐ Inhaled☐ (Epi-pen or Benadryl)

Cause of the allergy: _____ Treatment: _____
Be specific: Ingestion☐ Exposure☐ Inhaled☐ (Epi-pen or Benadryl)

D. 504: Has your child ever qualified for a 504 plan? Yes___ No___

IEP: Has your child ever qualified for an IEP plan? Yes___ No___

Health History Informed Consent

Your signature gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for emergency plans.

Parent/Guardian signature_____**Phone**_____**Date**_____

For Office Use Only
Please Circle One
Income Eligible: Yes / No
If yes, and enrolled, student should be classified as (L) in student information system

2022-2023

Completion of this form DOES NOT qualify your child for the Free or Reduced Meal Program. Submission of this application is not a guarantee of acceptance into the VPK program.

Name of Student: _____ Date of Application: _____

SSN of Student: _____ Date of Birth of Student: _____

Name of Applicant: _____ Relationship to Student: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: ( ) _____ Work Phone #: ( ) _____ Cell Phone #: ( ) _____

Part A - Family Information

Please list information for all other household members

Section 1

	Name(s) of ALL OTHER CHILDREN in the Household	Date of Birth	School	Grade
1.				
2.				
3.				
4.				
5.				

Section 2

	Name(s) of ALL OTHER ADULTS in the Household	Relationship to Student
1.		
2.		
3.		
4.		
5.		

Total # of household members: _____

Part B - Program Participation

Please check (√) if Child /Family /Household member provides documentation of participation, in one or more of the following programs, currently or during past school year (*Documentation required-See Part D).

(√)		(√)		(√)		(√)		Case #
	Early Head Start		Foster Care		Migrant		Families First (TANF)	
	Head Start		Homeless		Food Stamps / EBT			

***If submitting proof of qualifying for any of the above programs, you do NOT need to complete Part C.**

Part C - Total Household Income

Please list ALL INCOME of all household family members and how often income is received.

Any falsification of information concerning income, residence, birth certificate and/or completion of this application and other forms may be reason for dismissal.

Income Instructions

From the list below, please write the Source of Income Code in the space provided to indicate the source(s) of income for each earning individual in the household. Also, please write the Monthly Payment or Wage Amount. Multiply the Payment or Wage amount by the number months you received the income and then calculate the Amount and the Total Annual Income.

Source of Income Codes							
A.	GROSS work income	D.	Pension(s)	G.	Veteran's Benefits	J.	SSI Disability
B.	Unemployment	E.	Retirement	H.	Child Support	K.	Other - please list ↓
C.	Workman's Comp	F.	Social Security	I.	Alimony		

Name of Adult	Employer (if applicable)	Source of Income Code (See list above)	Monthly Payment or Wage Amount	Multiplied by (X)	How many months did you receive this income in the last year?	Total Amount
			$ -	X		$ -
			$ -	X		$ -
			$ -	X		$ -
			$ -	X		$ -
			$ -	X		$ -
					Total Annual (Yearly) Income	$ -

Part D - INCOME VERIFICATION

Please check (√) all documents submitted as Proof of Income or Program Participation.					
	Pay Stub / Verification of pay by employer		Retirement Documentation		Foster Care Reimbursement
	W-2 Form		Social Security		SSI Documentation
	Income Tax Form 1040A or 1040		Veteran's Benefit Letter		TANF Documentation
	Unemployment Compensation		Child Support		AFDC / Public Assistance Payment
	Workman's Compensation Documentation		Alimony Documentation		TennCare Verification
	Pension Stubs		Other (Specify): →		

I certify that the above information in this application is correct. I further understand that any falsification of information concerning income, residence, birth certificate and/or completion of this application and other forms may be reason for dismissal from Tennessee's Voluntary Pre-K Program.

Printed Name of Applicant: _____ SSN #: _____

Signature of Applicant: _____ Date: _____

Name and Signature of LEA employee reviewing this application

I certify that I have examined the above income documentation and verification information. **Completed**
forms must be maintained in accordance with FERPA.

Printed Name / Title of LEA employee: _____

Signature of LEA employee: _____

Date Reviewed by LEA employee: _____