



School Year: _____
Site: _____
Date Received: _____
Entered into NCPK: _____
Entered into NCWise: _____
<b>FOR OFFICE USE ONLY</b>

**North Carolina Pre-Kindergarten Program Application**

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
*First Middle Last*

Address: \_\_\_\_\_  
*Street City Zip*

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell or Work Phone: \_\_\_\_\_

Family size: \_\_\_\_\_ Adults living with family: \_\_\_\_\_

Child lives with:  Both Parents  Mother  Father  Other: \_\_\_\_\_

Sibling Names/Ages: \_\_\_\_\_

Race: *(check all that apply)*

- American Indian or Alaska Native  Asian  Black or African American  
 Native Hawaiian or Other Pacific Islander  Spanish/Hispanic/Latino  White or European American  
 Other: \_\_\_\_\_

Gender:  Male  Female N.C. Resident  Yes  No U.S. Citizen  Yes  No

Which elementary school will your child attend? \_\_\_\_\_

- Tentatively approved preschool sites (check preferred site):  Almost Home  Central Davie Preschool  Cooleemee Preschool  
 Cornatzer Preschool  Kountry Kids Learning Center  Mocksville Preschool  Mudpies (Mocksville Child Dev)  
 Pinebrook Preschool  William R. Davie Preschool  Shady Grove Preschool  Young Children's Learning Centez  
 Mocksville Head Start

Is English spoken in the home? No English Some English We speak fluent English

What language(s) are spoken in the home? \_\_\_\_\_

Total **annual** income prior to taxes is (unless child is in Foster Care where income is \$0): Mother \$ \_\_\_\_\_ Father \$ \_\_\_\_\_

Other income (welfare, child support, social security, retirement)?  Yes (If yes, please provide documentation of the amounts)  No

Are you currently employed? Yes No If no, are you currently looking for employment or going back to school? Yes No

Is your child currently enrolled in a Pre-Kindergarten or childcare program? Yes No

If yes, which one and the dates enrolled? \_\_\_\_\_

If no, has your child ever been enrolled in a childcare program?  Yes  No

If yes, where did your child attend? \_\_\_\_\_

**Mailing Address and Contact Information**

DCS Preschool  
 220 Martin Luther King Jr. Road  
 Mocksville, NC 27028  
 336-751-0016

Are you or your spouse an active member of the military?  Yes  No

Do any of your children receive subsidy from the Department of Social Services?  Yes  No

Does your child have any special developmental needs or disabilities?  Yes  No

If yes: Does your child have an Individualized Education Plan?  Yes  No

Does your child have any chronic health problems such as asthma, diabetes, sickle cell anemia, etc.?  Yes  No

If yes, please explain (doctor's note must be provided to prove diagnosis): \_\_\_\_\_

Has your child received a developmental screening or evaluation?  Yes  No

If yes, please tell us about any areas of concern. \_\_\_\_\_

Is there any other information you would like to share with us? \_\_\_\_\_

**The following must be turned with this application:**

- \_\_\_birth certificate
- \_\_\_proof of income

The following may be verified by school staff before your application may be accepted:

- \_\_\_residency

The following documentation is required before your child can attend a North Carolina Pre-Kindergarten program:

- \_\_\_immunization records
- \_\_\_kindergarten health assessment

**Please read the following statements carefully and initial by each.**

\_\_\_I certify that all of the given information is true and correct and that all income is reported. I understand this information is being given for the receipt of state funds. North Carolina Pre-Kindergarten officials may verify the information on this application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state laws.

\_\_\_The information on this form will be used in the determination of North Carolina Pre-Kindergarten programs. I understand that I am releasing information so that my child may be considered for the North Carolina Pre-Kindergarten I program.

\_\_\_I understand there may be a waiting list for North Carolina Pre-Kindergarten services.

\_\_\_I understand that if my child is selected to participate in the North Carolina Pre-Kindergarten program, parent involvement will be critical to the success of my child. I/We commit to participate as requested by North Carolina Pre-Kindergarten sites.

\_\_\_I understand that transportation to and from North Carolina Pre-Kindergarten sites is the responsibility of the family.

\_\_\_I give permission for my child to receive developmental, hearing, vision, dental, and/or speech and language screening while attending the North Carolina Pre-Kindergarten program.

\_\_\_I understand that if there is any change in my child's status- address, attendance in any type of licensed care, phone numbers, guardianship, etc. - I will contact Central Davie Education Center immediately and inform them of changes.

\_\_\_I understand that if my child participates in North Carolina Pre-Kindergarten they may be photographed and the pictures may be used in the following ways: center display, center scrapbook, newspaper, TV broadcasts, North Carolina Pre-Kindergarten related publications, etc.

**Parent /Guardian Printed Name** \_\_\_\_\_

**\*Parent/Guardian Signature Required** \_\_\_\_\_ **Date** \_\_\_\_\_

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# Children's Medical Report

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Address of Parent of Guardian \_\_\_\_\_

## A. Medical History (May be completed by parent)

1. Is child allergic to anything? No \_\_\_ Yes \_\_\_ If yes, what? \_\_\_\_\_

2. Is child currently under a doctor's care? No \_\_\_ Yes \_\_\_ If yes, for what reason? \_\_\_\_\_

3. Is the child on any continuous medication? No \_\_\_ Yes \_\_\_ If yes, what? \_\_\_\_\_

4. Any previous hospitalizations or operations? No \_\_\_ Yes \_\_\_ If yes, when and for what? \_\_\_\_\_

5. Any history of significant previous diseases or recurrent illness? No \_\_\_ Yes \_\_\_ ; diabetes No \_\_\_ Yes \_\_\_ ; convulsions No \_\_\_ Yes \_\_\_ ; heart trouble No \_\_\_ Yes \_\_\_ ; asthma No \_\_\_ Yes \_\_\_ .  
If others, what/when? \_\_\_\_\_

6. Does the child have any physical disabilities: No \_\_\_ Yes \_\_\_ If yes, please describe: \_\_\_\_\_

Any mental disabilities? No \_\_\_ Yes \_\_\_ If yes, please describe: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**B. Physical Examination:** This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.

Height \_\_\_\_\_% Weight \_\_\_\_\_%

Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Throat \_\_\_\_\_

Neck \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_ Abd/GU \_\_\_\_\_ Ext \_\_\_\_\_

Neurological System \_\_\_\_\_ Skin \_\_\_\_\_ Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Results of Tuberculin Test, if given: Type \_\_\_\_\_ date \_\_\_\_\_ Normal \_\_\_ Abnormal \_\_\_\_\_ followup \_\_\_\_\_

Developmental Evaluation: delayed \_\_\_\_\_ age appropriate \_\_\_\_\_

If delay, note significance and special care needed; \_\_\_\_\_

Should activities be limited? No \_\_\_ Yes \_\_\_ If yes, explain: \_\_\_\_\_

Any other recommendations: \_\_\_\_\_

Date of Examination \_\_\_\_\_

Signature of authorized examiner/title \_\_\_\_\_ Phone # \_\_\_\_\_