Bradford Area School District

George G. Blaisdell Elementary School · P.O. Box 375 · 265 Constitution Avenue · Bradford, PA 16701
Telephone: 814-362-6834 Fax: 814-362-5485 Web Site: www.bradfordareaschools.org E-mail: basd@bradfordareaschools.org

Kimberly J. Swanson, Principal
Wesley S. Lohrman, Assistant Principal

Dear Parent/Guardian:

Thank you for your interest in the Bradford Area School District's Pre-K Program. Enclosed is an application packet and instructions for the **2023-2024** school year. Please fill out all forms and submit them with the required documentation to George G. Blaisdell Elementary School.

The BASD Pre-K Program is federally funded and the district is required to follow all guidelines. The grant **requires** all students to meet the age and income qualifications for admittance. The information requested on the enclosed application will enable the district to comply with these requirements. **NO APPLICATION WILL BE PROCESSED WITHOUT THE REMITTANCE OF ALL FORMS AND REQUESTED DOCUMENTATION.**

In addition to the enclosed application packet, we are requesting the following documentation for the 2023-2024 school year:

1) **Proof of residency** - The BASD Pre-K program is for the residents of the BASD attendance area. Therefore, we are requesting verification of address. Examples of acceptable proof of residency would be a copy of lease agreement, sales agreement, deed, mortgage statement, real estate tax bill, driver's license, current utility or credit card bill. The proof of residency must include name and address.
2) **Verification of student age** - All students must attain the age of four by September 1, 2023 to qualify for acceptance into our program. Proof of your child's date of birth is required. Acceptable documentation includes birth certificate, baptismal certificate or transcript of the record of baptism - duly certified and showing date of birth, notarized statement from parents indicating the date of birth, duly attested transcript of the birth certificate, or duly certified transcript of birth.
3) **Proof of household income** – Acceptable documentation includes copy of paycheck, food stamp number, direct certification (TANF) case number, etc. If no household income, complete the "Zero Income Declaration Letter" in the packet.
4) **Immunization records** – proof of immunizations

The Bradford Area School District's Pre-Kindergarten Program requires all students to be "**toilet trained**" by the first day of school. Exceptions will be considered upon submission of a doctor's script due to a medical and/or physical reason.

If an IU Program is currently serving your child, then a meeting will occur with the IU staff, parents, and the BASD administrative staff to determine if change of placement into the BASD Pre-K Program is deemed appropriate.

Sincerely,

Kimberly Swanson

Kimberly Swanson
Principal

2022-2023 PA Pre-K Counts Enrollment Form

(This information is confidential to the PA Pre-K Counts program)

Date Form Completed: _____ / _____ / _____
MM **DD** **YY**

Last Name (Child)	First Name (Child)	Middle Initial

Street Address		County	
City		State PA	Zip Code
School District of Residence			
Home Phone	Work Phone	Email Address	

Child's Date of Birth	Age	Gender
	☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Male ☐ Female

Race *(optional)*

- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Not Applicable
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Other

Ethnicity *(optional)*

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Not Applicable

Primary Language

- ☐ English
- ☐ Spanish
- ☐ Other _____ (please specify)

Name of Parent or Guardian completing this application	Gender
	☐ Male ☐ Female

Relationship to Child	(Select)
☐ Father	☐ Biological
☐ Mother	☐ Foster
☐ Guardian	☐ Adoptive
☐ Other _____ (please specify)	☐ Other _____ (please specify)

Role

☐ Primary Guardian ☐ Legal Guardian

☐ Secondary Guardian ☐ Other _____

(please specify)

List Household Members below for determination of family size *(required)*:

	Relationship to Child	*Age*
1	ENROLLING CHILD	
2		
3		
4		
5		
6		
7		
8		

Per PKC Statute, Regulations, and Guidance, the following members of the household are included in family size:

- Parent of the child (biological or adoptive mother or father, stepmother or stepfather, caretaker or spouse)
- A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
- A child who is 18 years of age or older but under 22 years of age who is enrolled in high school, a general educational development program, or a post-secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent on the income of the parent or caretaker or spouse of the parent or caretaker.
- Others supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program. ***If counted toward family size, any applicable income of these persons must also be counted for eligibility purposes.***

Note: A family size value of one (1) with an income of $0 is entered when a foster child is applying for Pennsylvania Pre-K Counts.

DETERMINED FAMILY SIZE =

Employment Status of parent/guardian

☐ Employed Full-Time
☐ Employed Part-Time
☐ Unemployed
☐ Other _____

Employment Status of 2nd parent/guardian (if applicable)

☐ Employed Full-Time
☐ Employed Part-Time
☐ Unemployed
☐ Other _____

Household Income Sources *(Must check all that apply):*

☐ Employment ☐ Self-Employment ☐ Unemployment Compensation ☐ Worker's Compensation ☐ TANF Cash payments

☐ Social Security ☐ SSI ☐ Child Support ☐ Alimony ☐ Other

Other Child Eligibility Risk Factor Criterion *(Must check all that apply):*

☐	**Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
☐	**Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services.
☐	**Education Level of Guardian:** Does not have high school diploma or GED or post-secondary degree.
☐	**English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.
☐	**Individualized Education Plan (IEP):** A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
☐	**Incarcerated Parent:** A child for whom one of the child's parents is currently in prison.
☐	**Homeless:** A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following: A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement; B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.
☐	**Migrant (Non-Immigrant)/Seasonal Student:** A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
☐	**Teen Mother:** A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided in this application and the associated income documentation is accurate. I understand that I may be asked to verify or substantiate information provided.

_____ _____

Parent/Guardian (Signature) **Date**

_____

Parent/Guardian Name (Print Name)

Bradford Area School District

Pre-Kindergarten Income Verification

Proof of household income – Acceptable documentation includes copy of paycheck, food stamp number, direct certification (TANF) case number, etc. If no household income, complete the "Zero Income Declaration Letter" in the packet.

Name of All Household Members	Earnings from work before deductions	Welfare, child support, alimony	Pensions, Retirement, Social Security	All other income	Check if no income
(Example) John Smith	$200/bi-weekly	$150/weekly	$100/monthly	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
	$_____/_____	$_____/_____	$_____/_____	$_____/_____	

Food Stamp number:_____

Direct Certification (TANF) number: _____

I certify that all information is true and that all income is reported.

Signature: _____ Date: _____

Print name: _____

Must include proof of income. Application will not be reviewed until proof submitted to GGB.

Zero Income Declaration Letter

Name (Parent/Guardian) _____

Name (Child) _____

Program Name _____

Program Year _____

I am signing this letter to declare that I currently do not have any income from any source. My financial support comes from (please describe):

_____

_____

_____

_____

_____

_____

☐ I agree to notify the above program about changes in my income within 30 days of the change.

☐ I certify that the information submitted is accurate and true to the best of my knowledge. I understand that by completing, signing, and dating this form, I declare I have no household income and that the information I am providing is correct. I understand that providing false information may result in denial of services.

_____ _____

Parent Signature Date

_____ _____

Reviewer Signature Date

Bradford Area School District
Pre-Kindergarten Parent Survey

STUDENT NAME:_____

1.) Pre-school or daycare previously attended: _____

_____

2.) Is the child you are applying for: Homeless ____ Foster Child _____ Migrant_____

Other (explain):_____

3.) Does your child have a disability? Yes_____ No_____

Please describe:_____

_____

4.) Was your child referred to B.A.S.D. by another agency? Yes_____ No_____

Agency making referral: _____

5) Is your child currently being served by an IU Program? Yes_____ No _____

Please describe: _____

_____

6) Please describe other concerns not mentioned above that may make your child

"Educationally Disadvantaged": _____

_____

_____

7.) Pre-Kindergarten goals I have for my child include:

_____

_____

_____

8.) I am able to participate in Pre-K parent activities: Yes_____ No_____

Best time for me: Daytime_____ Lunch Time_____ Evening_____

Bradford Area School District
PO Box 375 • 150 Lorana Avenue • Bradford, PA 16701
Phone: 814-362-3841 Fax: 814-362-2552 Web Site: www.bradfordareaschools.org E-mail: basd@bradfordareaschools.org

pennsylvania
DEPARTMENT OF EDUCATION

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's First and Last Name: _____

Child's Date of Birth: _____
(Month/Day/Year)

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? ☐ No ☐ Yes (language) _____
2. Does your child communicate in a language other than English? ☐ No ☐ Yes (language) _____
3. What is the language that your child first learned to speak? _____
4. Has your child previously received ELL Services? ☐ No ☐ Yes Date services began? _____
5. If your child received ELL Services, was an Interpreter provided? ☐ No ☐ Yes

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Copy of Survey to ELL Administrator ☐ Date: _____

Bradford Area School District

Student Health History

Student Name:_____ **Date of Birth:**_____

Today's Date:_____

Developmental History:

Was child born Premature/Early?:_____ Problems in Hospital after birth_____

Approximate age that Child:

Walked:_____ Talked:_____ Potty Trained:_____

Did your child require any services through Early Intervention (speech, Physical therapy, occupational therapy)? (List)_____

_____

Medical History: Please fill out completely

Allergies (Medications, foods, plants, environmental, bees etc.) _____

_____

_____

Any Medications your child takes (prescription and over the counter)_____

_____

Any Health Problems or Chronic Illness:_____

_____

Surgeries or Hospitalizations (with approximate age or year)_____

_____

Any History of the following: (Please provide Year or age of student)

Asthma_____ **Diabetes**_____ **Fainting Spells**_____

Pneumonia_____ **Frequent Ear infections**_____ **Heart Problems:**_____

Seizures (Describe): Febrile(fever)_____**OR Seizure Disorder**_____

Whooping cough_____ **Rheumatic Fever**_____ **Chicken Pox**_____

Urinary problems_____ **Stomach/Intestinal problems**_____ **Tuberculosis**_____

Other (explain):_____

_____

Nutrition: Special Diet Required:_____ Picky Eater:_____

Emotional History (yes or no):

Abnormal Sleep Patterns_____ Bed Wetting:_____ Disobedient_____

Temper Tantrums_____ Fights with other children_____

History of any traumatic event for student: (death of a parent, foster care, divorce)

_____

Child's Primary Doctor:_____ phone number_____

Any specialists that your child sees (allergist, ENT, cardiologist, neurologist, etc):

Doctor:_____ phone number_____

Doctor:_____ phone number_____

Doctor:_____ phone number_____

Child's Dentist:_____ Phone number_____

_____ _____

Signature of person completing form Relationship to student

Bradford Area School District

George G. Blaisdell Elementary School · P.O. Box 375 · 265 Constitution Avenue · Bradford, PA 16701
Telephone: 814-362-6834 Fax: 814-362-5485 Web Site: www.bradfordareaschools.org E-mail: basd@bradfordareaschools.org

LETTER OF ACKNOWLEDGEMENT

HEALTH SERVICES

The State of Pennsylvania requires certain health screenings be provided to your child by the Bradford Area School District. By your signature, you acknowledge that these screenings will be provided to your child. At their respective grades, you will be informed of the physician and dental exams. If you prefer to take your child to their own doctor or dentist (at your own expense), the appropriate paperwork will be provided for your doctor to fill out for your child's school health record. If at any time you have questions concerning specific health services provided by the school district, please contact the school nurse.

Screenings/Examinations

K	Vision, Hearing, Height & Weight, Physical & Dental
1	Vision, Hearing, Height & Weight
2	Vision, Hearing, Height & Weight
3	Vision, Hearing, Height & Weight, Dental
4	Vision, Height & Weight
5	Vision, Height & Weight
6	Vision, Height & Weight, Physical, Scoliosis
7	Vision, Hearing, Height & Weight, Dental, Scoliosis
8	Vision, Height & Weight
9	Vision, Height & Weight
10	Vision, Height & Weight
11	Vision, Hearing, Height & Weight, Physical
12	Vision, Height & Weight

Medication Notes:
In accordance with Board Policy No. 210, medication should be given before or after school hours, whenever possible. If, however, it is essential that your child receive medication during school hours, the medication will be administered under the following conditions:

- **No** medication will be dispensed until the health room has a **written order** from the prescribing **doctor.**
- All medication MUST be delivered to the health room by a parent or responsible adult, **not by the student.**
- All medication must be in the original container and be plainly marked with the student's name, name of the medication, dosage & time to be administered.

Student Name:_____

Parent/Guardian Signature:_____ Date:_____

pennsylvania
DEPARTMENT OF HEALTH

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

_____

_____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student...*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student...*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student...*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student...*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student...*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Asthma/lung problems ☐ Behavioral health issue ☐ Diabetes ☐ Inherited disease/syndrome ☐ Kidney problems ☐ Seizure disorder ☐ Sickle cell trait or disease Other_____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ Cardiomyopathy ☐ High blood pressure ☐ High cholesterol ☐ QT syndrome ☐ Marfan syndrome ☐ Ventricular tachycardia ☐ Other_____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	CHECK ONE: NORMAL	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes ☐ No ☐

Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam_____20_____

Print name of examiner _____

Print examiner's office address _____ **Phone** _____

Signature of examiner _____ **MD ☐ DO ☐ PAC ☐ CRNP ☐**

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL GGB Elementary DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
Last First Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough or Township | County | State | Zip

REPORT OF EXAMINATION

TOOTH CHART

		RIGHT								LEFT								
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
	UPPER																	Upper
	LOWER																	Lower

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____
Signature of Dental Examiner

_____
Print Name of Dental Examiner

_____
Address