



## DOCUMENTATION CHECKLIST

### REQUIRED WITH APPLICATION

- ☐ Complete Application (be sure you have included)
  - Child's ethnicity **and** race
  - Number of Children & Ages/Birthdates
  - Signature
- ☐ Copy of child's birth certificate
- ☐ Any legal guardianship documentation (if applicable)
- ☐ Medical Action Plan (if needed see page 2)
- ☐ Household Income (check all that apply)
  - ☐ Pay stubs: If monthly, include at least one pay stub
  - ☐ For weekly include at least 4 consecutive pay stubs
  - ☐ For bi-weekly or twice-monthly, include at least 2 consecutive pay stubs
  - ☐ Child support
  - ☐ Unemployment
  - ☐ SSI/TANF
  - ☐ Signed Statement of No Income/Unverifiable income
- ☐ Categorical eligibility (check all that apply)
  - ☐ WIC
  - ☐ Public Housing
  - ☐ TANF/Work First
  - ☐ Medicaid
  - ☐ SSI
  - ☐ Food & Nutrition Services
  - ☐ SNAP/Food Stamps
- ☐ Site of preference on bottom of page 2 (\*\*preference does not guarantee placement)

### RECOMMENDED WITH APPLICATION

- ☐ Children's Medical Report (**\*\*not required for eligibility but required within 30 days of start date\*\***)
- ☐ Immunization record (**\*\*not required for eligibility but required within 30 days of start date\*\***)



# ROBESON COUNTY PRESCHOOL APPLICATION

## STUDENT INFORMATION

## DATE RECEIVED:

## DATE COMPLETED:

First Name:	Middle Name:	Last Name:	
Preferred Name:	Date of Birth:	SSN:	Gender:
Current address:		Email Address:	
City:	State:	ZIP Code:	
U.S. Citizen    Y <input type="checkbox"/> N <input type="checkbox"/>	Ethnicity (Hispanic)    Y <input type="checkbox"/> N <input type="checkbox"/>	Primary Language Spoken at Home:	<input type="checkbox"/> English <input type="checkbox"/> Spanish    Other: _____

## Child's Race (Check all that apply)

American Indian <input type="checkbox"/>	African American/Black <input type="checkbox"/>	Native Hawaiian or Other Pacific Islander <input type="checkbox"/>
Asian <input type="checkbox"/>	White <input type="checkbox"/>	

## FAMILY INFORMATION

Who does the child reside with?    ☐ Both Parents/Step-Parents    ☐ Mother (only)    ☐ Father (only)    ☐ Legal Guardian/ Custodian    ☐ Foster    ☐ Relative

Is your family homeless?    ☐ 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 living in a car.

Number of Children in the Home:    Child 1 Age & Birthdate:    Ages & Birthdates of all other children:  
 Child 2 Age & Birthdate:  
 Child 3 Age & Birthdate:

Mother/Stepmother/Guardian Name:	Home Phone:	Business Phone:	Cell Phone:
Address:			

Employed ☐    Seeking Employment ☐    In Post-Secondary Education ☐    In High School/GED Program ☐    Job Training ☐    Other ☐

Place of Employment:

Father/Stepfather/Guardian Name:	Home Phone:	Business Phone:	Cell Phone:
Address:			

Employed ☐    Seeking Employment ☐    In Post-Secondary Education ☐    In High School/GED Program ☐    Job Training ☐    Other ☐

Place of Employment:

Is at least one parent or legal guardian an active duty member of the military, or was a parent or legal guardian of this child seriously injured or killed while on active duty?    Y ☐    N ☐

## Eligibility (Not used for Title I Eligibility) - Only respond for those living in the home with the child.

Income: Do you receive: (check all that apply and include documentation)		Categorical: Does anyone in your home receive: (check all that apply and include documentation)	
Mother/Stepmother/Guardian	Father/Stepfather/Guardian		
<input type="checkbox"/> Wages from Employment	<input type="checkbox"/> Wages from Employment	<input type="checkbox"/> WIC	<input type="checkbox"/> SSI
<input type="checkbox"/> Child Support	<input type="checkbox"/> Child Support	<input type="checkbox"/> Public Housing	<input type="checkbox"/> Food & Nutrition Services
<input type="checkbox"/> Unemployment	<input type="checkbox"/> Unemployment	<input type="checkbox"/> TANF/Work First	<input type="checkbox"/> SNAP
<input type="checkbox"/> SSI/TANF	<input type="checkbox"/> SSI/TANF	<input type="checkbox"/> Medicaid	



**EMERGENCY CARE INFORMATION**

Name of Child's Doctor:	Office Phone:	
Hospital Preference:	Phone:	
Name of Child's Dentist:	Office Phone:	
In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals:		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

**CONTACTS**

Child will be released only to the parents/guardians listed. The child can also be released to the following individuals, as authorized by the person who signs this application.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

**HEALTH CARE NEEDS**

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached?

Y ☐ N ☐

Does your child have any allergies? ☐ Y ☐ N If yes, please list them, the symptoms and type of response required for allergic reactions:

Does your child have any health care needs or concerns? ☐ Y ☐ N If yes, please list them, the symptoms and type of response required for these health care needs or concerns:

Does your child have any particular fears or unique behavior characteristics? ☐ Y ☐ N If yes, please list them:

Does your child have any types of medication taken for health care needs? ☐ Y ☐ N If yes, please list them:

Share any other information that has a direct bearing on assuring safe medical treatment for your child:

**PRIOR PLACEMENT**

☐ Child has never been served in any preschool or child care setting

☐ Child is currently unserved

☐ Child is in unregulated child care

☐ Child is not receiving subsidy but is in some kind of regulated child care, if so list child care:

☐ Child is receiving subsidy and is in some kind of regulated child care, if so list child care:

☐ Do you have any siblings in a public school or child care, if so would it be easier for your child to attend the same school or child care facility? If so list the name of the school or facility.

How will your child be transported to NC Pre-K? \_\_\_\_\_

**SPECIAL NEEDS**

Does your child have any documented special needs: (i.e.) speech, blindness, orthopedic, hearing, chronic illness, social, emotional or behavior issues? ☐ Y ☐ N

Does your child have an Individualized Education Plan (IEP)? ☐ Y ☐ N

Does your child currently receive services from any community based provider for his/her disability, social, emotional, or behavior issues? ☐ Y ☐ N

**PLACEMENT**

**If accepted into the program, do you have a location preference\*: ☐ Y ☐ N (See next page for site choices)**

Preferred Sites: 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

\*Site placement is based on program availability and preference cannot always be honored.

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency. I certify that all the information provided is true, correct, and complete. I understand that information is provided to document eligibility for receipt of program funds. Program staff may verify information on this application. Misrepresentation may subject me to prosecution under applicable North Carolina state laws and disqualify my child's application. Completed application requires child's original birth certificate, child's shot record, and parent income verification (used to determine NC Pre-K eligibility).

☐ **By checking this box, and including my cell number, zip code, and child(ren)'s birthdate, I acknowledge that I will be enrolled in a texting service to receive text messages about resources and events for families with children 0-8 years old from Bright by Text and ROAR (Robeson Overcoming Adversity Through Resilience). I also understand that I can unsubscribe from these messages at any time.**  
<https://brightbytext.org/Privacy-Policy>

Signature of Parent:	Date:
I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.	
Signature of Administrator:	Date:

<b>OFFICE USE ONLY</b>			
<b>SCHOOL DISTRICT:</b>			
<input type="checkbox"/> NC Pre-K Eligible	<input type="checkbox"/> Title 1 Eligible	<input type="checkbox"/> PSRC Site:	NC Pre-K    Y <input type="checkbox"/> N <input type="checkbox"/>
<input type="checkbox"/> NC Pre-K Non Eligible	<input type="checkbox"/> Title 1 Non Eligible	<input type="checkbox"/> NC Pre-K Site:	

ROBESON COUNTY PRE-KINDERGARTEN SITES		
PRIVATE SITES	PRIVATE SITES, CONT'D	PUBLIC SCHOOL SITES, CONT'D
Angel's Childcare And Learning Center 910-858-0614	Wee Farm Learning Center 910-738-6070	Piney Grove Elementary 910-671-6025
Cottonwood Pre-Elementary 910-618-1300		Prospect Elementary 910-521-4766
First Baptist Early Childhood Ministry 910-738-6608		Rex-Rennert Elementary 910-843-5298
Island Grove Baptist Christian Daycare 910-522-1393	PUBLIC SCHOOL SITES	Rosenwald Elementary 910-628-4291
Jamestown Day Care Center, Inc. 910-739-8861	Deep Branch Elementary 910-738-2514	Rowland Norment Elementary 910-671-6030
Kid Kare Learning Center 910-628-0042	East Robeson Primary 910-671-6055	Shining Stars Preschool (Lumberton) 910-671-4343
Kids' Academy Daycare & Preschool 910-739-1501	Fairgrove Elementary (Title I Only) 910-628-8290	Shining Stars Preschool (Pembroke) 910-521-0559
Kidz Pointe Learning Center 910-843-3873	Long Branch Elementary 910-739-3864	St. Pauls Elementary 910-865-4103
Little Feet Learning Academy 910-738-1471	Magnolia Elementary 910-671-6070	Tanglewood Elementary (Title I Only) 910-671-6035
Pampers, Hugs, & Luv's Learning Center #2 (St. Pauls) 910-865-2380	Oxendine Elementary 910-843-4243	Townsend Elementary (Title I Only) 910-844-5086
Precious Angels' Day Care 910-674-4766	Parkton Elementary 910-858-3951	Union Chapel Elementary 910-521-4456
Riverwood Pre-Elementary 910-521-9001	Pembroke Elementary 910-521-4204	Union Elementary 910-521-4772
Tiny Tots Daycare Center 910-843-8240	Peterson Elementary 910-843-4125	W.H. Knuckles Elementary 910-671-6020

**\*\* Submitting an application at a site does not guarantee placement at that site. This application may be approved for a NC Pre-K, Title I, or Exceptional Children placement in any Private or Public. \*\***

# 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 # \_\_\_\_\_



## Statement of No Income

To Whom It May Concern:

I am reporting that I have no earned income, as stated on my child's Robeson County NC Pre-K Program application.

\_\_\_\_\_  
Parent's Name

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Statement of Unverifiable Income

To Whom It May Concern:

I am reporting \$\_\_\_\_\_ per \_\_\_\_\_ (ie. week, month, year) as income to be used for my child's Robeson County NC Pre-K Program application. I understand that this income will count toward eligibility for my child to receive NC Pre-K services. I am not able to provide employment documentation for the Robeson County Partnership for Children to verify this earned income.

\_\_\_\_\_  
Parent's Name

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date