Martinsville City Public Schools

Empowering Success One Learner At A Time

Preschool Programs
2020 - 2021

About our Programs:

- Each classroom has a licensed teacher and a highly-qualified paraprofessional
- Provide bus transportation to/from school daily – only preschool students ride our buses and each bus has an assistant riding both morning and afternoon
- Offer breakfast and lunch to all students daily
- Follow Martinsville City Public Schools calendar and inclement weather policy
- Provide a full day schedule - 7:45 AM - 2:45 PM
- Provide a daily rest time
- Provide the opportunity to participate in local and out-of-town field trips to enhance student learning
- Provide various opportunities for parent involvement throughout the school year
- Partner with Boys & Girls Club of the Blue Ridge to offer an after-school program

The following are required when applying to any MCPS Preschool Program:

- ✓ Be three or four years of age by September 30, 2020
- ✓ Be a resident of the City of Martinsville (residency verification required)
- ✓ Submit a completed application (all parts must be completed for consideration)
- ✓ Submit all required documentation (list attached)
- ✓ Signed Parent Agreement

All Preschool Classes are located at:
Clearview Early Childhood Center
800 Ainsley Street
Martinsville, VA 24112
276 - 403 - 5800

Required Documents for Preschool Application

The following documents must be submitted with your child's preschool application. Applications will not be reviewed until all supporting documentation is on file.

- **Child's State Issued Birth Certificate**

- **VA School Entrance Health Form** – completed after 8/6/2019
  (form attached – must be completed by parent and physician and must include immunization record)

- **Proof of Income** – Proof of income must be submitted for each parent, guardian, or legal custodian who is working or receives income from other sources.
  - **2019 Income Tax Returns OR W-2's (preferred)**
  - Pay stubs for the past four weeks
  - SNAP, TANF, SSI - Letter from issuing agency indicating how much assistance is received monthly

- **Proof of Residency** – You must provide **two** of the following documents:
  - Rent receipt from the current month or one month previous to when the application is submitted. The rent receipt must show the name of the person paying rent; property address; rental company name, address, and phone number
  - Lease or mortgage agreement from the current month or one month previous to application date
  - City of Martinsville Personal Property tax statement or receipt (must include address of residency)
  - City of Martinsville Utility Bill (current month)
  - Voter Registration Card
  - Current Driver's License or DMV issued photo ID
  - Bank Statement or Loan Statement (no older than 45 days)
  - Home Owner/Rental/Car Insurance statement (must be current)
  - SNAP or TANF statement of benefits from Department of Social Services (must have physical address, no PO Boxes)

***Please note – all documents submitted for proof of residency must include the name and address of the person completing the application. The address must be the physical address where the child resides. Additional documents may be requested at the discretion of the Director.**

Clearview
Early Childhood Center

A Great Place to
Play. Learn. Grow.

Martinsville City Public Schools

Preschool Application

2020 - 2021

Please check below the program for which you are applying:

☐ PK-3 Program (My child will be 3, but not 4, on or before September 30, 2020)

☐ VPI Program (My child will be 4, but not 5, on or before September 30, 2020)

Are you a resident of the City of Martinsville? ☐ Yes ☐ No

*Please note – if you are not a resident of the City of Martinsville, your child does not qualify for the MCPS Preschool Program. Out of Zone requests are not accepted for preschool students.

Child's Full Name _____
First Middle Last

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Date of Birth:_____ Gender: ☐ Male ☐ Female

What is the student's first language? _____

What is the primary language spoken at home? _____

Does the student speak any language other than English? ☐ Yes ☐ No

If yes, what language(s)? _____

What is the student's preferred language when speaking:

with family? _____

with friends? _____

Student Information

Is your child completely toilet trained? (even when napping) ☐ **Yes** ☐ **No**	**If No, Explain:**
Has your child previously attended a preschool or daycare program? ☐ **Yes** ☐ **No**	**Location:**
Does your child have any diagnosed emotional or behavioral issues? ☐ **Yes** ☐ **No**	**If Yes, Explain:**
Does your child have any diagnosed medical conditions such as asthma, allergies, diabetes? ☐ **Yes** ☐ **No**	**If Yes, Explain:**
Has your child been found eligible for Special Education or speech services? ☐ **Yes** ☐ **No**	**If Yes, Explain:**
Do you know of any students related to your child who are applying for the MCPS preschool program (brother/sister, cousin, etc)? ☐ **Yes** ☐ **No**	**If Yes, Explain:**

Do you have any concerns about your child's development in any of the following areas? Please explain any areas of concern.

☐ Physical Development _____

☐ Vision _____

☐ Speech _____

Does your child speak in sentences of at least four words most of the time? ☐ Yes ☐ No

☐ Hearing _____

☐ Behavior _____

If you have any other concerns about your child's development that have not been previously indicated, please tell us about those concerns below.

_____

_____

_____

_____

_____

_____

_____

Family Information

Mother/Guardian Information	Father/Guardian Information
Name:	**Name:**
Address:	**Address:**
Home Phone:	**Home Phone:**
Cell phone:	**Cell phone:**
Date of Birth:	**Date of Birth:**
Employed: □ Yes □ No **Employer:**	**Employed: □ Yes □ No** **Employer:**
Last grade completed/GED?	**Last grade completed/GED?**

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

If parents are divorced, who has legal custody of the child? _____
*If you have legal custody orders, a copy must be provided to the school office.

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian_____

Number of Adults in Household: _____ Number of Children in Household: _____

Please list child's siblings living in the home:

Name:_____ Date of Birth:_____ School:_____

Name:_____ Date of Birth:_____ School:_____

Name:_____ Date of Birth:_____ School:_____

Name:_____ Date of Birth:_____ School:_____

Name:_____ Date of Birth:_____ School:_____

Name:_____ Date of Birth:_____ School:_____

Please check all that apply

☐ Social Services is involved in the family (does not include food stamp cases)
Name of Case Worker_____

☐ Government Assistance Currently Receiving

- ☐ SNAP (food stamps)
- ☐ TANF
- ☐ Medicaid/FAMIS

Does your child have medical insurance coverage? ☐ Yes ☐ No
If yes, please indicate coverage type

☐ Medicaid ☐ FAMIS ☐ Private Insurance Provider Name_____

Please check all that apply

☐ Homeless

☐ Moved two or more times in the past year

☐ Parent(s) had difficulty reading and/or learning in school

☐ Parent receives or has received mental health services

☐ Parent/Guardian has a serious physical condition which requires ongoing medical care

☐ Parent or Guardian currently incarcerated

Admission to the Martinsville City Public Schools Preschool Program is determined by level of need. Areas of need are evaluated and scored based on the information you provide with this application. Therefore, all parts of the application must be competed, and all required documentation must be submitted, in order for the application to be reviewed. Space is limited. Once the program is full, students not accepted to the program will be placed on a waiting list, and will be called if space becomes available.

You will be notified of acceptance to the MCPS Preschool Program by mail. *If your mailing address is different from your home address please be sure to indicate that on the application. Acceptance letters are generally mailed by Mid-June. Please notify the office if you have any changes in contact information.

Parental Agreement

Martinsville City Public Schools offers this family focused, school-readiness preparatory program for families who qualify. This program is optional and is a privilege for those to which it is offered. The purpose of the program is to offer children the opportunity to prepare for kindergarten in a full day, public school environment. In order to participate in this program, the following guidelines must be followed.

Attendance and Transportation

- The school day begins at 8:00 a.m. Students may arrive no earlier than 7:45 a.m. The school day ends at 2:45 p.m. Car riders must be picked up by 2:50 p.m.
  An after-school program is offered through Boys & Girls Club of the Blue Ridge. A separate application must be completed for the after-school program.
- Bus transportation – Preschool only buses transport students to & from school. A parent or other adult listed on the student's authorized pick-up list is required to be at the bus stop to receive your child daily. Students will not be allowed to get off the bus without an authorized adult at the bus stop and will be returned to the school. Excessive returns to school can put your child's preschool enrollment in jeopardy.
- After 5 unexplained absences, the family's participation in the program will be jeopardized and a meeting with the teacher and/or Director will be scheduled.
- After 5 tardies per month, a meeting with the teacher and/or Director will be scheduled.

Family Involvement

- Parents agree to have at least one home visit (at the address where the student resides) with the teacher each school year.
- Parents are required to attend scheduled parent-teacher conferences and parent/child/family events throughout the school year.
- Parents are required to cooperate with the school in handling any discipline or learning problems that may arise.
- Parents are required to report any changes of address and/or phone number to the school immediately.
- Parents are expected to conduct themselves in a professional and respectful manner at all times. Disruptive and/or disrespectful behavior of the parent may result in your child's removal from the program.

By signing this application, I agree that:

- All information provided is true and accurate to the best of my knowledge.
- The administrators of Clearview Early Childhood Center have my permission to verify any of the information provided on/with this application.
- I understand that all information will remain confidential and will only be released to necessary personnel.
- If my child is accepted to the MCPS Preschool Program at Clearview Early Childhood Center, I will adhere to the policies and guidelines of MCPS and CECC.

Signature_____ **Date**_____

Please return the completed application and required documents to:
Clearview Early Childhood Center
800 Ainsley Street
Martinsville, VA 24112

Martinsville City Public Schools

Ethnicity and Race Questionnaire

Student's Name: _____ School: _____ Grade:____

Please answer **BOTH** Question 1 and Question 2. If both questions are not answered school personnel are required to select one for both.

Question 1: Is this student Hispanic or Latino? (choose only one)

- ☐ No, not Hispanic or Latino
- ☐ Yes, Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South American, Central American, or other Spanish culture or origin, regardless of race)

Question 2: What is the student's race? (choose one or more)

- ☐ American Indian or Alaska Native (a person having origins in any of the original peoples of North and South America [including Central America], and who maintains tribal affiliation or community attachment)
- ☐ Asian (a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)
- ☐ Black or African American (a person having origins in any of the black racial groups of Africa)
- ☐ Native Hawaiian or Other Pacific Islander (a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands)
- ☐ White (a person having origins in any of the original peoples of Europe, the Middle East or North Africa)

Parent/Guardian Signature _____ Date: _____

Student Signature _____ Date: _____

Completed by School Designee _____ Date: _____

Title_____

***Information must be kept securely for 3 years from the date obtained.**

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Name of Parent or Legal Guardian 2: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Emergency Contact: _____ Phone: ____-____-_____ Work or Cell: ____-____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.): _____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school.*** *When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____ Date: _____/_____/_____

Signature of person completing this form: _____ Date: _____/_____/_____

Signature of Interpreter: _____ Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |___|___|___|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) ❑ Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**___/___/___

Student's Name:_____ Date of Birth: |___|_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[___]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**|___|___|___|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at
http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/_____

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

Body Mass Index (BMI): _____ BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐

TB Screening: ☐ No risk for TB infection identified ☐ No symptoms compatible with active TB disease
☐ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date:_____ TST Reading ____mm TST/IGRA Result: ☐ Positive ☐ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead: _____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Refer

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ___Left ___Right

☐ Hearing aid or other assistive device

Vision Screen

☐ With Corrective Lenses (check if yes)

Stereopsis	☐ Pass	☐ Fail		☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test – needs rescreen**

Dental Screen

☐ Problem Identified: Referred for treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):
☐ **Well child; no conditions identified of concern to school program activities**
☐ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____

___ **Allergy** ☐ food: _____ ☐ insect: _____ ☐ medicine: _____ ☐ other: _____
Type of allergic reaction: ☐ anaphylaxis ☐ local reaction Response required: ☐ none ☐ epinephrine auto-injector ☐ other: _____

___ **Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) **☐ By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ Date: ____/____/_____

Practice/Clinic Name: _____ **Address:** _____

Phone: _____-_____-_____ **Fax:** _____-_____-_____ **Email:** _____