LOGAN COUNTY SCHOOLS KINDERGARTEN ENROLLMENT

Students must enroll at their home school.

Kindergarten registration packets are available at your local elementary school or at logancs.schoolinsites.com. Parents can print a packet or pick-up a packet to complete and bring to their home school site on the enrollment date; or they may pick-up and complete the packet on the day of enrollment.

Students currently in a four-year (4yr) old Pre-K program do not need to complete this enrollment process. They will be automatically enrolled in kindergarten at their home school.

Pre-K registration for the 2020-2021 school year will be made public at a later date.

Kindergarten Enrollment Schedule for 2020-2021

Date	Time	Schools
February 4-7, 2020	**8:30 AM--3:00 PM**	**Buffalo, Chapmanville Primary, Holden, Hugh Dingess, Justice, Logan, Man, Omar, South Man, Verdunville**

If you are unable to register at this time, please contact your local school to schedule an appointment.

Please bring the following information to registration in order to complete your child's file:

- ✓ Certified Copy of Child's Live Birth Certificate from Vital Statistics *(must be age 5 before July 1, 2020 to attend kindergarten)*
- ✓ Child's Immunization Record, Health Check Form, and Dental Record
- ✓ Child's Social Security Card
- ✓ Proof of Residency (must include physical address)

A Kids First Wellness Initiative & Screening is mandatory for all children entering school for the first time. Arrangements for the screening will be announced when the schedule is completed. A parent/legal guardian must accompany their child to the screening.

If you have additional questions, please call your local school or Danita Noel, Logan County Elementary Director at (304) 792-2076.

Office use only.

Personnel must initial this folder when folder is complete.

_____Date folder was completed with priority items (Pre-K only). _____Initials of staff completing folder.

_____Live Birth Certificate _____Proof of Residency _____Proof of Income or Checked Income Identification Form_____ Immunization Record

_____Student Residency Form (McKinney Vento Act) _____Social Security Card _____ Current Medical /Insurance Card

_____Health Check Form _____ Dental Screening _____Court Order Custody Papers

2020-2021 Logan County Universal Pre-K and Kindergarten Registration Folder

Bring this completed packet on the enrollment date to your child's home school site.

* Place inside the folder a copy of your child's Social Security Card, Medical Card/Insurance Card. (If needed a copy can be made at registration site).

* Place inside the folder the completed Health Check Form and Dental Screening Form. (These forms should be received at school or PRIDE Community Services Office within thirty days of enrollment or prior to first day of school attendance).

* Complete the Student Residency Form and Home Language Survey that is located inside the folder.

* Include copies of total court orders awarding custody of the child, if parents are separated or divorced.

The Following Documents Must Be Provided Before Your Child Enters School:

* Place inside the folder a Certified Birth Certificate from the West Virginia State Department of Vital Statistics located in Charleston, WV. It must be the original with raised seal, not a copy! (Certificates from a hospital and county courthouse are not acceptable.) Children born outside West Virginia must also have a certified copy from the Department of Vital Statistics/State Capital from the state where the child was born. Students must be 4 years old before **July 1, 2020** to enter the 4 year old Pre-K program and 5 years old before **July 1, 2020** to enter kindergarten. *Certified Birth Certificate is required for the completion of the packet.*

* Place child's Immunization Record from a physician or health department inside the folder. *Immunization Record is required for the completion of the packet.*

* Place Current Proof of Residency inside folder *(only acceptable forms of Proof of Residency are: a current utility bill, or a current rent receipt).* If not available, obtain from a staff member and complete an Affidavit of Residency. *Proof of Residency is required for the completion of the packet.*

* (FOR PRE-K ONLY) Place inside the folder a Proof of Income or a completed Income Identification Form (available in the folder). *Proof of Income or Income Identification Form is required for the completion of the packet.*

----------**(PLEASE COMPLETE THE SECTION BELOW FOR PRE-K ENROLLMENT ONLY)**----------

Preschool Centers Locations:

Buffalo Elementary	Chapmanville Primary	Holden Elementary	Hugh Dingess Elementary	Justice Elementary
Logan Elementary	Logan Head Start Center	Man Elementary	Omar Elementary	South Man Elementary
Verdunville Elementary				

List your child's home school_____.

First Choice_____ Second Choice_____ for attendance

Parents desiring to transfer a student to a district school in an attendance area other than the one in which they reside must complete and submit a "Request for Student Transfer" to Logan County Schools BOE office by May 1, 2020 to be eligible for the lottery.

Does your child have a sibling in school? _____ If so, indicate sibling's name, _____school they attend, _____and grade _____.
Yes/No

Student Legal Name _____ **Birthdate** (mm/dd/yyyy) ___/___/___
Last First Middle

2020-2021
LOGAN COUNTY UNIVERSAL PRE-K AND KINDERGARTEN
STUDENT INFORMATION FOLDER

Sex **M** **F** (circle one) Birthplace _____ (City) _____ (State) Student Social Security _____

Transfer from: _____ (School) _____ (City) _____ (State)

Home Phone: ( ) ____-_____ Is English the Primary Language spoken in your home? (Yes) _____ (No) _____

Native Language _____

EN=English, AR=Arabic, CA=Cambodian, CC=Chinese Cantones. CM=Chinese Mandarin
CR=Creole. CR=Creole, FR=French, GR=German, HI=Hindi, HMHmong. IT=Italian,
KO=Korean, LA=Laotian, NA=Navajo, PO=Polish, PT=Portugese. RU=Russian,
JA=Japanese, SP=Spanish. TA=Tagalog. TH=Thai. VT=Vietnamese, OT=Other.

Ethnic Group _____
What is your race? (Choose one or more of the race categories).

A=Asian or Pacific Islander, B=Black, H=Hispanic.
W=White, I=American Indian/Alaskan

Transportation _____
01=Bus Student
02=Non-Bus Student

Number in Household _____

Foster child: Yes or No (circle one)

Was your child previously enrolled in any of the following?

Birth to 3 ____ Day Care ____ Early Head Start ____ Head Start ____ Preschool ____ Starting Points ____ Other _____

Date of last physical exam: _____ Date of last dental exam _____

Is your current address a temporary living arrangement due to loss of housing or economic hardship? Yes No (circle one)

Who does child reside with? ___Parent ___Other Family _____ (specify relationship) ___Other _____ (specify relationship)

Student Emergency Care Information

Student Name _____ **Date of Birth** _____

Primary Guardian (Specify: Father/Mother/Other: _____) **Name:** _____

Phones: Home: ( ) _____-_____ Cell: (_____) _____-_____ e-mail _____ **Occupation:** _____
Unlisted? _____

Address: (physical) _____ (mailing) _____
(if different)

Employer: _____ **Work Phone:** (_____) _____-_____ **Ext:**___ **Pager:**( ) _____-_____

Secondary Guardian (Specify: Father/Mother/Other: _____) **Name:** _____

Phones: Home: ( ) _____-_____ Cell: (_____) _____-_____ e-mail _____ **Occupation:** _____
Unlisted? _____

Address: (physical) _____ (mailing) _____
(if different)

Employer: _____ **Work Phone:** (_____) _____-_____ **Ext:**___ **Pager:**( ) _____-_____

Directions to Student's Home: _____

_____

Directions to Home of a Second Emergency Contact: (other than student's home address listed above) _____

_____

Persons, other than guardians, to notify in case of emergency or allowed to pick up child (must be 18 years or older and have proper identification).

Name	**Relationship**	**Phone** (Home Cell)

Doctor: _____ **Address:** _____ **Phone:** ( ) _____-_____

Dentist: _____ **Address:** _____ **Phone:** ( ) _____-_____

Insurance Name: _____ **Insurance Policy or Medicaid Number :** _____

Medical Conditions or Special Needs (include allergies and current medication) _____

PARENT AUTHORIZATION (*Please initial each blank)*

____I authorize school staff to administer basic First Aid to my child in the classroom or in transit should injury occur. ____If we are unable to contact the parent and/or the child's condition requires immediate care, permission is hereby given to arrange for emergency medical treatment in keeping with the policies and regulations of the State of West Virginia, the Logan County Board of Education and PRIDE Community Services Inc.

_____ _____ _____ _____
Signature of Parent or Legal Guardian Date Staff Signature Date

Logan County Universal Pre-K and Kindergarten

Student Legal Name _____ (Last First Middle) **Birthdate** (mm/dd/yyyy) ___/___/____

Please initial each statement to verify receipt and/or acknowledge understanding and agreement.

I certify that:`

Yes_____ I have received a copy of Health Insurance Portability and Accountability Act (HIPAA).

Yes_____ I have received a copy of Family Educational Rights and Privacy Act (FERPA).

Yes_____ I have received copies of the Child Protection Policy, Guidelines for Positive Behavioral Approach, and Strategies for Positive Behavior. I have read this material or it has been explained to me and I will apply it daily.

Yes_____ I understand that enrolling my child in Logan County Universal Pre-K means teaching staff may obtain the following screenings: Developmental, behavioral, motor, language, social, cognitive, and emotional.

Yes_____ I am aware that Logan County Board of Education staff and PRIDE Head Start staff are mandated reporters of suspected child abuse or neglect.

Yes_____ I am aware that I may not post pictures, videos, or audios of children, other than my own, on social media.

Yes_____ or No_____ pictures, videos or audios taken of my child can be used in newspapers, in displays, on bulletin boards, or in other forms of educational publications.

Parent or Guardian_____ Date_____
Signature

Parent or Guardian_____
Please Print

Staff Signature _____ Date_____

Office Use Only Teacher must sign and fill in the students' start date.	Teacher Signature_____ Start Date of Student_____

Logan County Early Childhood Survey

In order to provide a high quality pre-k and kindergarten program, we need you to assist in this survey and provide suggestions to improve our programs.

1. Please list your child's home school. _____

2. Was your child enrolled in any program as a 4-year old? (Yes ____ No ____)

   In what kind of program did your child participate?
   Logan County Schools Pre-K ____ Head Start ____ Day Care ___
   Private Preschool ____ Baby Sitter ___
   Other _____

3. What reason(s) did your child not attend Logan County Universal Pre-K as a 4 year old?

   Transportation needed _____ Before school/After school care needed _____
   Was not aware of the program _____ Preferred location was not available____
   Where was the preferred location for your child to attend? _____
   Other reason(s) for not attending _____
   _____

4. What could the school district do to better serve families in an early childhood program?
   Suggestions_____
   _____
   _____
   _____

gearing up for Kindergarten

Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

5 and 6 Year Form

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Weight _____ Height_____ BMI_____ Pulse_____ BP_____ Resp_____ Temp_____ Pulse Ox (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Foster Child _____ ☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization_____ ☐ Other _____

Oral Health
Date of last dental visit_____
Current oral health problems _____
Water source ☐ Public ☐ Well ☐ Tested
Fluoride supplementation ☐ Yes ☐ No
Fluoride varnish applied *(5 years, apply every 3 to 6 months)*
☐ Yes ☐ No _____

Vision Acuity Screen:
R _____ L _____
Wears glasses? ☐ Yes ☐ No

Hearing Screen
20 db@
R ear _____ 500HZ R ear____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear _____ 500HZ L ear____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

Developmental

Developmental Surveillance (✓*Check those that apply)*
☐ Child can balances on one foot, hops and skips
☐ Child is able to tie a knot, has mature pencil grasp, can draw a person with at least 6 body parts, prints some letters and numbers and is able to copy squares and triangles
☐ Child has good articulation, tells a simple story using full sentences, uses appropriate tenses and pronouns, can count to 10, and names at least 4 colors
☐ Child follows simple directions, is able to listen and attend, and undresses and dresses with minimal assistance

☐ Concerns about child's behavior, speech, learning, social or motor skills_____

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Referrals: ☐ Developmental
☐ Mental/behavioral health/trauma- **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other _____
☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title

School Entry Requirements

The information above this line is intended to be released to meet school entry requirements

Medical History

☐ Initial Screen ☐ Periodic Screen
Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations:_____

☐ **Family health history reviewed** _____

Concerns and/or questions_____

Social/Psychosocial History

What is your family living situation_____

Family relationships ☐ Good ☐ Okay ☐ Poor
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _____

Are you and/or your partner working outside home? ☐ Yes ☐ No

Child care/after school care _____

How much **stress** are you and your family under **now**?
☐ None ☐ Slight ☐ Moderate ☐ Severe
What kind of stress? (✓ *Check those that apply)*
☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other_____

Child's grade in school_____
Favorite subject_____
Any problems?_____
Activities outside school_____
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Risk Indicators (✓ *Check those that apply)*

Child exposed to ☐ Cigarettes ☐ E-Cigarettes ☐ Alcohol
☐ Drugs (prescription or otherwise)_____
☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)
Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA
☐ Witnessed violence/abuse ☐ Threatened with violence/abuse
☐ Scary experience that your child cannot forget_____

Do you utilize a car/booster seat for your child? ☐ Yes ☐ No
Does your child wear protective gear, including seat belts?
☐ Yes ☐ No
☐ Excessive television/video game/internet/cell phone use

General Health

☐ Growth plotted on growth chart
☐ BMI calculated and plotted on BMI chart

Continue on page 2

Name_____ DOB_____ Age_____ Sex: ☐ M ☐ F

Nutrition/Physical Activity/Sleep
Normal eating habits? ☐ Yes ☐ No
Fruits/Vegetables/Lean protein per day_____
☐ Vitamins_____
☐ Normal elimination_____
☐ Physical activity/exercise an hour most days
Type of physical activity/exercise _____
Normal sleeping patterns? ☐ Yes ☐ No
Hours of sleep each night?_____

See Periodicity Schedule for Risk Factors

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Lead Risk**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk** *(year 6)*
☐ Low risk ☐ High risk

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	_____
Skin	☐ N	☐ Abn	_____
Neurological	☐ N	☐ Abn	_____
Reflexes	☐ N	☐ Abn	_____
Head	☐ N	☐ Abn	_____
Neck	☐ N	☐ Abn	_____
Eyes	☐ N	☐ Abn	_____
Ocular Alignment	☐ N	☐ Abn	_____
Ears	☐ N	☐ Abn	_____
Nose	☐ N	☐ Abn	_____
Oral Cavity/Throat	☐ N	☐ Abn	_____
Lung	☐ N	☐ Abn	_____
Heart	☐ N	☐ Abn	_____
Pulses	☐ N	☐ Abn	_____
Abdomen	☐ N	☐ Abn	_____
Genitalia	☐ N	☐ Abn	_____
Back	☐ N	☐ Abn	_____
Hips	☐ N	☐ Abn	_____
Extremities	☐ N	☐ Abn	_____

Possible Signs of Abuse ☐ Yes ☐ No

Concerns and/or questions_____
_____
_____

Anticipatory Guidance

(Consult Bright Futures, Fourth Edition for further information https://brightfutures.aap.org)

Social Determinants of Health
- ☐ Neighborhood and family violence
- ☐ Food security
- ☐ Family substance use (tobacco, alcohol, drugs)
- ☐ Emotional security and self-esteem
- ☐ Connectedness with family

Developmental and Mental Health
- ☐ Family rules and routines
- ☐ Concern and respect for others
- ☐ Patience and control over anger

School
- ☐ Readiness
- ☐ Established routines and school attendance
- ☐ Friends
- ☐ After school care
- ☐ Parent -teacher communication

Physical Growth and Development
- ☐ Oral health (dental visits, brushing and flossing, fluoride, limits on sugar sweetened beverages and snacks)
- ☐ Nutrition (healthy weight, vegetable, fruit consumption, calcium and vitamin D intake, healthy foods in school)
- ☐ Physical activity (60 minutes per day)

Safety
- ☐ Car safety
- ☐ Outdoor safety
- ☐ Water safety
- ☐ Sun protection
- ☐ Harm from adults (sexual abuse)
- ☐ Home fire safety
- ☐ Firearm safety

☐ **Other**
_____
_____
_____

Plan of Care

Assessment ☐ **Well Child** ☐ **Other Diagnosis**

Labs
- ☐ Hemoglobin/hematocrit *(if high risk)*
- ☐ Blood lead *(if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS)*
- ☐ TB skin test *(if high risk)*
- ☐ Lipid profile *(year 6, if high risk)*
- ☐ Other _____
_____

Referrals
See page 1, school requirements

Prior Authorizations
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit ☐ 6 years of age ☐ 7 years of age
☐ Other_____

☐ **Screen has been reviewed and is complete**

See page 1, school requirements for required signature

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No____Unknown____Yes____
   - Fluoridated water? No____Unknown____Yes____
   - Fluoride Supplement diet? (tablets____, liquid____) No____Unknown____Yes____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

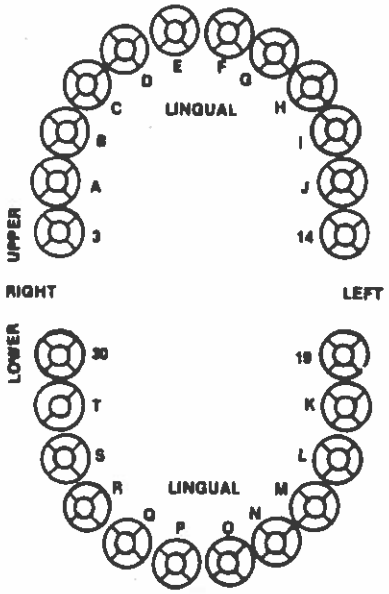
PART I. TO BE COMPLETED BY HEAD START STAFF

3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____Date last visit_____
4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____
5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type_____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___is, ___is not) complete. If not, explain here, as well as items checked.
   _____
   _____

   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

   Signature_____ Date_____

INTERVIEWER: GO TO FORM 6

LOGAN COUNTY SCHOOLS 2020-2021
Student Residency Questionnaire

This questionnaire is intended to address the McKinney-Vento Homeless Education Assistance Act. Answers to this questionnaire are confidential and will help determine the services a student may be eligible to receive.

1. Is student living with someone other than their parents/guardians? (*Parent is not living in the house*)
   - ☐ Yes ☐ No
2. Is student's current address a temporary living arrangement due to loss of housing or economic hardship?
   **A long-term, cooperative living arrangement among families or friends that is fixed, regular and adequate should not be considered a homeless situation, even if the parties are living together to save money.*
   - ☐ Yes ☐ No
3. Is student in a foster care placement?
   - ☐ Yes ☐ No

If you answered YES to any question, please continue and complete the remainder of the form and return to school principal.

Name of Student	Name of School	DOB	Grade	WVEIS/Lunch Number

Name of Parent/Guardian/Foster Parent _____

Address _____

Phone # _____ **Cell #** _____ **Other #** _____

Please select the one which "best" describes current living arrangements:

☐ Temporarily staying with family or friends due to loss of housing or economic hardship.

☐ Living in motel/hotel due to loss of housing or economic hardship.

☐ Residing in an emergency shelter or in transitional/supportive housing for the homeless.

☐ Residing in car, park, abandoned building, or substandard housing.

☐ Foster placement through Department of Health and Human Resources, family, kinship or residential placement.

☐ Residing with someone who does not have legal custody and/or is not the legal parent.

Is/are student(s) eligible for special education services? ____Yes ____No

Individual completing this form _____

Signature of Parent/Guardian/Foster Parent _____ **Date**_____

Please return this form to the principal at your school: **For further information contact:**

Cathy M. Adkins, Homeless Liaison
Logan County Schools
506 Holly Ave. Box 477
Logan, WV 25601

Phone: 304-792-2043 Fax: 304-792-2027

Rev. 2/12/15

Office use only

_____
Date Received

_____
WVEIS #

Logan County Schools

HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Sex: ❑ Male ❑ Female

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

1. Was your child born in the United States? ❑ Yes ❑ No
   If yes, in which state? _____
   If no, in what other country? _____

2. Has your child attended any school in the United States for any three years during their lifetime? ❑ Yes ❑ No
   If yes, please provide school name(s), state, and dates attended:
   Name of School _____ State _____ Dates Attended _____
   Name of School _____ State _____ Dates Attended _____
   Name of School _____ State _____ Dates Attended _____

3. What language is spoken by you and your family most of the time at home? _____

4. If available, in what language would you prefer to receive communication from the school? _____

5. Please check if your child is:
   A. ❑ Native American Indian
   B. ❑ Alaska Native
   C. ❑ Native Pacific Islander
   D. ❑ Native U.S. Virgin Islander

6. Is your child's first-learned or home language anything other than English? ❑ Yes ❑ No

If you responded "Yes" to question number 6 above, please answer the following questions:

7. What language did your child learn when he/she first began to talk? _____

8. What language does your child most frequently speak at home? _____

9. What language do you most frequently speak to your child? (Father) _____
   (Mother) _____

10. Please describe the language <u>understood by your child</u>. (Check only one)
    A. ❑ Understands only the home language and no English.
    B. ❑ Understands mostly the home language and some English.
    C. ❑ Understands the home language and English equally.
    D. ❑ Understands mostly English and some of the home language.
    E. ❑ Understands only English.

_____ _____
Parent or Guardian's Signature Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	

GUIDELINES FOR POSITIVE BEHAVIORAL APPROACH FOR UNIVERSAL PRE-K AND LOGAN COUNTY SCHOOLS KINDERGARTEN

In accordance with West Virginia Department of Education Policy 4373, Expected Behaviors in Safe and Supportive Schools and with Head Start Performance Standard 1302.45, a program must "Provide supports for effective classroom management and positive learning environments; supportive teacher practices; and, strategies for supporting children with challenging behaviors and other social, emotional, and mental health concerns".

PRIDE Community Services Head Start Program & Logan County Schools believe in setting age appropriate limits, guiding conduct and helping children to learn appropriate behavior. If inappropriate behavior occurs, students are treated in a fair, safe, consistent and responsible manner. We believe it is important for children to understand why certain behavior is inappropriate and how to modify it. Therefore, throughout the school year, teachers provide lessons that help children identify and control their emotions, as well as, integrate social-emotional aspects into all areas of the classroom during all times of the day. Students are taught calming techniques that can be used when they are experiencing big emotions and are encouraged to help problem solve.

The teaching staff is trained to use redirection. In addition, a quiet or calm-down area is created for each classroom in order to give children the opportunity to re-group and then re-enter the classroom/play area when ready. This area contains soft items and calming tools, as well as books on self-regulation. Rather than being left alone in the calm-down area to deal with their emotions, a staff member guides a child in calming down and once the child is ready he/she is taught how to work through their emotions and taught what they can do better. Behavior anecdotal records are kept by the teacher and parents are notified when their child exhibits behavioral challenges. The staff works with families to develop a plan supportive of each child's needs.

PRIDE Community Services Head Start Program and Logan County Schools do not permit the use of any method of corporal punishment or physical or verbal abuse such as, but not limited to, hitting, jerking, shaking, yelling, withholding food or playground privileges, isolation, ridicule, embarrassment or humiliation of the children. Approved methods of physical restraint may only be used as a protective measure when a child is exhibiting behavior which may be dangerous to themselves or to others.

STRATEGIES FOR POSITIVE BEHAVIOR FOR UNIVERSAL Pre-K AND LOGAN COUNTY SCHOOLS KINDERGARTEN

Strategies for Developing Positive Behavior:

1. Make children aware of your expectations.
2. Avoid unnecessary rules (no more than five rules in a classroom). Children should participate in forming the classroom rules.
3. Create a classroom management chart and review it on a weekly basis.
4. Make children aware when a transition will be taking place.
5. Help build children's self-esteem and teach positive discipline.
6. Be an example for the children by demonstrating composure (speak with students using calm, reassuring tone of voice).
7. Give children choices when possible.
8. Praise children for demonstrating positive behavior.
9. Do something unexpected (i.e. Brain Breaks).
10. If you anticipate problems, intervene and change the situation if possible.
11. Assess a situation based upon what has been observed.
12. Use redirection.
13. Turn the behavior into something positive.
14. Ignore behaviors if they are not a danger to self or others.
15. Utilize calming area, chill zone, cool down (area in the classroom where children can relax, decompress and recover from any sensory overload in the classroom).

LOGAN COUNTY UNIVERSAL PRE-K
CHILD PROTECTION POLICY
POLICY REFERENCE

WEST VIRGINIA CODE 49-1-1, 2,5; 49-216; 49-6A-1-10

"**Child**" means a person under the age of eighteen.

"**Abused Child**" is one whose parent or guardian inflicts or attempts to inflict or allows to be inflicted as a result of inadequate supervision, physical injury upon the child which seriously endangers the physical or mental health of such child or inflicts sexual abuse upon the child.

"**Neglected child**" means harm or threatened harm to a child's health or welfare by a person responsible for the child's health and welfare.

- A neglected child is one whose physical or mental condition is impaired or endangered as a result to the present refusal, failure or inability of the child's parent or custodian to supply the child with necessary food, clothing, shelter, medical care, education or supervision notwithstanding efforts of the state department or remedy the inadequacy, and the condition is not due primarily to the lack of financial means of the parent or custodian; or the disappearance/absence of the child's parent or custodian.

Any Pre-K personnel **"Participating in good faith in any act permitted or required by this article shall be immune from any civil or criminal liability that otherwise might result by reason of such actions".**

Medical and mental examinations

(a) At any time during proceedings under this article court may, upon its own motion or upon motion of the child or other parties, order the child or other parties to be examined by a physician, psychologist or psychiatrist, and may require testimony from such expert, subject to cross-examination and the rules of evidence: provided, that the court shall not terminate parental or custodial rights of a party solely because the party refuses to submit to the examination, nor shall the court hold such party in contempt for refusing to submit to an examination. The physician, psychologist or psychiatrist shall be allowed to testify as to the conclusions reached from hospital, medical, psychological or laboratory records provided the same are produced at the hearing. If the child, parent or custodian is indigent, such witnesses shall be compensated out of the Treasury of the State, upon certificate of the court wherein the case is pending. No evidence acquired as a result of

any such examinations of the parent or any other person having custody of the child may be used against such person in any subsequent criminal proceedings against such person.

(b) If a person with authority to file a petition under the provisions of this article shall have probable cause to believe that evidence exists that a child has been abused or neglected and that such evidence may be found by a medical examination, the person may apply to a circuit judge or juvenile referee for an order to take such child into custody for delivery to a physician or hospital for examination. The application may be on forms prescribed by the Supreme Court of Appeals or prepared by the prosecuting attorney or the applicant, and shall set forth facts from which it may be determined that probable cause exists for such belief. Upon such sworn testimony or other evidence as the judge or referee deems sufficient, the judge or referee may order any law-enforcement officer to take the child into custody and deliver the child to a physician or hospital for examination. If a referee issues such an order the referee shall by telephonic communication have such order orally confirmed by a circuit judge of the circuit or adjoining circuits who shall on the next judicial day enter an order of confirmation. Any child welfare worker and the child's parents, guardians or custodians may accompany the officer for such examination. After the examination the officer may return the child to the custody of his or her parent, guardian or custodian, retain custody of the child or deliver custody to the state department until the end of the next judicial day, at which time the child shall be returned to the custody of his or her parent, guardian or custodian unless a petition has been filed and custody of the child has been transferred to the department under the provisions of section three of this article.

Logan County Universal Pre-K
PRIDE Community Services Notification of Rights under FERPA

The Family Educational Rights and Privacy Act (FERPA) affords parents and students over 18 years of age ("eligible students) certain rights with respect to the student's education records.

These rights are:

1. The right to inspect and review the student's education records within 45 days of the day PRIDE receives a request for access.

Parents or eligible students should submit to the Head Start Director a written request that identifies the record(s) they wish to inspect. PRIDE will make arrangements for access and notify the parent or eligible student of the time and place where the records may be inspected.

2. The right to request the amendment of the student's education records that the parent or eligible student believes are inaccurate.

Parents or eligible students may ask PRIDE to amend a record that they believe is inaccurate. They should write the Head Start Director, clearly identify the part of the record they want to changed, and specify why it is inaccurate. If PRIDE decides not to amend the record as requested by the parent or eligible student, PRIDE will notify the parent or eligible student of the decision and advise them of their right to a hearing regarding the request for amendment. Additional information regarding the hearing procedures will be provided to the parent or eligible student when notified of the right to a hearing.

3. The right to consent to disclosures of personally identifiable information contained in the student's education records, except to the extent that FERPA authorizes disclosure without consent.

One exception, which permits disclosure without consent, is disclosure to school officials with legitimate educational interest. A school official is a person employed by the School/Head Start as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person serving on the School/Head Start Board; a person or company with whom the School/Head Start has contracted to perform a special task(such as an attorney, auditor, medical consultant, or therapist); or a parent or student serving on an official committee, such as disciplinary or grievance committee, or assisting another school official in performing his or her task.

A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

Upon request, PRIDE discloses education records without consent to officials of another school district in which a student seeks or intends to enroll.

4. The right to file a complaint with the U.S. Department of Education concerning alleged failures by the School District to comply with the requirements of FERPA. The name and address of the office of administrators FERPA are:

Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202-5901

LOGAN COUNTY UNIVERSAL PRE-K
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60 days of such revision. If you should have any questions or require further information, please contact our Privacy Officer at (304) 752-6868.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses or disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment and health care operations. Any use or disclosure of your protected health information, required for anything other than treatment, payment or health care options requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We may use and disclose your personal information with health care providers for coordination and management of your care. Providers include physicians, hospitals, and other caregivers who provide services to you.

Payment: We may use and disclose information in your health record to determine eligibility, coordinate care, review medical necessity, pay claims, obtain external review and respond to complaints. For example, we may use information for your health care provider to help process your claims. We may also use and disclose your personal information to obtain payment from others that may be responsible for such costs.

Health Care Operations: We may use and share your health records as part of our operations in servicing your benefits. Operations include quality improvement activities; accreditation by independent organizations; responses to your questions, grievance or external review programs; and disease management, case management and care coordination. We may use and disclose information for our general administrative activities such as detection and investigation of fraud and auditing.

Business Associates: There may be instances where services are provided to our organizations through contacts with third-party "business associates." Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that we require of our own employees and affiliates.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you unable to agree or object to a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public and private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine using professional judgment, that you intend to consent to use or disclose under the circumstance. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The following describes your rights regarding the health information we maintained about you. To exercise your rights, you must submit your request in writing to:

PRIDE Community Services, Inc.
Attn: Privacy Officer
Post Office Box 1346
Logan, WV 25601

Logan County Schools
Attn: Danita Noel
P.O. Box 477
Logan, WV 25601

Right to Request Restrictions: You have the right to request that we restrict uses and disclosures of your health information to carry out treatment, payment, health care operations or communications with family and friends. We are not required to agree to the restriction.

Right to Receive Confidential Communications: You have the right to request that we send communications that have your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

Right to Inspect and Copy: You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage and preparation or an explanation or summary of the information.

Right to Amend: You have the right to have us amend your health information for as long as we maintain such information. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is subject of the request was not created by us, is not available for inspection as specified by law or is not accurate and complete.

Right to Receive an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). Your first request for accounting in any twelve-month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same twelve-month period.

Right to Obtain a Paper Copy: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.