Kids' Corner Preschool – VPK Program Information
2024 - 2025 School Year

Thank you for your interest in choosing Kids' Corner Preschool for your child's educational needs. We have been serving the community for over 30 years, and we look forward to having your child as part of our program.

The Voluntary Pre-Kindergarten Education Program, or VPK, is a free prekindergarten program for 4 and 5-year-old children who reside in Florida. **Participating children must be 4 years of age on or before September 1st.** Please be advised that the state of Florida has strict attendance requirements for VPK programs. We are required by the state to offer 540 hours of pre-k instruction. In return, the state pays the students' tuition. Once enrolled in our VPK program, each student is expected to be in class from 9:00 am until 12: 15pm daily and will be allowed 20% absences per month.

Qualifying students are required to have a "Certificate of Eligibility"/VPK Voucher for admittance into a VPK Program. Visit elcpinellas.net to obtain a State VPK voucher. If you have any difficulty, call The Early Learning Coalition at 727-400-4411.

There is no registration fee required for VPK. There is a suggested, but not required, annual fee of $100 per child for supplies and activities.

Please complete and return the attached form to register your child for the 2024 - 2025 school year.

If you have questions, please contact:
Roxane Fineo
Kids' Corner License #C860622
2875 State Road 580 Clearwater, FL 33761
schooldirector@northwoodpc.org or 727-723-7679

Kids' Corner Preschool 2024 -2025
VPK Registration Form

Student's Full Name _____

Age _____ D.O.B _____ Age on September 1, 2024_____

Parent/Guardian Name _____ Telephone _____

Address _____ Cell/Business _____

City _____ State_____ Zip_____

e-mail address _____

Parent/Guardian Name _____ Telephone _____

Address _____ Cell/Business _____

City _____ State_____ Zip_____

e-mail address _____

We may take pictures for special events or projects. We may live stream programs and ceremonies. Please indicate your choices by initialing below:

_____ I give permission to have my child photographed.
_____ Please do not photograph my child

_____ I give permission to be in the class directory.
_____ Please do not include me in the class directory.

Please fully complete and return this page

pclb

CHILD'S ENROLLMENT RECORD

DIRECTOR'S USE ONLY

Date enrolled_____

Child's full legal name_____
First *Middle* *Last* *Nickname*

Date of Birth_____ **Sex**_____

Primary Hours of Care From_____To_____ **Days of Week in Care**_____

Child's Physical Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Family Information: **Child Lives with**_____

Parent's Name_____ Parent's Name_____

Address:_____ Address_____

_____ _____

Home Phone:_____ Home Phone:_____

Employer:_____ Employer:_____

Address:_____ Address:_____

_____ _____

Work Phone_____Cell_____ Work Phone_____Cell_____

Custody: Mother_____Father_____ Both_____ Other_____ Name_____

Emergency Contacts:
Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the children's center in case of illness, accident or emergency, **if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:**

Name_____

Home Phone_____Cell Phone_____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Name_____

Home Phone_____ Cell Phone _____

Address_____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Please use additional sheet of paper to list name, address and phone number of any other people authorized to pick the child up.

CONTINUED ON BACK

CHILD'S ENROLLMENT RECORD

(Back Page)

Medical Information:

Child's Physician/Health Resource _____

Telephone Number _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Hospital Preference _____

Name of Dentist _____ Telephone _____

Address _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Meals typically served while in care: ☐Breakfast ☐AM Snack ☐Lunch ☐PM Snack ☐Supper

Emergency Care Plan instructions (if applicable) _____

_____

_____

_____

MISCELLANEOUS INFORMATION

List all known allergies _____

_____

List all identifying scars, birthmarks, skin discolorations _____

Special medical or dietary needs of child _____

_____

List any areas of concern _____

_____

My signature below verifies that:

I give permission to consult the child's physician/health resource listed above in case of emergency if parent/legal guardian cannot be reached.

I have received a copy of the "Know Your Child's Children's Center" brochure.

I was notified in writing of the disciplinary and expulsion policies used by the children's center.

I was provided the food and nutrition policies used by the children's center.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

_____

Signature of Custodial Parent or Legal Guardian **Date**

pclb

EMERGENCY MEDICAL RELEASE

This form must contain only one child's name, and be the original notarized form.

A new notarized form is required when there is a change in legal guardianship.

Please Print Information

Child's Full Name:_____ Birthdate:_____

Allergies:_____

Medicines Routinely Taken:_____

Name of Custodial Parent(s)/Legal Guardian(s):_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Home Telephone _____ Cell Telephone_____ Work Telephone _____

Family Physician's Name/Health Care Resource:_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City* *State* *Zip Code*

Telephone (___) _____

Hospital Preference:_____
Name *City*

Medical Insurance Company:_____

Policy #:_____ Expiration Date:_____

Emergency Contact (if custodial parent/guardian cannot be reached)**:**_____

Address:_____ _____ _____ _____
Street Address (number, apartment #, street) *City,* *State,* *Zip Code*

Home Telephone _____ Cell Telephone _____ Work Telephone _____

Sign in the presence of the Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child

_____, in the event of an emergency at which time
(Child's Full Name)

I cannot be reached. I give consent to transport by ambulance if situation warrants it.

_____

Signature of Custodial Parent/Legal Guardian (Affiant)

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ _____ 20_____
(Month) *(Day)* *(Year)*

by means of ☐ physical presence or ☐ online notarization by _____ who is personally known
(Name of Affiant)

to me or has produced _____as identification.
(Type of identification)

SEAL OF NOTARY

Signed:_____(*Signature of Notary*)

Authorization for Pick-Up from Northwood Presbyterian Church Programs - Kids' Corner Preschool & Northwood Child Care

Children will be released from NPC's campus only to the person(s) authorized, in writing, by the parents/legal guardian(s). In compliance with the "Policy for the Protection of Children and Adults" of Northwood Presbyterian Church, all parents/legal guardian(s) are asked to provide an additional person(s) authorized to pick-up the child from our facility, including in the case of illness, accident, or emergency, if the parents/legal guardians cannot be reached. ***Children may not be released to anyone under the age of 18, including siblings.*** This form will be kept on file in the Director's office, and copies will be given to the teachers/counselors in charge of the class/program.

The following person(s) is/are authorized to pick-up my child from: (Please check program)

_____**Kids' Corner Preschool** _____**Northwood Child Care**

Child's name: _____

Name:_____

Telephone #(s):_____

Address:_____
(Street Address/City/State/Zip Code)

Date added:_____Parent's Signature:_____

Name:_____

Telephone #(s):_____

Address:_____
(Street Address/City/State/Zip Code)

Date added:_____Parent's Signature:_____

Name:_____

Telephone #(s):_____

Address:_____
(Street Address/City/State/Zip Code)

Date added:_____Parent's Signature:_____

FLORIDA DEPARTMENT OF HEALTH

FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; Rule 64D-3.046, Florida Administrative Code

REQUIRED	REQUIRED		REQUIRED
LAST NAME	**FIRST NAME**	**MI**	**DOB (MM/DD/YY)**
REQUIRED			
PARENT OR GUARDIAN	**CHILD'S SS# (optional)**	**STATE IMMUNIZATION ID# (optional)**	

PAGE 7 IMMUNIZATION GUIDELINES

Directions:

- Enter all appropriate doses and dates below.
- Sign and date appropriate certificate (A, B, or C) on form.
- See DH Form 150-615, Immunization Guidelines - Florida Schools, Childcare Facilities and Family Daycare Homes (July 2010) for information and instructions on form completion. Guidelines are available at: www.immunizeflorida.org/schoolguide.pdf.

VACCINE	DOE CODE	Dose 1 MM/DD/YY	Dose 2 MM/DD/YY	Dose 3 MM/DD/YY	Dose 4 MM/DD/YY	Dose 5 MM/DD/YY
DTaP/DTP	A	2 MONTHS	4 MONTHS	6 MONTHS	1 - 1 1/2 YEARS	4-6 YEARS
DT	B					
Tdap	P					
Td	Q					
Polio	D	2 MONTHS	4 MONTHS	6-18 MONTHS	4-6 YEARS	
Hib	E	2 MONTHS	4 MONTHS	6 MONTHS	12-15 MONTHS	
MMR (Combined)	F	1 - 1 1/2 YEARS	4-6 YEARS			
(Separate)	G, H	*Measles (dose 1)*	*Measles (dose 2)*	*Mumps (dose 1)*	*Mumps (dose 2)*	
	I	*Rubella (dose 1)*	*Rubella (dose 2)*			
Hepatitis B	J	BIRTH	2 MONTHS	6-8 MONTHS		
Varicella	K	1 - 1 1/2 YEARS	4-6 YEARS			
Varicella Disease	L					
PneumoConju	N	2 MONTHS	4 MONTHS	6 MONTHS	12-15 MONTHS	

Select appropriate box(es)
Certificate of Immunization for K-12

Part A-Complete

☐ DOE Code 1: Immunizations are complete K-12 (Excluding 7th grade/middle school requirements)

☐ DOE Code 8: Immunizations are complete for 7th grade

I have reviewed the records available, and to the best of my knowledge, the above named child has adequately been immunized for school attendance, as documented above.

Temporary Medical Exemption **Expiration date:** _____

☐ **Part B-Temporary**

Part B (For children in daycare, family daycare homes, preschool, kindergarten and grades 1 through 12 who are incomplete for immunizations in Part A) **Invalid without expiration date.** DOE Code 2

I certify that the above named child has received the immunizations documented above and has commenced a schedule to complete the required immunization. Additional immunizations are not medically indicated at this time.

Permanent Medical Exemption

☐ **Part C-Permanent**

Part C (For medically contraindicated immunizations, list each vaccine and state valid clinical reasoning or evidence for exemption.)

DOE Code 3 _____

I certify the physical condition of this child is such that immunizations as indicated in Part C above are medically contraindicated.

Physician or Clinic Name:
AND ADDRESS
REQUIRED

Physician or
Authorized Signature: REQUIRED
Issued By: REQUIRED
Date: Required

Florida HEALTH

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

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

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

Name of Child (Last, First, Middle)	Birth Date

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: _____ _____ _____
(Exam must be within one year of enrollment) Month Day Year

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/____	Left 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
Vision - With Glasses	Right 20/____	Left 20/____		Hearing – Left	Passed ☐	Failed ☐	Referred ☐

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Abdomen	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Postural assessment	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____

TB risk assessment done ☐ ***(Please review Targeted Testing Guidelines listed below.)***

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
☒	___/___/___	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. ***Do not record administration of any TB test or related information on this form.***

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

CHILD HEALTH AND DEVELOPMENT QUESTIONNAIRE

(To be completed by parent or guardian)

Date_____

Child's Full Name _____

Date of Birth _____ Race _____ Sex _____

Name of Parent or Guardian completing form _____

Please answer the questions on this form. We feel this information will help us be more effective in working with your child.

Childhood Disease Child has had		Date
Chicken Pox		_____
Measles	3 Day (Rubella)	_____
	10 Day (Rubella)	_____
Scarlet Fever		_____
Rheumatic Fever		_____
Mumps		_____
Strep Throat		_____

Is your child taking over-the-counter or prescribed medication regularly at home? ☐ Yes ☐ No

If yes, what?_____

Is your child taking vitamins regularly at home? Yes ☐ No ☐

If yes, what?_____

List any known allergies to food or environment_____

Describe the allergic reaction_____

Does your child complain of feeling ill often? ☐ Yes ☐ No

Have you ever suspected your child of having seizures? ☐ Yes ☐ No

Describe your child's appetite_____

Does your child dislike any foods? ☐ Yes ☐ No If so, what?_____

What does your child usually eat for breakfast before arriving at the center? _____

_____

How easily does your child fall asleep?_____

What is the usual bedtime? _____ Wake up time? _____

What is the usual naptime?_____ Wake up time?_____

Is the child completely toilet trained? ☐ Yes ☐ No

Does the child remain dry all night? ☐ Yes ☐ No

When did the child begin to walk alone? _____

Are other adults (not family) able to understand the child's speech? _____

Does your child have a regular playmate? ☐ Yes ☐ No Same Age ☐ Yes ☐ No

Older ☐ Yes ☐ No Younger ☐ Yes ☐ No

What is your child's favorite toy or activity at home?_____

Does your child have temper tantrums? ☐ Yes ☐ No

Does your child bite his nails? ☐ Yes ☐ No Twist his hair? ☐ Yes ☐ No

If you could describe your child in one word, what would it be?_____

Please list your child's strong points, such as happy, curious, loving, etc. _____

_____

Is there anything else, medical or otherwise, that we need to know about your child? _____

_____

Food Experience Permission Form

I give permission for my child _____ to participate in food related activities.

Please check one of the following:

_____My child DOES NOT have a food allergy or dietary restriction.

_____My child DOES have a food allergy or dietary restriction. He or she may participate, but may not eat or handle the following items (please list below)

_____

_____

_____My child DOES have a food allergy or dietary restriction. He or she may not participate in activities.

_____ _____

Parent Signature Date