Dr. Tanya Turner
Superintendent

Mr. James Bunch
Assistant Superintendent

Perquimans County Schools
P. O. Box 337
Hertford, North Carolina 27944

PQ Schools

Dear Parent / Guardian:

The following required documents must be turned in completed by May 15, 2025 **before** a screening appointment can be scheduled.

_____ **NC Pre-K Application**

_____ **Verification of Income** (W-2s, paystubs for at least one month, etc.)

_____ **Birth Certificate** (Your child must be four years old on or before August 31)

_____ Proof **of Residency** (i.e., water bill, electric bill, lease agreement. etc.)

_____ Health **Assessment** (must be within 1 year of 1st day of school)

_____ Dental **Assessment** (date of exam must be within 1 year of the 1st day of school)

_____ **Immunizations** (up to date)

_____ **Categorical Eligibility** (required supporting documentation pg. 2)

_____ **Additional Health Documents or Release Forms** (pg. 3)

If you have any questions, you may contact Trisha Brickhouse or Jasmine Raynor at 426-5741.

Sincerely,

Trisha Brickhouse

Trisha Brickhouse, MSA NBCT
Chief Academic Officer of Curriculum and Instruction
NC Pre-K Director

Perquimans County Schools NC Pre-K Application

Perquimans Central School NC Pre-K
PO Box 129/181 Winfall Boulevard, Winfall, NC 27985
Phone: (252)426-5332 Fax: (252)426-5480

Please return the completed application and required documentation to Perquimans Central School or Perquimans County Schools Central Office. This application is not complete without proper proof of the child's birth date, proof of residency, and all sources of family income. You must also submit a current health assessment, dental screening, and immunization records.

Contact Trisha Brickhouse for questions at 252-426-5741

Child's Information

Child's First Name: Last Name: Date of Birth:

Gender: ☐ Male ☐ Female Hispanic: ☐ Yes ☐ No

Race *(Please check all that apply)*: ☐Native American Indian/Alaska Native ☐ Asian ☐ White ☐ Black/African American ☐Pacific Islander/Hawaiian

Is the child a US Citizen?: ☐ Yes ☐ No/Do not know

Is child a North Carolina resident?: ☐Yes ☐No

County of Residence: Application Date:

Family Information

Parent/Legal Custodian/Guardian:

Family Address: City: State: Zip:

Primary Phone Number: Alternate Phone Number:

Email where parent/custodian can be reached:

With whom does the child reside? ☐Mother only ☐Father only ☐ Both parents ☐Legal Custodian ☐Legal Guardian ☐Other, please specify: _____

Does the child live with an adult who has legal custody or guardianship? ☐ Yes ☐ No

If the child lives with an adult who has legal custody, is the adult a relative or non-relative who has legal custody or guardianship? ☐Relative: _____ ☐Non-relative ☐Unknown

Housing status: ☐Permanent ☐Homeless or Emergency Homeless Shelter ☐ Hotel/Motel ☐ Battered Women and Children Shelter ☐Hospital for 30 days or under ☐ Lack of permanent nightime address ☐Other:

Family Size *(List all family members in the household.)*

Name	Relationship to Child	Date of Birth	Provide details if the family member has special needs.

Total number of adults in the house: _____ Total number of children under the age of 18 in the house: ____

Total number of family members in house: _____

***Income Documentation:* Please submit check stubs for each employed parent to document pay for one month, child support, retirement, worker's compensation, statement from a supervisor, IRS 1040, unemployment/social security benefits letters, or copies of all W-2s.**

Mother/Stepmother/Guardian Information: *(only if living in the home)*

Name:

Phone Number Home: Cell: Work:

Check all that apply: ☐Employed Number of hours worked per week: _____

☐Attending secondary education ☐Attending high school/GED ☐Attending job training

☐Seeking Employment ☐ Other Employment/Explain:

Wages Before Taxes	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Alimony	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Child Support	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Worker's Comp	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Unemployment	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSI/TANF/Work First	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Overtime	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly

Father/Stepfather/Guardian Information: *(only if living in the home)*

Name:

Phone Number Home: Cell: Work:

Check all that apply: ☐Employed Number of hours worked per week: _____

☐Attending secondary education ☐Attending high school/GED ☐Attending job training

☐Seeking Employment ☐ Other Employment/Explain:

Wages Before Taxes	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Alimony	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Child Support	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Worker's Comp	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Unemployment	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSI/TANF/Work First	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
Overtime	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSA	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly
SSDI	$	This amount is	☐Yearly	☐Monthly	☐Twice Monthly	☐Bi-Weekly	☐Weekly

Home Language Survey

Is your child Limited English Proficient: ☐Yes ☐ No

What is the primary language spoken in the home?

In what language would you like for your child to be screened?

Military Involvement:

Is at least one parent or legal guardian on this child an active duty member of the military? ☐Yes ☐No

Was a parent or legal guardian of this child seriously injured or killed while on active duty? ☐Yes ☐No

Additional Eligibility Categories *(Check all that apply. Please provide documentation.)*

☐Experiencing Homelessness ☐ In foster care ☐ Receiving refugee services

Receiving Public Assistance *(for family sizes of 8 or less*)*

☐WIC* ☐ SNAP* ☐ Public Housing* ☐ TANF/Work First*

☐ Medicaid ☐ SSI* ☐ Food and Nutrition Services (Food Stamps)*

PQ Schools

NORTH CAROLINA NC Pre-K Prekindergarten Program

Additional Health and Developmental Factors

Does your child have a chronic health condition?

☐ Yes *(Please indicate areas of concern with check below.)* ☐ No

If yes, include appropriate documentation or sign below to release records to the child care agency.

	Seizures		Allergies		Anemia
	Weight		Behavior/Emotional		Asthma
	Diabetes		High Lead Level		Hyperactivity
	Other:				

Has your child been diagnosed with a disability and have an active IEP?

☐ Yes *(Please indicate area of disabilities with check below.)* ☐ No

If yes, include appropriate documentation or sign below to release records to the child care agency.

	Autistic		Deaf/Blind		Hearing Impaired
	Multi-handicapped		Other Health Impaired		Developmental Delay
	Orthopedically Impaired		Speech/Language Impaired		Visually Impaired
	Traumatic Brain Injury		Other:		

I give permission for _____ to provide a copy of the IEP, developmental
(Doctor's Name / Facility / Testing Location)
screening, or other information pertaining to chronic health conditions, disabilities, or IEP to the Perquimans Central School NC Pre-K screening staff.

Parent signature: _____ Date: _____

Child's Prior Placement at the time of enrollment

	Child has never been served in any preschool or child care setting
	Child is currently unserved (at home now but may previously have been in child care or some other preschool program)
	Child is currently enrolled in Headstart
	Child is in unregulated child care
	Child is in a one or two-star facility
	Child is not receiving subsidy but is in some kid of regulated child care or preschool program
	Child is receiving subsidy and is in some kind of regulated child care or preschool program.

☐ Yes ☐ No Was the child previously served by Perquimans Central School as a three year old?
If yes, in what capacity?

Parent/Guardian Signature

I certify that all information provided is true, correct, and complete. I understand that demographic, medical, and financial information is provided to document eligibility for receipt of program funds. Program staff may verify information on this application. Deliberate misrepresentaton may void the application and subject me to prosecution under applicable state laws.

Parent/Guardian Signature: _____ Date: _____

Relationship to child: _____

PQ Schools

NORTH CAROLINA NC Pre-K Prekindergarten Program

Initial next to each statement:

_____ I understand that if my child is selected for participation, family involvement is expected. My family will cooperate with programs to submit the necessary documentation and applications for services.

_____ I understand that transportation may be provided by a public school bus that will consist of students from Pre-K through fifth grade. I also understand that riding a bus is a privilege, not a right. Bus referrals or other incidents may result in a bus suspension.

_____ I understand that if there is a change in my child's address, phone number, or attendance it is my responsibility to notify the Pre-K Staff and inform them of changes.

_____ I understand that my child will need a current, updated health assessment before she/he attends a program, along with a current copy of their immunization record.

_____ I understand that due to program guidelines and funding my child may be placed on a waiting list.

_____ _____

Parent/Guardian Signature Date

January 2016rev

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name:

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

Public Health
HEALTH AND HUMAN SERVICES

Dental Screening Form

When the Health Assessment Transmittal Form issued by NCDPI is used to complete the NC Pre-K child's health assessment, a **separate dental screening** must also be completed due to it not being included on the NCDPI form. Per NC Child Care Rule 10A NCAC 09 .3005 Child Health Assessment, the child's health assessment must include a dental screening, which may be recorded on this form.

Child's Name: _____
Birth date: ____/____/____
Gender: ____ **Male** ____ **Female**
Parent or Guardian: _____
Address: _____
City: _____
Phone number: _____ **School/Pre-K:** _____

Screener's Name _____ Screening Date___ /___/___

Organization/Practice Name _____

Phone number_____

Professional affiliation (please check one):

____Dentist
____Dental Hygienist
____Physician
____Physician Assistant
____Registered Nurse
____Other Health Professional: _____

Pattern of early childhood cavities:

- o No cavities/decay present or no obvious problem
- o Cavities/decay present or dental care needed (comment required)
- o Referral for Urgent Care (comment required)

Comments:

Signature_____ **Date**_____