

Sheridan Early Childhood Center

4107 South Federal Blvd.
Sheridan, CO 80110
Ph. 720-833-6600 Fax. 1-720-246-2918
E: SheridanECC@ssd2.org



Preschool Application

This is an application to express interest in enrolling your child into the Sheridan Early Childhood Center Preschool Program. Please fill out the attached forms and bring back the complete packet to the school.

When you bring the forms back to school, we will need you to bring your child's original Birth Certificate, current shot records (immunizations) and proof of income. The Sheridan Early Childhood Center is funded through federal and state grants. There are qualifications that are necessary for children and families to be accepted into the preschool program based on these regulations. Due to these regulations, we need proof of income on all employed parents, birth certificate, immunization records, as well as any family history or child history that might indicate any educational or health issues. The questions and information gathered in this application are only used to verify that your family meets the required qualifications for our program.

Thank you for your interest and we look forward to working with your family!

Please turn in the following documents with your application (we can make copies):

- _____ Birth Certificate
- _____ Immunizations/ Medical or Non-Medical Exemption
- _____ Proof of Income (all guardians – taxes from prior year or 3 months of pay stubs)
- _____ Proof of Address
- _____ Current Physical
- _____ Current Dental

Child's Primary Language is _____.

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Dear Applicants,

Thank you for your interest in the Sheridan Early Childhood Center. We would like to explain some key elements of our program and the enrollment process. First and foremost, the Sheridan Early Childhood Center is a high quality, comprehensive program for young children and their families. We have three different funding sources: Head Start, Colorado Preschool Program (CPP) and Colorado Early Childhood Special Education.

There are overlapping requirements for our program. However, one key requirement is children must be at least 3 years old on or before October 1st to apply to our school. Children who turn 5 prior to October 1st are not eligible for the ECC and will be referred to our kindergarten program at Alice Terry. Below is an outline of the enrollment process:

1. Turn in a complete application including:

- Child's Birth Certificate
- Immunizations
- Physical Exam
- Dental Exam
- Proof of Address
 - Utility bill with your name on it
 - Rental agreement with your name on it
 - Mortgage statement with your name on it
- Proof of current income – all supporting guardians
 - 3 months of pay stubs
 - TANF documents
 - SSI documents
 - Tax form 1040
 - W-2 forms
 - Unemployment documents
 - Written statement from your employer
 - Foster care documentation
 - Child Support documentation

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2. Once a completed application has been turned into the ECC, you will be invited to attend a "screening day." On that day, a family interview and child screening will occur. At the family interview, staff will discuss your child and your family history. We will invite your child to come and play with us to observe their developmental skills.
3. Next, the enrollment committee reviews the applications and place children in classrooms or on a wait list if there are no openings. Once school has begun, family interviews are conducted quarterly.
4. Acceptance letters are mailed in late July. The letter will have your child's teachers' names and "Jump Start" information.

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The Sheridan Early Childhood Center sets a strong foundation for learning for children and their families. We believe family members are a child's first and most influential teachers. *Thus, we need the child's family member to participate in many ways:*

- **Emphasis on attendance** – We expect each child to attend a minimum of 85% of the time.
- **Literacy focus** – We expect families to read and explore books daily with their child.
- **Volunteers** – We expect families to support their child's educational experience through volunteering. We have numerous opportunities to volunteer depending on your availability and comfort level.
- **Family and Community Meetings** – We expect families to participate in the numerous opportunities for development and enrichment in our program.
- **Family Education** – We expect families to support their child's educational experience at the ECC by attending home visits, parent teacher conferences, family nights and other activities connecting children to an educational experience.

Thank you again for exploring the opportunities the Sheridan Early Childhood Center has to offer. If you have further question, please contact the school.

Thanks,

Aimee Chapman
Director
Sheridan Early Childhood Center
Englewood CO 80110
Phone 720-833-6600

Date Received _____

Start Date _____

SHERIDAN SCHOOL DISTRICT

DISTRITO ESCOLAR DE SHERIDAN

STUDENT NAME: _____
Nombre del Estudiante

STUDENT ID # _____
ID DEL ESTUDIANTE

Grade _____
Grado

Office Use Only

NEW STUDENT APPLICATION APLICACIÓN PARA NUEVOS ESTUDIANTES

Uso de la Oficina

☐ **IN DISTRICT**
DENTRO DEL DISTRITO

☐ **OUT OF DISTRICT *****
FUERA DEL DISTRITO

We must have the following BEFORE beginning school...

Necesitamos lo siguiente ANTES de comenzar la escuela....

____ **Completed Application**
Aplicación Completa

____ **Proof of Address (Property Bill/Contract)**
Comprobante de Domicilio (pago o contrato de la propiedad)

____ **Birth Certificate**
Acta de Nacimiento

____ **Special Services/IEP (If Applicable)**
Servicios Especiales/IEP (si es aplicable)

____ **Immunizations/Medical or Non-Medical Exemption**
Cartilla de Vacunación/Exención Médica o no Médica

____ **Custody Papers (If Applicable)**
Papeles de custodia si es aplicable

*** Most Recent Grade Card Most Recent Attendance Report Behavior Report***
Tarjeta más reciente de Calificaciones Reporte más reciente de Asistencia Reporte de conducta

Sheridan School District No. 2 is an equal opportunity educational institution and does not unlawfully discriminate on the basis of race, age, gender, color, sex (which includes gender identity), sexual orientation (which includes marital status), religion, national origin, ancestry, creed, disability or need for special education services, genetic information or conditions related to pregnancy or childbirth. Inquiries concerning Title VI, Title IX, Section 504 and ADA may be referred to Jenny Pilger, Special Education Director (720) 833-6601, jpilger@ssd2.org or Patrick Sandos, Superintendent, (720) 833-6620, psandos@ssd2.org, 4150 S Hazel Ct., Englewood Colorado, 80110 or to the office of Civil Rights, U.S. Department of Education, Region VIII, Federal Office Building, 1244 North Speer Blvd., Suite 310, Denver, Colorado, 80204, (303) 844-2991.

El Distrito Escolar de Sheridan No. 2 es una institución educativa que ofrece igualdad de oportunidades y no discrimina fuera de la ley en base a raza, edad, género, color, sexo (que incluye la identidad de género), orientación sexual (que incluye el estado civil), religión, nacionalidad, descendencia, credo, discapacidad o que tiene necesidad de servicios de educación especial, información genética o condiciones relacionadas con embarazo o parto. Las preguntas relacionadas al Título VI, Título IX, Sección 504, ADA pueden ser referidas a Jenny Pilger, Directora de Educación Especial al (720) 833-6601 o a Patrick Sandos, Superintendente, (720) 833-6620, psandos@ssd2.org, 4150 S Hazel Ct., Englewood Colorado, 80110 o a la oficina de Derechos Civiles, Departamento de Educación de EE.UU., Región VIII, Edificio de la Oficina Federal, 1244 North Speer Blvd., Suite 310, Denver, Colorado, 80204, (303) 844-2991.

SHERIDAN SCHOOL DISTRICT

STUDENT REGISTRATION FORM
DISTRITO ESCOLAR DE SHERIDAN
FORMA DE INSCRIPCION PARA ESTUDIANTES

☐ **EARLY CHILDHOOD CENTER** ☐ **FORT LOGAN NORTHGATE 6 - 8**
☐ **ALICE TERRY ELEMENTARY** ☐ **SHERIDAN HIGH SCHOOL**
☐ **FORT LOGAN NORTHGATE 3 - 5** ☐ **SOAR ACADEMY**

Grade Entering _____
Grado al que Ingresa

Student's Legal Name: _____
Nombre del Estudiante *(Last) Apellido* *(First) Nombre* *(Middle) 2do nombre*

Gender (M/F) _____ **Birth Date:** _____ **Place of Birth:** _____

Sexo *Fecha de Nacimiento* *Lugar de Nac.* *(City) Ciudad* *(State or Nation) Estado o País*

Please answer BOTH of the following questions.

REQUIRED - SE REQUIERE

MUST CHECK ONE of the following Ethnicities: DEBEN MARCAR UNA de las siguientes categorías étnicas

☐ **Hispanic or Latino** (*Hispano o Latino*) ☐ **Not Hispanic or Latino** (*No Hispano o Latino*)

REQUIRED - SE REQUIERE

MUST CHECK ONE OR MORE that apply POR FAVOR MARQUEN UNO O MAS a las que aplican

Racial categories: Categorías Raciales:

☐ **American Indian or Alaskan Native** (*Indio Americano o Nativo de Alaska*)
☐ **Asian** (*Asiático*)
☐ **Black or African American** (*Negro o Afro Americano*)
☐ **White (or of Spanish origin)** (*Blanco (o de origen hispano)*)
☐ **Native Hawaiian or Other Pacific Islander**
(*Nativo Hawaiano o de otras Islas del Pacífico*)

School transferring from: _____ **City and State** _____
Escuela de donde es Transferido *Ciudad y Estado*

How many consecutive years has student been enrolled in US? _____ **What month and year?** _____ **in Colorado?** _____ **What month and year?** _____
¿Cuántos años consecutivos ha estado su niño inscrito en una escuela en Estados Unidos? Mes y año *en Colorado? Mes y Año*

Has your student attended Sheridan Schools in the past? _____ **Yes** _____ **No** **Is this student a refugee?** _____ **Yes** _____ **No**
¿Su estudiante ha asistido a las escuelas de Sheridan en el pasado? Si *No* *¿Es un estudiante refugiado? Si* *No*

Has student ever been enrolled in Special Education/Gifted & Talented programs? _____ **Yes** _____ **No**
¿Su estudiante ha estado inscrito en un programa de Educ. Especial o para Niños Dotados? Si *No*

If Yes, which one? _____ **Special Ed. (IEP)** _____ **G/T** _____ **504** _____ **Reading Program**
¿Si contesto Si, en cual? Educ. Especial (IEP) *G/T* *504* *Programa de Lectura*

Household Address:

Domicilio de la Familia

(Number) Número (Street) Calle (Apt #) (City) Ciudad (State) Estado (Zip) Código Postal

Main Phone: _____
Número de Teléfono Principal

Parent/Legal Guardian Demographic Data
Datos Demográficos del los Padres/Tutores Legales

Adult Name (Nombre del adulto): _____ Adult Name (Nombre del Adulto): _____
Relationship (Relación): _____ Relationship (Relación): _____
Employer (Lugar de Trabajo): _____ Employer (Lugar de Trabajo): _____
Work Phone (Teléfono del Trabajo): _____ Work Phone (Teléfono del Trabajo): _____
Cell Phone (Teléfono Celular): _____ Cell Phone (Teléfono Celular): _____
E-Mail Address (Dirección Electrónica): _____ E-Mail Address (Dirección Electrónica): _____

Marital Status: _____ Married _____ Divorced _____ Separated _____ Single _____ Widow
Estado Civil Casado Divorciado Separado Soltero Viudo

Student Resides With:
El Estudiante Vive con:

_____ Both Parents (Ambos Padres) _____ Father Only (Solo con el Padre) _____ Legal Guardian (Tutor Legal)
_____ Mother Only (Solo con la Madre) _____ Father & Stepmother (Padre y Madrastra) _____ Foster Parent (Padres Adoptivos)
_____ Mother & Stepfather (Madre y Padrastro) _____ Other Relative (Otro Familiar) _____ Emancipate / Independent Student
(Emancipado/Estudiante Independiente)

Please give names of all other adults living in the home if different from mother and father listed above:
Por favor, anote los nombres de otros adultos que viven en la casa aparte de la madre y padre nombrados arriba

1. _____ 2. _____
3. _____ 4. _____

All Children Living in Household Todos Niños que viven en casa	School Attending Escuela que Asisten	Age Edad	All Children Living in Household Edad Todos Niños que viven en casa	School Attending Escuela que Asisten	Age Edad
1 _____	_____	_____	2 _____	_____	_____
3 _____	_____	_____	4 _____	_____	_____
5 _____	_____	_____	6 _____	_____	_____
7 _____	_____	_____	8 _____	_____	_____

Emergency Contact (Contacto de Emergencia): _____ Phone (Teléfono): _____

Emergency Contact (Contacto de Emergencia): _____ Phone (Teléfono): _____

Name(s) of person(s) other than parent and/or Emergency Contact(s) to whom the student may/may not be released
(Please provide documentation for persons who may not pick up student):

Nombre(s) de persona(s) aparte de los padres y/o o Contacto de Emergencia que pueden/no pueden recoger al estudiante. (Por favor, muestre documentación sobre las personas que no pueden recoger a un estudiante)

1. _____ (May / May Not) 2. _____ (May / May Not)
(Puede/No puede) (Puede/No puede)
3. _____ (May / May Not) 4. _____ (May / May Not)
(Puede/No Puede) (Puede/No puede)

Failure to completely and truthfully answer all above questions may result in removal from school. I certify the answers to the above questions are up-to-date, accurate, and complete.

(El no responder completamente y con la verdad a todas las preguntas puede resultar en la remoción del estudiante de la escuela. Certifico que las respuestas a las preguntas de la parte de arriba están actualizadas, precisas y completas.)

Parent Signature _____
Firma de los Padres

Date _____
Fecha

Proof of Income Worksheet (Required when applying for tuition assistance)

Child's Name: _____ **Date of Birth:** _____

In order to be considered for Head Start or Colorado Preschool Program funding you must submit three (3) months proof of income for all adult family members with this form.

You may submit: 3 months of pay stubs, 1040 income tax form from last year, or a letter from your employer verifying hours you work and your rate of pay.

Complete the following:

Mother's/Guardian's Name _____

Employer _____

Days and Hours of Work _____

Do you receive regular overtime? _____

<u>Employed</u> ___full-time ___part-time	<u>Frequency of Pay</u> ___weekly ___every other week ___twice per month ___monthly
--	--

Father's/Guardian's Name _____

Employer _____

Days and Hours of Work _____

Do you receive regular overtime? _____

<u>Employed</u>	<u>Frequency of pay</u>
<input type="checkbox"/> full-time	<input type="checkbox"/> weekly
<input type="checkbox"/> part-time	<input type="checkbox"/> every other week
	<input type="checkbox"/> twice per month
	<input type="checkbox"/> monthly

Child lives with: (circle one) both parents mother father guardian: _____
(Name)

Living Situation: (circle one) own residence relatives/friends doubled-up other: _____

Do you receive: (check all that apply, fill in the amount you receive, supporting documentation is required)

— TANF \$ _____
 — SSI \$ _____
 — Unemployment \$ _____
 — Alimony/Child Support \$ _____
 — WIC _____
 — Food Stamps _____
 — Housing Subsidy _____
 — CCCAP (parent fee \$ _____)
 — Other income _____

Are you enrolled in school or a job-training program? Yes No Please explain: _____

Names of **ALL** people in your household who are supported by the above income(s) (if more space is needed, use the back of the sheet).

NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH

I certify that all of the above information is true and correct, that all income is reported, and that deliberate misrepresentation of the information may subject me to prosecution under State and Federal laws and/or expulsion of my child from the program.

Parent/Legal Guardian signature: _____ **Date:** _____

SHERIDAN EARLY CHILDHOOD CENTER

HEALTH HISTORY

Date: _____

Child's Name _____ Birth Date _____

Date of last Physical Exam _____

Family's Physician _____ Phone _____

Physician's Address _____

Date of last Dental Exam _____

Family Dentist _____ Phone _____

Dentist's Address _____

Has your child ever lost consciousness from:

_____ Injury

_____ Illness

_____ Fainting

_____ Crying

_____ Holding his/her breath

Is your child on any medication (over the counter or prescription)? Please explain.

Does your child have any problems with bedwetting, daytime accidents or constipation? _____

If yes, please explain. _____

Has your child ever been evaluated for special needs? _____

Where? _____ What type of testing? _____

Has your child ever received any special services? _____

What type? (Speech/language, physical or occupational therapy, special education or counseling)

Where? _____

Does your child have an I.E.P.? _____

Did either parent receive special education services in school? _____

Please explain. _____

Can most people understand your child's speech? _____

Does your child have any habits that you are concerned about? _____

If yes, please explain. _____

Is there anything that particularly frightens your child? If yes, please explain. _____

Is your child usually (check any that apply):

____ happy

____ sad

____ friendly

____ shy

____ calm

____ good-natured

____ irritable

Does your child cry easily? _____

What makes your child angry? _____

Does your child make friends easily? Explain if no _____

Are your child's friends the same age, older, or younger? _____

Does your child prefer to play indoors or outdoors? _____

Does your child like to pretend while playing? _____

Mother's age when pregnant with this child: _____ Father's age: _____

Signature of Parent/ Legal Guardian _____ Date _____

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Child's Name _____ Birth Date _____

I give permission for my child's physician and Sheridan Early Childhood Center to discuss my child's health concerns.

Parent Signature _____ Date _____

PHYSICAL EXAMINATION

Medicaid guidelines require all Medicaid children to receive EPSDT physical.

Review of Health History (include birth and development)? _____

Any limitations in this child's activities while in school? _____

Does this child have any recurrent chronic illness health problems of concerns with development?

Allergies _____

Describe reaction _____ Medications _____

***The following screenings are required for Head Start Programs and EPSDT screening for Medicaid patients:**

_____ Head/Ears/Eyes/Nose/Throat

_____ Cardio/Respiratory Abdomen/GI

_____ Extremities/Back/Chest

_____ Developmental (speech, fine and gross motor)

_____ Genitalia

_____ Skin nodes

_____ Height

_____ Weight

_____ Hearing

_____ Vision

_____ Blood Pressure

_____ WIC recipient?

_____ **Lead** _____ Date Done

_____ Hct/Hgb _____ Date Done

_____ Results

_____ Results

Office Telephone Number _____

Office Address _____

Physician's Signature _____

Date of physical exam _____

Recommended Date of next physical exam _____

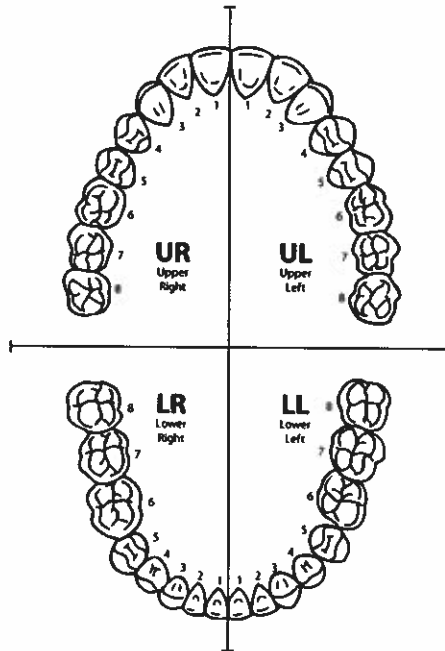
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Dental Examination

Child's Name _____

Date of Birth _____



Priority Group

_____ Needs Attention Immediately

_____ Needs Attention Soon

_____ Needs Routine Care

Additional Comments:

Results of Examination

_____ This child is referred for further dental examination and/or treatment

_____ This child does not need dental treatment at this time

_____ This child cannot be examined at this time

Office Telephone Number _____

Office Address _____

Dental Examiner's Signature _____

Date of Exam _____

Recommended Date of next Dental Exam _____