Date Application Received: _____

Cuddle Zone Learning Center

445 Allentown Dr Allentown PA 18109 (610) 434-2644

PREK COUNTS APPLICATION FORM

2025-2026 SCHOOL YEAR

Child's First Name: _____ Child's Last Name:_____

DOB:__/___/___ Gender: Male / Female Age at start of program year : ___ 3 ___ 4

Street Address: _____County: _____

City_____ State_____ Zip Code_____

School District of residence: _____ Phone No. _____

Email: _____ Household Size: _____

Child care is needed beyond the free PKC portion (5 hours) of the day: _____

Is this child currently receiving CCW subsidy (at any program)? _____

Primary Language: ☐ English ☐ Spanish ☐ Other _____
(please specify)

Attach Documents:

☐ Copy of 2024 Federal 1040 (page 1 showing total household income and list of dependents

☐ Copy of Child's Birth Certificate

☐ Child's Immunization Records and upon acceptance a completed Physical Form including TB assessment form

Name of Parent/Guardian Completing this Form:_____

Relationship to child: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____
(please specify)

Family Type: ☐ One Parent ☐ Two Parent ☐ Adoptive
☐ Foster ☐ Relative/Guardianship ☐ Other _____
(please specify)

Race (optional): ☐ Black or African American ☐ White ☐ Other _____
(please specify)

☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaskan Naive

Ethnicity (Optional): ☐ Hispanic ☐ Non-Hispanic ☐ Non-Applicable

Household Information

List Household Members below for determination of family size (required):		
	Name	Relationship to child
1	Enrolling Child	----------
2		
3		
4		
5		
6		
7		
8		

Per PKC Statute, Regulations, and Guidance, the following members of the household are included in family size:

- Parent of the child (biological or adoptive mother or father, stepmother or stepfather, caretaker or spouse)
- A biological, adoptive, unrelated or foster child or stepchild of the parent or caretaker who is under 18 years of age and not emancipated.
- A child who is 18 years of age or older but under 22 years of age who is enrolled in high school, a general educational development program, or a post-secondary program leading to a degree, diploma or certificate and who is wholly or partially dependent on the income of the parent or caretaker or spouse of the parent or caretaker.
- Others supported by the income of the parent(s) or guardian(s) of the child enrolling or participating in the program. ***If counted toward family size, any applicable income of these persons must also be counted for eligibility purposes.***

Note: A family size value of one (1) with an income of $0 is entered when a foster child is applying for Pennsylvania Pre-K Counts.

Determined Family Size = _____

Employment Status of parent/guardian

☐ Employed Full Time ☐ Employed Part Time ☐ Unemployment ☐ Other _____

Employment Status of 2nd parent/guardian (if applicable)

☐ Employed Full Time ☐ Employed Part Time ☐ Unemployment ☐ Other _____

Household Income Sources: (Must Check all that apply)

☐ Employment ☐ Self-Employment ☐ Unemployment Compensation ☐ Worker's Compensation ☐ TANF Cash payments

☐ Social Security ☐ SSI ☐ Child Support ☐ Alimony ☐ Other _____ (please specify)

Other Child Eligibility Risk Factor Criterion (Check all that apply):

☐ Disability or developmental delay (verified with copy of IEP or other source of documentation from the parent or EI provider) and/or participation in one of the Early Intervention programs. Specify which one: _____

☐ English Language Learner: A child whose first language is not English and who is the process of learning English is considered an English Language Learner

- ☐ Behavioral Supports (A child who is receiving mental health treatment or who was referred from a health practitioner)
- ☐ Child's Family or Living Structure: A child with a single parent, divorced parents, or with relatives as guardians
- ☐ Child Protective Services: A child who is a foster child, a kinship care child or receiving Children and Youth Services
- ☐ Teen parent: A child whose mother or father was under the age of 18 when the child was born
- ☐ Migrant (Non-Immigrant)/Seasonal Student
- ☐ Education level of Guardian: does not have a high school diploma or GED
- ☐ Homeless: A child who lacks a fixed, regular and adequate nighttime residence
- ☐ Incarcerated Parent: A child for whom one of the child's parents is currently in prison
- ☐ Eligible for or Receives Public Assistance: TANF, SSI, SNAP

- ☐ Concerns Regarding Child's Physical Development or Existing Medical Condition (currently not receiving Early Intervention Services)

- ☐ Concerns Regarding Child's Speech or Language Development (currently not receiving Early Intervention Services)

- ☐ Concerns Regarding Child's Social, Emotional or Behavior Development (currently not receiving Early Intervention Services)

Family Assurances

By signing below, I acknowledge and agree to the following:

☐ I understand that my child's eligibility for Pennsylvania Pre-K Counts (PA PKC) is subject to the program's two-year participation limit. My child must be at least three years old.

☐ Once my child reaches the age required to enroll in Kindergarten in the public school district where we live, I understand they will no longer be eligible for PA PKC funding.

☐ I understand that my child's **enrollment is contingent upon meeting the eligibility criteria**, including income verification and prioritization based on risk factors.

☐ I understand that the PA Pre-K Counts (PKC) program is an educational program with attendance requirements. I agree to ensure my child's regular attendance and to notify the program in case of absences. My program's PA Pre-K Counts hours of operation will be determined based on child's classroom placement.

☐ I understand that the PKC portion of the day will be secular (non-religious) in nature and will not include religious instruction during the PKC portion of the day.

☐ I understand that once an enrollment start date is confirmed, the child's PA Pre-K Counts enrollment status may be shared with other OCDEL-funded programs, such as the Early Learning Resource Center (ELRC) or Early Intervention, to ensure proper coordination of funding and services.

Parent/Guardian Certification

To the best of my knowledge, the information provided in this application and associated income documentation is accurate. I understand that I may be asked to verify or give proof of the information provided.

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Printed Name: _____

For Head Start Eligible families (100% of FPL or below) ☐ **Check if not applicable**

I have been informed of my child's eligibility for Head Start and given the following:

☐Contact information for the following Head Start location:
Head Start of the Lehigh Valley 1520 Hanover Ave, Allentown PA 18109
P: 610 437-6000 www.CSCinc.org

My signature below indicates that I have been informed about my options but may still choose to enroll in the Cuddle Zone Pre-K Counts program.

_____

Parent/Legal Guardian (Signature) Date

2025 Federal Poverty Level Guidelines

Family Size	100% (Head Start Eligible)	300% (PreK Counts Eligible)
1	$15,650	$46,950
2	$21,150	$63,450
3	$26,650	$79,950
4	$32,150	$96,450
5	$37,650	$112,950
6	$43,150	$129,450
7	$48,650	$145,950
8	$54,150	$162,450
Each additional family member	+$5,500	+$16,500

"Getting to Know You" Notes

(To be completed by the child's Parent/Guardian prior to enrollment)

Parents: Please complete this form to allow us to get to know a little more about your child so that we can best be prepared to help them transition into their new classroom!

Childs' Name:_____Date of Birth:___/___/___ Anticipated Start Date:___/___/___

*Parent Email:_____*Parent Phone #(___)____-_____Preferred contact: phone / email

Any Nicknames:_____ Does your child have any pets?_____

Siblings Names and Ages:_____/_____/_____/_____

Other important family members living at home? _____

Does your child have any fears? Examples: the dark, water, spiders, loud noises, heights

_____

Please list some of your child's likes and dislikes:
Likes: examples: legos, playground, dinosaurs, books, water play, painting, play-doh,

_____

Dislikes/Fears: examples: sensory materials, dirty hands, water, foods/beverages

_____

Previous child care experience? Where and How long?_____

Is your child able to use the bathroom and change their clothes with minimal assistance? ___yes ___no

Please explain:_____

Please circle any of the following items that you already have in your home:
Crayons / Markers / Scissors / Glue stick / liquid glue /stickers / ipad or tablet / legos / magnatiles

Helpful hints/ personal strengths/ special information about your child including allergies/diet restrictions:

_____

Please share any goals that you may have for your child or areas for development you would like our teachers to focus on in the classroom:

1._____

2._____

3._____

____(initial here) I am aware that in addition to completing this form, a "Getting to Know You" Meeting is available for me and my child with management as well as the classroom teachers at my request within 60 days of enrollment or at anytime thereafter at parent request.

*Parent Signature:_____*Date:_____

(This form is to be reviewed by all classroom teachers and kept in the child's classroom file)

INDIVIDUALIZED EDUCATION PLANS (IEP) AND INDIVIDUALIZED FAMILY SERVICE PLANS (IFSP) INFORMATION SHEET

Child's Name _____

Your child's growth and development is measured with developmental assessments. If your child currently has an IEP/IFSP, it would be beneficial to share a copy of this plan with us so that we can work together to ensure that the guidelines are put into practice. You do not have to provide this information if you do not wish to do so.

_____ I am providing a copy of my child's IEP or IFSP

_____ I am not providing a copy of my child's IEP or IFSP

_____ Not applicable to my child

I have applied for services for my child:

_____

Name of agency

My child is currently receiving services from: _____

_____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

Return to:
Cuddle Zone Learning Center
445 Allentown Dr, Allentown PA 18109
FAX 610 434-3005

ALLENTOWN HEALTH BUREAU
245 North 6th St
Allentown, PA 18102
Ph. 610.437.7760 Fax 610.437.8799

TUBERCULOSIS ASSESSMENT REPORT FOR CHILD CARE FACILITIES

Please return to the child's daycare provider, not the Health Bureau

Age-appropriate tuberculosis assessment should be performed by the healthcare provider as part of the physical exam that is required by the City of Allentown Codified Ordinance for admission *to licensed Child Care Facilities.* Age-appropriate tuberculosis assessment may be performed **yearly**, in conjunction with the physical assessment.

Name of Child: _____Date of Birth: _____
NAME of DAY CARE FACILITY___Cuddle Zone Learning Center_____

To determine the risk of acquiring Tuberculosis infection, the following questions should be asked of the parent/guardian.

____yes ____no 1. Have you or your child been exposed or had any household contact with someone who has or is suspected to have active tuberculosis?
____yes ____no 2. Are you or your child from a foreign country or have you been outside the U.S. in the last six months?
____yes ____no 3. Are you or your child a household contact with someone who has been in jail or homeless in the last five years?
____yes ____no 4. Do you or your child have cancer, chemotherapy treatments, HIV infection, chronic asthma, or long-term steroid use?
____yes ____no 5. Has your child had household contact with someone with a positive Tuberculosis Test?

If "yes" to any of these questions, a tuberculosis test is required according to the guidelines and recommendations as follows: For children under the age of 2 years, a PPD skin test is required. For children over 2 years, a QuantiFERON Gold test is recommended but a PPD test is acceptable. Testing must be interpreted by a healthcare provider. Frequency of testing should be done accordingly to the degree of risk of acquiring Tuberculosis infection.

Date: _____
_____ Tuberculosis assessment completed – No need for TB Testing at this time.
_____ Tuberculosis testing completed by: _____

PPD METHOD (5TU) (CHILDREN UNDER 2)
DATE PPD APPLIED: _____
GIVEN BY: _____
RESULTS IN 48-72 HOURS: _____MM
INTERPRETED BY: _____
DATE: _____

QUANTIFERON TB GOLD PLUS TEST
DATE OF TESTING: _____
RESULTS: _____
POSITIVE NEGATIVE
INTERPRETED BY: _____
DATE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

The Cuddle Zone Learning Center
Family Dentist Report

Student's Name _____

Address _____

_____

The above named child last visited my office on:

_____
DATE

At that time, all necessary dental corrections had been made.

_____ _____
YES NO

If the answer is NO, please complete the following:

1. Primary teeth Fillings _____ Extractions _____
2. Permanent teeth Fillings _____ Extractions _____
3. Diseases of supporting tissues _____
4. Gross malocclusion producing facial deformity or interfering with function

   _____
5. Cleft Palate _____ Cleft lip _____

   Other congenital malformations _____
6. Prosthetic replacements for missing teeth _____

This child is currently under treatment. YES _____ NO _____

Please return to:
Michele McEllroy
The Cuddle Zone
Learning Center, Inc.
445 Allentown Drive
Allentown, PA 18109
P: 610-434-2644
F: 610-434-3005

Signature _____ DDS DMD

Address _____

_____

By: _____

Date Signed: _____