ALGEN HOLDING COMPANY

www.TheAlGenHoldingCo.org
d/b/a

The Harvard Children's Academy
4900 Baltimore Avenue
Philadelphia, PA 19143
Ph.: (215) 729-9900
Fax: (215) 729-9901
Email: hca@thealgenholdingco.org

AWB Children's Center
196 E. Herman Street
Philadelphia, PA 19144
Ph.: (215) 848-1974
Fax: (215) 848-9963
Email: awb@thealgenholdingco.org

Franklin Day Nursery
719 Jackson Street
Philadelphia, PA 19148
Ph.: (215) 389-2991
Fax: (215) 389-2323
Email: info@thealgenholdingco.org

Franklin Day Nursery Northeast
5416 Rising Sun Avenue
Philadelphia, PA 19120
Ph.: (267) 428-5814
Fax: (267) 428-5847
Email: fdnne@thealgenholdingco.org

Preschool Application

for Academic Year

2021-2022

AlGen Holding Company Partners

Full Day Pre-K!

Ages 3-5

3 yrs old before Sept 1st, 2021
5 yrs old after Sept 1st, 2021

Program Benefits

Free Nutritious Meals
High-Quality Curriculum
Access to Nurses
Special Needs Support
Parent Participation

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Thank you for your interest in AlGen Holding Company's preschool program! Completing and submitting a Preschool Application does not guarantee that your child will be accepted to our preschool program. For your best chance at acceptance, please submit your child's completed application ***AS SOON AS POSSIBLE***.

1. Complete ALL necessary steps below. As you collect each item, check off the box.

Applications will not be accepted without all supporting documentation.

- ☐ **I have filled out the entire application**
- ☐ **I have proof of child's date of birth** (Birth certificate, health insurance card, etc.)
- ☐ **I have documentation of family income** (Tax forms, 4 consecutive paystubs, or financial support letter)
- ☐ **I have proof of Philadelphia residency** (bill, driver's license, lease, etc.)
- ☐ **I have my child's health insurance card**
- ☐ **I have my child's physical** (health assessment within the year) **and immunizations**
- ☐ **I have proof of child's dental visit (within the year)**
- ☐ **I have picture identification of parent/guardian** (Current State or Federal Photo ID)
- ☐ I have proof of TANF (DPW) cash, SNAP/food stamps, medical assistance *(if applies to you)*
- ☐ I have a custody order *(if applies to you)*
- ☐ I have a foster letter *(if applies to you)*
- ☐ I have a homeless verification letter/shelter letter *(if applies to you)*

Free preschool programming is offered at all of AlGen Holding Company's sites (based on your family's program eligibility) beginning July 1st. **TO APPLY PLEASE HAND-DELIVER OR EMAIL YOUR CHILD'S APPLICATION DIRECTLY TO THE SITE OF YOUR CHOICE LISTED BELOW.**

AlGen Holding Company Site Name:	Site Address	Zip	Phone #	Program	Offering Virtual Option	Before/After Care (Fees Apply)
SITE#1: THE HARVARD CHILDREN'S ACADEMY	4900 BALTIMORE AVENUE PHILADELPHIA, PA	19143	(215) 729-9900	FEDERAL HEAD START	YES	YES
DIRECTOR: MARIA SANTOS	**EMAIL ADDRESS:** hca@thealgenholdingco.org **WEBSITE:** www.TheAlGenHoldingCo.org		Fax#: (215) 729-9901	ELRC-SITE TODDLERS		
SITE#2: ALLEN WESLEY BROOKS, JR., CHILDREN'S CENTER (AWB)	196 E. HERMAN STREET PHILADELPHIA, PA	19144	(215) 848-1974	FEDERAL HEAD START	YES	YES
DIRECTOR: SANORRA PAYNE	**EMAIL ADDRESS:** awb@thealgenholdingco.org **WEBSITE:** www.TheAlGenHoldingCo.org		Fax#: (215) 848-9963	ELRC-SITE INFANTS TODDLERS		
SITE#3: FRANKLIN DAY NURSERY	719 JACKSON STREET PHILADELPHIA, PA	19148	(215) 389-2991	FEDERAL HEAD START	YES	YES
DIRECTOR: LISA OLIVER	**EMAIL ADDRESS:** info@thealgenholdingco.org **WEBSITE:** www.TheAlGenHoldingCo.org		Fax#: (215) 389-2323			
SITE#3: FRANKLIN DAY NURSERY NORTHEAST	5416 RISING SUN AVENUE PHILADELPHIA, PA	19120	(267) 428-5814	FEDERAL HEAD START	YES	YES
DIRECTOR: LISA OLIVER	**EMAIL ADDRESS:** fdnne@thealgenholdingco.org **WEBSITE:** www.TheAlGenHoldingCo.org		Fax#: (267) 428-5847	ELRC-SITE INFANTS TODDLERS		

PRIMARY PARENT The adult who is primarily responsible for the care and well-being of the child.				
First Name:		**Last Name:**		
Date of Birth:		**Gender:** O Male O Female		
Primary language:		**Other language(s):**		
Home Address:				
Apt./Unit #:	**City:**		**State**:	**Zip Code:**
Phone #:		**Email Address:**		
# of People in household		**# of People in family**		
Marital Status Select one	O Married	O Single	O Widowed	O Separated/Divorced
Relationship to Child Select one	O Parent/Step-Parent		O Grandparent	
	O Foster/Kinship Parent, related to child		O Foster Parent, not related to child	
	O Guardian, related to child		O Guardian, not related to child	
	O Other (specify):		O Teen Parent – parent was under the age of 18 when child was born	
Race/Ethnicity Select all that applies	O Hispanic or Latino/a	O American Indian		O Asian
	O Black or African American	O Multi-Racial or Bi-Racial		O Native Hawaiian
	O Pacific Islander	O White		O Other (specify):
Education Select highest Diploma/Degree earned or highest Grade Level completed	O High School Diploma	O GED		O ESL – English as a Second
	O Some college/Vocational/Associates		O Bachelors/Advanced degree	
	O 11th Grade	O 10th Grade		O 9th Grade or lower
Employment, School, Job Training Select all that applies	O Employed/Self-Employed	O Unemployed/Not Employed		O Disabled
	O Member of the U.S. military on active duty		O Veteran of the U.S. military	

Do you have health insurance? *If 'Yes', name of health insurance provider:*					O Yes	O No
Are you pregnant?	O Yes	O No	**Are you receiving mental health treatment?**		O Yes	O No
Do you receive benefits?	O WIC	O SNAP	O Medical	O TANF Cash	O SSI	

SECONDARY PARENT An adult who shares in the care of the child.			
First Name:		**Last Name:**	
Date of Birth:		**Gender:** O Male O Female	
Employment, School, Job Training Select all that applies	O Employed/Self-Employed	O Unemployed/Not Employed	O Disabled
	O Member of the U.S. military on active duty	O Veteran of the U.S. military	

OPTIONS

CHOOSE THE OPTION OF SERVICES YOU WOULD LIKE: Your child may be selected for your second choice, if there is no available Face to Face spaces. Please do not pick Virtual services, if your child is not willing or able to participate 5-days a week. Laptops will be provided for Virtual services.

Site Choice for FACE TO FACE (M-F):	**Site Choice for VIRTUAL (M-F):**

PREK CHILD				
First Name:		**Last Name:**		
Date of Birth:		**Gender:** O Male O Female		
Race/Ethnicity Select all that applies	O Hispanic or Latino/a	O American Indian	O Asian	
	O Black or African American	O Multi-Racial or Bi-Racial	O Native Hawaiian	
	O Pacific Islander	O White	O Other (specify):	
Primary language:		**Other language(s):**		
Child is receiving Early Intervention services:		O IEP	O EFSP	O ER	O Suspected
Child's mother and/or father is currently incarcerated:			O Yes	O No

HOUSING			
Housing Information Select your current situation	O Own	O Rent	O Transitional housing – Since what date?
	O Shelter – Since what date?		O Train or bus station, park or in car – Since what date?
	O Living with relatives or others to due to lack of alternative, adequate housing or due to the loss of housing – Since what date?		O Hotel/Motel, camping ground or other similar situation due to lack of alternative, adequate housing or due to the loss of housing– Since what date?
	O Temporary housing situation due to emergency: eviction, flood, fire, hurricane, etc.		O Abandoned apartment building
	O Other _____		
Optional Information	New to the country?		O Yes O No
	Has an agency such as HIAS, NSC, Bethany, JEVS, New World Association, AFAHO, or other worked with you?		O Yes O No

FAMILY INCOME

Primary Caregiver Income			Secondary Caregiver Income		
Employment Type	**Amount**	**Frequency**	**Employment Type**	**Amount**	**Frequency**
O Employment			O Employment		
O SSI/ TANF CASH			O SSI/ TANF CASH		
O Unemployment			O Unemployment		
O Other:_____			O Other:_____		

I understand that this information will be used to create my Parent Portal COPA account, and I will receive an email with my sign-in information at the email given on this form. I understand that my application is not complete until I sign in and upload my all supporting documentation.

Completing a Parent Portal COPA Account and submitting and finalizing an application does NOT guarantee that my child will be accepted to a preschool program.

Parent Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Permission Form for Use of Student Picture, Voice, Video, Work and/or Full Name by the AlGen Holding Company d/b/a AWB Children's Center, Franklin Day Nursery, Franklin Day Nursery Northeast, and The Harvard Children's Academy

This letter is to request permission for your child's picture, voice, video, work and/or full name to be used for the purposes stated below.

Please read the options below and mark those that apply.

I/We GRANT permission for any photo/image, voice, video, work and/or full name of this student to be:

☐ Published on the AlGen Holding Company's website and/or individual center's Social Media page in order to promote our programs and celebrate student work.

☐ Published in recruitment flyers, pamphlets and videos for potential students, parents, teachers, and staff.

☐ Used in presentations, manuals, and handouts for professional development for teachers, directors, and other staff.

☐ Used during information sessions for students and families.

☐ Published in an album/collection of student work to be distributed to students, parents, teachers, directors, staff, and/or other employees.

OR

☐ I/We DO NOT GRANT permission for any photo/image, voice, video, work and/or full name of this student to be used for any of the purposes stated above.

Student's Name: _____

Center Name: _____

Print name of Parent/Legal Guardian: (print) _____

Signature of Parent/Legal Guardian: (sign) _____

Date Signed: _____

Please return this form to your Center Director as soon as possible. Thank you.

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

Child's Name (Last):	Child's Name (First):	Child's Date of Birth:
Parent/Guardian Name:	Address:	Contact Phone #:

PA child care providers must document that enrolled children have received age-appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL, 60007. The schedule is available at www.aap.org or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine care and emergencies (describe, if any): ❑ **NONE**	**DATE OF MOST RECENT WELL-CHILD/PHYSICAL EXAM:**
Allergies to food or medicine (describe, if any): ❑ **NONE**	Do not omit any information. This form may be updated by health professional (initial and date new data).

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:

LENGTH/HEIGHT	**WEIGHT**	**BLOOD PRESSURE**
_____IN/CM %ILE_____	_____LB/KG %ILE_____	(BEGINNING AT AGE 3) _____/ _____

PHYSICAL EXAMINATION	**☑ = NORMAL**	**IF ABNORMAL - COMMENTS**
HEAD/EYES/EARS/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMETIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**COMMENTS**
DTap/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TESTS	**DATE OF TEST**	**NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL**
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (attach additional sheets if necessary)

❑ **NONE** **NEXT APPOINTMENT – MONTH/YEAR:**

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
ZIP CODE:	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

#3: CHILD DENTAL HEALTH/DENTAL EXAM FORM

Child's Name_____ Date of Birth _____

SECTION 1: Completed by parent/guardian

1. Has your child been to the dentist? ☐ No ☐ Yes – if 'Yes', date of child's last dental visit _____
2. Does your child have (or had) cavities or caries? ☐ No ☐ Yes – If 'Yes', how many? _____
3. Does your child have any problems with his/her teeth, gums, or mouth? ☐ No ☐ Yes
   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth? _____

SECTION 2: Completed by child's Dentist

1. Date of child's most recent:
   Dental Examination_____Teeth Cleaning_____Fluoride Treatment _____
2. Has child ever needed dental treatment? ☐ No ☐ Yes
   If Yes, type of dental treatment _____
   Has dental treatment been completed? ☐ No ☐ Yes – if 'Yes', date of completion _____
3. Date of child's next dental visit_____

Dental Office Stamp

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____

IT'S TIME TO GO TO THE DENTIST!

Please Note:

- Addresses and phone numbers may change over time; call before visiting any of the providers listed below.
- For additional dental providers and/or information, please refer to the following:
  - 1-800-DENTIST (Toll-free, nationwide)
  - 215-925-6050 – Philadelphia County Dental Society (for private dentists in your area)
  - American Academy of Pediatric Dentistry - www.aapd.org
  - American Dental Association - www.mouthhealthy.org
  - PCCY (Public Citizens for Children and Youth) - 215-563-5848 - www.pccy.org/issues/child-health/dental
  - Philadelphia Department of Public Health - www.phila.gov/health/services/Serv_DentalCare.html

PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH – CITY HEALTH CENTERS

HEALTH CENTER #2
1930 S. Broad St., Unit #14, 19145
215 - 685 - 1822

HEALTH CENTER #3
555 S. 43rd St., 19104
215 - 685 - 7506

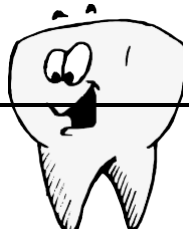
HEALTH CENTER #4
4400 Haverford Ave., 19104
215 - 685 - 7605

HEALTH CENTER #5
1900 N. 20th St., 19121
215 - 685 - 2938

HEALTH CENTER #6
301 W. Girard Ave., 19123
215 - 685 - 3816

HEALTH CENTER #9
131 E. Chelten Ave., 19144
215 - 685 - 5738

HEALTH CENTER #10
2230 Cottman Ave., 19149
215 - 685 - 0608



FEDERALLY QUALIFIED HEALTH CENTERS

ESPERANZA HEALTH CENTER
3156 Kensington Ave., 19134
215 - 302 - 3156

FAIRMOUNT HEALTH CENTER
1412 Fairmount Ave., 19130
215 - 684 - 5349

MARIA DE LOS SANTOS
401 W. Allegheny Ave., 19133
215 - 291 - 2509

ABBOTTSFORD - FALLS
4700 Wissahickon Ave., Suite 110, 19144
215 - 843 - 9720

HEALTH ANNEX
6120-B Woodland Ave., 19142
215 - 727 - 4721

STEPHEN & SANDRA SHELLER (11TH ST. FAMILY HEALTH)
850 N. 11th St., 19123
215 - 769 - 1100

ST. CHRISTOPHER'S
Pediatric Dentistry
3601 A. St., 19134
215 - 427 - 5065

TEMPLE
School of Dentistry
3223 N. Broad St., 19140
215 - 707 - 2863

PENN DENTAL MEDICINE
Pediatric Dentistry
240 S. 40th St., 19104
215 - 898 - 8965

CAVITY BUSTERS
- 240 Geiger Rd., 19115 — 215 - 677 - 0380
- 6801 Ridge Ave., 19128 — 215 - 483 - 6633
- 330 W Oregon Ave - 19148 — 215 - 467 - 6000

PEDIATRIC DENTAL ASSOCIATES
- 6404 E. Roosevelt Blvd., 19149 — 215-743 - 3700
- 2301 E. Allegheny Ave., 19134 — 215-282 - 8000
- 3509 N. Broad St., 19140 - within Temple Hospital, Boyer Pavilion, 6th Floor — 215 - 707 - 6411

DENTAL DREAMS
- 2107-B Cottman Ave., 19149 — 215 - 235 - 4060
- 5675 N. Front St., 19120 — 215 - 224 - 0440
- 2459 Aramingo Ave., 19125 — 215 - 427 - 2800

KIDS SMILES
- 5828 Market St., 19139 Entrance B — 215 - 747 - 6901
- 2821 Island Ave., 19153 Suite 210 — 215 - 492 - 9291

DOUGLAS R. REICH, DMD
- 7122 Rising Sun Ave., 19111 — 215 - 725 - 8300

job 08/2015 rev.