Pittsburgh Public Schools
Students first
Always, in all ways.

Pittsburgh Spring Garden
Early Childhood Center

1501 Spring Garden Avenue
Pittsburgh, PA 15202

PHONE: 412-529-4591
FAX: 412-325-6777

Child's Name: _____

Child's Date of Brith: _____

Partner Location: _____

The following completed forms and information are ***mandatory*** to enroll your child:

- Proof of Income – copies of paystubs, W2, COMPASS printout, SNAP documentation, etc.
- Immunizations – completed by a physician
- Copy of Child's Birth Certificate
- Two Proofs of Residence
- Physical Examination – completed by a physician, within 45 days of enrollment
- Dental Form – completed by a dentist, within 45 days of enrollment

**Please return all forms to the Center Director.**

www.pghschools.org
Parent Hotline:
412-529-HELP (4357)

Child's Name _____ Date of Birth _____

HSSAP PPS
EC Application

Application Status _____ Pending _____
Application Date _____ Re-enrollment Date _____
Enroll Date _____ Waitlisted _____

| Child's Legal Name (Last): | | (First): |
|---|---|---|
| Gender at birth:<br>Male<br>Female | Date of Birth: | Primary Language:<br>Secondary Language: |

Race (circle all that apply):
American Indian or Alaska Native African American Asian
Hawaiian/Pacific Islander Hispanic White
Other _____

Does your child have a sibling(s) in Pittsburgh Public Schools?
If yes, provide child(ren)'s name, school, and grade:

In what type of setting is the child living now?
_____ Housing is adequate, child's needs are met in the home environment
_____ Family is sharing the housing of other persons due to loss of housing, economic hardship, or similar reason
_____ Family is living in a motel, hotel, trailer park or camping ground due to lack of alternative accommodations
_____ Family is living in an emergency or transitional shelter.
_____ Family is living in a nightime residence that is a public or private place not designated for or ordinarily used as a regular sleeping accommodation for human beings
_____ Family is living in a car park, public space, abandoned building, substandard housing, bus or train station, or similar setting
_____ Family is living in a situation that is not considered "fixed"
_____ Family is living in a situation that is not considered "regular"
_____ Family is living in a situation that is not considered "adequate"

Type of Health Insurance for applicant: ___Medicaid ___CHIP ___Private
___Military ___Other ___None

Child's Medicaid Eligibility Status ___Eligible ___Not Eligible ___Potentially Eligible

Primary Health Coverage (Health Insurance)

Secondary Health Coverage (Health Insurance)

Child's Name _____ Date of Birth _____

| Primary Parent/Guardian Name | Male _____<br>Female _____ | Date of Birth |
|---|---|---|
| Highest Grade Completed | Employment Status<br>_____ Full time _____ Part time<br>_____ Student _____ Disabled<br>_____ Unemployed _____ Retired | |
| Race (circle all that apply):<br>American Indian or Alaska Native African American Asian<br>Hawaiian/Pacific Islander Hispanic White<br>Other _____ | | |
| Relationship to Child | Living address (include zip code) | |
| Email address | | |
| Phone - home/work/cell/other (circle one) | Phone - home/work/cell/other (circle one) | |

| Secondary Parent/Guardian Name | Male _____<br>Female _____<br>Non-binary _____ | Date of Birth |
|---|---|---|
| Highest Grade Completed | Employment Status<br>_____ Full time _____ Part time<br>_____ Student _____ Disabled<br>_____ Unemployed _____ Retired | |
| Race (circle all that apply):<br>American Indian or Alaska Native African American Asian<br>Hawaiian/Pacific Islander Hispanic White<br>Other _____ | | |
| Relationship to Child | Living address (include zip code) | |
| Email address | Living with family<br>____ Yes<br>____ No | |
| Phone - home/work/cell/other (circle one) | Phone - home/work/cell/other (circle one) | |

Child's Name _____ Date of Birth _____

Complete for Primary Caregiver: TANF (cash) ____ Yes ____ No
TANF (food stamps/SNAP) ____ Yes ____ No
WIC ____ Yes ____ No

Is a Parent/Guardian active in the military? ____ Yes ____ No
if yes, what branch? _____

Referred for services by a child welfare agency? ____ Yes ____ No

Parental status
____ One-parent household ____Two-parent household
____ Foster parent ____ Other _____

# in Family _____ # of children _____ # aged 0-3_____
# aged 4-5 _____ # in household supported by you _____

| Emergency Information | | | | |
|---|---|---|---|---|
| Name | | Relationship to Child | | |
| Address | City | State | Zip | Phone |
| Name | | Relationship to Child | | |
| Address | City | State | Zip | Phone |
| Name | | Relationship to Child | | |
| Address | City | State | Zip | Phone |

| Child's Physician Information | | | | |
|---|---|---|---|---|
| Physician's Name | | Phone | | |
| Practice Name | Address | City | State | Zip |

| Child's Dentist Information | | | | |
|---|---|---|---|---|
| Dentist's Name | | Phone | | |
| Practice Name | Address | City | State | Zip |

| Additional People Residing in the Household (all children and adults) | | | | |
|---|---|---|---|---|
| Last Name | First Name | DOB | Gender | Relationship to Child |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Child's Name _____ Date of Birth _____

As part of the Early Childhood Grant requirements, we work with parents/guardians to identify family goals, strengths, and resources to help achieve those goals. This collaborative process called the Family Partnership Agreement, ensures that both staff and parents are actively involved, with staff providing ongoing support and follow-up throughout your child(ren)'s time in the program. If you qualify and accept a spot in the Early Childhood Program, you agree to participate in this process.

Certification - I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information will be held in strict confidence with the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____ Date _____

*Families who are determined ineligible for HSSAP due to income will be given information on local PreK Counts Programs. This may be via brochure, application, or contact information for PreK Counts providers.*

Child's Name _____ Date of Birth _____

Child's Health Record & Nutrition Information
(To be completed by parent)

## HEALTH HISTORY

| Pregnancy/Birth | | Yes | No | Explain "Yes" Answers |
|---|---|---|---|---|
| 1. | Did mother have any problems during pregnancy or delivery? | | | |
| 2. | Was child born more than 3 weeks early or late? | | | |
| 3. | What was child's birth weight? Please write in "yes" column. | | | |
| 4. | Was anything wrong with child at birth or in the nursery? | | | |
| 5. | Is the mother pregnant now? | | | |
| 6. | If so, is she receiving prenatal care? | | | |

| Hospitalization/Illness | | Yes | No | Explain "Yes" Answers |
|---|---|---|---|---|
| 7. | Has your child ever been hospitalized or operated on? | | | |
| 8. | Has your child ever had accidents? (broken bones, head injuries, burns, poisoning? | | | |
| 9. | Has your child ever had a serious illness? | | | |

| 10. | Past Illnesses | Yes | No | How Often? |
|---|---|---|---|---|
| | Accidents | | | |
| | Allergies | | | |
| | Asthma | | | |
| | Chicken pox | | | |
| | Ear infection | | | |
| | Elevated lead levels | | | |
| | Eczema | | | |
| | Heart problems | | | |
| | Heart murmur | | | |
| | Hernia | | | |
| | Lead poisoning | | | |
| | Kidney problems | | | |
| | Measles | | | |
| | Meningitis | | | |
| | Polio | | | |
| | Strep Throat | | | |
| | Scarlet fever | | | |
| | Tonsillitis | | | |
| | Pneumonia | | | |
| | Tuburculosis (TB) | | | |
| | Seizures | | | |
| | Sickle Cell disease | | | |

Child's Name _____ Date of Birth _____

| 11. | Allergies | Reactions |
|---|---|---|
| | Foods | |
| | Medications | |
| | Other | |

| General Health | | Yes | No | Explain "Yes" Answers |
|---|---|---|---|---|
| 12. | Does your child have difficulty seeing (squinting, cross eyes, looks too closely at books)? | | | |
| 13. | Does your child have problems with their ears or hearing (frequent earaches, discharge, favoring one)? | | | |
| 14. | Is your child currently taking any medications? If yes, write its name in "Yes" column. | | | |
| 15. | Do you have any other concerns about your child (circle all that apply): Health Speech/language Behavior Hearing Vision Other _____ | | | |

| Nutrition | | Yes | No | Explain "Yes" Answers |
|---|---|---|---|---|
| 16. | Does your child have any food allergies? | | | |
| 17. | Is your child on a special diet? Was it prescribed by a doctor? | | | |
| 18. | Does your child take vitamin or mineral supplements? | | | |
| | Do they contain iron? | | | |
| | Do they contain fluoride? | | | |
| | Prescribed by a doctor? | | | |
| 19. | Any big changes in your child's appetite in the past month? | | | |
| 20. | Does your child take a bottle? | | | |
| 21. | Does your child eat or chew things that aren't food? | | | |
| 22. | Does your child have trouble chewing or swallowing? | | | |
| 23. | Does your child often have diarrhea or constipation? | | | |
| 24. | Do you have any concerns about what your child eats? | | | |

Child's Name _____ Date of Birth _____

# Family Support Form/Family Partnership Agreement

| Parent/Guardian's Name |
|---|
| Child's Name |

| Do you need assistance with any of the following? | | Yes | No | Explain "Yes" Answers |
|---|---|---|---|---|
| 1. | Emergency | | | |
| 2. | Crisis Assistance | | | |
| 3. | Food | | | |
| 4. | Housing | | | |
| 5. | During the past six months, have you at any time been homeless or lived in an emergency shelter? | | | |
| 6. | Clothing | | | |
| 7. | Transportation | | | |
| 8. | Mental Health Services | | | |
| 9. | Literacy or Educaiton | | | |
| 10. | English as a Second Lanugage | | | |
| 11. | Adult Educaiton | | | |
| 12. | Job Training | | | |
| 13. | Substance Abuse Prevention/Treatment | | | |
| 14. | Child Abuse and Neglect Services | | | |
| 15. | Domestic Violence Services | | | |
| 16. | Chidl Support Assistance | | | |
| 17. | Health Education (including Prenatal) | | | |
| 18. | Assistance to Families of Incarcerated | | | |
| 19. | Parenting Education | | | |
| 20. | Marriage Education | | | |
| 21. | Health Problems or Disabilities | | | |
| 22. | Are you involved with any other community agencies that can provide assistance? If yes, what is the name of the group? | | | |

# Family Outcomes Assessment

*The purpose of this assessment is to help us understand your family's unique strengths and challenges. By evaluating different areas of your family's life, we can better determine how to support you and your family throughout your time in our program. The information you provide will help us connect you with the right resources, services, and guidance to create a positive impact in your life.*

*Your responses are confidential and will be used to tailor our support to your needs. This assessment covers various aspects of family life, and we ask that you rate each area based on your current situation. Your honest responses will allow us to offer the most effective assistance in helping you and your family reach your goals and thrive.*

*Thank you for taking the time to complete this assessment. We're here to support you every step of the way.*

# Family Outcomes Assessment Updated

**Participant Name:** _____ **ChildPlus ID:** _____

**Date Completed:** _____ **Case Worker:** _____ **School Year:** _____

Scoring Legend: 5.0 Thriving 2.0 Concern
4.0 Self-Sufficient 1.0 Crisis
3.0 Stable

| Assessment Item | Beginning Score | End Score |
|---|---|---|
| **Family Well Being** | | |
| Housing | | |
| 1. Homeless or on the verge. Very temporary housing (such as with friend for 1 week). At a Shelter. Camping, living in vehicle, etc. No income for housing. Dangerous or bad situation. Utilities shut off.<br><br>2. Temporary housing. Live with friends/family. Money for rent/utilities uncertain. Unsafe or crowded. No money for repairs. Landlord not fixing problems. Use help from agencies to get by (LIHEAP, PRC, etc.). Utilities shut off or on the verge.<br><br>3. Semi-permanent. Relatively safe and secure. Some repairs needed. Mostly have ability to pay housing/utilities/repairs. Minor landlord issues. Subsidized/Metro housing. Some help from agencies to get by (LIHEAP, PRC, etc).<br><br>4. Safe and secure dwelling for at least 12 months. Able to pay rent/mortgage. Able to pay utilities. Repairs taken care of.<br><br>5. Able to own or live in long term affordable housing. Safe housing. Enough room for family size. Suits needs and preferences. Able to pay utilities. | | |
| Safety | | |
| 1. Family is in imminent danger. (Violence in home and in neighborhood).<br><br>2. Family involved or open case with DCF (child abuse/neglect) and/or domestic violence.<br><br>3. Family has a past history with DCF (child abuse/neglect) and/or domestic violence.<br><br>4. Family has a safety plan in place.<br><br>5. Family in no immediate danger and family members report they are safe in their environment. | | |
| Health | | |
| 1. No regular doctor or dentist. Need help finding resources. No Insurance. Can't afford doctor/dentist. Can't afford or skipping needed medications. Serious illness in family.<br><br>2. No/Poor insurance. No regular doctor or dentist. Use emergency room for doctor. Need help finding resources. Only go to doctor/dentist when an emergency. Unmet medical/dentist needs. Behind on immunizations.<br><br>3. Access to doctor and dentist through clinics. Typically able to see doctor/dentist when needed. Adequate insurance coverage. Immunizations are up to date. Typically able to obtain medications.<br><br>4. Family doctor and dentist. Immunizations up to date. Everyone is healthy. Money/insurance for medical.<br><br>5. Family doctor. Family dentist. Immunizations completed. Iron level test done. Lead level test done. Everyone is healthy. Money/insurance for medical. Yearly physicals. | | |

**Assessment Notes:**

# Family Outcomes Assessment Updated

**Participant Name:** _____ **ChildPlus ID:** _____

| Assessment Item | Beginning Score | End Score |
|---|---|---|
| Mental Health/Substance Abuse | | |
| 1. Unmanaged depression, anxiety, eating disorder, or other mental health issue. Struggles to cope. Possible danger to self/others. Substance abuse. Unable to function in society. More bad days than good.<br><br>2. Able to function most days. More good days than bad. Medications partially helping. No treatment until in crisis. Not enough support.<br><br>3. Some mental health issues, but medication/coping skills take care of it. In counseling/treatment. Have support. Able to function normally.<br><br>4. No mental health issues. Somewhat confident. Good relationships. Mild stress at times.<br><br>5. Self-confident. Strong sense of identity. Non-stressed. Strong relationships. No mental health issues. | | |
| Transportation | | |
| 1. No vehicle. No access to transportation with others. Walk everywhere. No driver's license.<br><br>2. Unreliable vehicle. May not be able to pay for needed repairs/gas. No driver's license. Unreliable resources for transportation.<br><br>3. Has access or utilizes public transportation.<br><br>4. Semi-reliable vehicle. Able to pay for some repairs, but not at this time. Able to get reliable rides. Have driver's license and insurance. Can afford gas for essential trips.<br><br>5. Reliable vehicle. Have driver's license. Have money for car repairs, payment, gas, regular maintenance and insurance. | | |
| Financial Security | | |
| 1. Limited or no income. Depend strongly on assistance to survive. No budgeting skills. Facing eviction/repossession. Go without meals/medical.<br><br>2. Inadequate income. Unable to pay all bills. Use some assistance to get by. Need help with budgeting skills.<br><br>3. Stable income. Struggle to pay bills on time. Access resources as needed. Fear unexpected costs. Some budgeting skills.<br><br>4. Adequate income. Able to pay most bills on time. Mostly able to follow budget. Some credit.<br><br>5. Reliable income. Able to pay bills on time. Has savings/retirement account. Have credit cards/good credit. Able to follow budget. | | |
| Employment | | |
| 1. Unemployed. Disabled with no benefits. No/limited prospects or skills. Long term unemployment. Barriers to employment (undocumented, criminal history, health issues)<br><br>2. Temporary or part-time with no benefits. Receiving unemployment compensation. Limited skills. Inadequate pay/benefits.<br><br>3. Stable or part-time/minimum wage job with some benefits. Needs additional job training and employment skills.<br><br>4. Full-time or adequate job. Meets basic needs. Some benefits.<br><br>5. Permanent and stable. Full benefits. Above average employment. Upgrading skills. Transferrable skills. | | |

**Assessment Notes:**

# Family Outcomes Assessment Updated

**Participant Name:** _____ **ChildPlus ID:** _____

| Assessment Item | Beginning Score | End Score |
|---|---|---|
| Food and Clothing | | |
| 1. No food or preparation facilities. Clothing inadequate. Malnutrition. Eating disorders. | | |
| 2. Limited knowledge of food preparation and food/clothing resources. Dietary requirements are not met. | | |
| 3. Sufficient personal and community resources for food/clothing. | | |
| 4. Have resources for healthy food and clothing. Dietary requirements for special condition i.e. pregnancy, diabetes, etc. | | |
| 5. Has ability and access to resources to provide healthy food and clothing. | | |
| **Positive Parent Child Relationships** | | |
| Nurturing Relationships | | |
| 1. No attachment between caregiver and child; severe behavior issues. | | |
| 2. Behavioral issues. Negative or non- consistent use of discipline. Overwhelmed. No support. Needs help with resources. Need parenting help/skills. Relationship issues. | | |
| 3. Somewhat stressed. Stable relationships. Stable environment. Mostly good parenting skills. Able to access resources. Parenting and or relationship skills could be improved. Some community involvement. Some support available. | | |
| 4. Relationships good. Environment good. Involved in community. Mostly positive parenting techniques. Stable support network. | | |
| 5. Stable/nurturing relationships. Positive techniques of guidance. Strongly involved in community. Strong support network. Supportive environment. | | |
| Child Development/Parenting Skills | | |
| 1. Parent/child roles and responsibilities are non-existent. | | |
| 2. Parent does not know how or where to get help on child development/parenting skills. | | |
| 3. Parent/child roles and responsibilities enforced but not always consistent or effective. | | |
| 4. Parent would like information on age-appropriate activities. | | |
| 5. Parent knows how to seek parenting assistance and understands developmental milestones. | | |
| **Family as Life Long Educators** | | |
| Family Education at Home | | |
| 1. Family is unable to support their child in any learning activities. | | |
| 2. Family has limited access to learning resources and has several concerns about their child's learning. | | |
| 3. Family feels somewhat confident about their child's learning. | | |
| 4. Family completes home activities and is aware of what the child is learning. | | |
| 5. Family is engaged in daily literacy activities in the home and is aware of what the child is learning. | | |

**Assessment Notes:**

# Family Outcomes Assessment Updated

**Participant Name:** _____ **ChildPlus ID:** _____

| Assessment Item | Beginning Score | End Score |
|---|---|---|
| School Readiness | | |
| 1. Family not interested in understanding assessment data and progress.<br>2. Family does not understand child assessment data and progress.<br>3. Family has some understanding of child assessment data and participates in parent conferences or program functions.<br>4. Family understands child assessment data and guides the child and knows how to support their child for school readiness.<br>5. Family seeks out information regarding school readiness goals. | | |
| Promoting Primary Language | | |
| 1. Family prohibits child from using native language in home.<br>2. Family discourages child from speaking native language in the home.<br>3. Family inconsistently uses native language.<br>4. Family consistently uses native language in the home and assists other parents with translations.<br>5. Family consistently uses native language in the home. | | |
| **Families as Learners** | | |
| Education, Training, and Life Goals | | |
| 1. No GED or High School diploma. English as second language. Need remedial courses in various areas, e.g., math, reading, writing, etc. No skills with computer/internet.<br>2. No GED or High School diploma. Able to access GED training. Able to access job training. Remedial courses needed. Has limited computer/internet skills.<br>3. Have GED or High School diploma. Able to access needed resources to attend college or job training. Need a few remedial courses. Have computer/internet skills.<br>4. Enrolled in college or vocational training. Have adequate computer/internet skills.<br>5. Working in chosen profession. Attained degree. Proficient with computer and internet. | | |
| Volunteering | | |
| 1. Family does not participate in volunteer opportunities.<br>2. Family volunteers occasionally. (i.e. at least 20-40 hours/school year)<br>3. Family volunteers on a monthly basis.<br>4. Family seeks out ways to volunteer.<br>5. Family volunteers on a weekly basis. | | |

**Assessment Notes:**

# Family Outcomes Assessment Updated

**Participant Name:** _____ **ChildPlus ID:** _____

| Assessment Item | Beginning Score | End Score |
|---|---|---|
| **Family Engagement in Transitions** | | |
| Transitions | | |
| 1. Family is not interested in advocating and/or supporting their child's education. | | |
| 2. Family is unaware of their role in supporting and advocating for their child's education. | | |
| 3. Family is beginning to understand and advocate for their child's learning and development in the transition process. | | |
| 4. Family attends transition meetings as required and gives input into the transition process. | | |
| 5. Family is aware, advocates and actively engages in transition planning. | | |
| **Family Connections to Peers and Community** | | |
| Families and Communities | | |
| 1. Family has no support network or any knowledge of community resources. | | |
| 2. Family has limited knowledge on community resources. | | |
| 3. Family knows resources available in the community and how to access. | | |
| 4. Family has dynamic support networks and is actively engaged in their community. | | |
| 5. Family is self-sufficient and is not dependent upon community resources. | | |
| **Families as Advocates and Leaders** | | |
| Leadership and Advocacy | | |
| 1. Family is not involved in any leadership/advocacy roles. | | |
| 2. Family has limited ability or barriers to participation. | | |
| 3. Family is interested in obtaining more information about leadership opportunities. | | |
| 4. Family is beginning to form leadership/advocacy partnerships with other parents and/or community groups. | | |
| 5. Family is actively serving in leadership/advocacy partnerships with other parents and/or community groups. | | |

**Assessment Notes:**

Pittsburgh Public Schools
Students first
Always, in all ways.

Pittsburgh Spring Garden
Early Childhood Center

1501 Spring Garden Avenue
Pittsburgh, PA 15202

PHONE: 412-529-4591
FAX: 412-325-6777

# Family Partnership Agreement

Child's Name: _____

Parent/Guardian Name: _____

In our efforts to better serve you and your family, we would like to establish a relationship with you. This family Goal Assessment provides the opportunity for the program to learn about and support your family in response to your interests, goals, strengths, and needs. This document will be reviewed at the beginning and end of the year in order to better assist you and work together to achieve your personal goals, as well as work on the program goals.

Please complete this as part of your child's application. Your Family Services Specialist will assist you with follow-up on these goals.

Family goals (goals you have for yourself and/or your family):

_____

_____

_____

_____

_____

What are the actions/steps that you are taking to achieve your goals?

_____

_____

_____

_____

www.pghschools.org
Parent Hotline:
412-529-HELP (4357)

Pittsburgh Public Schools

Students first
Always, in all ways.

The Family Services Specialist will assist you in achieving your goals in the following ways (to be determined with the FSS):

_____

_____

_____

_____

Progress on goals:

_____

_____

_____

_____

Notes:

_____

_____

_____

_____

Program expectations (check if you need information or support with any of these):

- ☐ At least 90% attendance
- ☐ Compliance with drop off and pick up policies
- ☐ Compliance with Early Childhood Policies and Procedures

Parent/Guardian Signature _____

Initial Date _____ Review Date _____ Final Date _____

Staff signature _____

Pittsburgh Public Schools

EARLY CHILDHOOD EDUCATION

EARLY CHILDHOOD EDUCATION PROGRAMS

www.pghschools.org/earlychildhood

earlychildhood@pghschools.org

412-529-4291

Parent Hotline:
412-529-HELP (4357)
www.pghschools.org

# Early Childhood Program
## Health Consent Form

Child's Name: _____

Date of Birth: _____

Center: _____

I, (Parent/Guardian)_____, give permission for (Child's Name)_____to receive the following health services:

**Please initial next to each service for which you are giving consent. These services will not be conducted without this authorization form:**

___ Permission for staff to provide first aid to your child and if necessary, call 911 for Emergency Medical/Dental Treatment and Transportation of your child by first responders (EMS) to a source of emergency treatment.
___ Behavioral Observation
___ Development Screening
___ Hearing Screening
___ Vision Screening
___ Height and Weight Measurement
___ Speech/Language Screening

I understand that these screenings are a requirement of the Early Childhood Performance Standards and that I will be informed of any results which indicate the need for further professional evaluation. Otherwise, a health summary will be provided within the program year. I understand that I have the right to be present during any screening or examination. I understand that I have the right to refuse to participate in any screening or examination. If I refuse these services, I must obtain the above screening or examination and provide documentation to the Early Childhood Program within 30 days of the date of refusal. Otherwise, my child will be placed on the waiting list until proof that these services were obtained is provided.

_____ _____
Parent/Guardian signature Date

_____ _____
Verifying Staff Signature Date

**Please return this form by mail, e-mail or fax to:**
Sherry LaFrance RN, CSN, Health Services Manager
Pittsburgh Public Schools, Early Childhood Program, Crescent Early Childhood Center, 8080 Bennett Street, Pittsburgh, PA 15221; Email address: slafrance1@pghschools.org Fax: (412) 325-8745

Para asistencia con este documento en español, por favor llame a la línea nueve al 412-529-6463 y seleccione la opción #1.

यो दस्तावेज सम्बन्धी सहयोगको लागि कृपया तपाइ सहज नजर (४१२) ५२१-६४६ मा फोन गरी अंक # २ छुने होला।

Kwa msaada kwa nyaraka(document) hii katika Swahili , tafadhali piga nsitari wa tisa 412-529-6463 kisha chaguwe uchaguzi la #3.

如需获得本文件的中文帮助，请拨打电话 412-529-6463 致电九号线，并选择选项 #4

حصول على المساعدة باللغة العربية ، إضغطوا على #5

Чтобы получить помощь по этому документу на русском языке, пожалуйста позвоните на Девятую Линию 412-529-6463 и нажмите #8.

Pittsburgh Public Schools

EARLY CHILDHOOD EDUCATION

EARLY CHILDHOOD EDUCATION PROGRAMS

www.pghschools.org/earlychildhood

earlychildhood@pghschools.org

412-529-4291

Parent Hotline:
412-529-HELP (4357)
www.pghschools.org

**Pittsburgh Public Schools Early Childhood Program**
**AUTHORIZATION TO RELEASE/OBTAIN INFORMATION**
*(To be completed by parent/guardian and returned to Early Childhood Health Office to forward to medical provider)*

Child's Name: _____ Date of Birth: _____

Name of Medical Provider/Doctor: _____
Address of Medical Provider/Doctor: _____

I, (Name of Parent/Guardian: _____, hereby request and authorize the medical doctor/provider to release the following information on my child compiled during the period of 06/01/2018-06/30/2024 *(Approximate date of services):*

_____ Dental Exam
**X** **Physical Exam/Immunizations**
**X** **Lead & Hemoglobin**
_____Physician Notes/Orders
_____ Medical History
_____Discharge Summary
_____Other:_____
**X** **Ongoing verbal contact between agency providers and Pittsburgh Public School Staff for the duration of the education program**

*HIV, Behavioral Health and Drug and Alcohol information contained in the parts of the records indicated will be released through this authorization unless otherwise indicated, Do Not Release.*

These records will be used for required documentation for enrollment in program. I understand the following:

- That my or my child's records will not be released or obtained by Pittsburgh Public Schools unless permission is provided for herein as evidenced by the signature on this authorization form.
- That the release of my or my child's records will be for the purpose stated on this form and only those items checked off will be released.
- That the records released by the Pittsburgh Public Schools may possibly be re-disclosed by the facility/agency/person and that the Pittsburgh Public Schools and its staff have no responsibility or liability as a result of the re-disclosure and that such information would no longer be protected by the Privacy Rule.
- That the disclosed information will no longer be protected by HIPPA or privacy act, and the releasing facility will not be responsible for the disclosure of the information.
- That this authorization is valid for one year unless documented otherwise.
- That I may revoke this authorization at any time by notifying, in writing, the party responsible for maintaining records, except for the information already disclosed.
- That the Pittsburgh Public Schools will not condition enrollment or eligibility for my or my child's educational services on whether I sign this authorization or not.
- That I am entitled to a copy of this Authorization form.

I have read this authorization and understand its contents and purpose.

Parent/Legal Guardian:_____ Date: _____

Because of the sensitive nature of this information, it will be treated with complete confidentiality. A copy of this authorization shall be considered valid.
**Dear Medical Provider:** Please forward health records by mail, e-mail or fax to:
Sherry LaFrance RN, CSN, Early Childhood Health Services Manager
Pittsburgh Public Schools, Early Childhood Program
Crescent Early Childhood Center, 8080 Bennett Street, Pittsburgh, PA 15221
Email address: slafrance1@pghschools.org Fax: (412) 325-8745

[Type here]

Para asistencia con este documento en español, por favor llame a la línea nueve al 412-529-6463 y seleccione la opción #1.

यो दस्तावेज सम्बन्धी सहयोगको निम्ती कृपया नाइन लाइन नम्बर (४१२)५२९-६४६ मा फोन गरी अंक # २ चुन्नु होला।

Kwa msaada kwa nyaraka(document) hii katika Swahili , tafadhali piga msitari wa tisa 412-529-6463 kisha chaguwe uchaguzi la #3.

=如需获得本文件的中文帮助，请拨打电话 412-529-6463 致电九号线，并选择选项 #4

حصول على المساعدة باللغة العربية ، إضغطوا على #5

Чтобы получить помощь по этому документу на русском языке, пожалуйста позвоните на Девятую Линию 412-529-6463 и нажмите #8.

Pittsburgh Public Schools

EARLY CHILDHOOD EDUCATION

EARLY CHILDHOOD EDUCATION PROGRAMS

www.pghschools.org/earlychildhood

earlychildhood@pghschools.org

412-529-4291

Parent Hotline:
412-529-HELP (4357)
www.pghschools.org

**Pittsburgh Public Schools Early Childhood Program**
**AUTHORIZATION TO RELEASE/OBTAIN INFORMATION**
*(To be completed by parent/guardian and returned to Early Childhood Health Office to forward to medical provider)*

Child's Name: _____ Date of Birth: _____

Name of Medical Provider/Doctor: _____
Address of Medical Provider/Doctor: _____

I, (Name of Parent/Guardian: _____, hereby request and authorize the medical doctor/provider to release the following information on my child compiled during the period of 06/01/2018-06/30/2024 *(Approximate date of services):*

__X__ **Dental Exam**
_____ Physical Exam/Immunizations
_____ Lead & Hemoglobin
_____ Physician Notes/Orders
_____ Medical History
_____ Discharge Summary
_____ Other: _____
__X__ **Ongoing verbal contact between agency providers and Pittsburgh Public School Staff for the duration of the education program**

*HIV, Behavioral Health and Drug and Alcohol information contained in the parts of the records indicated will be released through this authorization unless otherwise indicated, Do Not Release.*

These records will be used for required documentation for enrollment in program. I understand the following:

- That my or my child's records will not be released or obtained by Pittsburgh Public Schools unless permission is provided for herein as evidenced by the signature on this authorization form.
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