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PreK Enrollment Application

We are glad you are considering sending your child(ren) to Belmont Academy or Belmont Charter School. To begin the school year, your child must be at least 3 years old prior to September 1st. When registering your child(ren) at Belmont Academy Charter School, priority is given to those students who reside within the Belmont Catchment area (as defined by PSD). When registering students at for kindergarten-8th grade, students must reside in the Belmont Catchment Area (as defined by PSD). Once you have provided your enrollment packet and documents to the school, your child(ren) is placed on the waiting list. Completed enrollment does not guarantee your child a spot for the 2020-2021 school year. See Head Start information on the reverse side of this form.

Student Name:

- ☐ Complete Enrollment Packet
- ☐ Proof of Residency (Any two (2) of the following are acceptable): deed, lease, mortgage agreement, notarized Residency Agreement, current utility bill, current credit card bill, property tax bill, vehicle registration, driver's license, and DOT identification card
- ☐ Proof of Age (Any one (1) of the following is acceptable: birth certificate, passport, court document
- ☐ Child's health insurance card
- ☐ Recent proof of income (pay stub, TANF cash, SSI, etc)
- ☐ Child's immunization record
- ☐ Child's recent physical assessment (within 1 year)
- ☐ Child's recent (within 6 months) dental examination record

School Contact Information

BACS Address: 907 N. 41st St., Philadelphia, PA 19104

Phone Number: 215.386.5768

Email: bacs@belmontcharternetwork.org

CEAWP/Belmont Head Start Information:

1. Head Start is a FREE Prekindergarten program for children 3-5 years old. Breakfast, lunch and snack are provided daily.
2. Enrollment spots are determined on the guidelines below:
    a. Students must be income eligible to be considered for a spot. See guidelines below.
    b. Students must have a complete enrollment file to be considered for a spot. This packet must be completed fully (all information filled in).
    c. Students are given a spot based on income and need (as determined based on the information you complete in this packet).
3. Enrollment in a Head Start program requires that
    a. Students must attend daily
    b. Students are brought to school and picked up on time by an adult (18 years or older).

# OF PERSONS IN FAMILY/HOUSEHOLD*	POVERTY GUIDELINE
1	$12,760
2	$17,240
3	$21,720
4	$26,200
5	$30,680
6	$35,160
7	$39,640
8	$44,120

For families/households with more than 8 persons, add $4,480 for each additional person.

- Acceptable income documents include: Pay stub
- Child Support
- W2
- 2019 Federal Income Tax Return
- Social security income letter/SSI
- Unemployment verification
- TANF Cash Assistance
- Letter from employer
- Foster care letter from agency

Translated versions for a Head Start application can be found at:
https://www.philasd.org/earlychildhood/programs-and-services/pre-kindergarten/
The main office can also email a translated copy at your request.

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Application for Preschool

Child's Information:

Name:	**Date of Birth:**	**Gender:** O Male O Femal
Address:		

Language:
What is the child's primary language at home? _____

Does the child speak a language other than English? O Yes O No

If Yes:

- What language? _____
- Does your child understand English? O Yes O Some O None

Do you need forms sent home in a language other than English?
O Yes O No If yes, what language? _____

Race/Ethnicity: *select all that apply*

O Black or African American	O Multi-Racial/ Bi-Racial	O White
O Hispanic or Latino/a	O Native Hawaiian	O Asian
O American Indian	O Pacific Islander	O Other (specify):

Parent/Guardian 1 Information:

Name:	Relationship to student:	Phone Number(s):
Address:	Email:	

Parent/Guardian 1 Information:

Name:	Relationship to student:	Phone Number(s):
Address:	Email:	

Child's Health Care Information:

Name of Doctor/Health Center/Clinic:	Phone Number	
Name of Dentist/Dental Clinic	Type of Health Insurance (circle all that apply) Medical Assistance CHIP Private Other	

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Emergency Contact and Escort Information

Student Name: _____

PreK students must be escorted to and from school by an adult (at least 18 years old). Parent/guardians must list two additional adults who can serve as an emergency contact for their child.

List individuals below who we cannot contact when the parent/guardian cannot be reached. These individuals are considered emergency contacts and must be willing to communicate with the school about the above student, act as an emergency contact, and be able and willing to pick the above student up from school due to emergency or illness. For the following individuals, you are giving them permission to pick up your children. Please list all phone numbers in order of calling preference. Anyone picking your child up from school may be requested to show photo id.

Name: _____ **Relationship to Student**: _____

Phone Number 1: _____ Circle One: Cell Home Work

Phone Number 2: _____ Circle One: Cell Home Work

Name: _____ **Relationship to Student**: _____

Phone Number 1: _____ Circle One: Cell Home Work

Phone Number 2: _____ Circle One: Cell Home Work

Name: _____ **Relationship to Student**: _____

Phone Number 1: _____ Circle One: Cell Home Work

Phone Number 2: _____ Circle One: Cell Home Work

Name: _____ **Relationship to Student**: _____

Phone Number 1: _____ Circle One: Cell Home Work

Phone Number 2: _____ Circle One: Cell Home Work

My signature below indicates that I understand the emergency contact and escort policy as listed above.

Parent/Guardian Signature: _____ Date: _____

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19130-4015

#4: POLICIES and CONSENT for EMERGENCY MEDICAL CARE and OTHER HEALTH SERVICES FORM

This form will be taken with your child when emergency medical care is needed.

Child's Name _____ Date of Birth _____

EMERGENCY MEDICAL CARE POLICIES

Parents, you are responsible for making arrangements for alternate care for your child if s/he is ill, needs close supervision or has a contagious condition and cannot attend preschool. You are also responsible for transportation if your child has an illness or minor injury while at preschool, not sufficiently severe to warrant emergency medical transportation.

In the event your child becomes seriously ill or injured and requires immediate medical attention, s/he will be accompanied by staff and taken to the nearest hospital emergency room in an emergency medical vehicle. We will attempt to notify you at once. Under the Medical Services/Minor Act, immediate emergency treatment will be initiated at the hospital. However, it is essential that your child's teacher and the hospital is able to locate you as soon as possible, to give either written or monitored verbal permission for comprehensive treatment. Please be sure to keep your child's teacher informed about how to reach you at all times.

You are responsible for the costs of medical treatment if your child is injured. Please contact Early Childhood Health Services if your child needs medical insurance.

A Doctor's note is required before your child can return to preschool if s/he has any of the following: an emergency room visit, certain cases of illness (contagious, serious, requires a long absence, surgery, etc.), or certain cases of injury (needing doctor's care, cast or brace, special activities, etc.). If you have any doubt, please obtain a Doctor's note whenever your child goes for medical care.

CONSENT for EMERGENCY MEDICAL CARE, PREVENTIVE SCREENINGS and OTHER HEALTH SERVICES

My signature below indicates that I understand the Emergency Medical Care Policies and give consent for:

1. The administration of minor first aid to my child by preschool classroom staff;
2. The emergency medical and/or dental care which may be necessary to preserve the life of my child or to prevent impairment of his/her health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for on-going care;
3. My child to participate in the Office of Early Childhood Education's screening program which may include, but is not limited to: developmental screening, behavioral screening, vision screening, hearing screening and dental screening. I understand that as part of the preventative health program, children participating in preschool programs of The School District of Philadelphia receive screenings during the school year;
4. The School District of Philadelphia's Office of Early Childhood Education Program Mental Health Consultation Services to provide services on an as needed basis. These services may include:
    a. Observation of my/our child in the preschool setting and consult with teaching staff regarding strategies and techniques to support my/our child's healthy social/emotional development;
    b. Conduct assessments and behavioral/developmental screenings, using standardized tools, across all domains of my/our child's development;
    c. Provide behavioral health consultation services to my/our child and his/her teacher within the early childhood facility;
    d. My/Our invitation to participate in team meetings and action plan development for my/our child's social/emotional well-being, where I/we will be provided with information about child-related issues and resources within my/our community that could be helpful.

If you have any questions about the above information, please speak with a representative from Early Childhood Health Services.

_____ _____
Signature of Parent/Guardian Date

Early Childhood Use Only

Name of Location: _____

Signature of Early Childhood Staff: _____ Date: _____

Form #5: *CHILD'S NUTRITION HISTORY*

Child's Name _____ Date of Birth _____

1. What foods does your child like? _____
2. What foods does your child dislike? _____
3. Place a check mark in the **No** or **Yes** column next to each question:

	No	Yes
Does your child take vitamins?		
Do the vitamins contain iron?		
Do the vitamins contain fluoride?		
Are the vitamins prescribed by a doctor?		
Is your child on a special diet?		
Is the diet recommended by a doctor?		
Has there been a noticeable change in your child's appetite in the last month?		
Does your child drink from a bottle?		
Does your child eat or chew things that aren't food? (example: dirt, clay, paint chips, crayons)		
Does your child have trouble chewing or swallowing?		
Does your child often have diarrhea?		
Does your child often have constipation?		
Do you have any concerns about what your child eats?		
Do you receive WIC?		
Do you receive Food Stamps?		

4. Place a check mark under the column that indicates the approximate number of times a week your child eats each food item:

	0	1	2	3	4	5	6	7	7+
Milk ~ whole, skim, low fat, lactose free									
Cheese, yogurt									
Eggs									
Peanut butter									
Beans, peas, soy, tofu, lentils									
Nuts, seeds									
Beef, chicken, turkey									
Fish, shellfish									
Rice, noodles, bread, tortillas, crackers, cereal									
Green vegetables, spinach, collard greens									
Winter squash, pumpkin, sweet potatoes, carrots									
Oranges, grapefruit, tomatoes, broccoli, fruit juice									
Other fruits and vegetables									
Oil, butter, margarine, jams, jellies, olive oil									
Cakes, cookies, sodas, fruit drinks, candy									

Child's Name: _____ Date of Birth: _____

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Health History

	Yes	No	Comments/Explanation
Does the child currently have active medical insurance?			
Does the family have active medical insurance?			
Prenatal History			
Did you receive prenatal care while you were pregnant?			
Were there any complications for you or your child during your pregnancy, delivery or after delivery?			
Were you using any substances while pregnant? (cigarettes, alcohol, drugs, prescription medication)			
Did either of you have to stay in the hospital longer than usual after birth?			
Was your child born more than three weeks early?			

Where was the child born? _____ Birth Weight: _____

Child's Health History	Yes	No	Comments/Explanation
Overnight hospitalization			
Emergency room visit			
Serious accident			
Surgery			Type of surgery: Date of surgery: Hospital: Problems or complications?
Seizures			
Any concerns with his/her eyes (wears glasses, crossed eyes, other)			
Any concerns with his/her ears/hearing (history of ear infections, tubes in ears, hearing loss, other)			
Asthma or bronchitis			
Heart conditions (heart murmur, other)			
Blood conditions (G6PD, high lead, sickle cell, anemia, other)			
Hernia (umbilical or inguinal hernia)			
Urinary tract infection, kidney infection			
Digestive concerns (acid reflux, stomach pain, diarrhea, constipation)			
Eczema, hives, rashes, boils			
Muscle conditions			
Allergies (seasonal, food, medication, other)			
Any other health conditions?			
Take medication daily or as needed			
Family Health History	Yes	No	Comments/Explanation
Any physical or mental health concerns in the family?			

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PreK Home Language Survey

Name: _____

Date: _____

Child's Birthdate: _____

1. What is/was the student's first language? _____

2. Does the student speak a language(s) other than English?

☐ YES ☐ NO

If YES, specify the language(s): _____

3. What languages is/are spoken in your home? _____

4. Can school documents be sent home in English? ☐ YES ☐ NO

5. Has the student attended any United States school during his/her lifetime?

☐ YES ☐ NO

If YES, complete the following:

Name of School	**State**	**Dates Attended**
_____	_____	_____
_____	_____	_____

Person completing this form (if other than parent/guardian): _____

Parent/Guardian Signature: _____ **Date:** _____

Child's Name: _____ Date of Birth: _____

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Family Information

Child's Name:	**Date of Birth:**
Mother's (or Primary Guardian) Information	
Name:	Phone Number:
Address:	Highest education completed:
Employment Status: ☐ Full-time ☐ Part-time *-Employer's Info:*	☐ In Training or School *-Name of School/Program:* *-Certificate/Degree:* *-Length of Program:*	☐ Unemployed ☐ Retired ☐ Disabled ☐ Stay at home parent ☐ Active Military or Veteran
Father's (or Secondary Guardian) Information	
Name:	Phone Number:
Address:	Highest education completed:
Employment Status: ☐ Full-time ☐ Part-time *-Employer's Info:*	☐ In Training or School *-Name of School/Program:* *-Certificate/Degree:* *-Length of Program:*	☐ Unemployed ☐ Retired ☐ Disabled ☐ Stay at home parent ☐ Active Military or Veteran
Is the child's mother or father currently incarcerated?	
Is the child's mother or father deceased?	
Is there an active custody order/arrangement for this child? ☐ yes ☐ no (if yes, please provide a copy)	
Who is raising the child? Has this changed over the child's life? (If yes, why?)	
Have there been any major changes in the family?	
Housing Status	
Has your family moved in the two years? ☐ yes ☐ no Were you displaced from your home? ☐ yes (explain below) ☐ no	
Is your family currently homeless? ☐ yes ☐ no If yes, circle one: doubled up (staying with friends/family) shelter transitional	
Has your family ever been homeless? ☐ yes ☐ no If yes, did your family move from temporary/transitional housing to permanent housing in the last 12 months? ☐ yes ☐ no	
Are you currently looking for other housing or worried about losing housing? ☐ yes ☐ no	

Child's Name: _____ Date of Birth: _____

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Who lives in the child's home?	
Adults	
Name:	Relationship to student:

Other Children (name, relationship to student)	Birthdate	Other Children (name, relationship to student)	Birthdate

Income			
Check your source of income below. *Income document must be provided to match.*			
O Employment	O Self-Employment	O Unemployment Compensation	O Worker's Compensation
O Social Security	O SSI	O Child Support	O Alimony
O Military/ Veteran's Benefits	O Commission	O Foster Care/Kinship Care	O Tips
O Pension/Retirement	O Strike Benefits	O Scholarship/Grant/Stipend	O Other (specify):
O Financial support from Family or Friend		O Rental Properties – someone pays you rent	
How often are you paid? ☐ weekly ☐ biweekly ☐ monthly ☐ annually ☐ other:			

Benefits/Services

Does your family receive any benefits?

☐ Medical assistance ☐ Food stamps ☐ Cash assistance (TANF) TANF #: _____

☐ SSI

Is your family currently receiving services?

☐ CCIS ☐ DHS ☐ Behavioral Health/Mental Health ☐ Other:

Agency & Contact Person:

Services Received:

Child's Name: _____ Date of Birth: _____

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Social Development History

Behavior/Social

Describe your child in a few words.

What does your child like to do? (Interests, talents, hobbies)

How does your child get along with other children?

How does your child get along with adults?

How is your child's behavior at home?

If your child is upset, what do you do to help him/her?

Do you have any concerns about your child's behavior? Please explain if yes.

Sleep Routines

What time does your child go to sleep at night? _____ wake up in the morning? _____

How does your child sleep?

Does your child take a nap? If yes, for how long?

Development

Developmental Stages: How old was your child when he/she...

Crawl		First word		Potty Trained	
Walk		Putting words together		Understand what is said/follow directions	

Is your child able to use his/her words to tell you what she wants/needs? ☐ yes ☐ no

Do you have any difficulty understanding the words he/she does say? ☐ yes ☐ no

Potty Training

Is your child fully potty trained*? ☐ yes ☐ no

**fully potty trained means child does not wear pull ups or diapers and does not need any assistance from an adult when going to the bathroom*

Does your child wear pull ups/diapers (check all that apply)? ☐ daytime ☐ naptime ☐ nighttime ☐ other:_____

Child's Name: _____ Date of Birth: _____

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Special Education/Early Intervention

Has your child every received and/or been evaluated for early intervention services (Elywn, Childlink)? ☐ yes ☐ no

Does your child have an IEP currently? ☐ yes (please provide a copy) ☐ no

If yes:

- Service coordinator's name (if known): _____
- What services does your child receive? (check all that apply)

☐ Speech Therapy ☐ Special Instruction ☐ Physical Therapy ☐ Occupational Therapy ☐ Behavior

☐ Other:

School/Daycare

Has your child ever attended school or daycare? ☐ yes ☐ no

Where and when?

Did your child like school/daycare? If not, do you know why?

Did the school have any concerns about your child? (learning, behavior, social)

Do you have any concerns about your child starting school at Belmont?

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Child's Name: _____ Parent/Guardian's Name: _____

Family Interest Survey

*Check any and all that interest you (help us plan future meetings)

- ☐ How to Help My Child At Home
  - ☐ With math
  - ☐ With literacy
  - ☐ With writing
- ☐ Play Group (how children learn through play)
- ☐ Healthy Eating
- ☐ Age appropriate behaviors (What is normal?) (How should I respond?)
- ☐ How to help my child build social skills
- ☐ Financial Workshops:
  - ☐ Budgeting
  - ☐ How to Save/Setting Up a Savings Account
  - ☐ Planning for the future
- ☐ I'm concerned about my child's progress. What should I do?
- ☐ Does my child have a disability? How do I know? How do I help?
- ☐ Speech & Language in Young Children: What's Normal? What's a Concern?
- ☐ What is special education?
- ☐ Other Ideas:_____

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET
PHILADELPHIA, PA 19130-4015

#9: 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).

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:

THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF EARLY CHILDHOOD EDUCATION
440 N. BROAD STREET
PHILADELPHIA, PA 19130-4015

#10: 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
- 1430 Snyder Ave., 19145 — 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.