In order for your child's application to be considered for Head Start, we must have the following items attached to the application…

- ✓ Income Verification (income tax, W-2, child support, income for ***all*** employment in last 12 months)
- ✓ Proof of Birth (birth certificate, hospital record, baptismal record, proof of guardianship-if applicable)
- ✓ Proof of Residency (utility bill – electric, gas) –needs to be in child file

We also would like:

- ✓ Medicaid, CHIPS or Private Insurance Verification
- ✓ Immunization Records

Intake Form 1

Eligible Child Demographic Form

SECTION I: BASIC DEMOGRAPHIC DATA

1. Eligible child's name: ________________ ________________ ________________
(First) (Middle) (Last)

2. Nickname: ___________ 3. Date of birth: ___/____/___ 4. Gender: ☐ Male ☐ Female

5. Race (check those that apply):

☐ American Indian/Alaskan Native ☐ White ☐ Asian
☐ Black or African American
☐ Native Hawaiian/Other Pacific Islander
☐ Other Specify: _____________

6. Ethnicity: ______________________
☐ Person's ethnicity is Latino or Hispanic

7. Language spoken at home:
Primary: ☐English ☐Other ______________

8. How well does the child speak English?
☐Very Well ☐Well ☐Not Well ☐Not at all
☐Infant/Toddler

SECTION II: RELATIONSHIPS

9. Other Children in Household	Relationship to Eligible Child	Date of Birth
____________________	_____________________	_____/_____/______
____________________	_____________________	_____/_____/______
____________________	_____________________	_____/_____/______
____________________	_____________________	_ ___/_____ /_____
____________________	_____________________	_____/_____/______

SECTION III: CHILD INFORMATION

10. Child to be cared for by someone other than the head of household in addition to Head Start (check all that apply): ☐Relative ☐Childcare center
☐Older sibling under age 12 ☐Adult non relative in non-relative's home ☐Other: Specify _________________
☐Older sibling age 12 or older ☐Adult non relative in child's own home ☐Not yet arranged

SECTION IV: ADDRESSES

11. Address (1) Street: ____
City: __________________ State: _____ Zip: _________ Effective Date: ____/____/____
(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other
Home Phone #1: ____________________ Home Phone # 2: ________________________

12. Address (2) Street: ____
City: __________________ State: _____ Zip: _________ Effective Date: ___/____/_____
(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other
Home Phone #1: ____________________ Home Phone # 2: ________________________

13. Child previously enrolled in Head Start: ☐yes ☐no
Program _____________________ Dates _____________

Intake Form 2
Family Member Demographics (Mother/Mother Figure)

SECTION I: BASIC DEMOGRAPHIC DATA

1. Person's role in household: ☐ Household Member ☐ Resides outside of home

2. Mother/Mother Figure's name: ________________ (First) ________________ (Middle) ________________ (Last)

3. Nickname: ___________ 4. Date of birth: ___/___/____ 5. Gender: ☐ Male ☐ Female

6. Race (check those that apply):

☐ American Indian/Alaskan Native ☐ White ☐ Asian
☐Black or African American ☐ Native Hawaiian/Other Pacific Islander
☐ Other Specify: _____________

7. Ethnicity: ______________________
☐ Person's ethnicity is Latino or Hispanic

8. Language spoken at home:
Primary: ☐English ☐Other ______________

9. How well does the mother speak English?
☐Very Well ☐Well ☐Not Well ☐Not at all

10. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

11. Email address: ____________________________________

CELL PHONE:______________________ Can we send you text information?:_Yes or No___
(Name of Mobile provider:_____________) *Please provide provider name so you can receive text messages.*

SECTION II: RELATIONSHIPS

12. Adults in Household (not guardians)	Relationship to Eligible Child	Date of Birth
________________________	____________________	_____/_____/______
________________________	____________________	_____/_____/______
________________________	____________________	_____/_____/______
________________________	____________________	_____/_____/______

SECTION III: ADULT INFORMATION

13. Applicant currently pregnant? ☐Yes ☐No 14. Due Date: _______________

15. Prenatal Care Provider: _________________________________

16. Teen parent questions:

Person is a teen mother	☐Yes	☐No	☐N/A
Attended Parent Program in School	☐Yes	☐No	☐N/A
Enrolled in Teen Parent Program	☐Yes	☐No	☐N/A
Teen Mother Dropped out of School	☐Yes	☐No	☐N/A

Reason:

17. Adult training questions:
Attended Vocational Training, Training or Business School: ☐Yes ☐No ☐N/A
Received certificate or license: ☐Yes ☐No ☐N/A
Participated in Government Training Program: ☐Yes ☐No ☐N/A
Training program(s) attended (check all that apply):
☐JOBS ☐JTPA ☐Job Corps ☐Other: Specify _____________
Willing to Pursue Additional Education/Job Training:
☐Yes ☐No ☐N/A

Front & Back

SECTION IV: ADDRESSES (Mother/Mother figure)

18. Address (1) Street: ____

City: __________________ State: _____ Zip: _________ Effective Date: _________

(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other ☐Same as child

Home Phone #1: ___________________ Home Phone # 2: _______________________

SECTION V: OCCUPATION

19. Person's primary occupational status (check all that apply): Currently employed: ☐ Yes or ☐ No

Paying job:

☐Full-time (more than 34 hrs per week)

☐Part-time

☐Seasonal- Non-agricultural

☐Seasonal- Agricultural

☐Employed and in school

In school: Start Date:_____/_____/___

☐Towards high school diploma/GED

☐Towards trade/business qualification

☐Towards college degree

☐Towards postgraduate degree

☐In school and employed

In job training program:

☐Training program with salary

☐Training program without salary

Unemployed: Date:_____/_____/____

☐With past employment experience

Time since last job: ____ months

☐With no previous employment experience

Other:

☐Homemaker ☐Retired

☐Unable to work due to disability ☐Not applicable

SECTION VI: EDUCATION

20. Highest level of education completed (check only one): Completion Date: _____/_____/______

☐No school completed	☐11th grade	☐Associate degree in college
☐Less than or equal to 4th grade	☐12th grade (no diploma)	☐Bachelor's degree
☐5th-8th grade	☐High School graduate/GED	☐Master's degree
☐9th grade	☐Some college (but no degree)	☐Doctorate degree
☐10th grade		

Was parent previously enrolled in Head Start? ☐yes ☐no

If yes, name of program: ______________________ Year _____________

Front & Back
Intake Form 3
Family Member Demographics (Father/Father Figure)

SECTION I: BASIC DEMOGRAPHIC DATA

1. Person's role in household: ☐ Household Member ☐ Resides outside of home

2. Father/Father Figure's name: ________________ (First) ________________ (Middle) ________________ (Last)

3. Nickname: ___________ 4. Date of birth: ____/___/___ 5. Gender: ☐ Male ☐ Female

6. Race (check those that apply):

☐ American Indian/Alaskan Native ☐ White ☐ Asian
☐Black or African American
☐ Native Hawaiian/Other Pacific Islander
☐ Other Specify: _______________

7. Ethnicity: _______________________
☐ Person's ethnicity is Latino or Hispanic

8. Language spoken at home:
Primary: ☐English ☐Other _______________

9. How well does the father speak English?
☐Very Well ☐Well ☐Not Well ☐Not at all

10. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

11. Email address: ____________________________________

CELL PHONE:______________________ Can we send you text information?:_Yes or No___
(Name of Mobile provider:______________) *Please provide provider name so you can receive text messages*

SECTION II: RELATIONSHIPS

12. Adults in Household (not guardians)	Relationship to Eligible Child	Date of Birth
		____/___/_______
		____/___/_______
		____/___/_______
		____/___/_______

SECTION III: ADULT INFORMATION

13. Teen parent question: Person is a teen father ☐Yes ☐No ☐N/A

14. Adult training questions:
Attended Vocational Training, Training or
Business School: ☐Yes ☐No ☐N/A
Received certificate or license: ☐Yes ☐No ☐N/A
Participated in Government Training Program:
☐Yes ☐No ☐N/A
Training program(s) attended (check all that apply):
☐JOBS ☐JTPA ☐Job Corps ☐Other:
Specify _____________
Willing to Pursue Additional Education/Job Training:
☐Yes ☐No ☐N/A

Front & Back
SECTION IV: ADDRESSES (Father/Father figure)

14. Address (1) Street: ____

City: __________________ State: _____ Zip: _________ Effective Date: _________

(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other ☐Same as child

Home Phone #1: ___________________ Home Phone # 2: _______________________

SECTION V: OCCUPATION

15. Person's primary occupational status (check all that apply): Currently employed: ☐ Yes or ☐ No

Paying job:

☐Full-time (more than 34 hrs per week)

☐Part-time

☐Seasonal- Non-agricultural

☐Seasonal- Agricultural

☐Employed and in school

In school: Start Date:_____/____/______

☐Towards high school diploma/GED

☐Towards trade/business qualification

☐Towards college degree

☐Towards postgraduate degree

☐In school and employed

In job training program:

☐Training program with salary

☐Training program without salary

Unemployed: Date:_____/_____/____

☐With past employment experience

Time since last job: ____ months

☐With no previous employment experience

Other:

☐Homemaker ☐Retired

☐Unable to work due to disability ☐Not applicable

SECTION VI: EDUCATION

16. Highest level of education completed (check only one): Completion Date: ____/_____/_____

No school completed

☐Less than or equal to 4th grade

☐5th-8th grade

☐9th grade

☐10th grade

☐11th grade

☐12th grade (no diploma)

☐High School graduate/GED

☐Some college (but no degree)

☐Associate degree in college

☐Bachelor's degree

☐Master's degree

☐Doctorate degree

Was parent previously enrolled in Head Start? ☐yes ☐no

If yes, name of program: ________________________ Year _____________

Front & Back
Intake Form 4
Family Information

Head of Household for this family: ________________________________ Date of Application: ____/_____/____

FAMILY INFORMATION

1. **Parent type** (check only one):

☐Two Parent family
☐Single Parent family (mother figure only)
☐Single Parent family (father figure only)
☐Single parent family (mother figure only) living w/partner
☐Single parent family (father figure only) living w/partner

Family Type (check only one)

☐ Biological
☐Foster
☐Other family (Please specify:______________)
☐Other relative (Please specify:_____________)

2. **Parent Status**

☐Single parent, not working or student
☐Single parent, working or student
☐Two parents, both working or students
☐Two parents, neither working or students
☐Two parents, one working or student

3. **Type of housing** (check only one):

☐House ☐Mobile home/trailer ☐Hotel/motel room ☐Rent to own
☐Apartment ☐Community shelter ☐Homeless/no housing ☐Other: __________________

4. **Housing payment arrangement** (check only one):

☐Exchange services for housing ☐Rent housing ☐Received subsidized housing
☐Make no payment for housing ☐Own housing ☐Other: Specify __________________

5. **Length of time at current address**:

☐ less than 6 months ☐ 6-12 months ☐ 1-2 years ☐ more than 2 years

6. Number of moves in the past 12 months? _____

7. **Homeless** in past 12 months (including current homelessness): ☐yes ☐no

7a. Length of time homeless: ☐ Less than 1 month ☐ 1-3 months ☐ 3-6 months ☐More than 6 months

7b. Family acquired housing during enrollment year: ☐ yes ☐ no

Student Residency Questionnaire

Where is the student presently living? (Check One)
___In his/her own house or apartment (Parent or Guardian listed on the lease or mortgage)
___In home of relatives or friends (Parent or Guardian is not listed on the lease or mortgage)
___In a motel, hotel, RV trailer or campground due to lack of other accommodations
___Unsheltered (or moving from place to place)
___In a shelter or transitional living facility

Is the current living situation temporary due to loss of housing or economic hardship? YES or NO
Is the child living with a non-custodial relative due to the incarceration of his/her custodial parent? YES or NO

8. Family currently has *primary* means of transportation: ☐ yes ☐ no
Indicate *primary* means of transportation by checking the box(es) that apply.

☐ Private Vehicle (car, truck, van) ☐ Friend/Relative's vehicle ☐ School Bus

☐ Public Transportation ☐ City Bus ☐ Other ☐ Taxi ☐ Parent Transport

9. Family has *alternate* means of transportation: ☐ yes ☐ no
Indicate *alternate* means of transportation by checking the box(es) that apply.

☐ Private Vehicle (car, truck, van) ☐ Friend/Relative's vehicle ☐ School Bus

☐ Public Transportation ☐ City Bus ☐ Other ☐ Taxi ☐ Parent Transport

Region XIV Head Start program does not own or operate school buses, nor provide transportation. If you would like to request assistance in locating community resources for transportation, please indicate below.

_____ Yes, I would like assistance.

_____ No, I do not need assistance.

10. Family referred from: ________________________________

TYPES OF SERVICES OR FINANCIAL ASSISTANCE CURRENTLY RECEIVING

☐No services received ☐Public Assistance/Welfare (e.g.TANF) ☐Food Stamps

☐Child Support/alimony ☐Public Housing Assistance ☐Foster care/adoption

☐Energy program assistance ☐Supplemental Security Income (SSI) ☐WIC

☐EPSDT ☐Unemployment Insurance

☐Medical financial assistance (e.g. Medicaid/Medicare, CHIP)

☐Parent Incarcerated ☐Family in need of assistance ☐Previously Enrolled

☐Migrant/Language ☐Teen Parent ☐Homeless

☐Disability ☐Referral from another agency – documented (not an IEP)

☐Other: Specify _______________

Intake Form 5
Certification/Signature Page

PARENT

I certify that information provided is correct to the best of my knowledge and is subject to verification. I am also aware that I may be subject to termination from the program if the information verified disqualifies me from eligibility.

______________________________ ______________________________
Applicant Signature/Firma del Aplicante: **Print Name of Applicant/Nombre (Use letra imprenta)**

Date/Fecha: ______________________________

Parents Do Not Write Below This Line

STAFF

Eligibility Determination Statement I hereby do certify that the family is eligible to participate in the Early Head Start/Head Start Program. Furthermore, I attest that the application/enrollment packet is complete and I have examined the documents (checked) below and certify that the family is eligible in accordance with Head Start regulations and Eligibility-Recruitment-Selection-Enrollment-Attendance policies.

Documents Reviewed (check all that apply):

☐INDIVIDUAL TAX FORM ☐W-2 ☐ CHILD SUPPORT PAYMENTS

☐PAY STUBS/PAY ENVELOPES ☐UNEMPLOYMENT ☐ SOCIAL SECURITY PAYMENTS

☐WRITTEN EMPLOYER STATEMENTS ☐CURRENT PUBLIC ASSISTANCE RECEIPTS (TANF)

☐WORK HISTORY- VERIFICATION OF EMPLOYMENT ☐ SUPPLEMENTAL SECURITY INCOME

☐WRITTEN VERIFICATION OF VERBAL DECLARATION OF INCOME

☐OTHER: ______________________________

AGENCY SIGNATURES

Interviewed/Assisted By: ______________________________ Date: ______/_______/_______

Staff Eligibility Certification Signature: ______________________________

Certification Date: ______________________________

Print Name of Certifying Staff Member: ______________________________

CHILD ACCEPTANCE DATE: _____/_____/_______ (by Region 14 Head Start)

CHILD ENROLLMENT/ ENTRY/ DATE (first day of service):_____/_____/_____

HEALTH HISTORY Form 6

NAME: ___________________________________ Date__________________________________

Insurance: CHIPS, Medicaid, Private, None Policy Number: _____________ Effective Date_________________

Does your insurance include dental coverage? _____________

Doctor:____________________ ____ **Dentist________________________**

Phone____________________ **Phone__________________**

Date of last physical_______________ **Date of last dental exam______________**

Prenatal History:

How far along in pregnancy were you when you went to the doctor? _____________Never went to doctor____

Were there any complications in pregnancy? Y N (Explain if yes)______________________________________

Any prenatal exposure to drug, alcohol, caffeine or tobacco? Y N (Explain if yes)_________________________

Delivered at Hospital__Birthing Center___Home___Other___Don't know___

Type of Delivery: Vaginal___C-Section___Don't know___

How long were you and baby in hospital? Mother___Baby___ Reason for any extended stay________________

Birth Weight_______

Any Birth Defects____

Concerning your child:

How many hours does your child sleep at night? _____ Does your child nap? ____ When?__________How Long?______

How does your child tell you he/she needs to go to the restroom?____

Does your child need help in the restroom? Y N

Since birth has your child been in the hospital or had surgery? Y N (If yes explain when and why)__________________

____

Does your child have any **chronic** conditions? Y N(Asthma, heart disease, diabetes, sickle cell anemia, skin disorders, seizures, constipation, diarrhea)____

Does your child have a developmental delay or diagnosed disability with IEP(HS) IFSP(EHS)? Y N (if yes explain)

____

Has your child had any preventable communicable diseases? Y N(measles, mumps, chickenpox)__________________

Has your child been diagnosed with a muscle, bone or joint problem? Y N_______________________________________

Has your child had any vision or hearing problems? Y N ____

Does your child have a diagnosed emotional problem?_Y N____

Date of last blood test for **Lead**______________________

Comments related to above conditions:____

Please list **allergies**:
(foods, medication animals, fur, dust, insects)

____

____

Please list **Medication:**

____

____

Does your child use any **assistive devices**?
(crutches, wheelchair, cane, walker, braces,
hearing aide, other):

List any **restrictions** in activity?

____

____

Is there any other health information that the school needs to know? ____

Update: Changes noted in RED INK

Date:__________________Any Changes__________________________Staff Signature_________________________

Date:__________________Any Changes__________________________Staff Signature_________________________

Date:__________________Any Changes__________________________Staff Signature_________________________

Intake Form 7
Head Start – CHILD NUTRITIONAL ASSESSMENT

Child's Name ____ Date of Birth: _____/______/______

Number of meals eaten per day _________ Number of snacks per day ___________

Favorite: Food______________________ Vegetable _________________ Fruit_____________________

Dislikes_____________________________ **Drinks with meals**:_____________________________________

Food Allergies Y N (List foods)____

Does your child take vitamins/fluoride/minerals? **Y N** Brand______________________________

Did your child experience any significant delays eating solids, drinking from a cup or feeding self? **Y N**

Does your child have trouble chewing or swallowing? **Y N**

Does your child take a bottle? **Y N**

Is child on a special diet? **Y N** Explain____

List foods your child does not eat for **medical, religious, or personal reasons**__________________________

Does your child eat dirt, paper, paint chips or other non-food items? **Y N** Explain_________________________

Any other nutritional
information____

Annual Update:

1. Any dietary changes____ WIC Y/N

Parent Signature____________________________ Staff Signature______________________Date_________

2. Any dietary changes____ WIC Y/N

Parent Signature____________________________ Staff Signature______________________Date_________

3. Any dietary changes____ WIC Y/N

Parent Signature____________________________ Staff Signature______________________Date_________

Note: Head Start requires a written physician statement in order to provide a special diet for any child with allergies.
All food is provided by Head Start. No foods are to be brought in by parents.
Head Start encourages good nutrition which limits high fat, high sugar and high salt foods.

For Head Start Use Only
Follow-up Needed ____ **yes** ____ **no Referred to:** _______________________________ Date __________
(Please complete referral for services and document in contact log.)

Intake Form 7
Early Head Start – CHILD NUTRITIONAL ASSESSMENT

Child's Name ____ **Date**: _______________

Infants: Is your infant currently:

breast fed? **Y N** How often does he/she nurse?____ How long does he/she nurse?___
bottle fed? **Y N** Formula Type_________________ Amt. at each feeding__________ How often? _____
Foods other than formula and amount: ____
Food Allergies **Y N** ___________________Does your infant take vitamins/fluoride/minerals? **Y N** ________
List any foods your child should not eat due to **medical, religious, or personal reasons**_______________

Toddlers:
Number of meals eaten per day _____ Number of snacks per day ________Food Allergies_______________
Favorite**:** Food _______________Vegetable _______________Fruit _______________ Dislikes___________
Drinks with meals:___________________ Does your child take vitamins/mineral? **Y N** Brand_________________
Did your child experience any significant delays eating solids, drinking from a cup or feeding self? **Y N**
Does your child have trouble chewing or swallowing? Y **N** Does your child take a bottle? **Y N**
Is child on a special diet? **Y N** Explain ____
List foods your child does not eat for **medical, religious, or personal reasons**_______________________
Does your child eat dirt, paper, paint chips or other non-food items? **Y N** Explain______________________
Any other nutritional information ____

Nutrition Entry Update (complete at entry) **Date:**______________

For children still on bottle: Brand of bottle used:_________________Type of nipple used:______________

Are there any changes in the above information: No (no further information needed) Yes(complete following)

Parent signature_________________________

Infants: Current Formula______________ Amt. at each feeding______ How often______
Solid foods introduced____
Allergies N Y____
Other____

Toddlers: Special Diet ____
Food Allergies____
Other ____

Annual Update:

1. Any dietary changes____ WIC Y/N

Parent Signature_________________________ Staff Signature____________________Date_________

2. Any dietary changes____ WIC Y/N

Parent Signature_________________________ Staff Signature____________________Date_________

3. Any dietary changes____ WIC Y/N

Parent Signature_________________________ Staff Signature____________________Date_________

Note: ***Head Start requires a written physician statement in order to provide a special diet for any child with allergies***.
All food is provided by Head Start. No foods are to be brought in by parents.
Head Start encourages good nutrition which limits high fat, high sugar and high salt foods.

For Head Start Use Only

Follow-up Needed ____ **yes** ____ **no** **Referred to:** _______________________________ Date _________
(Please complete referral for services and document in contact log.)

Region 14/15 Education Service Center
Early Head Start/Head Start

(Early head Start and Head Start Programs are required to obtain a statement from a healthcare professional determining whether a student is up-to date on a schedule of age appropriate preventative and primary medical care. The Texas Health Step periodicity Schedule is utilized to determine age appropriate)

Date of Exam:___/___/__ Name: ____DOB_______

Height_______ **Weight**______ **Head Circ.**_______ (0-24 m) **Vision Screen** Pass Fail **Hearing Screen** Pass Fail **Newborn Screen** Pass Fail

Is child up-to-date on Blood lead? Yes No Drawn today Yes No Lead Risk questionnaire Yes No
(Due at 12m & 24m)
Is child up-to-date on Hgb/Hct? Yes No Drawn today Yes No
(Due at 12m)

Medical Information	Instructions or modifications for care while in school
Allergies:	
Medical Diagnosis:	
Medication:	

Needs Treatment: □Yes □No Explain____
Treatment Received: □Yes □No Explain____
Referral and/or follow-up needed____

Immunizations:
Up-to-Date_____

Given today: Dtap_____ IVP____ Hib___ Hep A___Hep B___Pneu___ MMR___ Varicella___ Other___

Deferred______ **Due to**____

This child is up-to-date on physical exam based on the Texas Health Step Schedule and is able to take part in day care/school program activities.

Provider Signature____ **Date**____/____/____

Address____ **Phone**___________________

Next Appointment Date______________________________
Physical Exams Due: 2, 4, 6, 9, 12, 15, 18, 24, 30 months of age
3, 4, 5 years of age

Head Start Only
Date received in office:__________________ **Form 2/2017**

Child Oral Health Assessment

Date of exam: ____/____/____ Name: ______________________________DOB____________

Early Head Start and Head Start Programs are required to obtain a statement from a dental healthcare professional determining whether a student is up-to-date on a schedule of age appropriate preventive oral health care. The Texas Health Steps Dental Periodicity Schedule is utilized to determine age appropriate.

This practice is the child's dental home Yes____ No_____

Oral Health Care Services completed during visit:

Examination: Yes No
Risk assessment: Yes No
Cleaning: Yes No
Fluoride varnish: Yes No
Dental sealants: Yes No

Dental treatment needed Yes No
All treatment completed Yes No
More appointments needed for treatments: Yes No
If yes Next appointment Date______________Time_______________Referred to:_________________________

Comments:____
____
____

Next routine appointment date:__________________ Time___________________
(Every 3-6 months)

Provider Signature ____________________________________ Date ___________________

Print Provider Name ____

Address____Phone_____________________

Head Start Use Only
Date Form received_____________Initial______

Form Updated 2/2017

Consents and Permissions

Child Name: ______________________________ Family Name: ______________________
First MI Last

I hereby give my permission for the following:

***Head Start /Early Head Start*:**	**(*Please initial in columns*)** Yes	No
Vision	________	________
Hearing	________	________
Heights and Weights	________	________
Social/Emotional Well-Being - Devereux Early Childhood Assessment (DECA/DECA I/T)	________	________
Developmental Screening (Brigance) *for Head Start/Early Head Start*	________	________

Other Permissions/Releases:	**(*Please initial in columns*)**	
1) Accompany class on Field Trip (child)	________	________
2) Release of ***parent*** name and contact information to parent committee officers for use obtaining help in school related projects.	________	________
3).Release of ***child name*** & ***photo*** –		
a. Social Media - (Facebook, Twitter, Instagram)	________	________
b. Newspaper / TV	________	________
c. Region 14 website	________	________
d. ESC Publications (Annual Report, Community Assessment, Flyers, Brochures)	________	________
e. Educational purposes (teacher trainings)	________	________
4) Other: Specify ____________________________	________	________

Attendance Policy*(important)	**(*Please initial in columns*)**	
1) I will bring my child to school and be on time every day unless they are sick.	________	________
2) I understand that excessive absences or tardiness is considered when re-enrolling a child for EHS and HS.	________	________
3) I will notify the school if my child is sick or going to be late.	________	________

I understand the above consents and permissions.

Parent/Guardian Signature: ____

Print Parent/Guardian Name: ______________________________ **Date** ____/____/______

Staff Signature: ______________________________ **Date** ____/____/______

Print Staff Name: ____

This form is valid through the current school year