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
- ✓ Foster forms (if applicable)

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
   Yes_____ No_____

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

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

☐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 _____

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 _____

Intake Form 4
Family Information

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

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

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

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

Front & Back

Front & Back

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**_____ Date last blood test for **Hemoglobin**_____

Comments related to above conditions:_____

Would anyone in household benefit from treatment for abuse of Alcohol_____, Drugs_____, Tobacco_____?

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. <u>No foods are to be brought in by parents</u>.
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**

Updated February 6, 2018

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

Updated February 6, 2018

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	_____	_____
Mental Health Consultation Services	_____	_____
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 to include video taping)	_____	_____
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