2020-2021

Head Start/Early Head Start Application

Returning Students

Name of Child: _____D.O.B._____

Address of Child: _____Phone: _____

Mother/Mother Figure: _____ D.O.B._____

Address _____ Phone: _____
(if different from child)

Phone Carrier: _____ Email address: _____

(Circle One) Single, Married, Separated, Divorced

Occupation: _____ How long? (Employed/Not Employed)_____

Education Level: _____ When obtained: _____

Father/Father Figure: _____ D.O.B._____

Address _____ Phone: _____
(if different from child)

Phone Carrier: _____ Email address: _____

(Circle One) Single, Married, Separated, Divorced

Occupation: _____ How long? (Employed/Not Employed)_____

Education Level: _____ When obtained: _____

Child's Sibling(s) _____D.O.B._____

_____D.O.B._____

_____D.O.B._____

Type of Housing: (Check One)

____House ____ Mobile Home/Trailer ____Community Shelter

____ Apartment ____ Hotel/Motel room ____Rent to Own

Homeless/No Housing, Other _____

Length of time at current address: _____ Homeless in past 12 mos. Yes or 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

Transportation: Yes or No (Check One or More)

____ Private vehicle ____ Public Transportation _____ Other

____ Friend / Relative ____ City Bus

Type of Services Received: (Check all that apply) ____ None

____ Medicaid/CHIP ____ Child Support / Alimony ____ Public Housing

____ Food Stamps/SNAP ____ Migrant / Language ____ Foster Care

____ WIC ____ TANF ____ Unemployment

____ Homeless ____ SSI ____ Teen Parent

Disability/Or Any Suspected Disability? Yes or No _____

_____Suspected Disability (Parent Given Resource Information) _____Date: _____

_____Has child ever received any services for developmental delay or disability? _____

If so, When: _____Where: _____

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:_____

_____ _____

Head Start Staff Signature **Date**

Intake Form 6

Child Health History

Child's Name_____ **Male**_____ **Female**_____ **DOB**_____ **Age**_____

School_____ **Head Start**_____ **Early Head Start**_____ **Date**_____

* Does your child have Medical Insurance? Yes_____ No_____ Name of Insurance Company:_____

* Does your child have Dental Insurance? Yes_____ No_____ Name of Insurance Company:_____

Reason for no medical / dental insurance? Pending_____ (need proof) Re-Applying_____ (need proof) Denied_____ (need proof) Other____

Child's medical doctor? Name_____ Phone_____ Date of Last Physical: _____

How long has your child been seen at this location? _____ Lead level drawn? Yes_____ No_____ Where? _____

Child's dentist? Name_____ Phone_____ Date of Last Dental Visit: _____

How often does your child visit their dentist? Every 6 months_____ Not Regularly_____ Child has never been to a dentist_____

* Does family receive WIC? Yes____ No____ Do you want information on WIC? Yes____ No____ * Does the family receive SNAP? Yes____ No_____

Would anyone in your household benefit from treatment for abuse of Alcohol_____, Drugs_____, and/or Tobacco_____?

Make a Copy of Cards

Check any conditions which your child has:

_____Asthma (Need asthma action plan from doctor)

_____Diabetes (Need diabetes treatment plan from doctor)

_____Blood lead level >5µg/dl (Need result from doctor)

_____Hearing Problems_____

_____Hearing Aids? Left_____ Right_____

(Need allergy action plans for any severe allergies)

_____Allergy to Insects_____

_____Allergy to Food_____

_____Allergy to Medication_____

*** Make a copy of any information provided ***

_____Bleeding Difficulties (Need doctor order for limitations and treatment)

_____Seizures, Convulsions (Need seizure action plan from doctor)

_____Febrile Seizures (Need doctor order for guidance and treatment)

_____Vision Problems_____

_____Wears glasses? Yes_____ No_____

_____Heart condition_____ (Need dr order for limitations)

_____Use assistive devices? Circle: crutches, wheelchair, walker, braces

_____Has EpiPen (Need allergy action plan from the doctor)

_____Other_____

Is your child taking any medications that will need to be administered by the school nurse during school hours? Yes_____ No_____
If yes, what medications? _____

Hospitalizations & Illnesses in the last 6 months . . .	Yes	No	Explain "Yes" Answers (make a copy of physician notes, if needed)
Has your child been hospitalized or operated on?			
Has your child had a serious accident (broken bones, head injuries, falls, burns, poisoning)?			
Has your child had a serious illness?			

DISABILITIES SERVICES: *** Make a copy of any information provided ***

- Do you suspect that your child has a disability or special need? **Yes**_____ **No**_____
- What type of disability does your child have?_____
- Has a professional assessed / diagnosed your child's disability? **Yes**_____ **No**_____
- Has your child received Early Childhood Intervention (ECI) services? **Yes**_____ **No**_____
- Do you have medical documentation or a school district Individual Education Plan (IEP)? **Yes**_____ **No**_____
- Does your child receive disabilities services from a community resource agency? **Yes**_____ **No**_____
  If yes, name of agency and type of service:_____

Child's Name:_____ **Date**_____

Behavioral / Wellness History	Yes	No	If "Yes" is marked please explain
Does your child have any problems sleeping?			Hours slept per night? _____ Naps per day? _____
Does your child have difficulty with toileting independently?			
Any difficulty with urination?			
Any frequent diarrhea / constipation?			
Does your child wear diapers / pull ups?			
Does your child get any indoor or outdoor physical play?			If yes, minutes per day?
Does your child use electronic devices (video games, computers, phone, and iPad)?			If yes, minutes per day?
Does your child watch TV or movies?			If yes, minutes per day?
Does your child's teacher need any special instructions in caring for your child?			
Does your child have difficulties socializing with other children his/her age?			
Does your child have difficulties separating from parents/other adults?			
Have there been any major changes in your child's life in the last six months?			
Are you or your family having any problems now that might affect your child?			
Is there anything else you want to tell us about your child that will help us understand his/her needs, attitudes, or behavior?			
Pregnancy / Birth History	**Yes**	**No**	**Explain "Yes" Answers (make a copy of physician notes, if needed)**
How far along in pregnancy were you when you went to the doctor?			_____Weeks _____Months _____Never went to the doctor
Were there any complications in pregnancy?			If yes, explain:
Any prenatal exposure to drugs, alcohol, caffeine or tobacco?			If yes, explain:
Any birth defects?			If yes, explain:
Where was your child delivered? Birth weight_____			____Hospital ____Birthing Center ____Home ____Don't know
How long were you and baby in the hospital?			Days for Mother_____ Days for Baby_____ Reason for any extended stay_____
Does the child have any birth problems or concerns that still affect them today?			

Parent/Guardian Name_____ **Phone Number**_____

Parent/Guardian Signature_____

Date Completed_____

Intake Form 7

Child Nutritional Assessment

Child's Name_____ **Male**_____ **Female**_____ **DOB**_____ **Age**_____

School_____ **Head Start**_____ **Early Head Start**_____ **Date**_____

Nutritional History / Information	Yes	No	If "Yes" is marked please specify
Does your child have food allergies?			What foods? **PHYSICIAN DOCUMENTATION REQUIRED**
Does your child have food intolerances?			What foods? **PHYSICIAN DOCUMENTATION REQUIRED**
Is your child on a special diet for: ☐ Religious Beliefs **(If yes, parent must provide written instructions on religious dietary practices**) ☐ Medical **(If yes, parent must provide written physician's instructions)**			Explain: **Head Start requires doctor's orders to provide special diet for allergies. All food provided by Head Start. No foods are to be brought in by parents.**
Breastfeeding? ☐ Not applicable			Feedings per day? _____ Minutes per feeding? _____
Bottle feeding? ☐ Not applicable Type of formula? _____			Feedings per day? _____ Ounces per feeding? _____ Brand of bottle used? _____ Type of nipple used? _____
Is child put to bed with a bottle? ☐ Not applicable			If yes, what is in bottle?
Are liquids, beside milk, drank from bottle during the day? ☐ Not applicable			If yes, what?
Does your take a child vitamin/fluoride/mineral supplement?			Contains: ☐ Iron ☐ Fluoride ☐ Prescribed by a doctor
Child drinks water?			☐ Tap water ☐ Bottled water ☐ Well water
Child drinks what during the day with meals/snacks? ☐ Cup ☐ Sippy cup			☐ Milk ☐ Water ☐ Juice ☐ Kool-Aid ☐ Other_____ ☐ Lactose free milk (needs doctor order for school) ☐ Soy milk (needs doctor order for school)
Is your child a picky eater?			
Has your child's appetite changed in the past month?			
Does your child eat or chew things that are not food?			If yes, what?
Do you have any concerns about what your child eats?			
Does your child have trouble with: ☐ Sucking ☐ Chewing ☐ Swallowing ☐ Refusal of any food group What type of difficulty?			
Eating Frequency: Number of meals per day _____ Number of snacks per day _____ Usual daily servings of: Bread/Grains_____ Meat/Beans_____ Milk/Dairy_____ Vegetable_____ Fruits_____ Soda_____ Sweets_____			
Child's favorite foods?			
Child's least favorite foods or disliked foods?			

Parent/Guardian Name _____ Parent/Guardian Signature _____

Date of Completion_____

Consents and Permissions

Child Name: _____ DOB _____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 Classroom Observation	_____	_____
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) Child to accompany class on Field Trip	_____	_____
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** _____/_____/_____

This form is valid through the current school year