

**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, SNAP, SSI)
- ✓ **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)
- ✓ **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: \_\_\_\_\_

Latino or Hispanic     Non-Hispanic

7. Foster Child: Yes \_\_\_\_\_ No \_\_\_\_\_

8. Language spoken at home:

Primary:  English  Spanish  Other \_\_\_\_\_

9. How well does the child speak English?

Very Well     Well     Not Well     Not at all  
 Infant/Toddler

**SECTION II: ADDRESSES**

10. 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: \_\_\_\_\_

11. 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: \_\_\_\_\_

12. Child previously enrolled in Head Start:  yes  no

Program \_\_\_\_\_ Dates \_\_\_\_\_

**SECTION III: RELATIONSHIPS**

13. Other Children in Household

Relationship to Eligible Child

Date of Birth


**SECTION IV: CHILD INFORMATION**

14. 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

## Front & Back Intake Form 2 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
- Two parents, both working or students
- Two parents, one working or student
- Single parent, working or student
- Two parents, neither working or students

**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

**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. TYPES OF SERVICES OR FINANCIAL ASSISTANCE CURRENTLY RECEIVING**

- No services received       Public Assistance/Welfare (e.g.TANF)       SNAP/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 \_\_\_\_\_

Family referred by: \_\_\_\_\_

**Intake Form 3  
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: \_\_\_\_\_  
 Latino or Hispanic  Non-Hispanic
8. Language spoken at home:  
 Primary:  English  Spanish  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**

<u>Adults in Household (not guardians)</u>	<u>Relationship to Eligible Child</u>	<u>Date of Birth</u>
_____	_____	_____/_____/_____ _____/_____/_____
_____	_____	_____/_____/_____ _____/_____/_____
_____	_____	_____/_____/_____ _____/_____/_____

**SECTION III: ADULT INFORMATION**

13. Applicant currently pregnant?  Yes  No 14. Due Date: \_\_\_\_\_
15. Are you currently receiving pre-natal service:  Yes  No

16. Prenatal Care Provider \_\_\_\_\_

17. Is your current pregnancy High Risk?  Yes  No

**18. 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 Reason:  Yes  No  N/A

**19. 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)**

20. 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: EDUCATION**

21. Highest level of education completed (check only one): Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> No school completed                         | <input type="checkbox"/> 11th grade                   | <input type="checkbox"/> Associate degree in college |
| <input type="checkbox"/> Less than or equal to 4 <sup>th</sup> grade | <input type="checkbox"/> 12th grade (no diploma)      | <input type="checkbox"/> Bachelor's degree           |
| <input type="checkbox"/> 5th-8 <sup>th</sup> grade                   | <input type="checkbox"/> High School graduate/GED     | <input type="checkbox"/> Master's degree             |
| <input type="checkbox"/> 9th grade                                   | <input type="checkbox"/> Some college (but no degree) | <input type="checkbox"/> Doctorate degree            |
| <input type="checkbox"/> 10th grade                                  |   |  |

**SECTION VI: OCCUPATION**

22. Person's primary occupational status (check all that apply): Currently employed:  Yes or  No  
Paying job: In school: Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Full-time (more than 34 hrs per week) | <input type="checkbox"/> Towards high school diploma/GED      |
| <input type="checkbox"/> Part-time                             | <input type="checkbox"/> Towards trade/business qualification |
| <input type="checkbox"/> Seasonal- Non-agricultural            | <input type="checkbox"/> Towards college degree               |
| <input type="checkbox"/> Seasonal- Agricultural                | <input type="checkbox"/> Towards postgraduate degree          |
| <input type="checkbox"/> Employed and in school                | <input type="checkbox"/> In school and employed               |

In job training program: Unemployed: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Training program with salary    | <input type="checkbox"/> With past employment experience        |
| <input type="checkbox"/> Training program without salary | Time since last job: ____ months                                |
|  | <input type="checkbox"/> With no previous employment experience |

Other:

- |   |   |
|---|---|
| <input type="checkbox"/> Homemaker                        | <input type="checkbox"/> Retired        |
| <input type="checkbox"/> Unable to work due to disability | <input type="checkbox"/> Not applicable |

Was parent previously enrolled in Head Start? yes no  
If yes, name of program: \_\_\_\_\_ Year \_\_\_\_\_

## Intake Form 4 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: \_\_\_\_\_

Latino or Hispanic     Non-Hispanic

8. Language spoken at home:

Primary:  English  Spanish  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. <u>Adults in Household (not guardians)</u>	<u>Relationship to Eligible Child</u>	<u>Date of Birth</u>
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

### 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)**

15. 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: EDUCATION**

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> No school completed                         | <input type="checkbox"/> 11th grade                   | <input type="checkbox"/> Associate degree in college |
| <input type="checkbox"/> Less than or equal to 4 <sup>th</sup> grade | <input type="checkbox"/> 12th grade (no diploma)      | <input type="checkbox"/> Bachelor's degree           |
| <input type="checkbox"/> 5th-8 <sup>th</sup> grade                   | <input type="checkbox"/> High School graduate/GED     | <input type="checkbox"/> Master's degree             |
| <input type="checkbox"/> 9th grade                                   | <input type="checkbox"/> Some college (but no degree) | <input type="checkbox"/> Doctorate degree            |
| <input type="checkbox"/> 10th grade                                  |   |  |

**SECTION VI: OCCUPATION**

17. Person's primary occupational status (check all that apply): Currently employed:  Yes or  No  
Paying job: In school: Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Full-time (more than 34 hrs per week) | <input type="checkbox"/> Towards high school diploma/GED      |
| <input type="checkbox"/> Part-time                             | <input type="checkbox"/> Towards trade/business qualification |
| <input type="checkbox"/> Seasonal- Non-agricultural            | <input type="checkbox"/> Towards college degree               |
| <input type="checkbox"/> Seasonal- Agricultural                | <input type="checkbox"/> Towards postgraduate degree          |
| <input type="checkbox"/> Employed and in school                | <input type="checkbox"/> In school and employed               |

In job training program: Unemployed: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Training program with salary    | <input type="checkbox"/> With past employment experience        |
| <input type="checkbox"/> Training program without salary | Time since last job: ____ months                                |
|  | <input type="checkbox"/> With no previous employment experience |

- Other:
- |   |   |
|---|---|
| <input type="checkbox"/> Homemaker                        | <input type="checkbox"/> Retired        |
| <input type="checkbox"/> Unable to work due to disability | <input type="checkbox"/> Not applicable |

Was parent previously enrolled in Head Start? yes no  
 If yes, name of program: \_\_\_\_\_ Year \_\_\_\_\_



# 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.

I am aware that I must follow all Head Start Performance Standards including but not limited to Developmental Assessments, Medical exams (Physicals), and Dental exams.

\_\_\_\_\_  
Applicant Signature/Firma del Apicante:

\_\_\_\_\_  
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 or SNAP)
- WORK HISTORY- VERIFICATION OF EMPLOYMENT               SUPPLEMENTAL SECURITY INCOME
- WRITTEN VERIFICATION OF VERBAL DECLARATION OF INCOME     FOSTER CARE
- OTHER: \_\_\_\_\_                       HOMELESS

### AGENCY SIGNATURES

Interviewed/Assisted By: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

In Person                       Telephone                       Virtual

CHILD ACCEPTANCE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ (by Region 14 Head Start)

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

### Region 14 ESC Head Start Staff Only

Staff Eligibility Certification Signature: \_\_\_\_\_

Certification Date: \_\_\_\_\_

Print Name of Certifvina Staff Member: \_\_\_\_\_

## 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 \_\_\_\_\_?

**Check any conditions which your child has:**

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

_____ 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 _____	_____ 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 _____
---	--

**(PHYSICIAN DOCUMENTATION REQUIRED)**

**Need allergy action plans for any severe allergies)**

_____ Allergy to Insects _____ _____ Allergy to Food _____ _____ Allergy to Medication _____	_____ Heart condition _____ (Need dr order for limitations) _____ Use assistive devices? Circle: crutches, wheelchair, walker, braces _____ Has Epi Pen (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 had a serious illness and/or hospitalized?			

**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 \_\_\_\_\_

<b>Behavioral / Wellness History</b>	<b>Yes</b>	<b>No</b>	<b>If "Yes" is marked please explain</b>
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?
Do you have any instructions for your child's teacher to help them understand your child's needs, attitudes, or behavior?			
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?			
<b>Pregnancy / Birth History</b>	<b>Yes</b>	<b>No</b>	<b>Explain "Yes" Answers (make a copy of physician notes, if needed)</b>
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?			

## 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 intolerances?			What foods?  <b>PHYSICIAN DOCUMENTATION REQUIRED</b>
Is your child on a special diet for: <input type="checkbox"/> <u>Religious Beliefs</u> (If yes, parent must provide written instructions on religious dietary practices)  <input type="checkbox"/> <u>Medical</u> (If yes, parent must provide written physician's instructions)			Explain:  <b>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.</b>
Breastfeeding? <input type="checkbox"/> Not applicable			Feedings per day? _____ Minutes per feeding? _____
Bottle feeding? <input type="checkbox"/> Not applicable Type of formula? _____			Feedings per day? _____ Ounces per feeding? _____ Brand of bottle used? _____ Type of nipple used? _____
Does your take a child vitamin/fluoride/mineral supplement?			Contains: <input type="checkbox"/> Iron <input type="checkbox"/> Fluoride <input type="checkbox"/> Prescribed by a doctor
Child drinks water?			<input type="checkbox"/> Tap water <input type="checkbox"/> Bottled water <input type="checkbox"/> Well water
Child drinks what during the day with meals/snacks? <input type="checkbox"/> Cup <input type="checkbox"/> Sippy cup			<input type="checkbox"/> Milk <input type="checkbox"/> Water <input type="checkbox"/> Juice <input type="checkbox"/> Kool-Aid <input type="checkbox"/> Other _____ <input type="checkbox"/> Lactose free milk (needs doctor order for school) <input type="checkbox"/> 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: <input type="checkbox"/> Sucking <input type="checkbox"/> Chewing <input type="checkbox"/> Swallowing <input type="checkbox"/> Refusal of any food group What type of difficulty?			
Eating Frequency: Number of meals per day _____ Number of snacks per day _____			
Child's favorite foods?			
Child's least favorite foods or disliked foods?			

### Consents and Permissions

Child Name: \_\_\_\_\_ (First MI Last)      DOB \_\_\_\_\_ Family Name) \_\_\_\_\_

***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 videotaping) \_\_\_\_\_
- 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*