BEAR RIVER HEAD START APPLICATION

YEAR: 2016-2017

Preschool Head Start (PHS) Early Head Start (EHS) Child Care Connection (CCC) Early Childcare Partnership (ECP)

95 West 100 South Suite 200 * LOGAN, UTAH 84321

CACHE COUNTY (435) 755-0081 OR TOLL FREE (877)755-0081 FAX: (435)755-0125

Box Elder (435) 723-7755 Fax 435-734-4932/ **Fielding** (435) 458-2700 / **Preston** (208) 852-3012 / **Oneida** (208) 766-2200

Dear Parents/Guardians:

Bear River Head Start is a free (no cost to the parents/guardians), federally funded, comprehensive preschool program. Federal income guidelines and child/family circumstances are considered to determine eligibility**.** Please complete a separate application for each child applying. **Please keep our office informed of any changes in your contact information (address, phone number).**

Please turn in these documents with the application:

- ☐ **Proof of age**-birth certificate, christening/blessing certificate **OR** other legal document.
- ☐ **Income verification**-Need 1 of the following documents, listed in order of preference.
  - W-2 form
  - Tax form (1040)
  - checks stubs = 12 months preferred
  - letter from employer
  - verification from TANF
  - SSI documentation
  - Foster care documentation

Children in Public Assistance (TANF), Foster Care or SSI programs are income eligible

Please attach a current copy of your child's/family's Public Assistance (TANF), Foster Care, or SSI document. This will be retained and kept with your child's application.

- ☐ **Immunization Record** (please copy front & back. Immunizations need to be up to date)

IF THE ITEMS LISTED ABOVE ARE NOT PRESENTED WITH YOUR APPLICATION WE WILL BE UNABLE TO KEEP & PROCESS YOUR APPLICATION.

Children with disabilities or special needs are welcome. Please attach a copy of your child's IEP or IFSP to the application.

Head start involves families as well as the Head Start Child. Parents support is vital to the success of the program. Parents (families) are encouraged to volunteer time to the program. Volunteering can include helping in the classroom, preparing activities at home, serving on Parent Committees, etc.

Upon acceptance into the program, your child will be assigned to a home-based or center-based class.

In addition, your family will receive Family Advocate services. Family Advocate services focus on strengthening the family, literacy/education and employability.

Center-based children may ride the Head Start bus for field trips.
Transportation is not provided to or from school.
Transportation Alternatives: parents can create car pools, ride the bus, or request the home-based option.

I have read and understand the above and would like to apply to have my child in Bear River Head Start, I understand that by submitting this application I am not guaranteed enrollment.

PARENTS PLEASE KEEP THIS PAGE. IT IS FOR YOUR INFORMATION
All Earnings Must be Reported

Gross Earnings from Employment & Unemployment *Retirement or Disability* *Financial Assistance*
Foster Care stipend *Child support or Alimony* *Self-employment income* *Farm self-employment income*

Preschool Head Start classes are held Monday through Thursday, 4 hours a day.
Classes are closed for all holidays & most breaks the public school has.

MEDICAL & DENTAL REQUIREMENTS-Contact *Health Specialist at 1-877-755-0081, ext 324.*

[ ] ***Physical***: Your child will need an up-to date physical exam with a medical doctor. Please obtain a copy of the most recent physical exam that was done.

[ ] ***Hematocrit/Hemoglobin:*** Your child will need a hematocrit or hemoglobin to be done if they are 12 month or older with their physical, if they are NOT on WIC for the 2015-2016 school year.

[ ] ***Lead Test***: If your child is 12 months or older has never had a lead test, obtain a lead test at the time of their physical, or call your child's doctor for a lab order. If your child does not have Medicaid call the Health Specialist at 435-755-0081, ext. 324.

[ ] ***Dental Exam***: Your child will need a dental exam with a dentist if he/she is 12 months or older. If your child is on a regular six month schedule with his or her dental care, please obtain a copy of your child's latest six month exam.

[ ] ***Immunizations***: **Immunizations needed for Preschool enrollment.**

Please refer to medical and dental requirements (attached to Physical & Dental Exams Forms) for a list of required immunizations.

Once I complete and turn in my child's application what will happen next?

Upon receiving your application, the Recruitment & Enrollment team will process your application & input the information into our database. Your child will then be placed on the income eligible or over-income waitlist for the site requested.

Head Start has specific slots for age-eligible **over-income** children, and the majority of those slots go to children with identified disabilities.

When will I hear if my child is in the program?

If you turn in an application between January and August (for the next program year – beginning September 2016), and if your child is selected to attend Bear River Head Start, you will receive a letter informing you that your child has been accepted into the program.

After August 24, 2016, your child will remain on the waitlist until there is an opening and they are selected (based on the ratings criteria). **You will be called** by a member of the Recruitment & Enrollment team IF your child was selected to fill the vacancy.

Will my child get into the program?

If your child is a foster or a homeless child, your chances are excellent; **but we cannot guarantee your child will get in.** The federal government determines who gets first priority in receiving services in Head Start and foster and/or homeless children are priority children.

If your child is **age and income eligible,** your chances are very good; **but we cannot guarantee your child will get in**. **We will have a waiting list every year**! The program **IS NOT** first-come first-served, but the sooner you turn in your application the better, as first selections are made early in the summer. Government regulations require services to **those in the community who need the services the most.** Therefore, each application is rated based on the information provided in the application.

Bear River Head Start Application 2016-17

Family Member Information

Staff Only
Child Plus #_______________________________ Date application received ________________________ Staff recruiter___________________________

[ ] **Preschool Head Start (PHS)** Serving children 3 (by Sept 1) -5 years old
[ ] **Early Head Start (EHS)** Serving children 0 – 3 & pregnant mothers
[ ] **Child Care Connection (CCC)** Serving children 3-5 years old
[ ] **Early Childcare Partnership (ECP)** Serving children 0-3 years old

Child's name:		**Preferred Name:**		**Date of birth:**
Primary Adult Name: (person filling out form)				**Date of birth:**
Living Address	**City**	**State**	**Zip**	**County**
Mailing Address (If different from living address)	**City**	**State**	**Zip**	**County**

Is your living address a temporary arrangement? (Excluding renters) [ ] YES [ ] NO	**If yes, is this due to loss of housing or because of inability to afford housing?** [ ] YES [ ] NO	**Do any of the following apply to your household at this time?** [ ] Sharing a residence [ ] Living in a hotel [ ] Living in a shelter [ ] Living in a car, park, campground, or public space [ ] Living in a space without adequate facilities

Home phone ( )	Cell phone ( )	Work phone ( )	Message phone ( )

# in Household	**# in Family**	**# of children in Family**	**# of Children ages 0-3**	**# of Children ages 4-5**

Parental Status in Home: [ ] One parent [ ] Two parents [ ]Relative [ ]Foster care

Primary Language Spoken at home:	**Language you prefer the visits/mail in** (circle one) English or Spanish

Please indicate a first choice with a "1" and a second choice with a "2"

Early Head Start Program Options: **Center-based UTAH** __ Cache
Home-based UTAH __ Box Elder __ Cache **IDAHO** __ Caribou/Bear Lake __ Franklin

Child Care Program Options: __ Early Childcare Partnership __ Child Care Connection

PHS Home Based Program Options: __ Box Elder __ Cache __Idaho

PHS Center Based Program Options: ***UTAH*** __ Brigham 1 __ Brigham 2 __ Fielding
__ Logan AM __ Logan AM (3 & 4 yr olds) __ Logan PM __ Logan AM (3 yr. olds) __ Logan PM (3 yr. olds)
__ Richmond __ Smithfield __ Hyrum AM __ Hyrum PM
IDAHO __ Paris __ Preston AM __ Preston PM __ Malad __ Soda Springs

Please mark all that you receive: [ ]**TANF** [ ] **SSI** [ ] **Medicaid** [ ] **WIC** ID#__________________
(The following documents will be required and retained with the application: SSI/TANF)

Referral (please present documentation)[ ]School District [ ]Health Department or WIC [ ]CAPSA [ ]Up to 3 program [ ]Doctor/Health Care Provider [ ]Division of Child & Family Services or CPS [ ]Other_____________________

PARENTS PLEASE MARK THOSE THAT APPLY: [ ] Past Head Start enrollee
[ ] Currently enrolled in **ANY** Head Start program [ ] Do you plan on applying for **ANY** other Head Start Program

Have you been convicted of a crime in the last seven (7) years? __ No __ Yes

If yes, please explain ____

CONVICTION WILL NOT BE A BAR FOR ENROLLMENT OF YOUR CHILD.

Certification: "I have carefully reviewed the documents and information I have provided to Bear River Head Start staff and, by signing this form, certify to the best of my knowledge and belief that all information regarding eligibility provided by me is true and accurate." "I further understand that this is an application for services that are paid for with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in serious legal consequences for me."

Parent/Guardian Signature____ **Date** ________________

Parent/Guardian Signature____ **Date** ________________

Witness/Staff Signature____**Date** ________________

CHILD CARE NEEDS

- Does this child need full day, full year childcare because you are working or in training? [ ] YES [ ] NO
- If yes, are services through Preschool Head Start, Child Care Connection, Early Childcare Partnership, or Early Head Start? [ ] YES [ ] NO
- Please select the type of child care the child receives during that part of the day when they are not in Preschool Head Start or Early Head Start? [ ] Family child care home [ ] Through a public school pre-kindergarten program [ ] Child care center or home [ ] At home or with relative or unrelated adult [ ] Other
- Do you receive Child Care subsidy? [ ] YES [ ] NO
  (Please provide subsidy documentation with your application)
- Name of Provider____________________________________

Early Head Start Parents: Please complete by mother of child if pregnant

Are you Pregnant? [ ] YES [ ] NO If you answered yes please answer the following questions.	What kind of medical insurance is covering your pregnancy? [ ] Public Assistance [ ] Private Insurance [ ] None Providers Name:	Prenatal Care Received: [ ] YES [ ] NO
(Due Date) Expected Delivery Date ___/___/___	Participating in support or educational groups for pregnancy, child birth, or parenting during current pregnancy? [ ] YES [ ] NO	
Visited Regularly by Nurse, Social Worker, School Support Person, etc. during current pregnancy: Visited by:_______________________ Agency:_________________________	Substance Use During Pregnancy: (Mark all that apply): Alcohol [ ] YES [ ] NO Other Drugs: [ ] YES [ ] NO Specify: __________________ Caffeine [ ] YES [ ] NO Non-Prescription Drugs: [ ] YES [ ] NO Specify: __________________ Cigarettes [ ] YES [ ] NO Prescription Drugs: [ ] YES [ ] NO Specify: __________________	Primary Prenatal Care Provider: ______________________________ Primary Health Care Provider: (If Different) __________________________

Medical or Health services currently received: ☐ **No services currently being received**

[ ] Medical Assistance Since ___/___/____

[ ] Substance Abuse Treatment Since ___/___/____

[ ] Other Services, Specify _________________

[ ] Mental Health Counseling/Treatment Since ___/___/____

[ ] WIC / Other Nutritional Services Since ___/___/____

BELOW THIS LINE OFFICE USE ONLY

Family Income for the last 12 months

Type codes: **ERN**-Earned **SUB**-Subsidized **TANF**-TANF **SSI**-SSI

Verification codes: **W2**-W-2 **TX-**Tax Forms **CS-**Checks stubs **EL-**Employer Letter **TANF-**TANF **Other-**fill in verification

Family Member	Date	Amount	Per *Week/ /Month/Year*	Annual Amount	Type	Verification

Proof of Birth Verified with:

[ ] Birth/Government ID Certificate

[ ] Blessing/Christening Certificate

[ ]Authorized Verification from Hospital

[ ]Government Identification

[ ]Other__________________

Initialed by:________

Up to Date Immunizations (Copy included with application)

[ ] Yes

[ ] No

Initialed by:_________

Yearly Income:

Verified by:________________________

Date:___________________

[ ] Income Eligible

[ ] Over Income

[ ] Other _________________________

Family Member Information

Primary Adult (person filling out form)

First Name **Last Name** **Date of birth:**

Lives with family? [ ] YES [ ] NO | **Provides financial support?** [ ] YES [ ] NO | **Gender:** Male [ ] Female [ ]

Education Level
[ ] Masters Degree
[ ] Bachelors Degree
[ ] Associates Degree
[ ] Training/Tech Cert.
[ ] Some College/Tech school
[ ] High School Graduate
[ ] GED
[ ] Grade 12
[ ] Grade 11
[ ] Grade 10
[ ] Grade 9 or less
specify__________

Employment Status
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

English Proficiency
[ ] None (doesn't speak or understand)
[ ] Poor (doesn't speak but understands)
[ ] Moderate (speaks & understands a little)
[ ] Proficient (speaks & understands)

Primary Language: [ ] English
[ ] Spanish
[ ] Other ___________________
Ethnicity:

Race (check all that apply)
[ ] Asian [ ] American Indian or Alaska Native
[ ] Black [ ] Pacific Islander
[ ] White [ ] Hispanic
[ ] Other________________________________

What is your relationship to the child applying to Bear River Head Start?

Do you have custody of the child applying? [ ] YES [ ] NO

Email:

Secondary Adult

First Name **Last Name** **Date of birth:**

Lives with family? [ ] YES [ ] NO | **Provides financial support?** [ ] YES [ ] NO | **Gender:** Male [ ] Female [ ]

Home Phone	Cell Phone	Employers Phone	Message Phone
( )	( )	( )	( )

Living address(if different from living address) **State** **Zip** **County**

Mailing address(if different from living address) **State** **Zip** **County**

Education Level
[ ] Masters Degree
[ ] Bachelors Degree
[ ] Associates Degree
[ ] Training/Tech Cert.
[ ] Some College/Tech school
[ ] High School Graduate
[ ] GED
[ ] Grade 12
[ ] Grade 11
[ ] Grade 10
[ ] Grade 9
[ ] Other ________

Employment Status
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

English Proficiency
[ ] None (doesn't speak or understand)
[ ] Poor (doesn't speak but understands)
[ ] Moderate (speaks & understands a little)
[ ] Proficient (speaks & understands)

Primary Language: [ ] English
[ ] Spanish
[ ] Other ___________________
Ethnicity:

Race (check all that apply)
[ ] Asian [ ] American Indian or Alaska Native
[ ] Black [ ] Pacific Islander
[ ] White [ ] Hispanic
[ ] Other________________________________

What is your relationship to the child applying to Bear River Head Start?

Do you have custody of the child applying? [ ] YES [ ] NO

Email:

Contact Information for Non-Custodial Parent of child applying

Do you give permission for Bear River Head Start to contact Non-Custodial **parent** for Head Start purposes?
[ ] YES [ ] NO [ ] N/A (not applicable)

Name Date of Birth	Address City State/Zip	Home ( ) Cell ( ) Work ( )

Needs for Services (if applicable)

Please list any specific concerns why you believe your child should be enrolled in Head Start. (Example: Child/Family concerns/needs/circumstances, disabilities, development concerns, divorce, parent difficulty reading/speaking, death in family within the last year) ____

____

____

Is your child on an IEP/IFSP?

[ ] NO [ ] YES [ ] POSSIBLE CONCERN

Name of School district or program.(Example: Up-to-Three or Idaho Infant & Toddler) ____________________

As legal guardian of ________________________, I give permission to the school district or program listed above to exchange information regarding my child for the purposes of enrollment priority in the Head Start Program.

Parent/Guardian______________________________

CHILD APPLYING FOR PROGRAM

Preferred first name:	**Last name:**	**Gender:** Male [ ] Female [ ] **Date of birth:**
English Proficiency [ ] None (doesn't speak or understand) [ ] Poor (doesn't speak but understands) [ ] Moderate (speaks & understands a little) [ ] Proficient (speaks & understands)	**Primary Language:** [ ] English [ ] Spanish [ ] Other ______________ **Ethnicity:**	**Race (check all that apply)** [ ] Asian [ ] American Indian or Alaska Native [ ] Black [ ] Pacific Islander [ ] White [ ] Hispanic [ ] Other______________________

Other Children in family (not child who is applying for Head Start)

First name:	**Last name:**	**Gender:** Male [ ] Female [ ]
Related by blood, marriage or adoption: [ ] YES [ ] NO **Relationship to child applying:**		**Date of birth:** **Lives with family?** [ ] YES [ ] NO

First name:	**Last name:**	**Gender:** Male [ ] Female [ ]
Related by blood, marriage or adoption: [ ] YES [ ] NO **Relationship to child applying:**		**Date of birth:** **Lives with family?** [ ] YES [ ] NO

First name:	**Last name:**	**Gender:** Male [ ] Female [ ]
Related by blood, marriage or adoption: [ ] YES [ ] NO **Relationship to child applying:**		**Date of birth:** **Lives with family?** [ ] YES [ ] NO

First name:	**Last name:**	**Gender:** Male [ ] Female [ ]
Related by blood, marriage or adoption: [ ] YES [ ] NO **Relationship to child applying:**		**Date of birth:** **Lives with family?** [ ] YES [ ] NO

First name:	**Last name:**	**Gender:** Male [ ] Female [ ]
Related by blood, marriage or adoption: [ ] YES [ ] NO **Relationship to child applying:**		**Date of birth:** **Lives with family?** [ ] YES [ ] NO

OTHER CHILDREN OR ADULTS IN HOUSEHOLD

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

OTHER CHILDREN OR ADULTS IN HOUSEHOLD

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

First name: **Last name:** **Gender:** Male [ ] Female [ ]

Related by blood, marriage or adoption: [ ] YES [ ] NO **Date of birth:**

Relationship to child applying: **Lives with family?** [ ] YES [ ] NO

Employment Status
[ ] This person is a child
[ ] Full time 35+ hours
[ ] Full time & training
[ ] Part time
[ ] Part time & training
[ ] Training or school
[ ] Seasonally employed
[ ] Retired or disabled
[ ] Unemployed
[ ] Homemaker

MEDICAL INFORMATION

Child's Name (printed) ___________________________ ID#:___________ Location:______________

EMERGENCY CONTACTS

NOT PRIMARY OR SECONDARY ADULTS, but other who can make decisions for your child, if you are not available

Name____________________________________	Relationship _________________	**Contact:** Yes [ ] No [ ]
Address ____		**Release:** Yes [ ] No [ ]
Home phone __________________	Cell phone ___________________	Work phone ___________________
Name____________________________________	Relationship _________________	**Contact:** Yes [ ] No [ ]
Address ____		**Release:** Yes [ ] No [ ]
Home phone __________________	Cell phone ___________________	Work phone ___________________
Name____________________________________	Relationship _________________	**Contact:** Yes [ ] No [ ]
Address ____		**Release:** Yes [ ] No [ ]
Home phone __________________	Cell phone ___________________	Work phone ___________________

Child's Medical Information

Insurance Information: Type (Public Assistance, e.g. Medicaid, EPSDT or equivalent)_______________________
Insurance Provider Name____
Insurance Policy Number____

Primary Care Provider: Physician Name____
Date of last or upcoming physical exam____
Phone Number ____

Dental Care Provider: Dentist's Name____
Date of last or upcoming dental exam____
Phone Number____

Allergies	Medication

I/We give permission for the Bear River Early Head Start/Preschool Head Start staff to provide first aid and seek emergency medical care, if necessary, for myself/ourselves and my/our child,_____________________________.

Signed:____ Date:_____________

BEAR RIVER HEAD START
HEALTH AND EDUCATION PERMISSION/RELEASE FORM

Child's Name_______________________________ Date of Birth______________ Telephone #:________________

ID #: ______ Location:________________

PERMISSION TO OBTAIN/RELEASE HEALTH DATA INFORMATION

Upon enrollment, I give permission for the Head Start Health Staff to obtain required health data from my child's health providers (doctor, dentist, WIC, Medicaid, insurance companies, mental health professionals) to meet medical, mental health, and dental follow-up services and Performance Standard requirements. This information may be obtained by mail, telephone and/or fax.

I also give permission for my health care providers to release the required health data information to the Head Start Health Staff. My health care provider can release this information by telephone, mail, and/or fax.

It is understood that the above information is to be used for professional purposes only and it is to be held confidential.

OTHER PERMISSIONS – ***(Please initial. Parent initials need to be up-dated yearly.)***

_____ **I give permission for Head Start to provide emergency first aid and seek emergency medical help for my child.**

_____ **I give permission for Head Start Staff to provide screenings on my child (vision, hearing, height and weight).**

_____ **I give permission for my child's name to be posted in the classroom if there is a medical condition or food allergy that all staff should be aware of.**

_____ **I give permission for Head Start to record video and take photographs and use these to promote our program in the community (newspaper, etc.)**

_____ **I give permission for Head Start to record videos and take photographs for use in evaluating university students and promote their program.**

_____ **I give permission for Head Start to record video for use in classroom observations.**

_____ **I give permission for Head Start to allow classroom photos and videos to be taken by parents.**

_____ **I give permission for Head Start to take my child on Head Start field trips.**

_____ **I give Bear River Head Start permission to release my child to the individuals listed on the back of this page in the event of an emergency.**

_____ **Every child is required to be screened to determine where the development level of the child is at the beginning of their time in Head Start. This information gives the teacher a starting point to plan the goals and activities for the children. I give Bear River Head Start permission to screen my child and I understand that all results will be kept confidential and reviewed with me. I understand I have the right to refuse permission for this screening.**

_____ **I give permission for Head Start to perform mental health observations in the classroom and at socializations.**

I understand that this permission form remains in effect for one year or for the duration my child remains in Head Start. I understand I may cancel/revoke this authorization at any time by submitting a written request.

_____________________________________ _____________________________________

Parent/Guardian Signature Date **Staff Signature Date**

BEAR RIVER HEAD START

Child Medical Information Form

Child's Name____ Birthdate______________ Gender: Male___ Female___

Parents Name____ Phone________________

HAS YOUR CHILD BEEN SERVED ON WIC FROM *DECEMBER 2015 TO PRESENT TIME?* [ ] YES [ ] NO

***Please state the city of the specific WIC department that services your child:*___________________ *WIC ID #*__________________**

If yes, please sign below. By signing below, you are giving Bear River Head Start permission to get documentation of your child's latest Hematocrit/Hemoglobin from WIC.

As the legal guardian of ____________________________,I give permission for Bear River Head Start to receive documentation of my child's latest Hematocrit/Hemoglobin.

____ ____________________

Parent/Guardian Signature Date

SCREENING PERMISSION FORM

Bear River Head Start has my permission to do necessary, non-invasive screenings throughout the year. These screenings will include:
(Please initial each blank)

_____Hearing and Vision _____Developmental Screening ______Height/Weight ______Social/Emotional Screening

These screenings are required for all children enrolled in Head Start. Be assured that the test information will be kept confidential and will only be used to plan special activities for your child.

Parent(s)/Guardian(s):____________________________________ Date:___________________

CHILD HEALTH RECORD

Pregnancy/Birth History (Please explain any "yes" answers on the line provided after each question.)

Yes	No	
___	___	Did mother have any health problems during this pregnancy or during delivery?______________________________
___	___	Did mother visit physician fewer than two times during pregnancy?____
___	___	Was child born outside of a hospital?____
___	___	Was child born more than 3 weeks early or late?____
___	___	Did the child have low birth weight?____
___	___	What was child's birth weight? ___________________lbs., ____________________oz.
___	___	Were there any health concerns with child at birth?____
___	___	Were there any health concerns with child in the nursery?____
___	___	Did child or mother stay in hospital for medical reasons longer than usual?__________________________________
___	___	Is mother pregnant now?____

Hospitalizations and Illnesses (Please explain any "yes" answers on the line provided after each question.)

Yes	No	
___	___	Has child ever been operated on or hospitalized?____
___	___	Has child ever had a serious accident (broken bones, head injuries, falls, burns,poisoning)?____________________
		____
		____
		____
___	___	Has child ever had a serious illness?____
___	___	Has child ever had chest x-rays____

Health Problems

Does child ***frequently*** have any of the following conditions? (Please explain any "yes" answer on the line provided after each question)

Yes	No	
___	___	sore throat___
___	___	cough___
___	___	urinary infections or trouble urinating___
___	___	stomach pain, vomiting, diarrhea___

Has child ever had ***OR*** currently have any of the following illnesses or conditions? (Please mark any applicable illness or condition)

- ☐ boils
- ☐ chickenpox
- ☐ eczema
- ☐ german measles
- ☐ scarlet fever
- ☐ diabetes
- ☐ high lead levels
- ☐ problems with teeth, gums, or mouth
- ☐ whooping cough
- ☐ hives
- ☐ polio
- ☐ asthma
- ☐ bleeding tendencies
- ☐ sickle cell disease
- ☐ overweight
- ☐ child abuse and neglect
- ☐ heart/blood vessel disease
- ☐ liver disease
- ☐ rheumatic fever
- ☐ measles
- ☐ mumps
- ☐ epilepsy
- ☐ underweight
- ☐ Tramatic Brain Injury (Head Injury)

Please further explain any illnesses or conditions that were marked above:

___

___

Yes	No	
___	___	Has child ever had a convulsion or seizure? If yes, when did it last happen?___
___	___	Is child taking medicine for seizures? If yes, what medicine?___

ALLERGIES: Please list all allergies and the **CHILD'S REACTION** to the allergens when he or she is exposed to them.

FOOD Allergies/Reaction:___

MEDICATION Allergies/Reaction:___

OTHER Allergies when near animals, furs, insects, dust, etc./Reaction:___

Vision and Hearing (Please explain any "yes" answers on the line provided after the question.)

Yes	No	
___	___	Does child have difficulty seeing (squint, crosses eyes, look closely at books)?___
___	___	Is child wearing (or supposed to wear) glasses? If yes, was last checkup more than one year ago?___
___	___	Does child have problems with ears/hearing (tubes in ears, pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?___

Medication/Doctor Information

Yes	No	
___	___	Is child taking any medication now? (Special consent form must be signed for Head Start to administer any medication) **If yes: What Medicine:**___
		Will it need to be given while child is at Head Start?___
		How often will the medication need to be given to the child?___
___	___	DOES CHILD TAKE **FLUORIDE TABLETS OR FLOURIDE RINSE?**
___	___	Is child now being treated by a physician or dentist?
		If yes, for what condition(s) or illness(s)?___
		Physician's Name:___

Yes	No	
___	___	Do any of the conditions discussed above hinder the child's everyday activities?
		If yes, describe how activities are limited:___
___	___	Did a doctor or other health professional tell you the child had this problem? ***If yes, when?***___
___	___	Are there any other conditions that have **NOT** been discussed that hinder the child's everyday activities?
		If yes, explain which conditions:___
		Describe how activities are limited:___
___	___	Did a doctor or other health professional tell you the child had this problem? ***If yes, when?***___

BELOW THIS LINE STAFF USE ONLY

USO DE PERSONAL SOLAMENTE

This section is to be completed by the staff recruiter. Please complete interview with parent, *INITIALS* by those that apply and an *NA* if it does not. ***Esta sección debe ser completada por el personal. Por favor complete la entrevista con los padres, ponga sus INICIALES a los que aplique y una NA a los que no aplique.***

_____ Current Income (check stubs, W2, tax form 1040, or employer letter)
Verificación de ingresos (Formulario de impuestos (1040), forma W-2, talones de cheques, carta de portón)

_____ Proof of age-birth certificate OR christening/blessing certificate
Prueba de edad (acta de nacimiento O acta de bautismo)

_____ Immunizations Record
Carta de Vacunas

_____ Scholarship/grants
Becas

_____ Child Support
Menutenicon de hijos

_____ WIC ID Number
Numero de WIC

_____ Health release initialed and signed
Firme y ponga sus iniciales en la forma de Autorización Para las Aéreas de Salud y Educación

_____ If marked Yes, as living arrangement temporary, document why.
Si marco SI, donde vive un arreglo temporal, explique su situación

_____ Verify all members have a full date of birth
Verifice que todos los miembros de la familia tengan una fecha de nacimiento completa.

_____ Medical & dental appointment dates & doctors information
Información medica y dental con fechas de citas

_____ SSI, TANF, or Foster Placement form
Forma de SSI, TANF, o colocación de hogar (Foster care)

_____ Complete emergency contact information
Complete la forma de Información de Contactos de Emergencia

______ Both parents education/employment status filled in with both or one working parents income.
Educación/estatus laboral de ambos padres, igual que el ingreso de ambos o de un solo padre.

I, the parent have completed this interview with a Bear River Head Start staff. He/she has reviewed that all information has been submitted with my application. By signing this form, I certify to the best of my knowledge and belief that all information regarding eligibility provided by me is true and accurate.
Yo el padre he completado esta entrevista con un representante de Bear River Head Start. El/Ella revisado que toda la información se ha presentado con mi solicitud. Al firmar este formulario, certifico a lo mejor de mi conocimiento y creencia que se proporciona toda la información relativa a elegibilidad por mí es verdadera y exacta.

I, staff member of Bear River Head Start, have reviewed and conducted this interview with the parent/guardian.
Yo, representante de Bear River Head Start, he revisado y completado esta entrevista con el padre/guardián.

Parent/Guardian Signature____ **Date** _______________
Firma del Padre/Guardián *Fecha*

Witness/Staff Signature____ **Date** _______________
Firma del Testigo/Personal *Fecha*

In order to more effectively let families know about Head Start and what we provide, we would appreciate one minute of your time. Please fill out this survey and return it with your application.

1, Circle the letter that best describes how you first heard about Head Start:

A. Past Head Start family
B. Neighbor or Friend
C. Reading a flyer
D. Listening to the Radio
E. Head Start booth, what booth_____________
F. Being contacted by a Head Start Employee
G. Phone book
H. Internet
I. Other ___________________

2, Circle the letter that best describes how you obtained an application:

A. Head Start mailed you one
B. From a Friend or Neighbor
C. From your Family Advocate
D. From a community event
E, From a Community agency
F. From a Head Start Teacher
G. Other___________________

Comments/Notes:

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