

BEAR RIVER HEAD START APPLICATION

YEAR: 2015-2016

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 **OR** christening/blessing certificate
- 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 2015), 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, 2015, 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 2015-16

Family Member Information

Staff Only

Child Plus # _____ Date application received _____ Staff recruiter _____

Preschool Head Start (PHS) **Early Head Start (EHS)** **Child Care Connection (CCC)** **Early Childcare Partnership (ECP)**
 Serving children Serving children Serving children Serving children
 3 (by Sept 1) -5 years old 0 - 3 & pregnant mothers 3-5 years old 0-4 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) <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, is this due to loss of housing or because of inability to afford housing? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do any of the following apply to your household at this time?			
		<input type="checkbox"/> Sharing a residence <input type="checkbox"/> Living in a hotel <input type="checkbox"/> Living in a shelter <input type="checkbox"/> Living in a car, park, campground, or public space <input type="checkbox"/> 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: <input type="checkbox"/> One parent <input type="checkbox"/> Two parents <input type="checkbox"/> Relative <input type="checkbox"/> 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 __ Oneida/S.Bannock					
PHS Home Based Program Options: __ Box Elder __ Cache __ Rich __ Caribou __ Franklin __ Snowville __ South Bannock					
PHS Center Based Program Options: <i>UTAH</i> __ Brigham AM __ Brigham PM __ Fielding __ Logan AM __ Logan AM (3 & 4 yr olds) __ Logan PM __ Logan AM (3 yr. olds) __ Logan PM (3 yr. olds) __ South Cache __ Richmond __ Smithfield __ CCC Combination __ Hyrum <i>IDAHO</i> __ Paris __ Preston AM __ Preston PM __ Malad __ Soda Springs					
Please mark all that you receive: <input type="checkbox"/> TANF <input type="checkbox"/> SSI <input type="checkbox"/> Medicaid <input type="checkbox"/> WIC ID# _____ (The following documents will be required and retained with the application: SSI/TANF)					
Referral (please present documentation) <input type="checkbox"/> School District <input type="checkbox"/> Health Department or WIC <input type="checkbox"/> CAPSA <input type="checkbox"/> Up to 3 program <input type="checkbox"/> Doctor/Health Care Provider <input type="checkbox"/> Division of Child & Family Services or CPS <input type="checkbox"/> 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

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

Are you Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO If you answered yes please answer the following questions.	What kind of medical insurance is covering your pregnancy? <input type="checkbox"/> Public Assistance <input type="checkbox"/> Private Insurance <input type="checkbox"/> None Providers Name: _____	Prenatal Care Received: <input type="checkbox"/> YES <input type="checkbox"/> NO
(Due Date) Expected Delivery Date ___/___/___	Participating in support or educational groups for pregnancy, child birth, or parenting during current pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO Other Drugs: <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: _____ Caffeine <input type="checkbox"/> YES <input type="checkbox"/> NO Non-Prescription Drugs: <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: _____ Cigarettes <input type="checkbox"/> YES <input type="checkbox"/> NO Prescription Drugs: <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: _____	Primary Prenatal Care Provider: _____ Primary Health Care Provider: (If Different) _____
Medical or Health services currently received: <input type="checkbox"/> No services currently being received <input type="checkbox"/> Medical Assistance Since ___/___/___ <input type="checkbox"/> Substance Abuse Treatment Since ___/___/___ <input type="checkbox"/> Other Services, Specify _____ <input type="checkbox"/> Mental Health Counseling/Treatment Since ___/___/___ <input type="checkbox"/> 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: <input type="checkbox"/> Birth/Government ID Certificate <input type="checkbox"/> Blessing/Christening Certificate <input type="checkbox"/> Authorized Verification from Hospital <input type="checkbox"/> Government Identification Initialed by: _____		Up to Date Immunizations (Copy included with application) <input type="checkbox"/> Yes <input type="checkbox"/> No Initialed by: _____		Yearly Income: Verified by: _____ Date: _____ <input type="checkbox"/> Income Eligible <input type="checkbox"/> Over Income <input type="checkbox"/> Other _____		

Family Member Information

Primary Adult (person filling out form)

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 <input type="checkbox"/> Masters Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Associates Degree <input type="checkbox"/> Training/Tech Cert. <input type="checkbox"/> Some College/Tech school	<input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Grade 12 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 9 or less specify _____	Employment Status <input type="checkbox"/> Full time 35+ hours <input type="checkbox"/> Full time & training <input type="checkbox"/> Part time <input type="checkbox"/> Part time & training <input type="checkbox"/> Training or school	
English Proficiency <input type="checkbox"/> None (doesn't speak or understand) <input type="checkbox"/> Poor (doesn't speak but understands) <input type="checkbox"/> Moderate (speaks & understands a little) <input type="checkbox"/> Proficient (speaks & understands)	Primary Language: [] English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Ethnicity:	Race (check all that apply) <input type="checkbox"/> Asian [] American Indian or Alaska Native <input type="checkbox"/> Black [] Pacific Islander <input type="checkbox"/> White [] Hispanic <input type="checkbox"/> 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

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 <input type="checkbox"/> Masters Degree <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Associates Degree <input type="checkbox"/> Training/Tech Cert. <input type="checkbox"/> Some College/Tech school	<input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Grade 12 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 9 <input type="checkbox"/> Other _____	Employment Status <input type="checkbox"/> Full time 35+ hours <input type="checkbox"/> Full time & training <input type="checkbox"/> Part time <input type="checkbox"/> Part time & training <input type="checkbox"/> Training or school	
English Proficiency <input type="checkbox"/> None (doesn't speak or understand) <input type="checkbox"/> Poor (doesn't speak but understands) <input type="checkbox"/> Moderate (speaks & understands a little) <input type="checkbox"/> Proficient (speaks & understands)	Primary Language: [] English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Ethnicity:	Race (check all that apply) <input type="checkbox"/> Asian [] American Indian or Alaska Native <input type="checkbox"/> Black [] Pacific Islander <input type="checkbox"/> White [] Hispanic <input type="checkbox"/> 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? <input type="checkbox"/> YES [] NO [] N/A (not applicable)		
Name	Address	Home () ()
Date of Birth	City	Cell () ()
	State/Zip	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 <input type="checkbox"/> Female <input type="checkbox"/>
		Date of birth:
English Proficiency <input type="checkbox"/> None (doesn't speak or understand) <input type="checkbox"/> Poor (doesn't speak but understands) <input type="checkbox"/> Moderate (speaks & understands a little) <input type="checkbox"/> Proficient (speaks & understands)	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____ Ethnicity:	Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other _____

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

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
		Date of birth:
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship to child applying:		

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
		Date of birth:
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship to child applying:		

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
		Date of birth:
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship to child applying:		

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
		Date of birth:
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship to child applying:		

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
		Date of birth:
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO	Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Relationship to child applying:		

OTHER CHILDREN OR ADULTS IN FAMILY

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status <input type="checkbox"/> This person is a child <input type="checkbox"/> Full time 35+ hours <input type="checkbox"/> Full time & training	<input type="checkbox"/> Part time <input type="checkbox"/> Part time & training <input type="checkbox"/> Training or school	<input type="checkbox"/> Seasonally employed <input type="checkbox"/> Retired or disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status <input type="checkbox"/> This person is a child <input type="checkbox"/> Full time 35+ hours <input type="checkbox"/> Full time & training	<input type="checkbox"/> Part time <input type="checkbox"/> Part time & training <input type="checkbox"/> Training or school	<input type="checkbox"/> Seasonally employed <input type="checkbox"/> Retired or disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status <input type="checkbox"/> This person is a child <input type="checkbox"/> Full time 35+ hours <input type="checkbox"/> Full time & training	<input type="checkbox"/> Part time <input type="checkbox"/> Part time & training <input type="checkbox"/> Training or school	<input type="checkbox"/> Seasonally employed <input type="checkbox"/> Retired or disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status <input type="checkbox"/> This person is a child <input type="checkbox"/> Full time 35+ hours <input type="checkbox"/> Full time & training	<input type="checkbox"/> Part time <input type="checkbox"/> Part time & training <input type="checkbox"/> Training or school	<input type="checkbox"/> Seasonally employed <input type="checkbox"/> Retired or disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status <input type="checkbox"/> This person is a child <input type="checkbox"/> Full time 35+ hours <input type="checkbox"/> Full time & training	<input type="checkbox"/> Part time <input type="checkbox"/> Part time & training <input type="checkbox"/> Training or school	<input type="checkbox"/> Seasonally employed <input type="checkbox"/> Retired or disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker

OTHER CHILDREN OR ADULTS IN FAMILY

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status	<input type="checkbox"/> Part time	<input type="checkbox"/> Seasonally employed
<input type="checkbox"/> This person is a child	<input type="checkbox"/> Part time & training	<input type="checkbox"/> Retired or disabled
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<input type="checkbox"/> Full time & training		<input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status	<input type="checkbox"/> Part time	<input type="checkbox"/> Seasonally employed
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<input type="checkbox"/> Full time 35+ hours	<input type="checkbox"/> Training or school	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Full time & training		<input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status	<input type="checkbox"/> Part time	<input type="checkbox"/> Seasonally employed
<input type="checkbox"/> This person is a child	<input type="checkbox"/> Part time & training	<input type="checkbox"/> Retired or disabled
<input type="checkbox"/> Full time 35+ hours	<input type="checkbox"/> Training or school	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Full time & training		<input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status	<input type="checkbox"/> Part time	<input type="checkbox"/> Seasonally employed
<input type="checkbox"/> This person is a child	<input type="checkbox"/> Part time & training	<input type="checkbox"/> Retired or disabled
<input type="checkbox"/> Full time 35+ hours	<input type="checkbox"/> Training or school	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Full time & training		<input type="checkbox"/> Homemaker

First name:	Last name:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Related by blood, marriage or adoption: <input type="checkbox"/> YES <input type="checkbox"/> NO		Date of birth:
Relationship to child applying:		Lives with family? <input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status	<input type="checkbox"/> Part time	<input type="checkbox"/> Seasonally employed
<input type="checkbox"/> This person is a child	<input type="checkbox"/> Part time & training	<input type="checkbox"/> Retired or disabled
<input type="checkbox"/> Full time 35+ hours	<input type="checkbox"/> Training or school	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Full time & training		<input type="checkbox"/> 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 _____

Consents for Screenings

Other Permissions/Releases

Heights/Weights	Y N	Lead	Y N	Share health records with school system	Y N
Hematocrit Hemoglobin	Y N	Dental	Y N	Use of child's photograph	Y N
Other (Specify)	Y N			Other (Specify)	Y N

Allergies

Medication

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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 2014 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)

- | | | |
|--|--|--|
| <input type="checkbox"/> boils | <input type="checkbox"/> whooping cough | <input type="checkbox"/> heart/blood vessel disease |
| <input type="checkbox"/> chickenpox | <input type="checkbox"/> hives | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> eczema | <input type="checkbox"/> polio | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> german measles | <input type="checkbox"/> asthma | <input type="checkbox"/> measles |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> bleeding tendencies | <input type="checkbox"/> mumps |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> sickle cell disease | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> high lead levels | <input type="checkbox"/> overweight | <input type="checkbox"/> underweight |
| <input type="checkbox"/> problems with teeth, gums, or mouth | <input type="checkbox"/> child abuse and neglect | <input type="checkbox"/> Traumatic 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 and mark all that apply with parent. Esta sección debe ser completada por el personal. Por favor complete la entrevista y marque todo lo que aplica a la familia.

- _____ 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
- _____ WIC ID Number (if applicable)
Numero de WIC (si es aplicable)
- _____ Health releases 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. (if applicable)
Si marco SI, en Es donde vive un arreglo temporal explique su situación (si es aplicable)
- _____ Verify all members have a full date of birth
Verifique 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 (if applicable)
Forma de SSI, TANF, o colocación de hogar (Foster care)(si es aplicable)
- _____ 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. They have 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 personal de Bear River Head Start. Han 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.
Yo, miembro 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*

