BEAR RIVER HEAD START APPLICATION

YEAR: 2013-2014

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

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) 730-2626 or 734-9343 / **Fielding** (435) 881-1881 / **Franklin** (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. Parent 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 Disablitity* *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 that public school's take.

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

[ ] ***Physical***: Your child will need a yearly physical exam with a medical doctor. If you child has visted the doctor with the year, please obtain a copy of the physical exam that was done.

[ ] ***Hematocrit/Hemoglobin:*** Your child will need a hematocrit or hemoglobin to be done at the time of their physical if they are NOT on WIC for the 2013-2014 school year.

[ ] ***Lead Test***: If you child 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 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 - that starts in September 2013), and IF your child is selected to attend Bear River Head Start, you will receive a letter informing you your child has been accepted into the program.

After August 27, 2013, 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 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 service 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 2013-14

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

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 1) 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: ***UTAH*** __ Brigham AM __ Brigham PM __ Fielding __ Hyrum __ Logan AM __ Logan AM (3 & 4 yr olds) __ Logan PM __ Logan AM (3 year olds) __ Millville __ Richmond __ Smithfield __ CCC Combination
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 certify that this information is true. I also understand that the information in this application will be held in strict confidence with in the agency and is available to me during normal business hours.* **I understand that I must contact Head Start if I have any changes to this application.**

Parent/Guardian Signature_____ Date _____

Parent/Guardian 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) 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? [ ] 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

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 FAMILY

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 FAMILY

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
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[ ] 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
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[ ] 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:______________

Insurance: Private, Medicaid, or other________________________
Circle one

Hospital: Name ______________________________________ Phone ________________________

Physician: Name ______________________________________ Phone ________________________

Date of last or upcoming physical exam_________________________

Dentist: Name ____ Phone _________________________

Date of last or upcoming dental exam____________________________

Allergies/Medical Condition	**Medication**

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 ___________________

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 ___________________

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 2012 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	□ whooping cough	□ heart/blood vessel disease
□ chickenpox	□ hives	□ liver disease
□ eczema	□ polio	□ rheumatic fever
□ german measles	□ asthma	□ measles
□ scarlet fever	□ bleeding tendencies	□ mumps
□ diabetes	□ sickle cell disease	□ epilepsy
□ high lead levels	□ overweight	□ underweight
□ problems with teeth, gums, or mouth	□ child abuse and neglect	□ 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?***_____

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. Passing by a Head Start 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:

Dear Parents/Guardians:

Head Start is excited that you are considering our program for your child and look forward to receiving your child's application.

PLEASE CONTACT CAMI AT 1-877-755-0081, EXT. 324, IF YOU DO NOT HAVE INSURANCE FOR YOUR CHILD, ARE UNABLE TO PAY FOR THE FOLLOWING EXAMS, OR NEED A DOCTOR AND/OR DENTIST FOR YOUR CHILD.

MEDICAL & DENTAL REQUIREMENTS

[ ] ***Physical***: Your child will need a yearly physical exam with a medical doctor.

[ ] ***Hematocrit/Hemoglobin:*** Your child will need a hematocrit or hemoglobin to be done at the time of their physical if they are NOT on WIC for the 2013-2014 school year. *If your child is on WIC, Head Start will obtain your child's HCT/Hgb by using the WIC release on the Medical Information Form, attached to the application. Make sure you sign this release if your child is on WIC. Please do* ***NOT*** *attempt to obtain your child's HCT/Hgb from the WIC office.*

[ ] ***Lead Test***: If your child has never had a lead test, obtain a lead test at the time of their physical. If your child does not have Medicaid insurance, please call the Health Specialist at 1-877-755-0081, ext 324.

[ ] ***Dental Exam***: Your child will need a dental exam with a dentist. 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:

DTP-4 shots	**HEP A-2 shots**	**HEP B – 3 shots**
HIB-1+ shot	**VARICELLA-1 shot**	**MMR – 1 shot**
POLIO – 3 shots	***PREVNAR/PCV/PNUEMOCOCCAL-4 shots**	

If one of your child's Prevnar/Pnuemococcal vaccines is NOT a PCV-13, then he or she must receive a PCV-13 vaccine to be considered up-to-date.

PLEASE TAKE THE ATTACHED FORMS TO THE DOCTOR/DENTIST. AFTER THE EXAMS, INCLUDE THEM WITH YOUR HEAD START APPLICATION.

Sincerely,

Rachel Cook- Health and Wellness Coordinator
Cami McArthur-Health Specialist
Cherie Pierce-Oral Health Specialist

BEAR RIVER HEAD START
DENTAL SERVICES FORM

Service Date: _____

Child's Name: _____

Parent's Name: _____

Dentist's Name: _____

Dental Insurance? Yes or No

Name of Insurance: _____

Services Rendered: **(Please Check all that apply)**

- ☐ Exam
- ☐ X-rays
- ☐ Child Prophy
- ☐ Fluoride
  * Was a fluoride supplement discussed/prescribed at this appointment? _____
- ☐ Oral Hygiene Instruction
- ☐ Restorations/Treatment *****Please include a treatment plan of work completed during this appointment.***

Results of Appointment:

☐ Child needs no further work at this time. Six month appointment set: _____.

OR

☐ Further Work is needed. ***Please include a copy of the treatment plan.***
- Follow up appointment is set for: _____.
- Anticipated number of appointments to complete treatment: _____.

OR

☐ Treatment discontinued. Please explain:

_____

_____

Comments:

_____

_____

I hereby certify that the services listed above have been performed.

_____ _____

Dentist Signature Date

Please Return to:
BRHS Oral Health Specialist
95 West 100 South #200
Logan, UT 84321
(435) 755-0081 ext. 240
FAX: (435) 755-0125

HEAD START HEALTH EXAM

CHILD'S NAME: _____ **DATE OF EXAM:** _____

Child's Birth date: _____ Physician: _____

Parent's Name: _____

Address: _____

Phone Number: _____

Please send to: Bear River Head Start
Attention: Health Specialist
95 W. 100 S., Suite 200, Logan, UT 84321
Fax: 435-755-0125

Required Information by Head Start

Ht: _____ Hematocrit: _____

Wt: _____ Hemoglobin: _____

Vision: _____ Lead: _____

EXAMINING PHYSICIAN PLEASE NOTE

The information asked for on this form is a Federal requirement of Head Start. If you are unable to complete all sections, please explain why in the section for comments. Also, any condition found to be abnormal needs a "YES" or "NO" checked in the Follow-up Needed area. Thanks.

Immunization Received today (if needed):

DTP Hib Polio Hep B MMR

CLINICAL EVALUATION

Dental Screening □ Y □ N
Concerns: _____ Referral Made □ Y □ N

□ Lead assessment completed with Parent (refer to back of form)
Insurance of Child _____
Lab Referral made □ Y □ N If not why? _____

*

CLINICAL EVALUATION	NORMAL	ABNORMAL	IF ABNORMAL, DESCRIBE FINDINGS	FOLLOW-UP NEEDED?	REFERRED
General Appearance				□ Y □ N	
Skin				□ Y □ N	
Hair				□ Y □ N	
Eyes: Pupils, EOM's, (Vision)				□ Y □ N	
Ears: Canals, TM (Hearing)				□ Y □ N	
Nose/ mouth				□ Y □ N	
Neck and Thyroid				□ Y □ N	
Heart and Circulatory (blood pressure)				□ Y □ N	
Chest and Lungs				□ Y □ N	
Lymph Nodes				□ Y □ N	
Abdomen (including hernias)				□ Y □ N	
Genito - urinary				□ Y □ N	
Bones, joints, muscles				□ Y □ N	
Gross motor function				□ Y □ N	
Fine motor function				□ Y □ N	
Reflexes, sensory				□ Y □ N	

Comments: _____

Reminder: If child is not on WIC, a lab order needs to be made for HCT/Hgb. EVERY child needs a lab order for a lead test. Head Start requires every child to receive a lead test and HCT/Hgb

_____ _____
Signature and Title **Date**

Feb 2010

Lead Screening Assessment

Lead exposure causes reductions in IQ, is correlated with failure to graduate from high school, as well as a tendency toward violence, addictive behaviors, and other behavioral and emotional problems. Lead toxicity screening is covered by Medicaid and many private health plans. The Centers for Disease Control and Prevention and the American Academy of Pediatrics recommend a lead risk assessment and a blood lead level test for all Medicaid eligible children between the ages of 6 and 72 months. This component of the CHEC screening is mandated by federal rules. **All children ages 6 to 72 months of age are considered at risk for lead poisoning and must be screened.**

La exposición al plomo puede causar una reducción en el cociente intelectual y esta relacionada con el incumplimiento de la escuela secundaria, asi como una tendancia hacia la violencia, comportamientos adictivos, y otros problemas emocionales y de comportamiento. La prueba para determinar el plomo toxico es cubierto por Medicaid y muchas de las aseguranzas privadas. El Centro para el Control y Prevención de la Enfermedad y la Academia Americana de Pediatras recomiendan una prueba del riesgo de plomo para todos los niños elegibles por Medicaid entres las edades de 6 a 72 meses. Esta prueba es mandatoria por las reglas federales. **Todos los niños entre 6 a 72 meses tienen el riesgo del envenenamiento de plomo y deben recibir la prueba.**

	Yes	No		Si	No
Does your child live in or regularly visit a house built before 1978?			¿Vive su niño en una casa construida antes del año 1978 o visita una regularmente?		
Does the house have peeling or chipping paint?			¿Tiene esta casa pintura que esta levantada o mellada o desportillada?		
Do your children live in a house built before 1978 with recent, ongoing, or planned renovation or remodeling?			¿Vive su niño en una casa construida antes del año 1978 que estan planeando renovar o ha sido recien renovada?		
Have any of your children or their playmates had lead Poisoning?			¿Ha tenido algunos de sus niños o sus amigos envenenamiento por el plomo?		
Do your children frequently come in contact with an adult who works with lead (e.g. construction, welding, pottery)?			¿Tiene su niño contacto regular con alguna persona quien trabaja con el plomo? (por ejemplo, construcción, soldadura, o alfarería)		
Does your child live near a lead smelter, battery recycling plan or other industry likely to release lead?			¿Vive su niño cerca a una planta de reciclaje de baterías/pilas, o otra fabrica que emite el plomo?		
Do you use any home or folk remedies that may contain lead?			¿Usa Usted algun remedio tradicional de casa que puede contener el plomo?		
Does your child live near a heavily traveled major highway where soil & dust may be contaminated with lead?			¿Vive su niño cerca a una autopista donde el polvo o la tierra pueden ser contaminados con el plomo?		
Does your home's plumbing have lead pipes or copper with lead solder joints?			¿Tiene su casa tuberías de plomo o cobre que estan unidos con soldadura de plomo?		

Has your Child received a blood lead test in the last 12 months? Yes or No

¿Ha Recibido su niño una prueba de sangre de plomo en los 12 meses pasados? Si o No

Guardian Signature: _____ Date: _____

Child's Name:_____ Class:_____

Office Use Only

Classification	High Risk	Low Risk
Determination	If the answer to ***any*** of the questions above is positive	If the answers to ***all*** of the questions above are negative
Action Required	Child should receive a blood test immediately and at subsequent screening examinations	Child is considered low risk for lead exposure, but should receive a blood test at 12 months and 24 months

PPhysicians are to reference CDC guidelines for patient management and treatment treatment.**

Dec 2008