

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 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 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 your child has visited 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 your 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
Mailing Address (If different from living address)		City	State	Zip
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
 - ☐ Child care center or home
 - ☐ Through a public school pre-kindergarten program
 - ☐ 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 ____/____/____ ☐ Other Services, Specify _____ ☐ WIC / Other Nutritional Services Since ____/____/____ ☐ Substance Abuse Treatment Since ____/____/____ ☐ Mental Health Counseling/Treatment 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 _____
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Primary Adult (person filling out form)

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 ☐ High School Graduate ☐ Masters Degree ☐ GED ☐ Bachelors Degree ☐ Grade 12 ☐ Associates Degree ☐ Grade 11 ☐ Training/Tech Cert. ☐ Grade 10 ☐ Some College/Tech school ☐ Grade 9 ☐ Other _____		Employment Status ☐ Full time 35+ hours ☐ Seasonally employed ☐ Full time & training ☐ Retired or disabled ☐ Part time ☐ Unemployed ☐ Part time & training ☐ Homemaker ☐ Training or school		
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:				

Do you give permission for Bear River Head Start to contact Non-Custodial **parent** for Head Start purposes?

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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	Primary Language: ☐ English	Race (check all that apply)	
☐ None (doesn't speak or understand)	☐ Spanish	☐ Asian ☐ American Indian or Alaska Native	
☐ Poor (doesn't speak but understands)	☐ Other _____	☐ Black ☐ Pacific Islander	
☐ Moderate (speaks & understands a little)	Ethnicity:	☐ White ☐ Hispanic	
☐ Proficient (speaks & understands)		☐ 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		Date of birth:
Relationship to child applying:		Lives with family? ☐ YES ☐ NO

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

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

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

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

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:
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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 ☐
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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
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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: _____

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

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

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: _____

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 | ☐ 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 FLUORIDE 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:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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/Pneumococcal 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: _____

Services Rendered: (Please Check all that apply)

Child's Name: _____

Parent's Name: _____

Dentist's Name: _____

Dental Insurance? Yes or No

Name of Insurance: _____

☐ Exam

☐ X-rays

☐ Child Propy

☐ 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