



H.C.C.A.O. Head Start Application

Dear Parent / Guardian:

Thank you for choosing our Head Start Program for your child's educational needs.

For your child to be enrolled into the Head Start Program you will need to complete this application and return it to us along with copies of your child's birth record, shot record, insurance and income for your family.

When you return the application bring in these things and we can make copies for you.

Before your child may be enrolled your child must also have a dental and physical. These forms for the doctor and dentist are enclosed in the application. Please keep them and take them to your appointment for the Drs. to fill out.

It is best if you return the application and items to be copied, if you cannot get your child's appointment until a later date.

These can be dropped off when they are completed at any Head Start Center or the Head Start Office.

Our hours are Monday – Friday 8 a.m. to 4:30 p.m.

If you have any question please contact me at 393-3458.

Thank You,

Pam Miller

Record & Recruitment Manager



APPLICATION CHECK LIST

Copies:

____ Physical *Date: _____ POINTS
____ Dental *Date: _____
____ Birth Record
____ Shot Record
____ Insurance _____ IE
____ Income
____ Custody Papers
____ Care Plan _____ OI

Forms:

____ Transportation Form
____ 3 Page Health Form
____ Lead Poisoning Assessment _____ AM
____ 3 Page Child's Health Record
____ Lead & Hemoglobin Permission Form
____ Permission and Policy Form _____ PM
____ Bus Policy Form
____ CSBG Form
____ CACFP Enrollment Form
____ Information Form
____ Ethnic and Racial Data Form

CHILD'S NAME _____ CENTER _____

BIRTHDATE: _____ PHONE: _____

PARENT NAME: _____

ADDRESS: _____

PICK-UP ADDRESS: _____

DROP-OFF ADDRESS: _____

AGE: _____

COMMENTS: _____

UPDATED TRANSPORTATION FORM FOR HEAD START

Child's Name: _____

Parents'/Guardians' Name: _____ Home # _____

Cell Phone # _____ Work # _____ Head Start Center _____

Custody Papers for Child: YES ___ NO ___ (Must have updated copies of any changes)

HOME ADDRESS: _____

TRANSPORTATION INFORMATION:

Child Pick Up Location : _____

Directions: _____

Child Drop Off Location: _____

Directions: _____

EMERGENCY CONTACTS:

Please note that these contacts may be called and do have permission for your child to be released to if you can not be reached. (Contacts will be called in order that they are listed.)

1. Name: _____ Address: _____
Relationship to Child: _____ Phone # _____

2. Name: _____ Address: _____
Relationship to Child: _____ Phone # _____

3. Name: _____ Address: _____
Relationship to Child: _____ Phone # _____

4. Name: _____ Address: _____
Relationship to Child: _____ Phone # _____

5. Name: _____ Address: _____
Relationship to Child: _____ Phone # _____

6. Name: _____ Address: _____
Relationship to Child: _____ Phone # _____

PARENT'S SIGNATURE: _____ DATE: _____

Ohio Department of Job and Family Services
**CHILD ENROLLMENT AND HEALTH INFORMATION
 FOR CHILD CARE CENTERS AND TYPE A HOMES**

This form shall be completed prior to the child's first day of attendance and updated annually and as needed.

Child's Name		Date of Birth		First Day at Center	
Home Address				City	
State		Zip Code		Home Telephone Number	
Parent/Guardian Name			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program?					
Parent/Guardian Name			Relationship to Child		
Home Address			Home Telephone Number		
City			State	Zip	
Email Address (if applicable)			Cell Phone		
Parent's Work/School Telephone Number			Parent's Work/School Name		
Parent's Work/School Address				City	
Please indicate if this name should be released if a parent/guardian, of a child attending the center/home, requests contact information for other parents/guardians. <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered yes, please indicate which number(s) above to include on the list <input type="checkbox"/> Work # <input type="checkbox"/> Cell # <input type="checkbox"/> Home # <input type="checkbox"/> Email					
Where can you be reached while your child is in this program?					
Emergency Contacts: Parents <u>cannot be listed</u> as emergency contacts. List the name of <u>at least one person</u> who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/home, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.					
Name			Name		
City		State	City		State
Telephone Number		Relationship to Child	Telephone Number		Relationship to Child
Other numbers where emergency contact can be reached (if applicable)			Other numbers where emergency contact can be reached (if applicable)		
Name of Physician or Clinic/Hospital					
Street Address					
City			State	Telephone Number	

Child's Name

Allergies, Special Health or Medical Conditions, and Food Supplements

Fill in this section accurately and completely. Please note that if your child has a **current** health or medical condition requiring child care staff to perform child specific care, such as: to monitor the condition, provide treatment, care, or to give medication, the JFS 01236 "Medical/Physical Care Plan" or equivalent form and/or the JFS 01217 "Request for Administration of Medication" must be completed and be kept on file at the center or type A home.

Does your child have any food, medication or environmental allergies? (*check all that apply*)

No

Yes - check all that apply Food Medication Environmental Please list and explain:

Does your child's allergy/allergies require child care staff to monitor child for symptoms, take action if a reaction occurs, or give emergency medication to your child? (*check one*)

No

Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Does your child have a special health or medical condition? (*check one*)

No

Yes - please explain

Does the special health or medical condition require child care staff to perform a procedure, or perform child specific care such as: to monitor your child for symptoms or administer medication during child care hours? (*check one*)

No

Yes - a JFS 01236 "Medical/Physical Care Plan" or equivalent form and if administering medication, a JFS 01217 "Request for Administration of Medication" must be completed.

Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (*check one*)

No

Yes - please explain

If yes, does this medication, food supplement, or medical food need to be administered at the child care center/type A home?

No

Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication, food supplement or medical food.

N/A - program does not administer any medications.

Does your child have any dietary restrictions, including those for medical, religious or cultural reasons? (*check one*)

No

Yes - please explain

Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group?

No

Yes - written instructions from the child's health care provider must be on the JFS 01217 "Request for Administration of Medication."

N/A - child does not attend a full time program.

Child's Name
List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.
List any additional information about your child that would be useful for staff to know, such as fears, eating or sleeping habits, or special routines. This information should not be medical or health related, as that information should be included on the previous page.

Diapering Statement

Is your child toilet trained? <input type="checkbox"/> Yes (If yes, skip to Emergency Transportation Authorization section) <input type="checkbox"/> No (If no, fill out the following)
The program's policy is to check diapers every ____ hours. Please indicate if you want your child's diaper checked according to the center/type A home's policy or another:
<input type="checkbox"/> I agree with the program's schedule <input type="checkbox"/> I do not agree, please check my child's diaper every ____ hours.

Emergency Transportation Authorization

Give <u>Permission</u> to Transport	OR	<u>Do Not Give Permission</u> to Transport
Center or Type A Home Name HEAD START / EARLY HEAD START		Center or Type A Home Name HEAD START / EARLY HEAD START
has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.	Do not sign both	does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. I wish for the following action to be taken:
Parent's Signature _____ Date _____		Parent's Signature _____ Date _____

Acknowledgement of Policies and Procedures

I have reviewed and received a copy of the center's or type A home's policies and procedures/handbook. <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(check one)</i>
This form, after being completed and signed by the parent/guardian, must be reviewed for completeness and signed by the administrator/designee prior to the child receiving care. After the child is attending the program the administrator shall have the parent/guardian review and initial the form when any changes/updates are made and at least annually. The parent/guardian and the administrator or designee shall initial and date the form in the section below to indicate when the form was last reviewed.
Parent/Guardian Signature(s) _____ Date _____
Administrator/Designee Signature _____ Date _____

The form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.			
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review
Parent/Guardian Initials	Date of Review	Administrator/Designee Initials	Date of Review

Note: This is a prescribed form which must be used by centers and type A homes to meet the requirements of rules 5101:2-12-37 and 5101:2-13-37. This form must be on file at the center or type A home on or before the child's first day of attendance and thereafter while the child is enrolled.



CHILD'S NAME: _____

1. Does your child live or regularly visit a house built before 1960? Yes No Unsure
2. Was your child's daycare center or babysitter's home built before 1960? Yes No Unsure
3. Does your home have peeling, chipping, dusting, or chalking paint? Yes No Unsure
4. Have any of your children's playmates had lead poisoning? Yes No Unsure
5. Does your child frequently come in contact with an adult who works with lead? (example: construction, pottery, welding, etc) Yes No Unsure
6. Does your child live near a lead smelter, battery recycling plant, or other industry likely to release lead? Yes No Unsure
7. Do you give your child any home or folk remedies which may contain lead? Yes No Unsure
8. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead? Yes No Unsure
9. Does your child drink well water? Yes No Unsure
10. Does your home have lead or copper pipes that are soldered with lead? Yes No Unsure

****If you have answered "Yes" or "Unsure" to any of the above questions your child may be at risk for Lead Poisoning.**

****Lead Screenings on all children should occur at age 1 and 2 years old, or up to 6 years of age if no test has been administered.**

There is no safe level of lead in the blood. Any confirmed level of lead in the blood is a reliable indicator that the child has been exposed to lead.

Parent/Guardian Signature that completed questionnaire:

Date: _____

CHILD'S HEALTH RECORD

Child's Name: _____ DOB: _____ Gender: _____

Parent/Guardians Names: _____

FAMILY HISTORY

1. Have any of the child's direct blood relatives (parents, grandparents, aunts, uncles, brothers or sisters) had any of the following conditions? Yes No

If yes, please check the condition(s)

___ Bleeding Conditions	___ Allergies	___ Anemia	___ Asthma
___ High Blood Pressure	___ Cancer	___ Diabetes	___ Heart Problems
___ Seizures	___ Mental Illness	___ Mental Retardation	___ Overweight
___ Tuberculosis	___ Sickle Cell Diseases	___ Sickle Cell Trait	___ SIDS
___ Other: _____			

CHILD'S MEDICAL RECORD

1. In the last year, has this child had any of the following conditions? Yes No

___ Allergies	___ Anemia	___ Asthma	___ Boils	___ Bleeding Conditions
___ Broken Bones	___ Cancer	___ Chicken Pox	___ Diabetes	___ Eczema
___ Hives	___ Heart Conditions	___ High Blood Pressure	___ High Lead	
___ Mumps	___ Measles	___ Immune System Disease	___ Inherited Disease	
___ Liver Disease	___ Seizures	___ Mental Retardation	___ Mental Illness	
___ Overweight	___ Pneumonia	___ Sickle Cell Disease	___ Sickle Cell Trait	
___ Tubes in Ears	___ Tonsils Removed	___ Rheumatic Fever	___ Scarlet Fever	
___ Underweight	___ Other			

Please comment on any checked condition:

2. Is your child receiving treatments for the following conditions? Yes No

___ Anemia	___ Asthma	___ Overweight	___ Hearing Difficulties
___ Vision Problems	___ High Lead Levels	___ Diabetes	___ Other

3. Is your child currently taking any medication at home? Yes NO

Name of Medication:

Dose:

How Often?

4. If your child has a health problem, has it been diagnosed by a doctor or health care professional?

Yes No

If yes, please explain:

5. Has your child ever had surgery? **Yes** **No**

If yes, please explain:

6. Has your child ever had a seizure? **Yes** **No**

If yes, please explain:

7. Has your child ever been diagnosed with asthma? **Yes** **No**

If yes, please explain how often, causes (if known) and date of last asthma attack:

If yes, has the child ever been hospitalized for asthma?

8. Has your child ever had an allergic reaction? **Yes** **No**

If yes please explain to what and what type of reaction your child had:

9. Has the child ever had problems with the following? **Yes** **No**

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent Ear infections | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Frequent Fevers |
| <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Frequent Bed-wetting | <input type="checkbox"/> Frequent Chest Pains |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Frequent Stomach Ache | <input type="checkbox"/> Problems with Urine |
| <input type="checkbox"/> Problems with Bowels | <input type="checkbox"/> Problems Eating | <input type="checkbox"/> Problems with Teeth |
| <input type="checkbox"/> Problems Hearing | <input type="checkbox"/> Problems with Seeing | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Frequent Trouble Sleeping | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Other Frequent Problems: | | |

10. Has your child ever been involved in a child abuse or neglect incident or case? **Yes** **No**

If yes, please explain:

11. Does your child have any additional conditions that interferes with his/her daily activities? **Yes** **No**

If yes, please explain:

BEHAVIOR/ ACTIVITY HISTORY

1. Does your child currently have an individual Education Plan (IEP)? **Yes** **No**

If so, what school district completed the IEP?

2. Children learn at different ages. To help Head Start assess your child's developmental level, please complete the following chart:

ACTION OR ACTIVITY	AT WHAT AGE DID YOUR CHILD DO THE FOLLOWING
Sit up without help	
Crawl	
Walk	
Talk	
Feed and dress self	
Use the toilet	
Understand things being said to him/her	
Follow simple directions	
Play with toys	
Use crayons	

MEDICAL AND DENTAL HOME

1. Do you have a regular doctor for your child? Yes No

Name of Doctor:

Address

Phone Number

When did you obtain a doctor for your child? **Before** Head Start enrollment or **After** (Please Circle)

2. Do you have a regular dentist for your child? Yes No

Name of Dentist:

Address

Phone Number

3. When did you obtain a dentist for your child?

Before Head Start enrollment or **After** (Please Circle)

4. Does your child need dental treatment? Yes No

If yes, has the appointment been made or is it completed?

***Parent/Guardian Signature that completed survey:** _____

***Date completed:** _____



HCCAO HEAD START / EARLY HEAD START
Lead & Hemoglobin Permission Form

Dear Parent Guardian,

HCCAO Head Start, Early Head Start and WIC will be offering lead and hemoglobin screenings to children enrolled. A member of the health team and WIC nurse will perform these services at the WIC office in Hillsboro, 1487 North High Street.

In order for your child to participate your signature and insurance information are required. Your signature will allow us to perform the test one time during the school year.

If your child has already received the lead and hemoglobin, we will need a copy of the results. If we do the screenings, a copy of the results will be sent to you.

Child's Information (Please Print.)

Name _____ Date of Birth ____/____/____

Address _____

City _____ State _____ Zip Code _____

Social Security # (REQUIRED) _____

Home Phone # _____

Please Check One (Please Print)

Name of Insurance _____ Medicaid _____ Private Insurance _____ No Insurance _____

- If you have private insurance you will be notified of the date due to a \$ 15.00 fee for lead test

Parent / Guardian Name _____ Date of Birth ____/____/____

Parent Signature _____ Date _____

HEAD START/ EARLY HEAD START

(Permission and Policy Form)

CHILD'S NAME: _____ CHILD'S BIRTHDATE: _____

1. I give Head Start and Early Head Start permission for my child to appear in photographs, films, local cable T.V. shows, newspapers, and videos. ___ yes ___ no

2. I give Head Start and Early Head Start my permission to release information to Help Me Grow. ___ yes ___ no

3. I give Head Start and Early Head Start my permission to have my child's name and phone number listed on the Parent Roster in my child's classroom. ___ yes ___ no

4. I give Head Start and Early Head Start my permission for my child to participate in all Head Start and Early Head Start screenings mandated by the Federal Performance Standards, during the school year in which my child is enrolled. (Height, weight, vision, hearing, speech, educational, and developmental.) ___ yes ___ no

5. I give my permission to Head Start and Early Head Start to have my child's health record and screening results sent to the appropriate public school at the completion of the school year. ___ yes ___ no
(PLEASE LIST CHILD'S SCHOOL DISTRICT _____.)

6. I give my permission for Head Start and Early Head Start to obtain medical and dental information from any physician or dentist office and any hospital or clinic my child has been a patient. ___ yes ___ no

7. I give Head Start and Early Head Start my permission to have my child's Creative Curriculum(Teaching Strategies Gold) information sent to my child's school district. ___ yes ___ no

8. During Head Start and Early Head Start program reviews, all regulatory authorities could have access to review your child's file. _____
Parent Initials

.....

GRIEVANCE PROCEDURES

Grievance / complaint must be in writing and signed by the person who makes the complaint. Unsigned grievances or complaints will not be answered.

1. Grievance / complaints are then submitted to the Family and Community Manager who will in turn give it to the Director of Early Childhood Program. If preferred the grievance / complaint may be submitted to the Director of Early Childhood Program directly.
2. The Director shall have 10 days to resolve the grievance or will present it to the Policy Council for discussion.

I give my permission for the above items and have read and understand the grievance procedures.

_____ Signature _____ Date

Highland County Community Action Organization, Inc School Bus Policy

HCCAO Head Start offers bus transportation for eligible children. Children and families must follow all the HCCAO Head Start rules as listed below, in the Parent Handbook and as explained by the bus driver.

1. Your child may be transported to and from a school-approved, specified location to the appropriate school each school day.
2. Only Head Start children, parents, staff, and volunteers may ride in Head Start buses. Parents are welcome to ride on the bus to school if room is available.
3. All children must remain in their Child Restraint Systems (CRS) while being transported. If your child will not stay in their CRS, the bus driver will first discuss the issue with the parent and document for the child's file. If improvement does not occur, Center Manager or Transportation Manager will then contact the parent to make alternate transportation arrangements. Bus transportation may resume once the child is able to stay in the CRS.
4. There will be no smoking on the bus at any time.
5. Please do not send backpacks, toys, umbrellas, or other objects with your child on the bus due to safety issues. If you need to send anything (change of clothes, forms, etc.) give them to the bus driver, so it can be secured on the bus.
6. **Children must be brought all the way to the bus door and met at the bus door by a parent/guardian or person 16 years old or older that is listed on the Transportation Form.**
7. You/responsible person and your child must be at the Designated Point of Safety (DPOS) **10 minutes** before the scheduled bus pick-up time and the scheduled drop-off time. If you are not at the DPOS at the designated time the bus will leave and you will need to bring the child to the center or pick them up at the center.
8. You and your child must stay at the Designated Point of Safety (DPOS) until the bus driver instructs you and the child to approach the bus during pick-up. At drop-off, you and your child must stay at the DPOS until the bus has left the stop.
9. The bus will stop only at designated locations. The driver will not stop between pick-up/drop-off locations to discharge children.
10. If there is a change in your telephone number, or number that you can be reached at, you are required to notify us right away. We must have a current working number for emergency situations.
11. If requesting a different pick-up or drop-off location you will need to complete the Transportation Form and return it to your driver or center for consideration/approval. It may take two (2) days for this process. Not all changes are guaranteed to have bus service.
12. If your child is sick or will not be riding the bus, please put the "red tag" sign in the window or appropriate location where the driver can see it. A "red tag" will be provided by the center.
13. It is very helpful for the bus driver, if your child is not coming, for you to call the center prior to the scheduled pick-up time.
14. In the event a child is taken home and there is no approved person to receive the child, the driver will contact the center and then continue on with the route. At that time the Center Manager or Transportation Manager will attempt to contact you by phone. If you can not be reached we will attempt to contact someone who is listed on the Transportation Form. Whoever is contacted will need to pick-up the child at the Head Start Center.
15. If all attempts to contact someone have failed, the Center Manager or Transportation Manager will contact the Highland County Sheriff's Department or the local police and have them pick-up the child.

I, _____, am the guardian of

Please Print Name

a minor child

Please Print Name

receiving transportation services provided by Highland County Community Action Organization, Inc. I have read and understand the procedures that apply to transportation and I consent and agree to abide by them. I have received a copy of these procedures and am aware that they are also located in the Parent Handbook.

Please Sign

Date

ARRIVAL AND DEPARTURE POLICY

Upon arrival, staff will transition children to the classrooms.

At time of departure, staff is responsible for taking children to designated buses.

SELF-TRANSPORT OR PARENT/GUARDIAN PICK-UP OR DROP-OFF

Parent/Guardian must sign child in/out on Sign-In/Out Log located in the child's classroom.

SS #: _____ Last Name: _____ First Name: _____
 DOB: _____ Address: _____
 City: _____ Zip: _____ County: _____
 Phone #: _____ Message Phone #: _____ Whose Phone: _____

Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity: <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Native Alaskan	<input type="checkbox"/> Other <input type="checkbox"/> Hispanic or Latin <input type="checkbox"/> Multi-Race (any 2 or more above) <input type="checkbox"/> White <input type="checkbox"/> Asian
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Agency Site:
 Highland County Community Action

Client E-mail:

Education:

A. 0-8 B. 9-12 (Non-Grad)
 C. HS Grad/GED D. 12+
 E. 2-4 yr. Grad College

Food Stamps:

Yes
 No

Health Insurance:

A. Medicaid D. Self-Ins.
 B. Medicare E. None
 C. Private F. Unknown

Farmer:

A. Farmer
 B. Migrant
 C. Seasonal

Veteran:

Yes
 No

Family Type:

E. Single Par/Female
 M. Single Par/Male

Two Parent
 Single
 Couple
 Other

Housing:

Own Homeless
 Rent Other
 Amount \$ _____

Income Eligibility Period:

A. Weekly D. Annually
 B. Bi-Weekly E. 13 Weeks

C. Monthly F. 3 Months
 G. 6 Months

Income Level:

In HH:

Length of time in home:

Years
 Months

Income Amount: \$

Source of Income:

A. Employment B. Unemployment C. Social Security D. TANF
 E. GA F. SSI/SSD G. Pension H. No Income I. Other J. Zero Income
 K. Refused – Only use for programs that do NOT require income verification

Other Household Members
 Use codes from above ONLY for information listed below

SS#	Last Name	First Name	DOB	Gender (M/F)	Disabled (Y/N)	Ethnicity (B, A, NHPI, NA, HL, W, O,MR)	Education (A, B, C, D, E)	Veteran (Y, N)	Health Insurance (A, B, C, D, E, F)	Income Period (A, B, C, D, E, F)	Source (A, B, C, D, E, F, G, H, I, J, K)	Income Amount	Relationship to Applicant

Code #:													Initials	Date
# of Units:													Intake:	
Date of Service:													Data Entry:	

I certify that this statement is true and correct to the best of my knowledge, and I authorize the release of any or all information necessary for verification purposes.

Applicant Signature: _____ Date: _____

CHILD AND ADULT CARE FOOD PROGRAM ENROLLMENT FORM

Prototype form for use by child care centers and Head Start programs

CACFP programs exempt from having an enrollment form on file are: Emergency Shelters, Outside-School-Hours, Youth Development & After School At Risk

Instructions for Completion		
<ul style="list-style-type: none"> • All parents/guardians are to complete a separate form for each child enrolled at the child care or Head Start center. • List the child's name, age, birth date, the days and hours normally in care and the meals normally received while in care. • If the child comes before and after school, list the hours in care for both the morning and afternoon. • CACFP Federal regulations 226.15(e)(2) require that the enrollment form be updated annually and signed by the child's parent or guardian. 		
CENTER NAME		
CHILD'S NAME (please print)	AGE	BIRTHDATE / / month / day / year

CHECK THE NORMAL DAYS AND HOURS YOUR CHILD IS IN CARE AND THE MEALS RECEIVED WHILE IN CARE										
Check (✓) Days Child Normally in Care	List Hours Child Normally in Care				Check (✓) Meals Child Normally Receives while in Care					
	Arrive	Depart	Arrive	Depart	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

SIGNATURE OF PARENT/GUARDIAN	DATE	DAY PHONE NUMBER
MAILING ADDRESS		
STREET /APT.	CITY	ZIP CODE

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination on the basis of race, color, national origin, age, sex and disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW Washington, DC 20250-9410 or call (202)720-5964 (voice and TDD). USDA is an equal opportunity provider and employer. (3/2005)

H.C.C.A.O. HEAD START/ EARLY HEAD START INFORMATION SHEET

Child's Name _____ DOB _____ Age _____

Mother's Name _____ DOB _____ Mother in Home? _____

Father's Name _____ DOB _____ Father in Home? _____

Number in Family ____ Number in Household ____ Is the child you are enrolling a Foster Child? ____

Do You Have Custody Papers? _____ Are You a Past Head Start Parent? _____

Do You Live With Someone Else? _____ Who? _____

Name of Other Family Members in Home:

1. _____ Relationship to Child _____ DOB _____

2. _____ Relationship to Child _____ DOB _____

3. _____ Relationship to Child _____ DOB _____

4. _____ Relationship to Child _____ DOB _____

5. _____ Relationship to Child _____ DOB _____

Mother's Educational Level ____ Graduated? ____ Father's Educational Level ____ Graduated? ____

What Childcare Do You Use? Daycare _____ Relative _____ Babysitter _____ None _____

Was Your Child in Early Head Start? ____ Did or Do You Receive Services From Help Me Grow? ____

Do You Need Childcare? _____ Do You Receive WIC? _____ Do You Receive SSI? _____

Anyone in your home receive SSI? ____ Whom? _____ Do you receive a Food Card? ____

Do you receive OWF? _____ Do you receive TANF? _____

Do You Have Medical Insurance? _____ What Kind? _____ Were You a Teen Parent? _____

Are You Expecting? ____ Is Either Parent in School or Training? ____ Full Time ____ or Part Time? ____

Are You Employed? ____ Are You Employed Part Time? ____ or Full Time ____

Is Your Spouse Employed? ____ Full Time ____ or Part Time ____ Does Either Parent Have a Disability? ____

Does Your Child Have a Disability? ____ Does Your Child Have an IEP? _____

Do You Have Any Concerns With Your Child's Behavior? _____ If Yes, Check Those That Apply:

Attention _____ Anger _____ Speech/Communication ____ Movement ____ Vision ____ Hearing ____

Is This Your Child's 1st. ____ 2nd. ____ or 3rd Year in Head Start?

- ***I hereby certify that all information provided in this application is true and accurate***

PARENT/ GUARDIAN SIGNATURE _____ DATE: _____

ETHNIC and RACIAL DATA FORM

Agency/Daycare Center _____

Agency/Daycare Address _____

The agency or daycare listed above receives Federal financial assistance for participating in the Child and Adult Care Food Program (CACFP). Because they receive Federal financial assistance they are required to record and maintain the Ethnic and Racial data of all children enrolled in the CACFP. This information is used solely for the purpose of determining compliance with Civil Right laws and will be kept confidential. We are requesting for each participant to 'Self Identify' and provide this information, however it is optional to Self Identify. If you choose not to Self Identify, then please be aware that the agency/daycare will need to make a judgment of your child's race and ethnicity because Civil Rights law require them to do so.

To Self Identify, please answer the following questions.

Child's name _____

Ethnic Category: Choose one

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino".	
Non-Hispanic or Latino:	

Racial Categories: Check all that apply

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America, (including Central America), and who maintains tribal affiliation or community recognition.	
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	
Black or African American: A person having origins in any of the black racial groups of Africa.	
Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa	
Other	

Parent/Guardian Signature _____ Date _____

Construyendo Para El Futuro

Esta guardería infantil diurna participa en el Programa de Alimentación Para Niños y Adultos en Guarderías (CACFP por sus siglas en inglés: Child and Adult Care Food Program) un programa Federal que provee comidas y bocadillos saludables a niños y a adultos en guarderías diurnas.

Todos los días más de 2.6 millones de niños participan en el programa del CACFP en centros y En hogares de familia para el cuidado de niños. Los proveedores son reembolsados por servir Comidas nutritivas que cumplen con los requisitos establecidos por el Departamento de Agricultura de los Estados Unidos (USDA). El programa juega un papel vital al mejorar la Calidad de las guarderías y al poner las guarderías al alcance económico de familias de bajos recursos.

Alimentos Hogares y centros del CACFP siguen los patrones alimentarios establecidos por USDA.

Desayuno	Almuerzo o Comida	Bocadillos (Dos de los cuatro grupos)
Leche	Leche	Leche
Fruta o verdura	Carne o un alternativo de carne	Carne o un alternativo de carne
Granos o pan	Granos o pan	Granos o pan
	Dos porciones diferentes de frutas o verduras	Fruta o verdura

Establecimientos

del CACFP Muchos tipos de establecimientos diferentes operan el CACFP, compartiendo el objetivo común de brindar comidas y bocadillos nutritivos a sus participantes. Estos incluyen:

- **Centros de Cuidado de Niños (Child Care Centers)** Centros para el cuidado de niños, ya sean públicos o privados pero no lucrativos, que hayan sido licenciados o aprobados; programas del Head Start, y algunos centros para lucro.
- **Hogares de Familia Para el Cuidado de Niños (Family Day Care Homes)** Hogares privados licenciados o aprobados.
- **Programas Escolares Después de Clases (After School Care Programs)** Centros en áreas geográficas de bajos ingresos que proveen bocadillos gratis a niños de edad escolar y a jóvenes.
- **Centros de Refugio Para Gente Sin Hogar (Homeless Shelters)** Centros de emergencia de refugio que proveen servicios residenciales y de comidas a niños sin hogares.

Elegibilidad Agencias estatales reembolsan establecimientos que ofrecen cuidado no residencial a los siguientes niños:

- niños hasta los 12 años de edad,
- niños de familias migratorias hasta los 15 años de edad
- jóvenes hasta los 18 años de edad en programas escolares después de clases en áreas de necesidad.

Para Más

Información Si está interesado en participar en el CACFP, por favor póngase en contacto con uno de los siguientes:

Organización Patrocinadora/Centro

HCCAO Head Start /EHS
1487 North High Street
Suite 500
Hillsboro, Ohio 45133

Ohio Department of Education

CACFP Consultant
25 S. Front Street, MS 303
Columbus, OH 43215-4183
614-466-2945

Building For the Future

This day care facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children receiving day care.

Each day more than 2.6 million children participate in CACFP at child care homes and centers across the country. Providers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of day care and making it more affordable for low-income families.

Meals CACFP homes and centers follow meal requirements established by USDA.

Breakfast	Lunch or Supper	Snacks (Two of the four groups:)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating

Facilities Many different homes and centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- **Child Care Centers:** Licensed or approved public or private nonprofit child care Centers, Head Start programs, and some for-profit centers.
- **Family Child Care Homes:** Licensed or approved private homes.
- **After School Care Programs:** Centers in low-income areas provide free snacks to School-age children and youth.
- **Emergency Shelters:** Programs providing meals to homeless children.

Eligibility State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under,
- Migrant children age 15 and younger, and
- Youths through 18 in emergency shelters and after school care programs in needy areas.

Contact

Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

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HCCAO HEAD START/ EHS
1487 North High Street
Hillsboro, Ohio 45133
937-393-3458

Ohio Department of Education

CACFP Consultant
25 S. Front Street, MS 303
Columbus, OH 43215-4183
614-466-2945

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