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 your 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

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:

_____ Consent of Release of Information Form _____ AM
_____ Transportation Form
_____ 3 Page Health 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:** _____

1575 N. High Street, Suite 100, Hillsboro,Ohio 45133 Phone: 937-393-4278 Ext. 242 * Fax 937-393-4461

Highland County

FAMILY & CHILDREN FIRST COUNCIL
CONSENT FOR RELEASE OF INFORMATION

Name: _____ Date Of Birth :_____

Social Security Number (Optional) : _____

Name: _____ Date Of Birth: _____

Social Security Number (Optional) : _____

Name: _____ Date Of Birth: _____

Social Security Number (Optional) : _____

Name: _____ Date of Birth: _____

Social Security Number (Optional): _____

Name: _____ Date Of Birth: _____

Social Security Number (Optional):_____

The following agencies have my permission to exchange/give/receive/share/re-disclose information regarding service delivery planning for the purpose of securing, coordinating, and/or providing services for the above named person(s):

__X___ member agencies of the Early Childhood Collaborative Council (list attached)
__X___ member agencies of the "Cluster" Intervention Team (list attached)
__X___ specific agencies: _____
__X___Others:_____

By signing this form, I authorize sharing of the following information if needed by the receiving agency to secure, coordinate, and provide services to the individual:

- **Identifying Information**: Name, birth date, sex, race, address, telephone number, social security number.
- **Case Information:** The above identifying information, plus medical (except for HIV or AIDS, unless initialed below), drug and alcohol treatment records, social history, treatment/service history, psychological evaluations, educational plans and assessment, and other personal information regarding me or the individual named above.
- **Financial Information:** Public assistance eligibility and payment information providing for establishing eligibility including but not limited to pay stubs, W2's and tax returns, and other financial information.
- **Employment/School Information:** Potential employment possibilities, employment and/or barriers to employment, work history as needed. When applicable, school/training enrollment, course work, tuition and fees, attendance, and grades.

AGENCY NAME	ECCC	IA	OTHER
Scioto-Paint Valley Mental Health Center	X	X	
Paint Valley Mental Health, Alcohol and Drug Addiction Board	X	X	
Hopewell Special education Resources Center	X	X	
Highland County Children Services	X	X	
Highland County Juvenile Court	X	X	
Highland County Community Action Organization, Inc.	X	X	
Highland County MR/DD	X	X	
Greenfield Area Medical Center-*Member of Adena Health System*		X	
Family Recovery Services & BRIDGE Program	X	X	
Hillsboro City Schools	X	X	
Great Oaks & Turning Point Applied Learning Center	X	X	
Ohio Rehabilitation Services Commission (BVR)			X
H/C Department of Job & Family Services / Child Support Enforcement Agency	X	X	
Highland County Board of Education	X	X	
Lynchburg-Clay Local Schools	X	X	
Greenfield-McClain Exempt Village Schools	X	X	
Bright Local Schools	X	X	
Fairfield Local Schools	X	X	
Highland County Head Start	X	X	
Highland District Hospital	X	X	
Highland County Domestic Violence Task Force			X
Highland County Board of Health	X	X	
Highland County Society for Children and Adults, Inc.	X	X	
Ohio State University Extension Services -- Highland County	X	X	
Family Information Network	X	X	
Southern State Community College/Success Center/ABLE			X
Samaritan Outreach Services			X
St. Vincent DePaul Society			X
Ministerial Society			X
Veterans Association			X
Mitchell Society			X
Adult Parole Authority			X
Community Corrections			X
Senior Citizens Center			X
Highland County Law Enforcement			X
Ohio Early Start			X
Green Thumb			X
Highland Metropolitan Housing Authority			X
Project STORK			X
Greenfield Outreach			X
Ohio Department of Job and Family Services (Employment Services)			X
Perspective Employers			X
School and Training Institutions _____			X
Family Stability Program			X
Highland County Educational Service Center			X
WEP Work Site (s) _____			X
Parent Representative Name: _____	X	X	
Other: _____			
_____			

**Information regarding the following shall not be released unless circled and initialed below.*

YES NO _____ HIV and AIDS related diagnosis and treatment

I understand that the Consent for Release for Information expires 90 days from termination of case unless otherwise indicated herein by the consumer. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing with the date and my signature. The revocation does not include any information, which has been shared between the time that I gave permission to share information and the time that it was canceled.

This consent expired on the _____day of _____, 20 _____

I understand that my signing or refusing to sign this consent will not affect public benefits or services for which I am eligible.

_____	_____
Signature of Person	Date
_____	_____
Signature of Parent / Guardian	Date
_____	_____
Witness / Agency Representative	Date

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

To all agencies receiving information disclosed as a result of this signed consent:

1. If the record released include information of any diagnosis or treatment of drug or alcohol abuse, the following statement applies:
   -Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by federal law.
   -Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.
2. If the records released include information of an HIV-related diagnosis or test results, the following statement applies:
   -This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed consent of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for the purpose of the release of HIV test results or diagnoses.
3. The information has been disclosed to you from records protected by federal and/or state confidentiality rules. Any further release of it is prohibited unless the person, to whom it pertains, DYS in the case of youth records, or applicable federal and / or state law, expressly permits the further disclosure.

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			
City		State	Zip
Home Telephone Number		Cell Phone	
Work/School Telephone Number		Work/School Name	
Work/School Address		City	

Please indicate if this name should be included on a parent roster ☐ Yes ☐ No
If you answered yes, please indicate which number above to list on the roster ☐ Work number ☐ Cell number ☐ Home number

Where can you be reached while your child is in this program?

Parent/Guardian Name		Relationship to Child	
Home Address			
City		State	Zip
Home Telephone Number		Cell Phone	
Work/School Telephone Number		Work/School Name	
Work/School Address		City	

Please indicate if this name should be included on a parent roster ☐ Yes ☐ No
If you answered yes, please indicate which number above to list on the roster ☐ work number ☐ cell number ☐ home number

Where can you be reached while your child is in this program?

Emergency Contacts: Parents **cannot be listed** as emergency contacts. List the name of at least one person 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 and at least one person listed must be within one hour of the center/home and able to take responsibility for the child in case you cannot be contacted.

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 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, 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? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ No

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:

☐ I agree with the program's schedule ☐ I do not agree, please check my child's diaper every _____ hours.

Emergency Transportation Authorization

Give *Permission* to Transport			**_Do Not Give Permission_ to Transport**	
Center or Type A Home Name			Center or Type A Home Name	
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.		**OR** **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.

Parent/Guardian Signature	Date

Signatures

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. 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 to indicate the date reviewed.

Parent/Guardian Signature(s)			Date
Administrator/Designee Signature			Date
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.

HEAD START APPLICATION

(Permission and Policy Form)

CHILD'S NAME:_____ CHILD'S BIRTHDATE_____

1. **I give my permission for my child to appear in photographs, films, local cable T.V. shows, newspapers, videos.** **___yes ___no**

2. **I give my permission for my Head Start child to go on walking field trips.** **___yes ___no**

3. **I give 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 my permission for my child to participate in all Head Start screenings mandated by the Federal Performance Standards, during the school year in which my child in enrolled. (Height, weight, vision, hearing, speech, educational, and developmental)** **___yes ___no**

5. **I give my permission to have my child's health record and screening results sent to the appropriate public school at the completion of the school year. (PLEASE LIST CHILD'S SCHOOL DISTRICT_____)** **___yes ___no**

6. **I give my permission for 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 my permission to have my child's Creative Curriculum information sent to my child's school district. The National Reporting System Assessment to the Nation Head Start Processing Center and Get It, Got It, Go results to the Ohio Department of Education. (In all of these testing children are identified by number only.) These tests are <u>required</u> by the Ohio Department of Education and the Federal Head Start Bureau.** **___yes ___no**

8. ***In case of an emergency 911 will be called and your child will be transported by EMS to the nearest hospital.*** **_____ *Parent Initials***

****

GRIEVANCE PROCEDURES

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

1. **Grievance/complaint is then to be submitted to the Family and Community Manage who will in turn give it to the Head Start Director. If preferred the grievance/complaint may be submitted to the Head Start Director directly.**
2. **The Head Start 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

Ohio Department of Education - Off for Safety, Health and Nutrition

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

- 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**

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

(Please complete all information)

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_____ Date of Birth _____
2. _____Relationship to Child _____Date of Birth _____
3. _____Relationship to Child_____ Date of Birth _____
4. _____Relationship to Child_____ Date of Birth _____
5. _____Relationship to Child _____Date of Birth_____

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 ?_____

Do you receive A Food Assistance Card? ____Do you receive TANF? ____ Do you receive OWF?____

Do you have insurance ____ If yes, what kind _____Were you a teen parent? _____

Are you expecting? _____ Is either parent/ guardian in school or training? _____

Are you employed? _____ How long? ____ Spouse employed? ____ How long? _____

Is this your child's 1st ____ 2nd. ____ 3rd. ____ year in Head Start?

Does either parent/ guardian have a disability?_____

Does you child have an IEP? _____ What school district will your child be attending? _____

Do you have any concerns with your child's behavior? _____ If yes, Check those that apply: Anger ____

Attention ___ Speech/Communication____ Movement _____Vision ____ Hearing_____Other_____

- **I hereby certify that all information provided in this application is true and accurate.**
  PARENT/ GUARDIAN SIGNATURE _____ **Date:** _____

HIGHLAND COUNTY HEAD START

HILLSBORO • GREENFIELD • BELFAST

Physical Examination Form

CHILD'S NAME: _____ SEX: _____ BIRTH DATE: ____/____/____ AGE: _____

CHILD'S HEALTH HISTORY-*RELEVANT INFORMATION (FROM HEALTH HISTORY, OR PARENT OBSERVATIONS)*

MEDICAL CONDITIONS	ROUTINE MEDICATIONS	SURGERIES	ALLERGIES

SCREENING TESTS: Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years of age. Enter dates if done previously. When recording results, enter at a minimum "N"=Normal, "S"=Suspect, or "A"= Atypical/Abnormal. Your full cooperation is very appreciative.

TEST	DATE	RESULT	TEST	DATE	RESULT
Height			*Hearing Screening		
Weight			*Vision Screening Acuity R/L Strabismus		
BMI					
Blood Pressure			*Hemoglobin or Hematocrit		
Urinalysis			*Lead (Most Recent)		

SCREENINGS

GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

FINDINGS, TREATMENTS, AND RECOMMENDATIONS:

* **IMMUNIZATIONS UP TO DATE:** YES or NO (please circle)
If the answer is "NO", please circle the immunizations the child is lacking below:

DTAP HIB HBV IPV MMR Next Scheduled Appointment Date: _____

ASSESSMENT	NORMAL FOR AGE	ABNORMAL	NOT EVALUATED	COMMENTS
General Appearance				
Posture, Gait				
Speech				
Head				
Skin				
Eyes: External Aspects				
Optic Fundoscopic Cover Test				
Ears: External Aspects				
Tympanic Membranes				
Nose, Mouth, Pharynx				
Teeth				
Glands *Lymphatic/Thyroid*				
Heart				
Lungs				
Abdomen *Include hernia*				
Bones, Joints, Muscles				
Muscular Coordination				
Genitalia				
Nutrition				
Neurological/ Social				
Gross Motor				
Fine Motor				
Communication Skills				
Cognitive				
Self-Help Skills				
Social Skills				

PHYSICAL EXAM

* DATE OF EXAMINATION: _____

_____ _____

* *Physician Signature* * *Date*

_____

* *Office Address, City, State, & Zip Code*

_____ / _____

* *Office Phone Number* * *Office Fax Number*

THIS FORM IS TO BE COMPLETED BY A HEALTH CARE PROVIDER

Please fax and/or return this form to: H.C.C.A.O Head Start • PO Box 838 • 1487 N. High St., Hillsboro, OH, 45133
(937) 393-3458 • Fax (937)393-7175

Revised 12/2008

HIGHLAND COUNTY HEAD START

HILLSBORO • GREENFIELD • BELFAST

Dental Examination Form

CHILD'S NAME: _____ **SEX:** _____ **BIRTH DATE:** ____/____/____ **AGE:** _____

PARENT(S) NAME: _____ **PHONE NUMBER:** _____

INSURANCE NUMBER (MEDICAID OR PRIVATE INSURANCE): _____

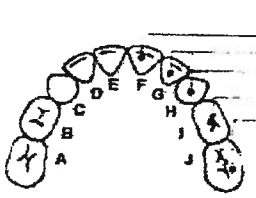
1) Diagnostic and Preventive Procedures Performed: ❑ Clinical Examinations ❑ Prophylaxis ❑ X-Rays ❑ Fluoride application ❑ Other _____

EXAMINATION AND TREATMENT RECORD:

INDICATE TEETH NEEDING TREATMENT (below on chart)

DATE OF EXAM: _____

Tooth # or letter	Description of Dental Services Required



Upper Teeth	Shed
Central Incisor	6-7 yrs.
Lateral Incisor	7-8 yrs.
Canine (Cuspid)	10-12 yrs.
First Molar	9-11 yrs.
Second Molar	10-12 yrs.

Lower Teeth	Shed
Second Molar	10-12 yrs.
First Molar	9-11 yrs.
Canine (Cuspid)	9-12 yrs.
Lateral incisor	7-8 yrs.
Central incisor	6-7 yrs.

2) Current Status: Cavities: _____ (How Many) Recurrent decay around old fillings: _____ (How Many)

Gums and supporting tissues: ❑ Normal & Healthy ❑ Slight inflammation (gingivitis) ❑ Moderate inflammation ❑ Advanced disease (periodontitis) Other: _____

3) Recommendation:

❑ No further treatment recommended at this time. Return in _____ months for an routine cleaning and examination.

❑ Additional dental treatment is required. Please complete the Treatment/Follow-up Plan identified below:

TREATMENT/ FOLLOW-UP PLAN

DENTAL TREATMENTS: Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

Date: _____ Outcome: _____

_____
DATE ALL TREATMENT WAS COMPLETED

I Certify that I, the Dental Care Provider has completed the service(s) listed in section 1, 2, & 3 including the Follow-Up Plan(if needed).

_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____ _____
Address, City, State & Zip Code Phone Number Fax Number

THIS FORM IS TO BE COMPLETED BY A DENTAL CARE PROVIDER.

Please fax and/or return this form to: H.C.C.A.O Head Start • PO box 838 • 1487 N. High St., Hillsboro, Ohio, 45133
(937) 393-3458 • Fax (937) 393-7175

Revised 12/2008

SS #: _____ **Last Name:** _____ **First Name:** _____

DOB: _____ **Address:** _____

City: _____ **Zip:** _____ **County:** _____

Phone #: _____ **Message Phone #:** _____ **Whose Phone:** _____

Gender:
☐ Female
☐ Male

Disabled:
☐ Yes
☐ No

Ethnicity:
☐ Black or African American
☐ Native Hawaiian/Pacific Islander
☐ Native American/Native Alaskan
☐ Other
☐ Hispanic or Latin
☐ Multi-Race (any 2 or more above)
☐ White ☐ Asian

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:
☐ F. 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					

													Initials	Date
Code #:														
# 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: _____

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**_____

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.

(OVER)

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.