APPLICATION CHECK LIST

- *Please note that children cannot be considered for enrollment unless application is complete. Must have a complete physical, dental. Copies of birth record, shot record, insurance and proof of income to be considered complete.*
  (This is for 2nd year children also.)

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
_____ Income Verification Form
_____ CSBG Form
_____ CACFP Enrollment Form
_____ Information Form
_____ Ethnic and Racial Data Form

CHILD'S NAME _____ CENTER _____ AGE_____

BIRTHDATE: _____ PHONE: _____ CELL: _____

PARENT NAME: _____

ADDRESS: _____

PICK-UP ADDRESS: _____

DROP-OFF ADDRESS: _____

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:** _____

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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ 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. ☐ Yes ☐ No

If you answered yes, please indicate which number(s) above to include on the list ☐ Work # ☐ Cell # ☐ Home # ☐ 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 <u>of 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? ☐ Yes (If yes, skip to Emergency Transportation Authorization section) ☐ 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:

☐ 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 HEAD START / EARLY HEAD START		**OR** Do not sign both	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.			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. ☐ Yes ☐ No *(check one)*

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.

HCCAO HEAD START
CBC BLOOD LEAD POISONING RISK ASSESSMENT QUESTIONAIRE

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 Disease	____ 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**

__Frequent Ear infections	__Frequent Sore Throats	__ Frequent Fevers
__ Frequent Cough	__ Frequent Bed-wetting	__ Frequent Chest Pains
__ Frequent Colds	__ Frequent Stomach Ache	__ Problems with Urine
__ Problems with Bowels	__ Problems Eating	__ Problems with Teeth
__ Problems Hearing	__ Problems with Seeing	__Eye Problems
__ Speech Problems	__ Frequent Trouble Sleeping	__ Temper Tantrums
__ 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:** _____

community Action PARTNERSHIP
Helping People. Changing Lives.

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 a nurse from the Hillsboro WIC office or the Greenfield WIC office will perform these services.

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. (PLEASE LIST CHILD"S SCHOOL DISTRICT _____.) ___ yes ___ no

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.

Head Start Eligibility Verification

1. Child's name: _____

2. Child's date of birth: _____

3. This child is eligible to participate in the program. ☐ Yes ☐ No

4. Check the applicable category of eligibility for this child:

☐ SSI
☐ Homeless
☐ Foster Care
☐ Public Assistance

☐ Income (*check box that applies*):
- ☐ Below federal poverty guidelines
- ☐ Between 100-130% of federal poverty guidelines (No More than 35% of enrolled children may fall Into this category)

☐ Over-income
- ☐ Counted as part of 10% maximum for non-AI/AN Programs
- ☐ Counted as part of the 49% maximum for AI/AN Programs

5. What documentation was used to determine eligibility?

☐ Income Tax Form 1040
☐ W-2
☐ TANF documentation
☐ Pay stub or pay envelope
☐ Unemployment
☐ Written statements from employers
☐ Foster care reimbursement
☐ SSI documentation
☐ Other

If other, please explain: _____

Documentation of no income: _____

I hereby certify that all documentation recorded above is a complete and accurate representation of income received by my family.

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date of eligibility verification: _____

Staff Name: _____ Title: _____

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: _____

Ohio Department of Education – Office 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

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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 Paper? _____ Are You a Past Head Start/ Early Head Start Parent? _____

Do You Live With Someone Else? _____ Who? _____Are You Homeless? _____

Name The Other Family Members in the Home:

1. _____ Relationship to Child _____ DOB _____
2. _____Relationship t o 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? _____

Do You Use Childcare? ____ Relative _____ Babysitter_____ None_____ Do You Need Childcare? _____

Was Your Child in Early Head Start? ____Was Your Child in Help Me Grow? ____Do You Receive WIC_____

Do You or Anyone in Your Family Receive SSI? _____ Who? _____ Do You Receive TANF? ____

Do You Receive OWF? _____ Do You Receive a Food Card? _____ Do You Have Medical Insurance? _____

What Kind of Insurance?_____ Were You a Teen Parent? _____ Are You Pregnant? _____

Parent/Parents in School or Training? _____Are You Employed? _____ Full Time _____ Part Time _____

Are You Employed Less Than One Year? _____ Spouse Employed? _____ Full Time _____Part Time _____

Spouse Employed Less Than a Year? _____ Parent/ Guardian Incarcerated? _____

Does Your Child Have a Disability? _____ IEP _____ Does Parent Have a Disability ? _____

Were You Referred by Another Agency? _____ Was Your Child on a Waiting List Last Year? _____

Is Anyone in Your Family Receiving Mental Health Counseling or Treatment? _____

Do You Have Any Concerns About Your Child's Behavior? _____What? _____

How Did You Hear About The Head Start Program? _____

Is This Your Child's ____ 1st. ____2nd. Or ____ 3rd. Year in Head Start?

- ***I hereby certify that all information provided in the 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**_____

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:

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

* **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: _____

_____ _____

Physician Signature *Date

_____

*Office Address, City, State, & Zip Code

_____ / _____

*Office Phone Number *Office Fax Number

* **DATE OF EXAMINATION:** _____

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): _____

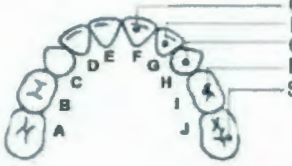
1) Diagnostic and Preventive Procedures Performed: ❑ Clinical Examinations ❑ Prophylaxis ❑ X-Rays ❑ Fluoride application ❑ Other_____

EXAMINATION AND TREATMENT RECORD:

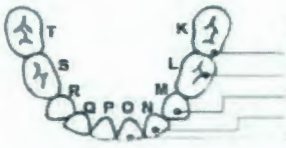
INDICATE TEETH NEEDING TREATMENT (below on chart)

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 a 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

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