



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:** _____

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 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. 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	Do Not Give <u>Permission</u> 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.	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		Parent's Signature
Date		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.



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	___ Inherited Disease
___ Mumps	___ Measles	___ Immune System Disease	___ Mental Illness	___ Mental Retardation
___ Liver Disease	___ Seizures	___ Sickle Cell Disease	___ Sickle Cell Trait	___ Pneumonia
___ Overweight	___ Tonsils Removed	___ Rheumatic Fever	___ Scarlet Fever	___ Other
___ Tubes in Ears				
___ Underweight				

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 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 from Help Me Grow and Job & Family Services for verification of cash assistance, food assistance and child support benefits. ___ 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

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:

- | | |
|--|---|
| <input type="checkbox"/> SSI | <input type="checkbox"/> Income (<i>check box that applies</i>): |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Below federal poverty guidelines |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Between 100-130% of federal poverty guidelines
(No More than 35% of enrolled children may fall
into this category) |
| <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Over-income |
| | <input type="checkbox"/> Counted as part of 10% maximum for non-AI/AN
Programs |
| | <input type="checkbox"/> Counted as part of the 49% maximum for AI/AN
Programs |

5. What documentation was used to determine eligibility?

- | | |
|---|--|
| <input type="checkbox"/> Income Tax Form 1040 | <input type="checkbox"/> Written statements from employers |
| <input type="checkbox"/> W-2 | <input type="checkbox"/> Foster care reimbursement |
| <input type="checkbox"/> TANF documentation | <input type="checkbox"/> SSI documentation |
| <input type="checkbox"/> Pay stub or pay envelope | <input type="checkbox"/> Other |
| <input type="checkbox"/> Unemployment | 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: _____

THE PAPERWORK REDUCTION ACT OF 1995(Pub.L.104-13) Public reporting burden for this collection of information is estimated to average.08 hours per Response, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct of sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number OMB 0907-0374: Expires 02/28/2013

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 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? _____

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: _____

Ohio Department of Education - Office for Child Nutrition
CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Required 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 schedule listed will frequently vary due to changes in parent/guardian schedule, check response box below chart.
- 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 an enrollment form be **completed 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										

Yes, The schedule listed above may frequently vary due to changes in parents/guardians schedule

SIGNATURE OF PARENT/GUARDIAN **DATE** **DAY PHONE NUMBER**

MAILING ADDRESS:
STREET /APT. **CITY** **ZIP CODE**

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html , or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

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.** This ethnic and racial information will remain confidential and on file for 3 years and will only be accessible to authorized personnel.

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

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	S C R E E N I N G S
Height			*Hearing Screening			
Weight			*Vision Screening Acuity R/L Strabismus			
BMI			*Hemoglobin or Hematocrit			
Blood Pressure			*Lead (Most Recent)			
Urinalysis						

GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

FINDINGS, TREATMENTS, AND RECOMMENDATIONS:

This is to certify that I have examined this child and found that this child:

- 1) Has had the immunizations required by section 3313.671 of the revised code for admission to school, or has had the immunizations required by the state Department of health for infants and toddlers, or is to be exempted from these requirements for medical reasons, and
- 2) Based upon his/her medical history and physical condition at the time of this examination, is free from apparent communicable disease and is suitable for enrollment in a child day care facility, and
- 3) Is up-to-date on the state EPSDT schedule.

What the Child needs to become up-to-date:

IMMUNIZATIONS NEEDED:

DTAP HIB HBV IPV MMR VARICELLA

ASSESSMENT	NORMAL FOR AGE	ABNORMAL	NOT EVALUATED	COMMENTS	P H Y S I C A L E X A M
General Appearance					
Posture, Gait					
Speech					
Head					
Skin					
Eyes: External Aspects					
Optic Fundoscopic Cover Test					
Ears: External Aspects					
Tympanic Membranes					
Nose, Mouth, Pharynx					
Teeth					
Glands <i>Lymphatic/Thyroid</i>					
Heart					
Lungs					
Abdomen <i>include hernia</i>					
Bones, Joints, Muscles Muscular Coordination					
Genitalia					
Nutrition					
Neurological/ Social					
Gross Motor					
Fine Motor					
Communication Skills					
Cognitive					
Self-Help Skills					
Social Skills					
* DATE OF EXAMINATION: _____					

* Physician Signature _____

* Date _____

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

* Office Phone Number _____

* Office Fax Number _____

Please fax and/or return this form to: H.C.C.A.O Head Start • 1487 N. High St. Suite 500, Hillsboro, OH, 45121 (937) 393-3458 • Fax (937)393-7175

Revised 3/2014

THIS FORM IS TO BE COMPLETED BY A HEALTH CARE PROVIDER



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

