HCCAO Early Head Start Application

Dear Parent/Guardian:

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

For your child to be enrolled into the Early 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, proof of insurance, and income for your family.

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

Before your child may be enrolled, your child must also have a completed physical and dental (if they are 24 months or older). These forms for the Dr. and the Dentist are enclosed in this application.

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

These can be dropped off when they are completed at the Early Head Start Office. Our hours are Monday thru Friday 8:00am to 4:30pm.

If you have any questions, please feel free to contact me at 937-393-3458.

Sincerely,

Gina Esposito

EHS Records and Recruitment Manager

APPLICATION CHECK LIST

Copies:

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

Forms:

_____ 3 Page Health Form
_____ Lead Poisoning Assessment
_____ 3 Page Child's Health Record
_____ Lead & Hemoglobin Permission Form
_____ Permission and Policy Form
_____ CSBG Form
_____ Information Form
_____ Ethnic and Racial Data Form

CHILD'S NAME _____ BIRTHDATE: _____

PHONE: _____

PARENT NAME: _____

ADDRESS: _____

AGE: _____

COMMENTS: _____

CHILD ENROLLMENT AND HEALTH INFORMATION FOR CHILD CARE

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 Program/Home
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/home?

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/home?

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. 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 family child care 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 your 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 program'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**	
Program or Home Name			Program or 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 program's or 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.

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 child care providers to meet the requirements to rules 5101:2-12-15 and 5101:2-13-15. This form must be on file at the program or home on or before the child's first day of attendance and thereafter while the child is enrolled.

Family Health History

Child's Name _____ DOB: _____ Gender: _____

Parent / Guardian Names: _____

Family History

1. Have any of the child's direct blood relatives (parents, grandparents, aunts, uncles, brothers and 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 ___ Seizures

_____ Heart Problems _____ Mental Illness _____ Mental Retardation

_____ Overweight _____ Tuberculosis _____ Sickle Cell ____ SIDS

_____ Sickle Cell Trait 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 ___ Cancer

___ Liver Disease ____ Broken Bones _____ Chicken Pox ____ Diabetes

____ Eczema ___Hives ____ Heart Conditions ____ High Blood Pressure ____ Mumps

____ High Lead ____ Measles ___ Immune System Disease ____ Inherited Disease

____ Seizures _____ Mental Retardation ____ Mental Illness ____ Overweight

_____ Pneumonia ____ Sickle Cell Disease ____ Sickle Cell Trait ____ Tubes in cars

____ Tonsils Removed ____ Rheumatic Fever _____ Scarlet Fever Other: _____

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

___ Anemia ____ Asthma ____ Overweight _____ Hearing Difficulties ____ Diabetes

___ Vision Problems ___ High Lead Levels _____ 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 explain:

Family Health History

5. Has your child ever had seizures? ___Yes ___ No

If yes explain:

6. Has your child ever been diagnosed with Asthma? _____ Yes _____ No

If yes explain:

Have they ever been hospitalized for Asthma?

7. Has your child ever had an allergic reaction? _____ Yes _____ No

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

8. Has your child ever had problems with the following? _____ Yes ____ No

____ Frequent ear infections ___Frequent sore throats _____ Frequent Fevers

____ Frequent Coughs ____ Frequent Bed Wetting ____ Frequent Chest Pains

____ Frequent Colds ____ Frequent Stomach Aches _____ Problems with Urine

____ Problem with Bowels ____ Problems Eating _____Problems with Teeth

____ Problems Hearing _____ Problems Seeing _____ Eye Problems

_____ Speech Problems _____ Frequent Trouble Sleeping _____ Temper Tantrums

_____ Other Problems: _____

9. Has your child ever been involved in a child abuse or neglect incident or case _____ Yes _____ No If yes, explain:

10. Does your child have any additional conditions that interferes with his/her daily activities? _____Yes ____ No

Behavioral / Activity History

1. Does your child currently have an IEP? ___Yes ____ No If so, what school district completed the IEP?

Family Health History

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 them	
Follow simple Directions	
Play with toys	
Use Crayons	

Medical 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 or After Enrollment? (Circle One)

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 or After Enrollment/ (Circle One)
4. Does your child need dental treatment? _____ Yes _____ No
   If yes, has the appointment been made or is it complete?

Parent / Guardian Signature that completed survey: _____

Date Completed: _____

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 or any other agency. (PLEASE LIST CHILD'S SCHOOL DISTRICT _____.) ___ yes ___ no

6. I give my permission for Head Start/Early Head Start to provide mental health consultation services. ___ yes ___ no

7. 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

8. I give Head Start and Early Head Start my permission to have my child's personally identifiable information (name, birthdate, phone number, address, etc.) sent to my child's school district or other agency if requested. ___yes ____no

9. 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

10. 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 Engagement 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** _____

Revised 4/25/17

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? _____Shared Parenting? _____

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: (i.e.: siblings, grandparents, Aunts, Uncles, etc.....)

1. _____ Relationship to Child _____ DOB _____
2. _____ Relationship to Child _____ DOB _____
3. _____ Relationship to Child _____ DOB _____
4. _____ Relationship to Child _____ DOB _____

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

Parents/Guardian in School or Training? _____ Where? _____ Grad. Date _____ Degree _____

Are You Employed? ___ Full Time _____ Part Time ____ Spouse Employed? _____ Full Time _____Part Time_____

Are You Employed Less Than One Year? _____ Spouse Employed Less Than a Year? _____

Do You Use Childcare? _____ Who? _____ Do You Have Subsidized 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/ Guardian / Spouse Incarcerated? _____

Does Your Child Have a Disability? _____ IEP _____ Does Parent / Guardian Have a Disability_____

Were You Referred by a Child Welfare Agency? _____ Who? _____

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? _____

*_*I hereby certify that all information provided in the application is true and accurate*_

PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____

Client ID #: _____ Program Year: _____

CSBG INTAKE FORM

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

 # In HH:

Family Type:
☐ F. Single Par/Female
☐ M. Single Par/Male
☐ Two Parent
☐ Single
☐ Couple
☐ Other

Housing:
☐ Own ☐ Homeless
☐ Rent ☐ Other

Length of time in home:
☐ Years
☐ Months

Income Eligibility Period:
☐ A. Weekly ☐ D. Annually
☐ B. Bi-Weekly ☐ E. 13 Weeks
☐ C. Monthly ☐ F. 3 Months
☐ G. 6 Months

Income Level:

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: _____

Outcome: Level 1 - _____ - # _____ Level 2 - _____ - # _____

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

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
(2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider. (rev. 12/3/2015)

ETHNIC and RACIAL DATA FORM

Sponsoring agency_____

Provider_____

Provider Address _____

The Provider and Sponsoring agency listed above receive 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 of our participants 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 Provider and Sponsoring agency 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**_____

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 _____

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:** _____

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

Revised 12/2008

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.

SCREENINGS

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)		

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 section3313.671 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.

IMMUNIZATIONS: PLEASE CHECK ONE BOX

IMMUNIZED/ UP TO DATE	IN PROCESS OF IMMUNIZATIONS	MEDICALLY CONTRAINDICATED/ NOT AGE APPROPRAITE
☐	☐	☐

IMMUNIZATIONS NEEDED:

DTAP HIB HBV IPV MMR VARICELLA HAV

_____ _____

* *Physician Signature* *Date

_____

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

_____/_____

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

PHYSICAL EXAM

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				

* DATE OF EXAMINATION: _____

Building For the Future

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

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

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

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

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

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

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

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

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

Sponsoring Organization/Center

H.C.C.A.O. Head Start
1487 North High Street
P.O. Box 838
Hillsboro, Ohio 45133

Ohio Department of Education
CACFP Consultant
25 S. Front Street, Third Floor
Columbus, OH 43215-4183
1-877-644-6338

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

Construyendo Para El Futuro

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

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

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

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

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

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

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

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

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

Organización Patrocinadora/Centro

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

Ohio Department of Education

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

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Spanish Version