Washita Valley Community Action Council

Head Start/ Early Head Start Enrollment Application

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Centerto be enrolled: _____ K8 #_____

Child's Name: _____Date of Birth:_____

Application Date:	Program: Head Start (3)5 Early Head Start (Birth)-3
1st Year 2nd Year 3rd Year	Full Day Part Day
Attended Early Head Start? z •	Attended another Head Start Program? z •

The folbwing documents are needed for completion of an enrollment application.

´ Z] À	Proofof Date of Birth	Copy of birth certificate, hospital record or other official document with date of birth (requirement)
´ Z] À	Income for 12 month period:	v í ì ð ì & Income dax & } Œ u v t-2 (Œ } u o o i } • Á } Œ l v Check stubs (} Œ šš Z í î o u • } v š Z • v SSI l ^ ^ / l ^ocument ~ / (‰ ‰ o] • • v Employer Statement onletterhead
´ Z] À	Immunization Record/ Exemption	Refer to appendix I, immunizations, in Requirements for Child Care Programs for immunization and exemption procedures
´ Z] À	Completed Consent Page	Must contain parent/guardian signature (requirement)
´ Z] À	Insurance Card	Attach copy if available (not a requirement)
´ Z] À	Social Security Card	Attach copy if available (not a requirement)
´ Z] À	Parent and Staff Signatures	Requirement for completion.

Immunizations

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The program policies have been provided to me upon enrollment and when revisions are made.

Selecting Child Care Programs, DHS publication "A Parent Guide" 87-91, Licensing Requirements for Child Care Programs, DHS publication 14-05, and the program compliance file are all made accessible to parents in a prominent location.

Child Care Program Use

Entry Date: _____ Withdrawal Date: _____ Transfer Date: _____

Child Information (Child's Legal Name)

First Name:	Middle Name:	Last Name:

Date of Birth: Child's Social Security #	Male Female	}vš š Eµu Œ ~/v oµ Eu }(}vš š	Primary Language: Secondary Language: ´ >]šš o ´ D} Œ š

Home/ Street Address:	City:	Zip: County	Parent/Guardians whom the child lives with: ***If Shared Custody- Is there custody documentation:***
Mailing Address:	City	Zip: County	
Child's Ethnicity: ,]•‰ v] }Œ > š]v} KŒ]´P]µv E}-v,]•‰ v] }Œ >š]v} KŒ]	Child's Race: ´ o lI (Œ] v u Œ] v ´ tZ]š ´]Œ] olDµ Œ]´ v /v] vl o •l v E š]À ´ W](] /•o v Œl E š]À ´ KšZ Œ W		

Special Needs Information

Do you have any concerns about this child's behavior or development? z • ´ E}

□ Behavior/Emotional Problems □ Developmental Delays □ Seizures/Convulsions □ Hyperactivity
□ Chronic Health Problems (such as Asthma, Diabetes, Arthritis) □ Rashes □ No significant health concerns

Does your child have specific needs involving routine care, behavior modification, communication, eating, or sleeping activities? ´ z • ´ tZ}v Ç •U • Œ] W zzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzz

Has your child been diagnosed with a specific disability or need? z • ´ tZ}v Ç •U o]•š W zzzzzzzzzzzz

Is this child on an IEP or IFSP? z • ´ E} Has this child been referred? ´ z • ´ E}

Will your child receive any specialized services from professionals from outside of this program's personnel?
´ z • ´ E} tZ v Ç •U / µv Œ•š v šZ š •]Pv v š ‰ Œ vš ‰ Œu]••]}v

I give permission for program personnel to consult with specialized personnel regarding the needs of my child?
´ z • ´ E} Parent }uu vš W zzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzz

Medical Information

Please indicate which types of insurance this child currently receives (Check all that apply) ´ ^}}v Œ Œ´]Œ š Wµ Œ´Zu‰ o}Çu vš • -care /v´T]i v , o š Z ^ ŒÀ]v •				
Child's Dr	Phone:		Date of Last Physical	
Clinic Address:	City:	State:		Zip
Child's Dentist	Phone:		Date of Last Checkup	
Dentist Clinic Address:	City:	State:		Zip

Does your child have any known allergies? ´ z • ´ tZ}v Ç •U o]•š W zzzzzzzzzzzzzzzzzz

Does the known allergy require any special precautions, actions, or medications? z • ´ E}

tZ v Ç •U • Œ] W zzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzzz

´ I understand that a signed parent/guardian permission is obtained prior to administration of medication

OSIIS - Authorization to Use or Share Protected Health Information to School or Day Care

Student Name**:**_____ Demographic/Client ID #:_____
(For School/Day Care receiving PHI to fill out)

Date of Birth:_____

I hereby authorize the Oklahoma Immunization Service to release my Immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS") to: _____.
(*Name of Person/Organization receiving PHI*)

The information may be disclosed for the following purpose(s):

☐ to ensure the student meets Oklahoma eligibility requirements for schools/day cares as outlined in Title 70 O.S. § 1210.191 and Oklahoma Administrative Code ("OAC") 310:535-1-2 and OAC 310: 535-1-3

☐ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information and revoke this authorization at any time in writing.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand I may change this authorization at any time in writing. However, I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be **one year** from the date of my signature or upon the occurrence of the following event [*e.g.*, child no longer enrolled in school/day care center] _____.

_____.

_____ _____
Signature of Student or Legal Representative Date

_____
Description of Legal Representative's Authority

Adult, Guardian, or Parent the child lives with:

First Name:		Last Name:		Relationship to Applicant
Date of Birth: Social Security #	Do´ &o´	Marital Status: ´D Po } - SP	Home/Cell phone number	Primary Language: Secondary Language: D ´
Ethnicity: ´	Race: Email			
Pregnant: Due Date:_____		Housing: ´ (Must attach questionnaire)	Education Level: ´ E ´	
Employment: ´ Unemployed Date uhEDWe:_____ ´W ime (<35 hrs) /&WeDy ´ ive Military Place Of Employment: Phone #			Are you a Veteran? ´ z Are you Active Military? ´ z Are you Disabled? ´ z	
Currently Attending School? Where?		Health Insurance? ´ z ´ D		

Adult, Guardian, or Parent the child lives with:

First Name:		Last Name:		Relationship to Applicant
Date of Birth: Social Security #	Do´ &o´	Marital Status: ´ D Po } - S	Home/Cell phone number	Primary Language: Secondary Language: ´D ´
Ethnicity: ´	Race: Email			
Pregnant: Due Date:_____		Housing: ´ (Must attach questionnaire)	Education Level: ´E - ´	
Employment: ´ Unemployed hEDWe:_____ ´W ime (<35 hrs) /&WeDy ´ ive Military Place Of Employment: Phone #			Are you a Veteran? ´ z Are you Active Military? ´ z Are you Disabled? ´ z	
Currently Attending hool? Where?		Health Insurance? ´ z ´ D		

House Hold Information:

(Information regarding OTHER people living in household) Use the key below for codes

Name	Date of Birth DDIIzzzz	Social Security Number	Gender	Relation To applicant	Ethnicity	Race	Education	Health Insurance	Current HS/EHS Child	Supported by income of Parent/Guardian
1.										
2.										
3.										
4.										
5.										

Relation to Applicant	Ethnicity	Race	Education List Highest grade completed	Health Insurance

Does your family receive?

Parental Status One parent Two parent Foster Child Non-parent Other: _____

Emergency Contact Information

when a parent or guardian cannot be reached

Name:	Telephone Number	Relationship to the child	Authorize to Contact	Authorize to Release
1.				
2.				
3.				

WVCAC Family Residency Questionnaire

McKinney-Vento Act Residency and Educational Rights Information
(Questionnaire must be completed for each student)

As of December 12, 2007, with the passage of the Head Start Reauthorization Act of 2007, any child whose current housing situation entitles them to services under section 725(2) of the McKinney-Vento Act (U.S.C. 11435(2) is considered automatically eligible for Head Start/Early Head Start services. Eligibility may be determined by completing this questionnaire.

Name of Parent Completing Questionnaire: _____

Name of Child: _____

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine whether the child may be automatically eligible for Head Start/Early Head Start Services.

1. Is your current address a temporary living arrangement? _____ Yes _____ No

2. Is this temporary living arrangement due to loss of housing or economic hardship? _____ Yes _____ No

If you answer "No" to both of the questions above, child is not automatically eligible for Head Start/Early Head Start under the McKinney-Vento Act.

******Staff and parent signatures are still required.******

Where is the family presently living? (Check one box.):

☐ *Living in a shelter, including transitional housing shelters; awaiting foster care, etc.*

☐ *Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, and housing not fit for habitation.*

☐ *Living in hotels/motels for lack of other suitable housing.*

☐ *Moving from place to place.*

☐ *Doubled-up;* ***Temporarily*** *living with family or friends due to lack of adequate housing or financial conditions.*

Address: _____ Zip: _____ Phone: _____

I certify that the information I have given is correct to the best of my knowledge. I understand that if the program determines that my child does not automatically qualify for Head Start/Early Head Start services under the McKinney-Vento Act, acceptance into the program will be decided based on the program's current child eligibility criteria.

_____ _____
Signature of Parent/Guardian/Unaccompanied Youth *Date*

Office Use Only:

☐ Eligible under McKinney-Vento Act ☐ Not Eligible

_____ _____
Staff Signature *Date*

If this is a Homeless Family, a Foster Family, OR if anyone in the household receives SSI or TANF then skip this income/ employment portion

Head Start/Early Head Start is an income eligible program. We must verify the family's household income
Verifying eligibility -- To verify eligibility based on income, program staff must use tax forms, pay stubs, or other proof of income to determine the family income for the relevant time period (A, B, or C)

(A) the 12 months preceding the month in which the application is submitted

(B) during the calendar year preceding the calendar year in which the application is submitted

(C) If the family can demonstrate a significant change in income for the relevant time period, program staff may consider current income circumstances.

How did you hear about our program?

´ Flyer ´ Staff ´ Newspaper ´ Family/Friend ´ DHS ´ Social Media ´ Other: _____

I understand that this is an application for services offered and does not constitute enrollment into any program. I certify that the information given on this application is true and accurate and all income has been reported. I understand that this information is being given for the receipt of federal and/or state funds; that officials may verify the information on this application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable federal and/or state laws.

Parent/Guardian Signature***: (required)*** _____ Date: _____

Interviewer's Signature: ***(required)*** _____ Date: _____

WVCAC Head Start & Early Head Start

Parental/ Guardian Consent

Child's Name_____ **Date of Birth**_____

I hereby give permission for Washita Valley CAC Head Start/ Early Head Start to:

- The Brigance EHS/Head Start Screen III is used to assess children from birth through five years of age. The screen reflects a view of the child's growth and learning. The purpose of this screening is to gather a broad sampling of a child's skills and behaviors. I agree to Brigance Screen _____ ***(parent initials)***

- A screening is conducted by a speech pathologist at the public school or with a private agency that is used to help staff and parents recognize when there may be a need for further evaluations and/or services.
  I agree to Speech Screen _____ ***(parent initials)***

- These screenings are conducted by trained Head Staff using an audiometer for hearing Good-Lite vision screen for vision. I agree to Vision and Hearing Screen _____ ***(parent initials)***

- Each child is measured 2 times a year by teaching staff. The results are graphed to determine the child's height and weight percentile. I agree to Height and Weight _____ ***(parent initials)***

- Teaching Strategies Gold is an on-going assessment that enables staff to assess and observe children to set individualized goals for each child. I agree to Teaching Strategies Gold _____ ***(parent initials)***

- The program provides children with dental education, tooth brushes, and fluoride toothpaste. I agree to my child using fluoride tooth paste _____ ***(parent initials)***

- WVCAC has access to print/ or view a copy of the immunization record from OK state website (OSIIS). I agree to allow my child's immunization record to be viewed/printed _____ ***(parent initials)***

- Use child's photo in classroom, newspaper, newsletter, or video. I agree to my child's photo being used _____ ***(parent initials)***

- Parents will always be the first point of contact in regards to minor medical emergencies. If a major medical emergency occurs WVCAC will contact local Emergency personnel for transportation and then will contact the parent/guardian listed on the application.

_____ _____

Parent/Guardian Signature **Date**