Stanislaus County
Office of
Education
Scott Kuykendall, Superintendent

Child & Family Services
Tony Jordan, Executive Director
1325 H Street • Modesto, CA 95354 • (209) 238-6300 FAX (209) 238-4217

FAMILY CHILD CARE EDUCATION NETWORK/ EARLY HEAD START PROGRAM APPLICATION REQUIREMENTS CHECKLIST (INITIAL ENROLLMENT)

To verify and determine eligibility for subsidized child care services, you must bring **copies** of the following documentation to your certification appointment:

ELIGIBILITY VERIFICATION – Documentation must be provided for **1** or more of these categories

- ☐ CPS or At-Risk Referral Letter
- ☐ Self-Declaration of Homelessness
- ☐ Current Aid Recipient Verification (Example: Notice of Action or Passport to Services)
- ☐ Guardian or Foster Parent: Documentation of any income received for the child
- ☐ Income Verification
  - ☐ 2018 W-2 Forms, 1040 and Tax Forms
  - ☐ Income documentation from all sources
    - Predictable Income: Gross Income for the month preceding
    - Unpredictable Income: Gross Income for the preceding 3 to 12 months
    - If employment is seasonal, agricultural, includes bonuses or commission provide past 12 consecutive months of income

FAMILY SIZE VERIFICATION –At least 1 of the following documents must be provided for **ALL** children counted in the family size:

- ☐ Birth Certificate
- ☐ Passport to Services from the county welfare department
- ☐ Adoption documents
- ☐ Court orders regarding child custody or guardianship

RESIDENCY VERIFICATION – Proof that you live in the State of California

- ☐ Any type of evidence of your street address or post office box dated within the past 30 days

NEED – All adults must meet at least **1** need criteria. Documentation to establish need is as follows:

- ☐ Employment Verification
- ☐ Declaration of Self-Employment & Support Documentation
- ☐ Training Verification & Class Schedule
- ☐ Educational Program Verification
- ☐ Request & Plan to Seek Employment
- ☐ Statement of Incapacity
- ☐ Request & Plan to Seek Permanent Housing
- ☐ CPS or At-Risk Referral Letter
- ☐ Homelessness Referral Letter

OTHER DOCUMENTATION – The following documents are also required:

- ☐ Emergency Card for each enrolled child
- ☐ Child's immunization record for each child being enrolled
- ☐ Family Information Form
- ☐ Family Needs Request & Referral
- ☐ Provider Information Form
- ☐ Head Start & Leaps and Bounds Collaboration
- ☐ If applicable, court orders if they affect your child care days/hours
- ☐ If applicable, child's Infant & Family Service Plan (IFSP) or Individual Education Plan (IEP)

NOTE: If your packet is not complete on your appointment date, we cannot accept it

IF YOU HAVE ANY QUESTIONS, PLEASE CALL YOUR FAMILY ELIGIBILITY SPECIALIST AT (209) 238-6300.

Revised 5/24/2019
State/CL-8.1

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INCOME

Reminder: You must submit full, current and consecutive 120 days gross income for each adult/child counted in the family size. If any individual's income fluctuates due to commission, bonuses or seasonal work, you must submit the past twelve months gross income. (Example: A payroll summary for the months of July 2016 through June 2017).

Countable Income Sources Countable income is income of individuals counted in the family size that shall be included when calculating the adjusted monthly income for purposes of determining income eligibility and family fees.	Non-Countable Income Sources Non-countable income is income of individuals counted in the family size that shall be excluded when calculating the adjusted monthly income for purposes of determining income eligibility and family fees.
1. Gross wages, salary, advances, commissions, overtime, tips, bonuses, gambling or lottery winnings	1. Earnings of child under eighteen (18) years
2. Wages for migrant, agricultural, or seasonal work	2. Loans
3. Public cash assistance (CalWORKs or TANF)	3. Grants or scholarships to students for educational purposes other than any portion used for living costs
4. Gross income from self-employment less business expenses with the exception of wage draws	4. Food stamps or other food assistance
5. Disability or unemployment compensation	5. Earned Income Tax Credit or tax refund
6. Worker's compensation	6. GI Bill entitlements, hardship or hazardous duty, hostile fire or immediate danger pay
7. Foster grants, payments or clothing allowance for children placed through child welfare services	7. Adoption assistance payments received pursuant to Welfare and Institution Code section 16115 et. seq.
8. Spousal support and/or child support from the former spouse or absent parent, or (documented) financial assistance for housing costs, car payments paid as part of or in addition to spousal or child support	8. Non-cash assistance or gifts
9. Survivor (i.e. SSA) and retirement benefits	9. Insurance or court settlements for pain and suffering
10. Rent for room within the family's residence	10. Reimbursements for work-required expenses that include uniforms, mileage, or per diem expenses for food and lodging
11. Dividends, interest on bonds, income from estates or trusts, net rental income or royalties	11. Business expenses for self-employed family members
12. Financial assistance received for the care of a child living with an adult who is not the child's biological or adoptive parent	12. Non-cash or in-kind assistance
13. Veteran's pension	13. All income of any individual counted in the family size who is collecting federal supplemental security income benefits (SSI) or state supplemental program benefits (SSP)
14. Pension or annuities	14. Disaster relief grants or payments, except any portion for rental assistance or unemployment
15. Inheritance	15. When there is no cash value to the employee, portion of medical and/or dental insurance documented as paid by the employer
16. Allowances for housing or automobiles provided as part of compensation	16. Spousal support and/or child support **paid to** a former spouse or absent parent or documented financial assistance for housing costs, car payments, health insurance etc...
17. Portion of student grants or scholarships not identified for educational purposes as tuition, books, or supplies	17. Federal Government stimulus income
18. Insurance or court settlements for lost wages and/or punitive damages	
19. Net proceeds from the sale of real property, stocks or inherited property	
20. Other enterprise for gain (Rent for room within family's residence	

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CHILD & FAMILY SERVICES EMERGENCY CARD

MEDIC ALERT **Health Concern** ☐ Yes ☐ No
(Asthma, Allergies, Medications, Health Problems: List _____ **)**

Is there a court order regarding custody of the child? ☐ **Yes** ☐ **No**

Child's Name _____
(Last) (First) (MI) (DOB)

Mailing Address _____
(Street Address)
_____
(City) (State) (Zip)

Physical Address _____
(Street Address)
_____
(City) (State) (Zip)

Mother/Guardian _____
(Last) (First) (DOB)

Father/Guardian _____
(Last) (First) (DOB)

Child's Doctor/Hospital to be called in case of emergency _____

Phone _____ Address _____

MediCal - Healthy Families - None - Private (name) _____ (circle one)

Child's Insurance # _____

Service Options: ☐ Center Based ☐ Home Based ☐ FCCH

Location _____

Phone _____

Teacher _____

Mother/Guardian Contact Info:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Father/Guardian Contact Info:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Permission for Medical Treatment: As the child's parent or legal guardian, I understand that in the case of my child's medical emergency, the center will call 911 and then notify me. I consent to my child's being transported to a physician or licensed medical facility. I give permission for diagnosis, treatment, and/or care which in the best judgement of the physician or dentist, may be required. This permission is valid for this school year as long as the child remains in the Head Start/State program.

Consentimiento para Tratamiento Médico: *Como el padre/la madre o tutor legal del niño/a, entiendo que en caso de una emergencia médica, el personal del centro primero llamará al 911 y despues me notificara. Doy consentimiento que se transporte mi niño/a a un consultorio médico para diagnosis, tratamiento, y/o cuidado cual sea necesario según el juicio del médico o odontólogo. Éste consentimiento será válido durante el año escolar en curso o mientras el niño/a continúe en el Programa Head Start/State.*

Signature/*Firma* _____ Date/*Fecha* _____
(Parent or Guardian) *(Padre o Tutor)*

Signature/*Firma* _____ Date/*Fecha* _____
(Parent or Guardian) *(Padre o Tutor)*

Emergency Contacts: If parents are not available, the following persons are authorized to take child(ren) from the facility, or be called in case of emergency. The child(ren) will **NOT** be able to leave with **ANY OTHER PERSON** without written authorization from the parent/guardian.

	Name	Relationship	Phone	Signature
1.				
2.				
3.				
4.				
5.				

Updates will be added to all copies of the emergency cards

Distribution: White – Health Yellow – Parent Pink – Emergency Card Binder Copy – State Eligibility File (if applicable)

Mandatory
Revised 5/19
CF/ERSEA-20

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FAMILY INFORMATION FORM

PLEASE PRINT CLEARLY

Single Parent/Guardian Household: ☐ Yes ☐ No - If "No" complete Parent/Guardian (B) information below

Parent/Guardian (A)

Name: _____

Birth Date: _____

Gender: ☐ Female ☐ Male

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian
- ☐ Native Hawaiian or Other Pacific Islander

Language: _____

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Relationship to Child: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Formal Separation ☐ Informal Separation

Email Address: _____

Need for Services:

- ☐ Actively Seeking Employment
  Circle the days you will seek employment:
  M T W Th F
- ☐ Employed / Self Employment
- ☐ School / Training
- ☐ Incapacitated
- ☐ Homeless
- ☐ CPS / At Risk

Parent/Guardian (B)

Name: _____

Birth Date: _____

Gender: ☐ Female ☐ Male

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian
- ☐ Native Hawaiian or Other Pacific Islander

Language: _____

Ethnicity:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Relationship to Child: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Formal Separation ☐ Informal Separation

Email Address: _____

Need for Services:

- ☐ Actively Seeking Employment
  Circle the days you will seek employment:
  M T W Th F
- ☐ Employed / Self Employed
- ☐ School / Training
- ☐ Incapacitated
- ☐ Homeless
- ☐ CPS / At Risk

Other individual(s) in the home that will **not** be enrolled on the program and are counted in family size:

Attach documentation.

Name:	Relationship to Parent(s)/Guardian(s):	Birth Date:

COMPLETE REVERSE SIDE

Revised 5/24/2019
State/PA-10.1

Complete one column per child/per provider.
(Make additional copies as needed)

Child Name: _____
Birth Date: _____
Gender: ☐ Female ☐ Male
Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander
Language: _____
Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino
Special Needs: ☐ Yes ☐ No
If Yes, attach current IEP or IFSP
Relationship to Parent/Guardian: _____

School Name: (if applicable) _____
Specify Track/Traditional: _____
Actual time in School: _____

Child Care Provider Name: _____
Specify the days and hours your child will be in child care (typically ½ hour before and ½ hour after is allowed for transportation)

Set Schedule:
Non-School Days
(Circle child care days)
S M T W Th F Sa
Child Care Hours:
From _____ To _____

School Days (if applicable)
(Circle child care days)
S M T W Th F Sa
Child Care Hours:
(before school)
From _____ To _____
(after school)
From _____ To _____

Varying Schedule:
Non-School Days
(Circle all possible child care days)
S M T W Th F Sa
Maximum number of days per week child care will be used. ____

Maximum number of hours per day child care will be used. ____

School Days (if applicable)
(Circle all possible child care days)
S M T W Th F Sa
Maximum number of days per week child care will be used. ____

Maximum number of hours per day child care will be used. ____

Child Name: _____
Birth Date: _____
Gender: ☐ Female ☐ Male
Race: ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander
Language: _____
Ethnicity: ☐ Not Hispanic or Latino
☐ Hispanic or Latino
Special Needs: ☐ Yes ☐ No
If Yes, attach current IEP or IFSP
Relationship to Parent/Guardian: _____

School Name: (if applicable) _____
Specify Track/Traditional: _____
Actual time in School: _____

Child Care Provider Name: _____
Specify the days and hours your child will be in child care (typically ½ hour before and ½ hour after is allowed for transportation)

Set Schedule:
Non-School Days
(Circle child care days)
S M T W Th F Sa
Child Care Hours:
From _____ To _____

School Days (if applicable)
(Circle child care days)
S M T W Th F Sa
Child Care Hours:
(before school)
From _____ To _____
(after school)
From _____ To _____

Varying Schedule:
Non-School Days
(Circle all possible child care days)
S M T W Th F Sa
Maximum number of days per week child care will be used. ____

Maximum number of hours per day child care will be used. ____

School Days (if applicable)
(Circle all possible child care days)
S M T W Th F Sa
Maximum number of days per week child care will be used. ____

Maximum number of hours per day child care will be used. ____

Parent/Guardian Signature_____ **Date**_____

Revised 5/24/2019
State/PA-10.1

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FAMILY NEEDS REQUEST & REFERRAL

Parent(s)/Guardian(s): _____

In an effort to assist you in meeting your unique family needs, we ask your cooperation in completing this form. This information will allow program staff to provide you with information about resources available. Indicate your top three (3) referral needs by ranking them in order of 1-3 (**1 being of greatest priority**). If you do not need referrals, check here ☐ and sign below.

___ Medical	___ Utility Assistance	___ Legal Services	___ Employment Opportunities
___ Dental	___ SSI / Social Security	___ TANF / Cash Aid	___ Vocational Training
			College (Specify Type):
___ CPR – First Aid	___ Driver's License	___ Food Stamps	___ _____
___ Family Counseling	___ Child Care Referrals	___ ESL	___ GED / Diploma
___ Children's Special Needs	___ Housing Assistance	___ Immigration	___ Other:_____
___ Emergency Food & Clothing	___ Renter's Rights	___ Unemployment	

Referrals		Referrals		Referrals	
Agency:		Agency:		Agency:	
Address:		Address:		Address:	
Phone:		Phone:		Phone:	
Website:		Website:		Website:	

Parent Signature _____ Date _____ Staff Signature _____ Date _____

FOR OFFICE PURPOSES ONLY

Follow-up:

Date	Staff Initials	Notes

White- Family File Yellow- Parent

Revised 5/24/2019
State/PA- 11.1

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PROVIDER INFORMATION FORM

TO BE COMPLETED BY THE PARENT/GUARDIAN

Print Parent/Guardian Name _____ **Phone Number**_____

Request (Select One):

- ☐ Initial provider (First enrollment for family/child)
- ☐ Change in child care provider (Note: Must be approved 2 weeks in advance)
  Previous provider name _____ Last date of service_____
- ☐ Alternate provider (Note: Must be approved 2 weeks in advance and limited to 10 days per fiscal year)
  Service dates _____ to _____
- ☐ Adding a second provider

List child(ren) affected by this request and the day/time care is needed:

Child Name	Day/Time–Non-school days	Day/Time–School days
Jane Doe	*Mon – Fri 7:30am – 5:30pm*	*Mon – Fri 3:00pm – 5:30pm*
John Doe	*Vary Sun – Sat; max 6 hr per day*	*Vary Sun – Sat; max 3.5 hr per day*

_____ _____
(Parent/Guardian signature) **(Date)**

TO BE COMPLETED BY THE PROVIDER

Completing this section indicates you have room for the children identified above

Print Provider Name _____ **Phone Number** _____

Provider Address _____ **Tax ID#** _____

_____**First Date Child Care Services will be available for child (ren).**

Provider Type (Select One):

- ☐ Licensed Center
- ☐ Licensed Family Child Care Home
- ☐ School Site Exempt
- ☐ Non Licensed, Exempt out of child's home
- ☐ Non Licensed, Exempt in child's home (Note: Must have a minimum of 3 children in care for the same period of time)

Note: New childcare providers must submit a copy of their policies/contract and rates. SCOE will be unable to contract with you if policies/contract and rates are not on file. Exempt providers must document their rates on a separate sheet of paper.

_____ _____
(Provider signature) **(Date)**

Provider Request Process

1) Parent/Guardian selects a child care provider
2) Parent/Guardian discuss' child care needs with Family Eligibility Specialist
3) Family Eligibility Specialist provides the parent/guardian with required documentation
    a. Exempt provider– Specialized packet depending upon type of exempt care
    b. Licensed or school site exempt – Provider Information Form only
4) Parent/Guardian and provider complete and submit required documentation to their Family Eligibility Specialist
5) Family Eligibility Specialist reviews requested action
    a. Complete documentation – Requested action will be effective 2 weeks from receipt of all documentation.
    b. Incomplete documentation – Returned to parent/provider for completion. Requested action will be effective 2 weeks from receipt of completed documentation.
6) A Certificate for Child Care Services and attendance claim is issued to the child care provider
7) Child care services may begin

Instructions for the Provider Information Form

Parent/Guardian section:

Parent/Guardian Name – Name of parent/guardian of enrolled child

Phone Number – Contact telephone number of parent/guardian

Request – Specify request

- Initial provider – Check this box if first enrollment for your family or child
- Change in child care provider – Check this box if your child(ren) are in the process of changing child care providers. Also, record your previous provider and the last date service was used.
- Alternate provider – Check this box if you are requesting to have an alternate provider for when your child is ill or when your regular provider is closed. Also, record the childcare service dates for the alternate provider.
- Adding a second provider – Check this box to add a second provider because one of the providers can not accommodate all of your child care needs or if you have elected to enroll your child(ren) in a licensed early education program for a half day.

List child(ren) affected by the request and the day/time care is needed – List only the children in your family who will be affected by the action. Also, record the day/time child care is needed with this provider.

Provider section:

Provider Name – Name of childcare provider that will provide services

Phone Number – Contact telephone number of the childcare provider that will provide services

Provider Address – Physical and mailing address of child care provider

SS# or Tax ID# - Providers social security number or tax id number

First Date of Service for child(ren) – Record the first date child care services will start

Provider Type – Check the appropriate box of the provider type that will be providing childcare services

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Child Information Sheet

Child's Name: _____ DOB: _____ Location: _____

Please answer all questions below to the best of your ability. The purpose of this information sheet is to provide the necessary support for you and your child during your enrollment in our program.

If you answer "Yes" to any of the following questions, please specify/explain.

Yes	No	Social/Emotional and Developmental
☐	☐	Does your child have a current IFSP or IEP? _____
☐	☐	Do you have any concerns regarding your child's development? _____
☐	☐	Does your child receive services provided by a Mental Health Professional? _____
☐	☐	Does your child receive services provided outside of the Head Start Program? _____
☐	☐	Does your child need any special accommodations while attending our program? (i.e., catheter, G-tube, glasses, leg braces, etc.) _____
☐	☐	Have you or your child recently experienced a traumatic event? _____
☐	☐	Is your child toilet trained? _____

Yes	No	Health and Nutrition
☐	☐	Does your child have any allergies? _____
☐	☐	Does your child have any special dietary needs? _____
☐	☐	Will your child need medication during program hours (i.e., inhaler, Epi-Pen, etc.)? _____
☐	☐	Do you have any other medical concerns about your child? _____
☐	☐	Please share any other concerns or observations you may have: _____

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Management Signature: _____ Date: _____

Date given to health/disability or appropriate staff: _____

Distribution: White: File Yellow: Appropriate Staff

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CHILD/FAMILY SERVICES CONSENT FORM

Child's Name: _____
Last First

Facility: _____ Date of Birth: ____/____/____ Sex: ___M ___F

I GIVE CONSENT:	***Screenings / Activities:***	**Y**	**N**
That my child, _____, may participate in the Screenings/Activities listed on the right. I understand that the Head Start Program requires that each child has completed health/dental screenings. I understand that the screenings listed have been explained to me and I understand that the screenings listed will be conducted at the center/FCCH/ Home Base Parent Socialization Events and are for information only. (Developmental screenings and ongoing assessments may include speech and language, cognitive, social emotional, fine/gross motor and ongoing developmental assessment.)	Hearing Screening	☐	☐
	Vision Screening	☐	☐
	Non-Invasive Hemoglobin	☐	☐
	Height/Weight Measurement	☐	☐
	Fluoride Varnish	☐	☐
	Fluoride Toothpaste	☐	☐
	Dental Exam/Screening by Dental Professional	☐	☐
	Developmental Screenings	☐	☐
	Dietitian/Nutrition Consult/ Referral	☐	☐
	Mental Health Consultant Services	☐	☐

I GIVE CONSENT:	**Y**	**N**
1. That my child may go on all field trips taken by the program, provided that I have received information about the specific trip, date, destination, time of departure and return prior to each trip. I understand that children will be accompanied by educators, facility staff, and volunteers. I may also attend.	☐	☐
2. That the Head Start Program has the right and permission to copy and publish photographs, video tapes or pictures of my child. The photograph/video, whole, in part, or composite, may be used as the program sees fit on publication of educational material, advertising thereof, or for any other lawful purpose for an indefinite amount of time.	☐	☐
3. That when my child is ready to transfer to another program or school, including Head Start, I request that his/her health and/or education records be transferred to the receiving program/school.	☐	☐
4. To allow agency staff to make home visits during the school year at MY CONVENIENCE.	☐	☐

I have exceptions/explanations to above items or to other considerations (i.e., holidays, etc.):

_____

_____

INFORMED CONSENT

I have read the foregoing and the above answers are true and complete to the best of my knowledge and belief. I understand that if any of this information changes, I am obligated to notify this program immediately. I understand the information provided above will remain strictly confidential.

_____ _____
Signature of Parent or Guardian Date Signature of Staff Date

Distribution: White – Child's File Yellow – Health Pink - Parent

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Consent for Release of Student Records

Stanislaus County Office of Education (SCOE) intends to contract with a company called Learning Genie. Learning Genie provides a web based application for teachers to use to collect child observations. Observations may be written notes, photos, or videos, and are used to complete ratings for child assessments. Teachers use child assessment information to develop individual and group lesson plans for children.

Effective use of Learning Genie requires that information related to your child's Head Start and/or State Program record to be shared with Learning Genie. Information includes, but is not limited to:

First Name	Last Name	Date of Birth	Center Name	Class Name
Gender	Enrollment Date	Withdrawn Date	Student Identifier	Ethnicity
Race	Primary Language	English Language Learner	IEP/IFSP	Adaptations
Assessment Ratings	Notes			

Under California Law, this information may be considered a "pupil record" and cannot be released to any person without prior written consent from the child's parent.

Signing this consent form gives SCOE permission to allow Learning Genie to access your child's "pupil record".

Pursuant to Education Code section 49075, I hereby give consent to permit access to my child's pupil records maintained by SCOE to the Learning Genie, including its employees, agents, subsidiaries, sub consultants and affiliates. The consent notice shall be permanently kept with my child's record file and shall only be used for the purposes stated herein.

Name of Student: _____
Head Start Center/
Family Child Care Home: _____
Classroom: _____

I hereby certify that I am a parent[1] of the above-named student of SCOE, with legal authority to execute this consent and release.

Dated: _____

Signature: _____
Printed Name: _____

[1] Pursuant to Education Code section 49061, concerning rights related to Pupil Records, "Parent" means a natural parent, an adopted parent, or a legal guardian. If the parents are divorced or are legally separated, only a parent having legal custody of the pupil may consent to release pupil records to other persons pursuant to Section 49075. Either parent may grant consent if both parents have notified the school district or county office of education in writing that such an agreement has been made.

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PHYSICAL SCREENING FOR CHILDREN

Child's Name _____ **Child's Date of Birth** _____
Last First

Parent Name _____ Childcare Center/ FCCH _____
Last First

PHYSICAL ASSESSMENT/ Well Baby Check

☐ 2 month ☐ 4 month ☐ 6 month ☐ 9 month ☐ 12 month ☐ 15 month
☐ 18 month ☐ 24 month ☐ 30 month ☐ 3 year ☐ 4 year ☐ 5 year

	No Problem	Problem Suspected	Result If Required	Comments
History and Physical Exam				
Nutritional Assessment				
Developmental Assessment				
Dental Assessment				
Hearing Screening or Assessment			Right Ear: Pass/Fail Left Ear: Pass/Fail	
Vision Screening or Assessment			Right Eye: R-20/ Left Eye: R-20/	
Anemia Risk Assessment or HGB/HCT Result				
Blood Pressure Risk Assessment or BP Result				
Lead Risk Assessment or Lead Test Result				

Tuberculosis Requirement

TB Risk Assessment ☐ **at risk** ☐ **not at risk** ***OR***
TB Test Date Given_____ **Read**_____ **Result**_____

Fluoride Preventative

Fluoride Varnish Applied:
☐ Yes Date: _____
☐ No
Fluoride Prescribed:
☐ Yes
☐ No

Height and Weight

Head Circumference: _____

Height: _____

Weight: _____

IMMUNIZATIONS GIVEN TODAY

DTP_____ HepB_____
IPV_____ HepA_____
MMR_____ HIB_____
Varicella_____ Other_____

MEDICAL EVALUATION: Comments / Referrals:

1. Are there any **physical or emotional conditions** (orthopedic, cardiac, eye, ear, etc.) which may affect participation in school activities?
   ☐ Yes ☐ No **Explain**: _____
2. **Is the child subject to any condition that may result in a classroom emergency** (e.g., epilepsy, seizures, fainting spells, diabetes, heart condition, allergic reactions (bee stings, etc.))? ☐ Yes ☐ No
   Explain: _____
3. Is this child under your regular care? ☐ Yes ☐ No **Date of examination:** _____

PHYSICIAN SIGNATURE _____ **Date** _____

_____ _____
Clinic Name Clinic Phone Number

Form For: Trisha Beal

Distribution: White – Health File Yellow – Parent Copy

Mandatory
Revised 5/19
CF/HS-18

What Does A **Safe Sleep Environment** Look Like?

The image below shows a safe infant sleep environment.

Baby's sleep area is in the same room, next to where parents sleep.

Use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet.

Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.

Do not smoke or let anyone else smoke around your baby.

Do not put pillows, blankets, sheepskins, or crib bumpers anywhere in your baby's sleep area.

Keep soft objects, toys, and loose bedding out of your baby's sleep area. Make sure nothing covers the baby's head.

Dress your baby in sleep clothing, such as a wearable blanket. Do not use a loose blanket, and do not overbundle.

Always place your baby on his or her back to sleep, for naps and at night.

NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development

SAFE TO SLEEP®

* A crib, bassinet, portable crib, or play yard that follows the safety standards of the Consumer Product Safety Commission (CPSC) is recommended. For information on crib safety, contact the CPSC at **1-800-638-2772** or http://www.cpsc.gov.

Safe Sleep For Your Baby

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

- Always place baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.
- Use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet with no other bedding or soft items in the sleep area.
- Share your room with baby. Keep baby in your room close to your bed, but on a separate surface designed for infants, ideally for baby's first year, but at least for the first 6 months.
- Do not put soft objects, toys, crib bumpers, or loose bedding under baby, over baby, or anywhere in baby's sleep area.

To reduce the risk of SIDS, women should:

- Get regular prenatal care during pregnancy.
- Avoid smoking, drinking alcohol, and using marijuana or illegal drugs during pregnancy or after the baby is born.
- Do not smoke during pregnancy, and do not smoke or allow smoking around your baby or in your baby's environment.
- Think about giving your baby a pacifier for naps and nighttime sleep to reduce the risk of SIDS.
- Do not let your baby get too hot during sleep.

- **Breastfeed your baby to reduce the risk of SIDS.** Breastfeeding has many health benefits for mother and baby. If you fall asleep while feeding or comforting baby in an adult bed, place him or her back in a separate sleep area as soon as you wake up.
- Follow guidance from your health care provider on your baby's vaccines and regular health checkups.
- Avoid products that go against safe sleep recommendations, especially those that claim to prevent or reduce the risk for SIDS.
- Do not use heart or breathing monitors in the home to reduce the risk of SIDS.
- Give your baby plenty of tummy time when he or she is awake and someone is watching.

For more information about the Safe to Sleep® campaign, contact us:

Phone: 1-800-505-CRIB (2742) | **Fax:** 1-866-760-5947
Email: SafetoSleep@mail.nih.gov
Website: http://safetosleep.nichd.nih.gov
Mail: 31 Center Drive, 31/2A32, Bethesda, MD 20892-2425
Federal Relay Service: Dial 7-1-1

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KEEPING YOUR CHILD SAFE IN THE FAMILY CHILD CARE HOME

A TIP SHEET FOR PARENTS

GATES

Please close and latch the gate/s when accessing a gate at the provider's home.

Signing in/out

Please ensure your child is signed in and out on the correspondence line everyday with your full signature and exact time before you leave the provider's home.

Doors

Please close the door when entering and leaving the provider's home. Ensure there are no other children besides yours leaving without an authorized adult.

Count Boards

The provider can use your assistance!!! You can change the number on the count board when your child arrives and leaves.

Entering and Exiting

Please use the assigned door for entering and leaving the provider's home at all times.

NO CELLS

Cell phones can be distracting! Please give your child your undivided attention during drop off and pick up times.

Remember: Keep children safe!!!

The supervision, safety and prevention of children's injuries is everyones responsibility !

ORIENTATION: REQUIREMENTS AFTER ENROLLMENT

ONLINE ORIENTATION PROCESS

STEP 1: Watch Family Child Care Home Education Network Orientation Video (Orange)

Visit: https://www.findchildcarestanislaus.org/step3programorientation

Website Password: CFS

PROGRAM ORIENTATION VIDEOS

Record questions (The Family Eligibility Specialist will answer any of your questions at your in-person meeting):

_____

_____

_____

STEP 2: Complete Knowledge Check

1) All Parents/Guardians counted in the family size must have a need for services: True or False

2) If your income or need fluctuates, how often will your documentation need updated? Every _____ months

3) It is the parents/guardians responsibility to inform the program of any changes within _____ days.

4) What are 2 ways you can submit your changes? _____ and _____

5) If you change a provider, how long does it take for the change in provider to be approved? _____ weeks

6) The authorized adult is required to **sign** and record the **exact time in/out** of care **daily**. True or False

7) If my child is absent from care, the attendance claim must include the reason for absence and signature. True or False

8) If you disagree with an action, such as being terminated or hours reduced, what should you do? _____

Include the completed Knowledge Check in your packet

SELECT A CHILD CARE PROVIDER
FAMILY CHILD CARE HOME EDUCATION NETWORK/EARLY HEAD START CHILD CARE PARTNERSHI

If your family is approved for services in the Family Child Care Home Education Network/Early Head Start Child Care Partnership (FCCHEN/EHS CCP) program, we will provide reimbursement for your child care services. Please select a provider following the steps below. **Note:** Provider reimbursement is not effective until a family has been approved for services and a Certificate for Child Care Services is issued.

STEP 1: Interview, Visit and Select a Provider from the FCCHEN/EHS CCP provider list

Ana Estrada	Newman	(209)595-8504			
Evelia Ruiz (Spanish)	Patterson	(209)892-6546	Alis Odesho	Turlock	(209)669-0417 (209)968-9581
Maria E Santana (Spanish)	Patterson	(209)892-7941	Gloria Solorio	Turlock	(209)277-0328
Maria E Garcia	Patterson	(209)892-8588	Linda Doman-Adeh	Turlock	(209)620-8599
Gloria Diaz	Patterson	(209)226-8394			

STEP 2: Ask Selected Provider to complete Provider Information form

STEP 3: Return Form with your family's pre-enrollment packet