WHAT TO BRING FOR ENROLLMENT: HOME-BASED HEAD START PROGRAM

WAITING LIST REQUIREMENTS

To verify and determine eligibility for Head Start services, you must bring the following documentation to your waiting list application appointment:

Eligibility Verification – At least one of the following documents must be provided to verify your eligibility:

- Past 12 months gross income from all sources
- If employed, current check stub and last years W-2 forms and 1040 tax form
- Last years W-2 forms and1040 tax form
- Current TANF (Passport for Services)
- Social Security Income
- Foster Care Assistance
- Declaration of Homelessness

Child Verification –At least one of the following documents must be provided for each child you are wanting to enroll:

- Birth Certificate
- Passport for Services from the county welfare department
- Adoption documents
- Records of Foster Care placement
- Court orders regarding child custody or guardianship
- If applicable, proof of pregnancy

Other Documentation – The following documents are also required:

- Medical Insurance Card
- Child's immunization record (Shot record)
- Child Information Sheet
- 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)

REQUIRED UPON ENROLLMENT

If you are selected for enrollment, you must provide the following documentation:

Enrollment Forms

- Proof of Physical or Physical Appointment

Stanislaus County Office of Education
Scott Kuykendall, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

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: _____

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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

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