Applicant & Family Member Information

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: _____			☐ Proficient		

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
			☐ Not Eligible ☐ On Medicaid ☐ Potentially		

Dental Coverage	Dental Coverage #	Dentist/Dental Home

Primary Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: _____			☐ Proficient		

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Natural/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Niece/Nephew		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

Email Address:

Secondary or Other Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: _____			☐ Proficient		

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Natural/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Niece/Nephew		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

Email Address:

Additional Child (Non-Applicant)*

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: _____			☐ Proficient		

Additional Child (Non-Applicant)*

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ Poor
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Moderate
☐ White	☐ Multi-Racial		☐ Moderate		☐ Proficient
☐ Other: _____			☐ Proficient		

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Living Address

Started Living At Date	Living Address	Address Line 2	ZIP	City	State	County

Family Mailing Address

Same as living?	Started Using Date	Mailing Address	Address Line 2	ZIP	City	State
☐ Yes ☐ No						

Phone Number(s)	Type (*check one*)	Note (*for example, an extension or best time to call*)
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Family Income

Income Verified by	Verification Date	TANF Status	SSI
		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ No

Family Member	*Amount*	*Per (for example: week, month, year)*	*Annual Amount*	*Description (for example: SSI, Job, Child Support)*	*Verification (for example: W2, check stub)*	*Note*
	$		$			
	$		$			
	$		$			

Income Notes

Emergency Contacts

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 2

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 3

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature_____ Date_____

THE PREP ACADEMY
EARLY CHILDHOOD EXCELLENCE

Child's Name: _____ Birth Date: _____ Sex: Female Male
Person Interviewed: _____ Relation to Child: _____
Interviewer: _____ Title: _____
Date: _____

All sections MUST be completed. Write N/A if it does not apply.

Pregnancy/Birth Information:

Did mother have any problems during pregnancy or delivery?	☐ Yes	☐ No
Did mother visit physician less than two times during pregnancy?	☐ Yes	☐ No
What was the length of the pregnancy? ☐ 9 months	☐ less than 9 months	
Was child born more than 3 weeks early?	☐ Yes	☐ No
Were there any health concerns with mother or child at birth?	☐ Yes	☐ No

If yes, please explain:

Health Information:

Has your child ever had a serious accident?	☐ Yes	☐ No
Has your child ever has a serious illness?	☐ Yes	☐ No
Has your child ever been hospitalized or had an operation?	☐ Yes	☐ No

If yes, date and reason:

Has your child ever been treated for any of the following? Check all that apply.

☐ Allergies (food, bees, latex, other) Please list: _____

☐ Anemia	☐ Earaches/Ear infections	☐ Over or under weight	☐ Stomach aches
☐ Asthma	☐ Eczema/Skin problems	☐ Painful urination	☐ Vision concerns
☐ Bleeding problems	☐ Hearing concerns	☐ Seizures	
☐ Diabetes	☐ Heart problems	☐ Sore throat	

Explain:

Is your child currently taking medication? ☐ Yes ☐ No
Will your child be taking medication at school? ☐ Yes ☐ No Medication: _____
If yes, the appropriate documentation must be completed and signed by parent/guardian and physician.

Has your child ever had a seizure? ☐ Yes ☐ No
If yes, when was the last episode? _____
Is your child currently taking seizure medication? (list name) ☐ Yes ☐ No
Please list name of seizure medication: _____

Name of Optometrist: _____ ☐ Do not have an Optometrist
Phone number: _____
Date of last exam: _____
Does your child have difficulty seeing? (squints, cross eyes, etc.) ☐ Yes ☐ No
If yes, explain: _____
Does your child wear glasses? ☐ Yes ☐ No

THE PREP ACADEMY
EARLY CHILDHOOD EXCELLENCE

Developmental Information:

Do you have concerns about how your child is developing in any of the following areas? Check all that apply.

☐ Behavior ☐ Eating ☐ Playing with other children ☐ Movement
☐ Dressing ☐ Listening ☐ Understanding directions ☐ Sleeping
Explain: _____ ☐ Speech

Does your child wear pull-ups or diapers? ☐ Yes ☐ No
Does your child have trouble toileting? (e.g. constipation, diarrhea, etc) ☐ Yes ☐ No
Did your child roll over when expected? ☐ Yes ☐ No
Did your child sit up when expected? ☐ Yes ☐ No
Did your child walk when expected? ☐ Yes ☐ No
Did your child talk when expected? ☐ Yes ☐ No

If yes to any, please explain:

Does your child use a: ☐ Bottle ☐ Pacifier ☐ Both ☐ Neither one
Is there current or past history of abuse/neglect, substance abuse or domestic violence? ☐ Yes ☐ No
Do you have any concerns that have not been mentioned above? ☐ Yes ☐ No
If yes, please explain:_____
_____

Dental Information:

Does your child brush teeth daily? ☐ Yes ☐ No
Has your child complained about teeth hurting? ☐ Yes ☐ No
Does your child take fluoride supplements? ☐ Yes ☐ No
Is there water in your home? ☐ City ☐Well ☐ Cistern ☐ Other
Dental Provider: _____ **Dental Insurance**: ☐ Yes ☐ No
Phone Number: _____
Date of last dental exam: _____
Does your child have any dental concerns? ☐ Yes ☐ No
If yes, please explain: _____

Nutrition Information:

Is there any food your child should not eat for medical, religious, or cultural reasons? ☐ Yes ☐ No
If yes, please explain: _____
Is your child on a special diet? ☐ Yes ☐ No
If yes, please explain: _____
Did your child's physician recommend it? ☐ Yes ☐ No
*If yes, a Modified Meal Plan form must be completed by parent/guardian **and** physician.*
Have there been any changes in your child's appetite in the last month? ☐ Yes ☐ No
If yes, please explain: _____
Does your child have trouble chewing or swallowing? ☐ Yes ☐ No
Does your child take vitamins and mineral supplements? ☐ Yes ☐ No
If yes, what kind: _____
Were they prescribed by your child's physician? ☐ Yes ☐ No

THE PREP ACADEMY
EARLY CHILDHOOD EXCELLENCE

What foods does your child especially like? Please list.

Please check the box(es) on the following table to indicate which foods your child eats and how often.

Food items	Never	2-3 times per week	Almost daily
Meat, fish or poultry			
Eggs, beans, peanut butter			
Milk, cheese, or yogurt			
Vegetables			
Fruits and/or juices			
Bread, rice, noodles, tortillas			
Cakes, cookies pies, other desserts			
Sugary drinks			

Medical Provider Information: (This section must be completed)

Does your child receive Women, Infant, and Children (WIC) vouchers? ☐ Yes ☐ No
Physician/health care provider: _____
City/State: _____ Phone number: _____
Date of last physical exam: _____
Insurance: ☐ Medicaid ☐Private ☐Applied for Medicaid ☐None ☐Other _____
Do you need assistance applying for a medical card? ☐ Yes ☐ No
Name of Preferred Hospital: _____
Address of Hospital: _____Telephone:_____

Staff signature: _____Date reviewed w/parent: _____

Is there anything else you would like to share with us about your child? ☐ Yes ☐ No
If you answered yes, please explain:
_____
_____

COMMUNITY ACTION COUNCIL MEDICAL PROCEDURE FOR SEEKING EMERGENCY MEDICAL CARE:

1. **CALL EMERGENCY MEDICAL TEAM AND BEGIN CARDIOPULMONARY RESUSCITATION/FIRST AID (AS NEEDED).**
2. **CONTACT PARENT/GUARDIAN.**
3. **CONTACT PERSON LISTED AS EMERGENCY CONTACT IF PARENT IS UNABLE TO BE REACHED.**

I, _____, parent/legal guardian of _____ give my permission for Community Action Council, Child Development/Head Start/Early Head Start/Migrant Head Start/EHS-CCP Program to seek medical attention for my child in the event of an emergency (medical or dental) if I cannot be reached and to hold harmless and release Community Action Council from all liability. I further agree to keep the facility informed of changes in telephone numbers and contact information where I can be reached.

Parent Signature: _____
Date: _____

THE PREP ACADEMY
EARLY CHILDHOOD EXCELLENCE

HIPAA Release Consent

Child's Name (print) _____ Date of Birth _____

I_____ give permission to: _____
(Parent/Guardian Name) (Health Care/Dental Provider Name)

To share the following information with **Community Action Council's The Prep Academy** so that this person or entity may assist my child with health care needs/issues.

The requested information may be shared for one year after the date on this authorization form or until I revoke the authorization.

I give permission for the following information to be shared: (***Check all boxes that apply***)

- ☐ Physical Exam/Well Child Exam/Immunizations
- ☐ Hearing and Vision Exams/Screenings
- ☐ Lead Screening
- ☐ Dental Exam/Treatment
- ☐ Health Information Regarding Behavioral or Mental Health Services
- ☐ IFSP/IEP
- ☐ Other _____

This form must be signed by the child's parent/guardian

Signature of Parent/Guardian _____ Date _____

Staff Signature_____ Date_____

I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient named above and may not be protected under Federal laws and regulations regarding the privacy of the protected health information.

This authorization must be signed and dated and may be revoked by notifying the Health Care/Dental Provider at any time except to the extent action has been taken prior to revocation.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for services or enrollment in Early Head Start/Head Start/Migrant Head Start.

I understand that the information disclosed is subject to re-disclosure by the recipient and may no longer be protected by the federal privacy regulations, 45 CFR 164 Subpart E.

Please fax the above requested information to:

Community Action Council
Attn: Health Services
Fax #:

THE PREP ACADEMY
EARLY CHILDHOOD EXCELLENCE

Consent Form

CHILD'S NAME_____ **DATE OF BIRTH**_____

I authorize the Head Start Program to complete the following screenings/exams for my child using the services of Nurse Practitioners, Dentists, CAC Staff, and other Health Professionals:

_____Developmental/Behavioral/Speech
_____Hearing Screen
_____Physical Exam/Well-Child Check
_____Dental Screen/Fluoride Treatment
_____Lead Screen
_____Social/Emotional
_____Growth Assessment (Height/Weight)
_____Dental Exam
_____Vision Screen
_____Blood Pressure

I grant my permission for the following:

_____ Sharing of information including records with public school system, agencies or professional who are currently providing services or determining the services that are necessary for my child.

_____ Providing classroom mental health consultation services for effective classroom management and positive learning environments; supportive teacher practices; and strategies for supporting children's social and emotional well-being.

_____ Electronic communications via email or text to cell phone numbers and/or email addresses provided by me.

_____ Share updated eligibility/registration information with the school district (to ensure a smooth transition for program/Kindergarten entry)

_____ Accompany class on field trips

_____ Permission for your child to appear in photographs or in audio/visual recordings. These digital materials may be used for educational or marketing purposes and may be published on a variety of media platforms, including print, online and social media.

_____ Participation in the Foster Grandparent Program (when appropriate). The Foster Grandparent Program is a CAC program that allows senior volunteers to assist in the educational development of program children.

_____ Home visits

**This consent is valid for one year from date of signature.*

Print Name of Parent/Guardian	Print Name of Witness
Signature of Parent/Guardian	Signature of Witness
Date	Date

**This consent is valid for one year from date of signature.*

THE PREP ACADEMY
EARLY CHILDHOOD EXCELLENCE

Fluoride Toothpaste Consent

Dear Parents:
Head Start Performance Standards require that children enrolled in our programs brush their teeth once daily using toothpaste containing fluoride. In order to abide by Head Start Performance Standards, we need your consent to use fluoridated toothpaste. By signing this consent, you acknowledge that your child's teeth will be brushed with fluoridated toothpaste once daily while at school. If you decide to not give consent, your child's teeth will be brushed with non-fluoridated toothpaste instead.

Toothpaste Consent Form

I, _____ DO/ DO NOT (circle one) give consent for my child
(Parent's name)

_____
(Child's Name) to brush his/her teeth at school using toothpaste containing fluoride.

Date Range: 8/1/2022 thru 7/31/2023

Signature: _____ Date: _____

Statement of Commitment
Child Development Programs
2022-2023

Welcome to the Community Action Council's Head Start, Early Head Start, Migrant Seasonal Head Start, and the Early Head Start – Child Care Partnership programs!

As an agency we are here to partner with you and your family in support of school readiness preparation in the areas of education, health/nutrition, family/community engagement, and disability/mental health. We live by the Community Action promise in that "…we care about the entire community and we are dedicated to helping people help themselves and each other." Our agency mission is to help Prevent Reduce and Eliminate Poverty.

With this being said we are requesting your true partnership in preparing you and your child for a life time of learning. As a program we are to make sure that we "provide parents with information about the importance of their child's regular and consistent attendance" Head Start Program Performance Standard 1302.51(a)(2) for their program. This means that in order for you and your child to maximize the benefits of your program we must have your child in attendance every day. We must have your child in attendance on time, healthy, and we need your engagement so that learning can proceed. We need you and your child ready to engage and learn during your Home-Based visits and socializations.

When it comes to attendance please have your child in their proper place on time. If your child is going to be late or not in attendance, we must have communication from you letting us know. This ensures that we know you all are safe and not in harm's way. You must ensure that we have communication as early as possible for tardiness and absences. For our Home-Based model, if you are unable to meet at your scheduled time you must contact your Home Visitor to reschedule your educational visit prior to your meeting. As staff we must implement our own outreach within the hour of your times normal arrival if we do not hear from you.

When it comes to being healthy we must partner to ensure that your child is up to date on the following: immunizations, physical exams/well child checks, dental exams, vision exams, and lead screenings. Statistics prove that when a child is healthy they are more capable to learn and retain.

Studies show that children have a higher chance to succeed when parents are actively engaged in their educational experiences. As a program we need you. We need your presence, ideas, and advocacy for your child. Family engagement in the classroom, center, parent meetings, group socializations and overall program success is vital to the future growth of your child.

As an agency and program we look forward to working with you this program year. We need your child in attendance every day, we need them healthy, and you engaged. This mixture will produce positive outcomes for all involved.

Again welcome and let's have a great year!

Child's Name _____

_____ _____

Parent Signature Date

_____ _____

Staff Signature Date

Father/Father Figure Engagement
Recruitment Form
2022-2023

Welcome to your Head Start program! We as a Head Start program want to engage the entire support system for your child and family. We are asking for your help. Please fill out the below information for the male role model in the life of your child. This person may also be a support to you and your endeavor to provide a strong foundation for your family. This person may be the child's father, grandfather, uncle, or just a family friend. We have a lot for him to do within our Head Start program and want to encourage him to do so. If you have any questions, please contact your program staff at any time.

Enrolling Child's Name: _____

Parent's name giving the recommendation: _____

Male role model for contact: _____

Contact Phone Number: _____

Contact Email Address (if available): _____

Best time of day for contact: _____ (a.m. or p.m.)

I do not have information for this part of the program at this time. ____

Thank you,

_____
Head Start Program Staff

Contact Number: ( )