The Erdman Head Start Center

Clinton County

Erdman Head Start Enrollment Form

After completing this document, please save and email it to Dorothy Campbell at dorothycampbell@clintoncap.org

Alternatively, you may print it and call 937-382-5624 to schedule an appointment.

The Erdman Head Start Center

Clinton County

Erdman Head Start Enrollment Form

To be considered for enrollment into the Head Start program please bring the following documents:

- Birth Certificate
- Shot Record
- Social Security Card
- Medical Card
- Proof of Income (W2, 1040, child support, statement of no income form (provided by us) OR
- Proof of one of the following: SNAP benefits, TANF, OWF, SSI, Kinship Reimbursement, Foster Care Reimbursement
- Custody Papers (if applicable)
- IEP (if applicable)
- Referral from doctor (if applicable)

If you have questions or need help with any of this, please contact
Dorothy Campbell at 937-382-5624 or dorothycampbell@clintoncap.org

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Eligibility Determination Interview

Child Name:	Date of Birth:	Gender:

Insurance: Y / N **Company Name:**________________

Family 12-month income verification

Circle Applicable: Employment Self-Employment (1099) Child Support SSI
SSD Unemployment Military Wages W-2/1040
OWF/TANF Other

Explanation: ____

____

____

____

____

Living situation *(if supported by someone else or homeless, 3rd party documentation required)*

Circle Applicable: Foster care Homeless Self-sustained Other

Information must contain 12 months of family living situation: ____________________

____

____

____

____

Any additional information: ____

____

____

____

____

Parent Signature: ______________________________ **Date:** __________

Parent Signature: ______________________________ **Date:** __________

Staff Signature: ______________________________ **Date:** __________

Custody Information

Child Name:

The child named above is in my legal custody, and I can provide legal documents to verify this custody. I understand that if I cannot provide verification of custody or other records as required of all enrollees, the student may not be admitted to this program.

Check Applicable

- ☐ Both biological parents are currently married to each other.
  (Both have legal rights)
- ☐ Biological parents were married at one point but are now divorced.
  (copy of custody papers must be on file with us)
- ☐ Parent(s) have legally adopted the child.
  (copy of legal adoption must be on file with us)
- ☐ Mother is not married to biological father – biological father is sole residential/custodial parent. *(copy of custody papers must be on file with us)*
- ☐ Biological parents are together but not married and the father is on the birth certificate.
  (Both have legal rights)
- ☐ Father was not married to the biological mother but is on the birth certificate and is an acting custodial parent. *(copy of custody papers must be on file with us)*
- ☐ Biological parents are separated, but there has been no documented legal action currently. *(Both have legal rights)*
- ☐ Temporary custody has been placed with ______________________________
  (copy of court papers must be on file with us)

Safety plan set up with:
(copy of safety plan must be on file with us)

- ☐ Grandparent – Power of attorney for residential grandparent/caretaker authorization affidavit must be provided at the time the application process has begun.
- ☐ Court appointed guardian/custody. *(Court papers must be on file)*
- ☐ Foster parents – Case worker for the child must complete application unless documentation states otherwise. *(copy of court papers must be on file with us and "Children services initial authorization release form" completed at time of application)*

Parent/Guardian Signature: ______________________________ **Date:** ____________

Household Information

WARNING: I certify that this information is true. If any part is false, my participation in this agency's program may be terminated and may be subject to legal action. I 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.

Home Occupants ***last name, first name, middle initial***	**Date of Birth**	**Gender**	**Race**	**Relationship to child**
				Child
				Primary Parent / Guardian

Child's Information	**Primary Parent/Guardian's Information**
Primary Language:	**Primary Language:**
Language Proficiency: None Little Moderate Proficient	**Language Proficiency:** None Little Moderate Proficient
Home Address:	**Home Address:**
Primary Doctor Name:	**Phone Number:**
Primary Dentist Name:	**Email:**
	Employment? **Circle Applicable:** **Yes - Full time** **Yes - Part time** **No** **Other**

Is the child receiving services for:

Circle Applicable: IEP/IFSP Speech Diagnosed Disability Other

Are you currently enrolled in Help Me Grow? Y / N

Is biological mother currently pregnant? Y / N

Current living arrangements? *Circle Applicable:* Own Rent Homeless Shelter Car Relative: Other:

Does child currently have health insurance? Y / N

Do you receive cash benefits (TANF/OWF) from ODJFS? Y / N

Do you receive SNAP? Y / N

Current or history of domestic violence with biological parents? Y / N

One or more biological parent incarcerated? Y / N

Were biological parent(s) teen parent(s)? Y / N

Current or previous care with Children's Services? Y / N

History of substance abuse with biological parents? Y / N

Current or previous mental health diagnoses in household? Y / N

Diagnoses? *(optional)*

Parent/Guardian Signature: ______________________________ **Date:** ____________

Certification of Income

Child Name:	Parent/Guardian:

Federal Income Verification: See attached verification documents for the last 12 months or previous calendar year. Must include tax form, W-2, pay stubs, unemployment statement, SSI documentation, OWF statement, child support statement, etc.

Source of Income	Dates Earned	Total Annual income	Total Federal Annual Income: $ Family Size:
☐ W-2 (box 1) ☐ 1040 (gross income only) ☐ Paycheck stubs ☐ Child Support Documentation ☐ Other income – Specify ☐ Public Assistance (TANF/SSI) ☐ SNAP ☐ Document			
Check one applicable category of edibility for this child ☐ Homeless ☐ Foster Care ☐ Income-Below Federal Poverty Guidelines (if self-reporting no income, parent/guardian must write statement with their signature in comment box or attach statement) ☐ Over Income			**Comments:**

Please read and mark the following items before signing:

- ☐ I have carefully reviewed the information on this form and, by signing this application, certify to the best of my knowledge that all information in this application is true and correct.
- ☐ I further understand that this is an application for services that are paid for with federal funds and that intentionally providing misleading, inaccurate, or untruthful information of a material nature could result in disenrolling of my child from Head Start and could have serious legal consequences for me.

Parent/Guardian Signature: ______________________________ **Date:** __________

Staff Signature: ______________________________ **Date:** __________

FOR OFFICE USE ONLY
I have examined the financial information provided to me by the applicant and have determined that the family is:
☐ **Eligible** ☐ **Not Eligible** *(may reconsider at later date)*

Verification: ______________________________ **Date:** __________

Residency Documentation

Please answer the questions below that best describe your living situation. The purpose of this information is to ensure the rights of your family under the McKinney-Vento Law.

MCKINNEY-VENTO HOMELESS ASSISTANCE ACT OF 2001

Title X, Part C of the No Child Left Behind Act – Sec 725

The term "homeless children & youth" means individuals who lack a fixed, regular, adequate nighttime residence; includes:

- *children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement.*
- *children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.*
- *children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and*
- *migratory children who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).*

What is the Meaning of Fixed, Regular, and Adequate Nighttime Residence?

- *Fixed nighttime residence: Stationary, permanent, and not subject to change.*
- *Regular nighttime residence: Used on a predictable, routine, or consistent basis.*
- *Adequate nighttime residence: Sufficient for meeting both physical and psychological needs typically met in home environments.*

Section A:

- ☐ Permanently reside with family by mutual consent, not due to a lack or loss of housing from economic circumstance.
- ☐ Rent / own my own home

STOP. *If you rent / own your own home, skip* ***Section B*** *and sign in* ***Section C****.*

Section B:

- ☐ Temporarily with friends or family because I cannot afford or find affordable housing.
- ☐ In an emergency or transitional shelter (family shelter, domestic violence).
- ☐ In a motel, hotel, camping grounds, weekly rate housing, substandard housing, or public space.
- ☐ In a vehicle of any kind.
- ☐ Other:

Section C:

I understand that this is an application for services that are paid for with federal funds and that intentionally providing misleading, inaccurate, or untruthful information could result in disenrolling my child from Head Start/Early Head Start and could have serious legal consequences for me.

Parent/Guardian Signature: ______________________________ **Date:** ____________

Enrollment & Health Information

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 #1			Relationship to Child
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City	State	Zip	
Email Address *(if applicable)*		Cell Phone *(if applicable)*	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which information 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 #2			Relationship to Child
Home Address ☐ Same as Child's		Home Telephone Number ☐ Same as Child's	
City	State	Zip	
Email Address *(if applicable)*		Cell Phone	
Parent's Work/School Name		Parent's Work/School Telephone Number	
Parent's Work/School Address			City

Please indicate if this name should be released if a parent/guardian, of a child attending the program/home, requests contact information for other parents/guardians. ☐ Yes ☐ No
If you answered yes, please indicate which information 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 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 Medical Foods

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 "Child Medical/Physical Care Plan for Child Care" must be completed and be kept on file at the program/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 to take action if a reaction occurs, or give emergency medication to your child? (*check one*)

☐ No

☐ Yes - a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed.

Does your child have a developmental delay or 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 "Child Medical/Physical Care Plan for Child Care" must be completed.

Is your child currently using any medication or medical food? (*check one*)

☐ No

☐ Yes - please explain

If yes, does this medication or medical food need to be administered at the child care program/home?

☐ No

☐ Yes - a JFS 01217 "Request for Administration of Medication" must be completed and kept on file for each medication and a JFS 01236 "Child Medical/Physical Care Plan for Child Care" must be completed for the medical food.

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 file.

☐ N/A - program does not provide meals or snacks to the child.

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.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as fears or ways that your child prefers to be comforted.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as eating or sleeping habits.

☐ Not applicable

List any additional information about your child that would be useful for staff to know, such as special routines, or behavior needs.

☐ Not applicable

Child's Name

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 2 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		**OR** Do not sign both	***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.			**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, 5101:2-13-15, and 5101:2-14-04. 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.

Program Agreement

Please acknowledge your understanding and permission for the following:

1. I understand that my child will play outside every day and that indoor activities include items such as paint, sand, and/or other messy materials. I will provide a weather appropriate change of clothes, and if soiled clothes come home, I will send in a new set of clothes (top, bottoms, underwear, and socks).
   Initial: ________

2. I give permission for any photos and/or videos taken of my child during program activities to be used and/or shared through various platforms, including but not limited to Classroom Dojo, Facebook, newspapers, displays, bulletin boards, brochures, websites, and other educational publications that promote the Erdman Head Start program or the Clinton County Community Action Program.
   Initial: ________

3. I give permission for my child's first name to be included on photos shared electronically with other families through various platforms, including but not limited to Facebook and Class Dojo.
   Initial: ________

4. I give permission for my child to go on walks to and/or around the adjoining Clinton County Aging Up Community Center (Senior Center) and within the surrounding senior housing community.
   Initial: ________

5. I give permission for my child to participate in screenings and assessments which may include developmental, sensory, behavioral, motor, speech and language, social-emotional, cognitive, perceptual, hearing, vision, growth and kindergarten readiness.
   Initial: ________

6. I understand that information about my child will be entered into a secure online system for two child assessments—'Teaching Strategies Gold' and the 'DECA' (social/emotional screening). Security systems are in place to prevent unauthorized people from accessing information.
   Initial: ________

7. I give permission for the Erdman Head Start Program to review my child's social-emotional screening results with their Mental Health Consultant. These results will be used to develop individual and classroom profiles, guiding activities that support and promote social and emotional growth. If deemed necessary, I also authorize the Mental Health Consultant to observe my child to provide additional support and enhance activities based on the screening results.
   Initial: ________

8. I give permission for Head Start to provide sunscreen (Coppertone Kids SPF 50 or higher) for my child during spring and summer months.
   Initial: ________

9. I give permission for my child to participate in water play when the temperature is above 85 degrees.
   Initial: ________

I verify that I have read and understand the above.

Parent/Guardian Signature: ______________________________ **Date:** ____________

Attendance Agreement

Please acknowledge your understanding and permission for the following:

- Parents are to call the Erdman Head Start program (837-382-5624) as soon as they know their child will be absent. If Head Start does not hear from you by the time school starts, the staff will call you to determine cause of the absence and possible family need.
- If the absence is due to factors other than illness, the program may initiate appropriate family support procedures.
- When a child misses 2 days with no contact, an Erdman Head Start staff person will visit the home.

I verify that I have read and understand the above.

Parent/Guardian Signature: ______________________________________ **Date:** ____________

Routine Trip Permission

Please acknowledge your understanding and permission for the following:

- Routine trip destination(s): Erdman Center Site A, Erdman Center Site B, Senior building, Senior complex, and covered patio
- Mode of transportation: (walking, school bus, public transportation, parent vehicles, provider vehicle, & driver)
- During this trip children will have access to water that is 18 inches or more in depth. Y / N

I verify that I have read and understand the above.

Parent/Guardian Signature: ______________________________________ **Date:** ____________

Transportation Agreement

Please acknowledge your understanding and permission for the following:

- I will be ready 5 minutes before my child's scheduled time. The bus may arrive 10 minutes later than the scheduled time.
- I will have my child ready; the bus can only wait for 1 minute when dropping off or picking up my child.
- I will stay back from the bus, in my POS (Point of Safety), until the driver motions the go-ahead to approach the bus.
- I will walk my child to and from the door.
- I understand that a Bus Monitor is always present on the bus <u>and is not allowed to exit the bus while children are riding.</u>
- Smoking and/or Vaping is NOT ALLOWED when putting my child on the bus or taking my child off the bus. This is against the law in the state of Ohio.
- I will update phone number changes for those listed on my child's emergency contact list regularly.
- **ONLY** those listed on my emergency contacts can get my child off the bus.
- An adult (18 or over) must be the one to get my child on or off the bus.
- Any person picking up my child, who is not known by staff, will be required to show a photo ID until the driver is comfortable that he/she knows the person.
- I will notify the center if my child will not be riding the bus to the center. I risk losing bus service if the bus stops 3 times in a row and my child does not get on.
- **IF NO ONE IS HOME TO GET MY CHILD OFF THE BUS:**
    1. The driver will locate a safe area to pull the bus over.
    2. The bus monitor will phone the center to begin calling the parent and other persons listed as emergency contacts.
    3. Parents or emergency contacts will be informed their child may be picked up at the center when the bus route is completed.
    4. **Upon the return of the child to the center and 30 minutes has elapsed and contact has not been made with a responsible party, the local child protective service and police will be called.**

I understand the rules listed in the Transportation Agreement. These rules are in place for my child's safety and help to provide a timely route to and from school. I understand that if we do not follow these rules, we may lose bus services.

Parent/Guardian Signature: ______________________________ **Date:** __________

Driver Signature: ______________________________ **Date:** __________

Transportation Manager /
Asst. Health Manager Signature: ______________________________ **Date:** __________

Will your child be picked up and/or dropped off with a caregiver by our busses? Y / N

Caregiver Name	Address	Phone Number

Do we have permission to release your child to the above-named caregiver? Y / N
What hours will your child be with the caregiver? ___:_____ to ___:_____

Child Health History

Child Name:	Date of Birth:	Gender:

Medical and Dental Home

1. Do you have medical insurance? ☐ Medicaid (Entire family) ☐ Insurance for only children ☐ Private Insurance ☐ No Insurance ☐ Other
2. Primary Doctor/Clinic Name: ______________________________ ☐No Doctor currently
   Date of Last Visit: __/___/____ Address:______________________Phone: ____-____-____
3. Primary Dentist/Clinic Name: ______________________________ ☐No Dentist currently
   Date of Last Visit: __/___/____ Address:______________________Phone: ____-____-____

Health Concerns & Allergy Information

4. Did mother or baby have any serious health problems during this pregnancy, delivery, or immediately after birth? Y / N If yes, explain: ____
5.

	YES	NO		YES	NO		YES	NO		YES	NO
Asthma			Eczema			G-Tube			Hearing Aide		
Diabetes			Respiratory Disorder			Anemia			Ear Tubes		
Seizure Disorder/ Epilepsy			Heart Disorder			Vision Problems/ Glasses			Other: ________		

6. Is your child allergic to anything? (Medications, Animals, Insects, Dust, Food, etc.) Y / N
   If yes, specify: ____
   What is the reaction? (rash, hives, etc.):____
7. Does your child require an antihistamine (Benadryl, Zyrtec, etc.)? Y / N
8. Does your child require an EpiPen? Y / N
9. Are there any other conditions that get in the way of the child's everyday activities? Y / N
   If yes, specify: ____
10. Will child need any medications or special accommodations for any health concerns at school? Y / N
    If yes, specify: ____

an 'Authorization to Give Medication' form must be completed to <u>administer</u> any medication at school

Disability & Mental Wellness

11. Does your child have a disability/mental wellness concern, or do you suspect may have a disability/mental wellness issue? If yes, specify: ______________________________ Y / N
12. Has a professional assessed/diagnosed your child? If yes, who? ____________________ Y / N
13. Has your child ever received Early Childhood Intervention (ECI) Services? Y / N
14. Is your child currently receiving services at home? If yes, what agency? ____________________ Y / N
15. Have documentation, Individual Family Service Plan (IFSP), or Individual Education Program (IEP)? Y / N

Help us better understand your child

16. Does your child regularly brush their teeth and with fluoride toothpaste? Y / N
17. Is your child potty trained? If no, explain______________________________ Y / N
18. Can your child tell you if they need go to the toilet? Y / N
    If no, how do you know they need to go?______________________________
19. Any big changes in child's life during last six months? Y / N
    If yes, describe: ______________________________
20. Are you/your family having any problems that may affect your child? Y / N
    If yes, describe: ______________________________
21. Was alcohol or illegal drugs consumed during pregnancy? Y / N
    If yes, describe: ______________________________

Parent/Guardian Signature: ______________________________ **Date:** ____________

Nutrition Assessment

Child Name:	Date of Birth:	Gender:

Eating Habits

1. How many meals does your child usually eat per day? ____________________

2. How many servings of the following food components does your child consume in a typical day?

Food component	Servings
Dairy: Such as milk, milk on cereal, cheese, yogurt, pudding, ice cream	0 1 2 3 4 5 6
Fruit: Such as 100% fruit juice, canned fruit, fresh fruit, applesauce	0 1 2 3 4 5 6
Vegetables: Such as broccoli, tomato, tomato juice, cabbage coleslaw, vegetable soup, corn, peas, green beans, sweet potatoes, lettuce	0 1 2 3 4 5 6
Fats, Sweets & Other: Such as bacon, mayo, salad dressing, potato chips, cheese curls, cake, cookies, doughnuts, candy, pop, tea, Kool-Aid	0 1 2 3 4 5 6
Meat: Such as eggs, fish, tuna, chicken, turkey, hamburger, steak, dry beans, soup beans, nuts, peanut butter, lunchmeat, hot dogs, sausage	0 1 2 3 4 5 6
Grains, Bread & Cereal: Such as sliced bread, biscuit, muffin, bun, bagel, tortilla, crackers, cereal, spaghetti, noodles, rice, macaroni, pizza	0 1 2 3 4 5 6

Special Diet

3. Is your child restricted from foods due to religious or personal beliefs? Y / N

If yes, check all that apply: ☐ Pork ☐ Beef ☐ Poultry ☐ Fish ☐ Eggs ☐ Milk ☐ Other _____

4. Does your child have any food allergies, intolerance or special formula? (If "No," skip to end)

If yes, check all that apply:

☐ Milk ☐ Milk Products ☐ All foods Containing Milk ☐ Eggs ☐ All foods containing eggs
☐ Whole Wheat/ Gluten ☐ Fish ☐ Shellfish ☐ Beef ☐ Legumes (Dry Beans/Peas)
☐ Tree Nuts/Seeds/Peanuts ☐ Soy
☐ Formula (specify) ____________________
☐ Vegetables (specify) ____________________
☐ Fruits/Juice (specify) ____________________
☐ Other (specify) ____________________

What kind of reaction does your child have when they eat these foods?

☐ Life-Threatening ☐Rash ☐ Diarrhea ☐ Nausea/Vomiting ☐Swelling
☐ Difficulty Breathing ☐ Other (specify) ____________________

Other

5. Do you receive WIC (Women, Infants and Children)? Y / N

6. Would you like to be referred to WIC? Y / N

7. Do you receive SNAP benefits (Food Stamps)? Y / N

8. Does your child feed themself? Y / N

I give consent for the Nutrition Assessment along with my child's height/weight to be sent to Head Start's Dietician Consultant for review and recommendations.

Parent/Guardian Signature: ______________________________ **Date:** __________

Erdman Head Start Center Dental Form

789 North Nelson Avenue, PO Box 32, Wilmington, OH 45177 Phone: 937-382-5624 Fax 937-504-5091

Child's name________________________ **Date of exam**________________________

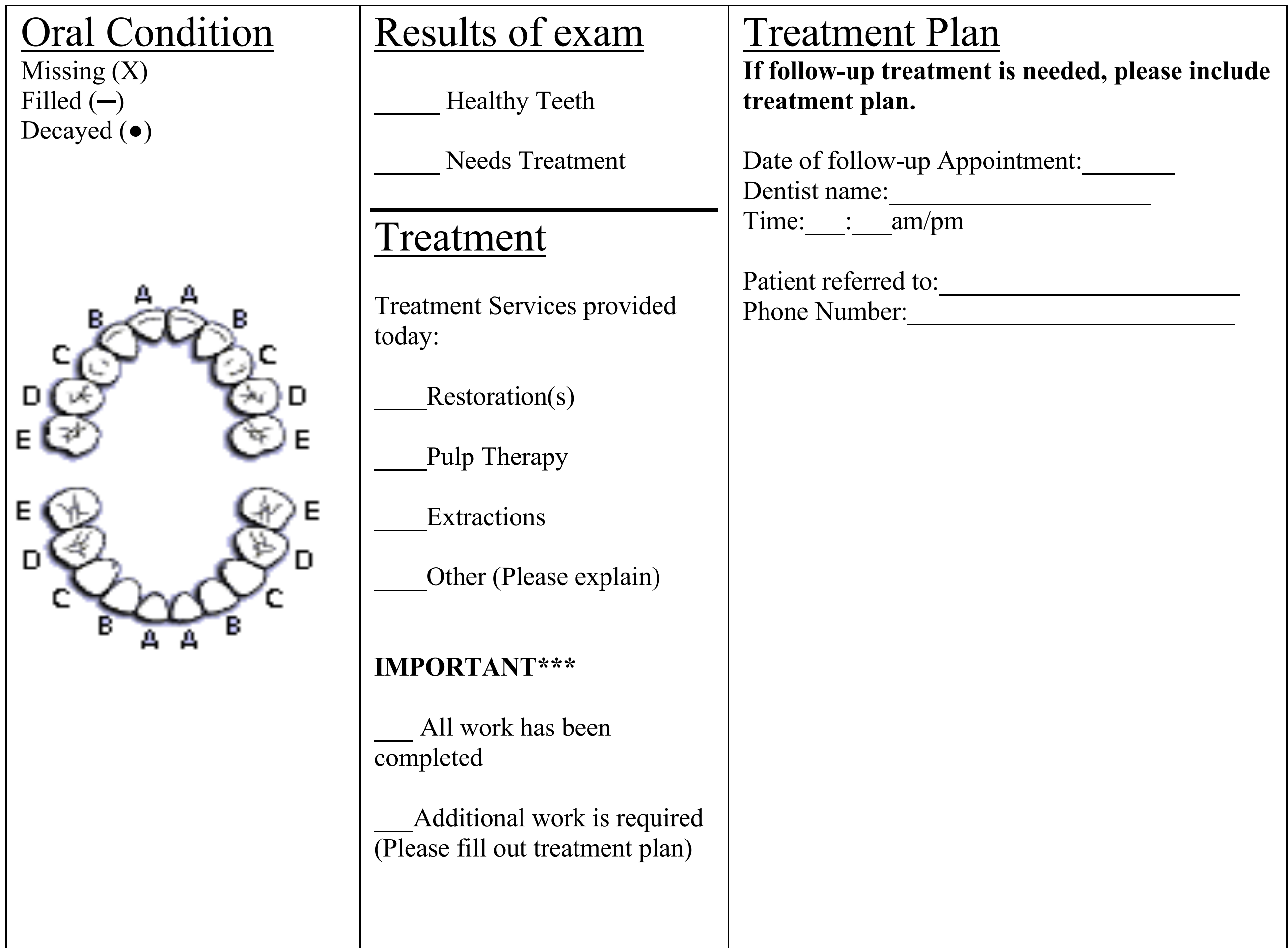
Parent name________________________ **Address**________________________

Child's date of birth____________________ ________________________

RELEASE: I give permission for my dentist's office to fax this completed form to Clinton County Head Start.

Signature of Parent or Legal Guardian ____________________________ **Date** ______________

(Provider use only)



Oral Condition	Results of exam	Treatment Plan
Missing (X) Filled (—) Decayed (●)	_____ Healthy Teeth _____ Needs Treatment	**If follow-up treatment is needed, please include treatment plan.** Date of follow-up Appointment:_______ Dentist name:____________________ Time:___:___am/pm Patient referred to:______________________ Phone Number:________________________
A A B B C C D D E E E E D D C C B B A A	**Treatment** Treatment Services provided today: ____Restoration(s) ____Pulp Therapy ____Extractions ____Other (Please explain) **IMPORTANT***** ___ All work has been completed ___Additional work is required (Please fill out treatment plan)	

PLEASE CHECK PREVENTITIVE SERVICES PROVIDED:

☐ Prophylaxis ☐ Fluoride ☐ Instruction in oral hygiene

I certify that I have completed the services listed and that itemized charges do not exceed my usual and customary fees.

______________________ ______________________ ______________________

Address or Stamp of Examiner **Signature of Examiner** **Date of signature**

Please return to Health Office

Erdman Head Start Center Medical Statement

789 North Nelson Avenue, PO Box 32, Wilmington, OH 45177   Phone: 937-382-5624   Fax 937-504-5091

RELEASE: I give permission for my dentist's office to fax this completed form to Erdman Head Start Center.
Parent/Guardian Signature: ________________________________ **Date:** ____________

Child's Name	Date of Birth
Note: Sections A and B must be completed by the examining Health Care Practitioner	
Section A - EXAMINATION	
✓ The above named child has been examined	
✓ The above named child is in suitable condition for participation in group care (i.e. free of infections disease, mentally and physically fit to be in group care).	
✓ This above named child is up to date on a schedule of age- appropriate preventative and primary health care (including EPSDT)	
✓ The above named child does not have allergies OR is allergic to the following (please list in space below):	
Optional Measurements and Recommended Assessments/Screenings: Height__________ Vision__________ ☐ Yes ☐ No Lead__________ ☐ Yes ☐ No Weight__________ Hearing__________ ☐ Yes ☐ No Hemoglobin__________ ☐ Yes ☐ No BMI__________ Dental__________ ☐ Yes ☐ No Other______________ Notes:	
Signature of Examining Health Care Practitioner	**Date of Examination**
Name of Examining Health Care Practitioner	Telephone Number
Street Address	City State and Zip Code

ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD INCLUDING DATES

IMMUNIZATION (Complete ONLY ONE SECTION below) **Section 5104.014 of the Ohio Revised Code requires immunizations against the following diseases:** Chicken pox, Diphtheria, Haemophilus influenzae type b, Hepatitis A, Hepatitis B, Influenza, Measles, Mumps, Pertusis, Pnuemococcal disease, Poliomyelitis, Rotavirus, Rubella and Tetanus.	
Section B – To be completed by the EXAMINING HEALTH CARE PRACTIONER: ☐ The above-named child has been immunized against the diseases listed above. *If an immunization is medically contraindicated or not medically appropriate for the child's age, note any exceptions by listing the specific immunization(s):*	**Initials of Examining Health Care Practitioner:** **Date**
Section C – To be completed by the child's parent ONLY IF WAIVING AN IMMUNIZATION(S): ☐ I have declined to have my child immunized for reasons of conscience, including religious convictions against all of the diseases listed above or against the following disease(s):	**Signature of Parent** **Date**

Child Questionnaire

Questions about behaviors children may have been listed on the following pages.
Please reach each question carefully and check the box that best describes your child's behavior, and if this is a concern to you. Be sure to answer the questions based on what you know about your child's usual behavior.

Questions	Often / Always	Sometimes	Rarely / Never	Concern
Does your child talk or play with adults they know well?	☐	☐	☐	☐
Does your child cling to you more than you expect?	☐	☐	☐	☐
When upset, can your child calm down within 15 minutes?	☐	☐	☐	☐
Does your child settle themselves down after exciting activities?	☐	☐	☐	☐
Does your child move from one activity to the next with little difficulty (for example, from playtime to mealtime)?	☐	☐	☐	☐
Is your child interested in things around them, such as people, toys, and foods?	☐	☐	☐	☐
Does your child do what you ask them to do?	☐	☐	☐	☐
Does your child stay with activities they enjoy for at least 5-15 minutes (other than electronics)?	☐	☐	☐	☐
Does your child sleep at least 8 hours in a 24-hour period?	☐	☐	☐	☐
Does your child use words to tell you what they want or need?	☐	☐	☐	☐
Does your child follow routine directions? For example, do they come to the table or help clean up their toys when asked?	☐	☐	☐	☐
Does your child cry, scream, or have tantrums for long periods of time?	☐	☐	☐	☐
Does your child do things over and over and get upset when you try to stop them?	☐	☐	☐	☐
Does your child hurt themselves on purpose?	☐	☐	☐	☐
Does your child destroy or damage things on purpose?	☐	☐	☐	☐
Does your child use words to describe their feelings and the feelings of others? For example, do they say, "I'm happy," "I don't like that," or "They're sad"?	☐	☐	☐	☐
Does your child like to play with other children?	☐	☐	☐	☐
Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐	☐	☐	☐
Is your child too worried or fearful?	☐	☐	☐	☐
Has anyone shared concerns about your child's behaviors?	☐	☐	☐	☐
Does your child follow rules at home or at childcare?	☐	☐	☐	☐

Pediatric ACE and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:

1. Has your child ever lived with a parent/caregiver who went to jail/prison?
2. Do you think your child ever felt unsupported, unloved and/or unprotected?
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?

   Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child?

   Or has any adult in the household ever hit your child so hard that your child had marks or was injured?

   Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*

Add up the "yes" answers for this first section: ☐

Please continue to the other side for the rest of questionnaire →

PART 2:

1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school?
(for example, targeted bullying, assault or other violent actions, war or terrorism)

2. Has your child experienced discrimination?
(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)

3. Has your child ever had problems with housing?
(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)

4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?

5. Has your child ever been separated from their parent or caregiver due to foster care, or immigration?

6. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?

7. Has your child ever lived with a parent or caregiver who died?

Add up the "yes" answers for the second section: ☐

Consent To Release Confidential Information

Please acknowledge your understanding and permission for the following:

Child's Name **Date of Birth**

Parent's Name

Child's Social Security Number **Parent's Social Security Number**

I, ____,
authorize Erdman Head Start Center to release and exchange information with:

Clinton County WIC (Women, Infants, Children)

____

____

This information will be used for the purpose of:

- **Exchange of information**
- **Assessment, evaluation and diagnosis**
- **Consultation**
- **Other: ____________________________________**

The following information may be released:

Medical Records	_____ **yes**	_____ **no**	______________
School Records	_____ **yes**	_____ **no**	______________
Mental Health Records	_____ **yes**	_____ **no**	______________
Other ______________	_____ **yes**	_____ **no**	______________

- **I release the Erdman Head Start program and personnel from any legal liability resulting from the release of information with the understanding that the Head Start personnel will exercise reasonable professional safeguards regarding this information.**
- **I understand that this information will only be released to the above identified agency/person.**
- **I further understand that I may revoke this consent at any time and that this consent if not revoked expires automatically a year from the date of the parent/guardian's signature.**

Parent/Guardian Signature: ______________________________ **Date:** __________

Witness Signature: ______________________________ **Date:** __________

Parent/Guardian Signature: ______________________________ **Date Revoked:** __________

Witness Signature: ______________________________ **Date:** __________

Clinton County Job and Family Services

EARLY CHILDHOOD EDUCATION

RELEASE OF INFORMATION/AUTHORIZED REPRESENTATIVE

Parent/Caretaker Name	Date of Birth	Social Security Number
Street Address	City	State
Child's Name	Date of Birth	Social Security Number

REASON FOR CONSENT TO RELEASE INFORMATION/AUTHORIZED REPRESENTATION

This consent gives permission for Clinton County Job and Family Services (CCJFS) to release eligibility regarding the Early Childhood Education (ECE) program to Clinton County Community Action Head Start Program

Clinton County Community Action Head Start cannot require you to complete this form as part of their enrollment process and/or to receive services.

CONSENT

I ____ understand that by signing this form, Clinton County Community Head Start program will have access to:

- Documentation related to eligibility of the Early Childhood Education (ECE) program, including any notices issued to me regarding the ECE program.

This authorization is good until eligibility for the ECE program has been completed.

This information may be released to:

Dorothy Campbell, Family Services Manager
dorothycampbell@clintoncap.org

Clinton County Community Action Head Start Program
789 N. Nelson Avenue
Wilmington, Ohio 45177
937-382-5624

Signature of Parent/Caretaker Date

Release of Information and any other documentation can be sent to:

Clinton_county_family_services@jfs.ohio.gov

Erdman Head Start Enrollment Form

After completing this document, please save and email it to Dorothy Campbell at dorothycampbell@clintoncap.org

Alternatively, you may print it and call 937-382-5624 to schedule an appointment.