The Improvement Association

This Section for Agency Use Only:

Applicant Name: _____

BC# _____ Previous Child Care: _____

Applicant & Family Member Information

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender

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 Health Coverage	Insurance #	Medicaid	Medicaid #	Doctor	Dentist
			☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible			

Adult 1

First	Middle	Last	Suffix	Nickname	Birthday	Gender

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

Phone # ☐ Cell ☐ Home ☐ Other / Email Address:

Adult 2

First	Middle	Last	Suffix	Nickname	Birthday	Gender

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		

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☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

Phone # ☐ Cell ☐ Home ☐ Other / Email Address:

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender

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		

This Institution is an Equal Opportunity Provider

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Applicant Name: ___________________________________

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☐ Other: ______________________			☐ Proficient		

- *This Section for Agency Use Only:*

Applicant Name: _____

Family Information, Income & Contacts

Family Information					
Living Address	Address Line 2	Zip	City	State	County
Mailing Address (if different)	Address Line 2	Zip	City	State	County
Employer Name (Adult 1)	Address Line 2	Zip	City	State	Phone #
Employer Name (Adult 2)	Address Line 2	Zip	City	State	Phone #

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	
TANF	Supplemental Security Income
☐ Yes ☐ No ☐ Formerly	☐ Yes ☐ No

Emergency Contacts				
Contact 1	Name	Relationship	Emergency Contact	Release To
			☐ Yes ☐ No	☐ Yes ☐ No
	Address	Zip	City	State
	Phone # 1	Phone # 2	Phone # 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 # 1	Phone # 2	Phone # 3	
	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	

I understand that my child <u>cannot begin classes</u> until his/her immunization record is given to the school nurse, secretary or TIA staff. If the record is incomplete I understand that I must present an appointment card for completion of the immunizations to the nurse, secretary or TIA staff <u>before my child can begin classes.</u>

_____

Parent Signature

I understand that if my child is selected to attend a 3 or 4-year-old program, I must present a completed physical examination form to the school nurse or secretary <u>before my child can attend classes.</u>

_____

Parent Signature

This Section for Agency Use Only:

Applicant Name: _____

Health Information

Does your child show signs of (Check all that apply)

☐ Speech Impairment
☐ Physical Impairment
☐ Hearing Impairment
☐ Mental Health Impairment
☐ Visual Impairment
☐ No Impairment
☐ Other (please explain) _____

Has he/she been professionally diagnosed? _____ No _____ Yes (Attach Documentation)

Service Provider for Impairment_____ Phone _____

Does your child have any of the following conditions (Check all that apply)

☐ Asthma
☐ Diabetes
☐ Seizures / Convulsions
☐ Food Allergies (please explain) _____

☐ Other Allergies (please explain) _____

Has he/she been professionally diagnosed? _____ No _____ Yes (Attach Documentation)

Service Provider for allergy/ condition: _____ Phone _____

Permits & Agreements

Please **Initial** questions 1 through16

My child _____ will receive the following health screenings.

1 ____ Physical Exam
2 ____ Vision
3 ____ Mental Health
4 ____ Dental Screening and Exam
5 ____ Hemoglobin or Hematocrit
6 ____ Hearing
7 ____ Lead

I, _____ give The Improvement Association the following permissions:

8 ____ For Head Start to secure emergency treatment in my absence _____Yes _____ No
9 ____ To allow The Improvement Association staff to make home visits _____Yes _____ No
10 ____ That my child may go on all field trips with the program _____Yes _____ No
11 ____ That my child will attend each day he/she is able _____Yes _____ No
12 ____ I will make effort to attend the bi-monthly Parent Center Committee Meetings _____Yes _____ No
13 ____ Myself or a Representative of my household will volunteer in the center _____Yes _____ No
14 ____ I give permission for my child to be assessed through Head Start _____Yes _____ No
15 ____ I will inform The Improvement Association within 24 hours of the next business day if my child or any member of the household has developed any reportable communicable disease as described in the Head Start Parent Handbook Exclusion Policy _____Yes _____ No
16 ____ The Improvement Association Head Start has the absolute right and permission to copyright and/or publish photographs or videos of the above named child and I agree that any such photographs and/or videos become the exclusive right of the Improvement Association, and I waive all rights thereto _____Yes _____ No

AGREEMENT: The Improvement Association Head Start agrees to notify parents/guardians when a child becomes ill and the parent/guardian agrees to pick child up within one hour. Parent/Guardian agrees to permit The Improvement Association Head Start to secure emergency treatment in my absence.
I understand that I have the right to review records maintained on my family and to dispute or correct any information I feel to be incorrect. I understand that the information provided above will remain strictly confidential.

_____ _____
Parent / Guardian Signature Date

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Releases

Provider Information Release (Please complete all areas, any area that is not applicable please indicate with N/A)

I, _____ (Parent / Guardian), give The Improvement Association Head Start Program consent to obtain from or give to the following agencies and/or person pertinent social, medical or other information about _____ (Child / Family Name), for whom I am legally responsible. In granting such permission, I understand that such information will remain confidential and will be used for the benefit of the child named above. This consent is valid for two years after the date signed.

	Name of Agency or Person
Department of Social Services (include County or City)	
Public School (include County or City)	
Physician	
Dentist	
Literacy Program	
Legal Assistance Agency	
Previous Child Care	
Other	

I release The Improvement Association and its staff from any legal liability for disclosing or acquiring information which I have permitted by signing this form.

_____ _____

Parent / Guardian Signature Date

Child Transportation Release (Please complete all areas)

I, _____ (Parent / Guardian), give The Improvement Association Head Start Program permission for my child(ren) _____ (Child / Family Name), To be transported, to and from the Head Start Center by _____ (Parent/Guardian or Bus). I hereby release The Improvement Association's Head Start program of all legal liabilities while by child is being transported by the public school system. I further understand that the driver(s) of the public school by is not an employee of The Improvement Association.

Permission Tracking Form (Please complete all areas)

I, _____ (Parent / Guardian), give The Improvement Association Head Start Program permission to receive information up to the grade three From _____ (County) Public Schools regarding my child's education gain (report card, promotion retention, education placement, etc.)

Permission to obtain medical services (Please complete all areas)

I, _____, give The Improvement Association Head Start Program permission to transport my child to appropriate service providers to receive medical services necessary to comply with Head Start regulation and meet the needs of the above mentioned child/family.

Permission to obtain medical information (Please complete all areas)

I, _____, give The Improvement Association Head Start Program permission to receive medical information necessary to comply with Head Start regulation and meet the needs of the above mentioned child/family.

Parent / Guardian Signature: _____ _____

Name Date

Head Start Staff Signature: _____ _____

Name / Title Date

Head Start Health Staff Signature: _____ _____

Name / Title Date

Interview Date: _____

Home Visit Directions

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Applicant Name: _____

Please complete all areas (any changes must be submitted in writing, form will be provided)

Child's Name: _____ **Parent Name:** _____

Address: _____

Phone: ( ) _____- _____ **Alt.: ( ) _____ - _____**

Directions to your home: (from your child's school)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Confidential Information

The following information will be kept strictly confidential and will not be released without your permission. Together, we will use this information to provide the most effective comprehensive services for you and your family.

Have you been convicted of a felony? Yes or No

Please Explain:_____

_____

_____

_____

_____

_____

Head Start Staff Signature: _____ _____

Name / Title Date