This Section for Agency Use Only:

Applicant Name: _____

The Improvement Association
Addendum to Application

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 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

Insurance Information

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

This Section for Agency Use Only:

Applicant Name: _____

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 _____. 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: _____ _____

This Section for Agency Use Only:

Name / Title

Applicant Name: _____

Interview Date: _____

Home Visit Directions

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