



Applicant Name: _____
BC# _____ Previous Child Care: _____

Applicant & Family Member Information

Applicant
First Middle Last Suffix Nickname Birthday Gender
Race: Asian, Black, White, Other
Hispanic: Yes, No
English Proficiency: None, Little, Moderate, Proficient
Other Language Proficiency: Poor, Moderate, Proficient
Primary Health Coverage, Other Health Coverage, Insurance #, Medicaid, Medicaid #, Doctor, Dentist

Adult 1
First Middle Last Suffix Nickname Birthday Gender
Race: Asian, Black, White, Other
Hispanic: Yes, No
English Proficiency: None, Little, Moderate, Proficient
Other Language Proficiency: Poor, Moderate, Proficient
Highest Grade Completed, Employment Status, Child's Relationship, Custody, Check all that apply:
Phone #, Cell, Home, Other, Email Address:

Adult 2
First Middle Last Suffix Nickname Birthday Gender
Race: Asian, Black, White, Other
Hispanic: Yes, No
English Proficiency: None, Little, Moderate, Proficient
Other Language Proficiency: Poor, Moderate, Proficient
Highest Grade Completed, Employment Status, Child's Relationship, Custody, Check all that apply:
Phone #, Cell, Home, Other, Email Address:

Additional Child (Non-Applicant) *
First Middle Last Suffix Nickname Birthday Gender
Race: Asian, Black, White, Other
Hispanic: Yes, No
English Proficiency: None, Little, Moderate, Proficient
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• 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)
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No					

Family Income			
TANF		Supplemental Security Income	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Emergency Contacts								
Contact 1	Name		Relationship		Emergency Contact		Release To	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address		Zip		City		State	
	Phone # 1		Phone # 2		Phone # 3			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		
Contact 2	Name		Relationship		Emergency Contact		Release To	
					<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address		Zip		City		State	
	Phone # 1		Phone # 2		Phone # 3			
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		

I understand that my child cannot begin classes 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 before my child can begin classes.

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 before my child can attend classes.

Parent Signature



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, Other Allergies

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

Service Provider for allergy/ condition: Phone

Permits & Agreements

Please Initial questions 1 through 16

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, 9 To allow The Improvement Association staff to make home visits, 10 That my child may go on all field trips with the program, 11 That my child will attend each day he/she is able, 12 I will make effort to attend the bi-monthly Parent Center Committee Meetings, 13 Myself or a Representative of my household will volunteer in the center, 14 I give permission for my child to be assessed through Head Start, 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, 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

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



Applicant Name: _____

Releases



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

I, _____, 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 _____, 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.

Table with 2 columns: Agency/Person Type and Name of Agency or Person. Rows include Department of Social Services, Public School, Physician, Dentist, Literacy Program, Legal Assistance Agency, Previous Child Care, and 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, _____, give The Improvement Association Head Start Program permission for my child(ren) _____ 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, _____, give The Improvement Association Head Start Program permission to receive information up to the grade three From _____ 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: _____



