Early Childhood Center

541-573-6461
655 W/ Fillmore
P.O. Box 460 Burns, OR 97720

Points ________

Program Option: ___Center-base Head Start, ___Home-base, ___ Preschool Promise

Enrolled Child's Name

First Name ______________Middle_____ Last Name______________ Suffix____ Nickname__________
Birth Date__________ Gender______ Race__________________ Primary Language______________
Primary Health Coverage______________________

Primary Adult________________________________ Birth Date________ Gender______ Race ______
Highest Grade Completed______ Employer____________ Phone#__________ F/T___ P/T___ Seasonal___
Relationship to Child__________ (Y or N) Custody___ Lives with Family___ Provides Financial Support___ WIC___

Primary Adult________________________________ Birth Date________ Gender______ Race______
Highest Grade Completed______ Employer____________ Phone#__________ F/T___ P/T___ Seasonal___
Relationship to Child__________ (Y or N) Custody___ Lives with Family___ Provides Financial Support___ WIC___

Physical Address ____________________________City________________________
Mailing Address (if different) ______________________City ______________________

Phone Numbers ______________________email_______________________________
Phone Number/ cell number ____

Other Household Members

Name	Relationship to child	DOB	Highest grade completed	Employed y/n

Eligibility

Age of child at time of enrollment ________ Preference: part day or full day ________________
Check any that apply: Homeless___ Military___ TANF___ SSI___ Foster Care___

X ________________________
Parent Signature
Date: ____________________

Total gross yearly income:
Family Member__________ Source__________$_______
Family Member__________ Source__________$_______

November 2020

Head Start is a comprehensive child development program that was developed to help young children from low income families be able to access preschool services. 35% of children in the program can be between 100%—130% of federal poverty guidelines and 10% of children can be over income. Head Start of Harney County gives preference to families most in need of Head Start services. The following questions are optional, but may help the program determine your family's eligibility. These questions can also help in determining Great Start enrollment.

Children with disabilities or on an IFSP: Speech___ Other______________________________
Date Diagnosed ______________________

What are the top issues facing your family? Check all the apply.

____Unemployment
____Job Training
____Housing
____Food
____Rural Area
____Literacy
____Language barrier (non-English speaking)
____Speech/hearing concerns
____Vision concerns
____Health concerns
____Dental concerns
____Immunizations

____Mental health counseling
____Insurance
____Death in family

____Adult education
____Better use of finances
____Childcare
____Transportation
____Single parent
____Teen pregnancy
____More recreational/social outlets
____Crime/incarceration/parole
____Drug/alcohol abuse
____Adoption within the last two years
____Involved with CPS
____Moved more than 2 times in the last five years
____Other:____________________

Emergency Contact List

Name:____________________________ Relationship to child__________ Phone # ________
(Must be someone other than yourself)

Name:____________________________ Relationship to child__________ Phone # ________

Name:____________________________ Relationship to child__________ Phone # ________

Name:____________________________ Relationship to child__________ Phone # ________

Name:____________________________ Relationship to child__________ Phone # ________

OHSP Oregon Head Start Program NHSA National Head Start Association

The Commission on Children and Families

Child Health History

Child's Name: Parent's Name: Date:

Does your child have seizures? If yes, please give details.

Does your child follow a special diet? If yes, please explain.

Is your child on WIC? _____yes _____no _____Not Interested

Is there any food your child should not eat for allergic, medical, religious, or personal reasons? What food(s)?

Does your child have any disabilities or feeding problems that need to be accommodated in the classroom such as: chewing, swallowing, needing help to feed self? If yes, please explain.

Does your child have any allergies? If yes, please give details as to what they are and any medication needed.

Does your child have asthma? If yes, please give details as to what causes an attack and any medication needed.

Does your child receive ongoing care for any chronic illness? Please explain.

Is your child on any medications? Please explain.

Does your child have trouble with teeth, gums, or mouth? Please explain.

Who is your insurance provider (check one):

OHP/Medicaid________ Private________ No Insurance________ Other (please list)____________

Place your initials next to the item that pertains to your child for Medical:

_____ I only take my child to the doctor when they are in need of care. Doctor:____________________

_____ My child receives regular medical check-ups from:____________________

_____ I authorize the Early Childhood Center to obtain well child/medical records information from (list the name of the provider and facility/organization):

Place your initials next to the item that pertains to your child for Dental:

_____ I only take my child to the dentist when they are in need of care. Dentist:____________________

_____ My child receives regular dental check-ups from:____________________

_____ I authorize the Early Childhood Center to obtain dental records information from (list the name of the provider and facility/organization):

Consent Information

Child's Name: ______________________________ **Date of Birth:** ______________________

___In an emergency, the Early Childhood Center has my permission to call an ambulance or take my child to any available physician or hospital at my expense.

___In an emergency, the Early Childhood Center has my permission to obtain medical treatment for my child, except for these restrictions. List, if applicable

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___I give my consent to the Early Childhood Center to administer natural hand lotion to my child's hands, except for these restrictions. List, if applicable

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___My child may be photographed for publicity or news purposes.

___I give my permission for the Early Childhood Center to mutually exchange progress data concerning my child with Harney County School District #3 from preschool through the end of 3rd grade. I understand that this information will not be shared with any other agency or individuals without my written permission.

___I give my permission to include my child in classroom videotaping. The Early Childhood Center has a portable video camera and as part of on-going training for our teachers and to assist in referring children who may need extra classroom assistance, we occasionally video tape the classroom. The tapes are reviewed by teaching staff (for training), the program Mental Health consultant, and parents/guardians.

___Screenings are given as part of the Early Childhood Center's programs. My child may participate in all health activities, which include: dental, developmental, hearing, speech, vision, and physical screenings.

___My child may be observed by the Early Childhood Center's Mental Health consultant.

I have read all the previous information and verify that everything I have checked and written is true.

Parent/Guardian Signature: ________________________________ **Date:** _______________

Printed Name: ____

Relationship to child: ____