

Early Childhood Center
541-573-6461
655 W Fillmore
P.O. Box 130 Burns, OR 97720

Program Option: Center-Base Head Start _____ Home-Base _____ Preschool Promise _____

Enrolled Child's Information:

First Name _____ Middle _____ Last _____ Nickname _____
 Date of Birth _____ Gender _____ Race _____ Primary Language _____
 Primary Health Coverage _____ Primary Dental Coverage _____

Primary Adult _____ Date of Birth _____ Gender _____ Race _____
 Highest Grade Completed _____ Employer _____ Phone# _____ F/T _____ PT _____
 Seasonal _____
 Relationship to Child _____ Custody (Y or N) _____ Lives w/ Family _____ Provides Financial Support _____ WIC _____

Secondary Adult _____ Date of Birth _____ Gender _____ Race _____
 Highest Grade Completed _____ Employer _____ Phone# _____ F/T _____ PT _____
 Seasonal _____
 Relationship to Child _____ Custody (Y or N) _____ Lives w/ Family _____ Provides Financial Support _____ WIC _____

Physical Address _____ City _____
 Mailing Address _____ City _____
 Phone Number _____ **Home or Cell** Email _____

Other Phone Numbers and Type _____

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 _____ SNAP _____

X _____
 Parent Signature and Date

Total gross yearly income:
 Family member _____ Source _____ \$ _____
 Family member _____ Source _____ \$ _____

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 will help the program determine your family's eligibility. These questions can also help in determining Preschool Promise enrollment.**

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

<input type="checkbox"/> Unemployment	<input type="checkbox"/> Job Training	<input type="checkbox"/> Food
<input type="checkbox"/> Literacy	<input type="checkbox"/> Speech concerns	<input type="checkbox"/> Hearing concerns
<input type="checkbox"/> Vision concerns	<input type="checkbox"/> Health concerns	<input type="checkbox"/> Dental concerns
<input type="checkbox"/> Mental health		
<input type="checkbox"/> Insurance	<input type="checkbox"/> Death in the family	<input type="checkbox"/> Divorce
<input type="checkbox"/> Eviction	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Adult education
<input type="checkbox"/> Better use of finances	<input type="checkbox"/> Childcare	<input type="checkbox"/> Transportation
<input type="checkbox"/> Single Parent		
<input type="checkbox"/> Teen Pregnancy	<input type="checkbox"/> Drug/alcohol misuse	<input type="checkbox"/> 5 years Chronic illness
<input type="checkbox"/> Language barrier (non-English speaking)		<input type="checkbox"/> Rural Area
<input type="checkbox"/> Moved more than 2 times in the last 5 years		<input type="checkbox"/> Loss of job
<input type="checkbox"/> Adoption within the last 2 years		<input type="checkbox"/> Involved with CPS
<input type="checkbox"/> Crime/ Incarceration/ Parole		<input type="checkbox"/> Other
<input type="checkbox"/> More recreational/social outlets		
Children with disabilities or on an IFSP: Speech _____ Other _____		
Date Diagnosed _____		

Emergency Contact List (Must be someone other than yourself)

Name: _____ Relationship to child _____ Phone# _____

Name: _____ Relationship to child _____ Phone# _____

Name: _____ Relationship to child _____ Phone# _____

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

Childs 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 administer first aid and life saving measures (Ex: CPR, AED), except these restrictions. List if applicable:

____ I give my permission for the Early Childhood Center to administer hypoallergenic lotion to my child's hands, except for these restrictions. List if applicable:

____ I give my permission for the Early Childhood Center to administer sunscreen to my child.

____ My child may be photographed. Photos may be used in the newspaper, posted around the child's classroom, or posted individually on the child's class dojo (secure platform - not to the public).

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

____ I give permission to include my child in classroom videotaping. The Early Childhood Center has a portable video camera, and as part of ongoing training for our teachers and to assist in referring children who may need additional class assistance, we occasionally videotape the classroom. The tapes are reviewed by teaching staff (for training purposes), the mental health consultant, and parents/guardians.

____ I give my child permission to participate in screenings provided by the Early Childhood Center. These screenings include: speech, developmental, hearing, dental, physical, and vision. List any restrictions if applicable:

____ My child may be observed by the Early Childhood Centers mental health consultant. Mental health consultant observes the classroom as a whole. Any referrals for individual observation will require additional consent.

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

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to child: _____