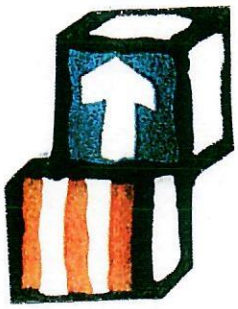
Community Action Committee, Inc.
Chambers-Tallapoosa-Coosa
Head Start
Chambers-Tallapoosa
170 S. Broadnax Street
Dadeville, AL 36853
256-825-4204
256-825-9806 (Fax)



PFCE/SOCIAL SERVICE

1: The application must be completed and signed. Please do not fill out #14, income information.

2. Please make sure that your mailing address is correct. Please notify us anytime your address and /or phone number changes.

3. Please list the birthdates and social security numbers for everyone in the household.

PLEASE PROVIDE US WITH THE FOLLOWING DOCUMENTS:

1. Certified birth certificate

2. Child's social security card

3. Medicaid or insurance card

4 Income verification for everyone in the household (check stub, child support, etc.)

5. Up-to-date blue slip/immunization slip for your child

6. A recent physical

7. A recent dental exam

Op. Year ____ Program ____ Description ____

Delegate ID ____ Application # ____

Early Child Development Program
ENROLLMENT APPLICATION

SECTION 1

1 Child's legal name: Last			First		Date of birth / /
2 Preferred name			3 Parent or guardian name(s)		
4 Family last name			Street address (P.O. box first, if any)		
5 Phone	Home/Message	Area code ( )	City		State
6 Phone	Other	Area code ( )	Zip		County code
7 Child's Medicaid # or Health Ins Company				Child's Social Security #	
Race: B H N W O	Sex: M F	Language: EN Other ____		Child's year in program: 1st 2nd 3rd	

8 Parental status: 0 = One parent T = Two parents F = Foster N = Not parent

Number of persons: In home ( ) In family ( ) Number of children: In family ( ) 6 years old or younger ( )

9 Child will get to program by B = Bus W = Walking P = Parent O = Other ____

10 Does child have a disability or special need? Y N Suspected (Describe; if disability has been diagnosed, give date/source)

11 Was child referred to program? Y N	By whom ?	Why?
12 Has a child in this family been enrolled in this program before this year? Y N		If yes, what year?
13 Are you on AFDC? Y N	Any specific family need or crisis? (Optional) Y N	If yes, describe below.

14 Income (list by family member)

Weekly x 52; Every 2 weeks x 26; Twice a month x 24; Monthly x 12 = Annual income

Family member	Amount	Per	x	Annual income	From whom
A.	$			$	
B.	$			$	
C.	$			$	
	Total yearly income of family			$	

15 Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/guardian's signature ____ Date ____

SECTION 2

▼ ▼ ▼ For agency use only. Do not write below this line ▼ ▼ ▼

Income verified? Y N By ( ) W-2 ( ) Check stub ( ) Tax return ( ) Letter ( ) Other.

Birth verified? Y N By ( ) Certified birth cert ( ) Hospital birth cert ( ) Health Dept cert ( ) Other

Signature of verifying staff member ____ Date ____

A9 Center name (8 letters max)	Center ID (4 digits)	Class (1 character)	Income status. E O Amount: $

A10 AFDC: Y N	USDA: F R N	USDA date: / /	USDA amt: $	Age: 3 4 ( )	Handicap X Z ( )
A11 Medicaid: E N	Transp: B W P O	Old Child ID:	Famseq.	Elig next yr? Y N	Sibling elig next yr? Y N
A12 Application status: B C I M V		Date of application / /		Acceptance status: N	

Eligibility Priority

A13 Parents		Handicap		A14 Income		Other		A15 Age	
Descr	Pts	Descr	Pts	Descr	Pts	Descr	Pts	Descr	Pts

A16 Comments

Child's name _____ Date of birth ____/____/____ Famseq # _____

SECTION 3 - SUPPLEMENTAL CHILD INFORMATION

1 Transportation

Pick-up location	Route number
Drop-off location	Route number
Directions to home	

2 Emergency contacts

Name 1	Address	Phone ( )	
	City	State	Zip
Name 2	Address	Phone ( )	
	City	State	Zip

3 Release child to

	Relationship		Relationship
Name 1		Name 2	
Name 3		Name 4	

4 Doctor

Name	Address	Phone ( )	
	City	State	Zip

SECTION 4 - FAMILY MEMBER INFORMATION

ADULTS
(List significant family members, beginning with head of family)

First and last name of adult(s) in home	Date of birth	Social Security #	Sex	Education level	Empl status	Occupation
A01		- -	M F			
A02		- -	M F			
A03		- -	M F			

CHILDREN
(List program applicant first, then any other children)

First and last name of children in home	Date of birth	Social Security #	Sex	Related to	How related	Participation status
C01 ---------- [program applicant] ----------				B12 A01 A02	C F G N O	A N Y O
C02		- -	M F	B12 A01 A02	C F G N O	A N Y O
C03		- -	M F	B12 A01 A02	C F G N O	A N Y O
C04		- -	M F	B12 A01 A02	C F G N O	A N Y O
C05		- -	M F	B12 A01 A02	C F G N O	A N Y O
C05		- -	M F	B12 A01 A02	C F G N O	A N Y O

☐ Check here if there are other children in the home, list on back.

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

NAME OF INTERVIEWER:_____ TITLE:_____

1. PERSON INTERVIEWED_____
   DATE_____, RELATIONSHIP TO CHILD_____
2. CHILD'S NICKNAME, IF ANY_____
3. CHILD'S ADDRESS *(Use pencil, keep current)*
   _____
   _____ Zip Code _____
   PHONE _____
4. FATHER'S NAME_____
5. MOTHER'S NAME_____
6. GUARDIAN'S NAME_____
7. CHILD IS USUALLY CARED FOR DURING THE DAY BY
   _____
   PHONE_____, RELATIONSHIP_____
8. LANGUAGE USUALLY SPOKEN AT HOME *(If more than one, place "1" by primary language):*
   _____English _____Spanish
   _____Other _____
9. SOURCE OF REIMBURSEMENT OR SERVICES *(Circle "Yes" or "No" for each source. Use pencil, keep current)*
   YES NO EPSDT/Medicaid (Latest certification No.):
   _____
   YES NO Federal, State or Local Agency:
   _____
   YES NO In-Kind Provider:_____
   YES NO Other (3rd party):_____
   ID NO.:_____
   YES NO WIC
   YES NO Food Stamps
10. DATE OF CHILD'S LAST PHYSICAL EXAM
    _____
11. DATE OF LAST VISIT TO DENTIST
    _____

12. USUAL SOURCE OF HEALTH AND EMERGENCY CARE
    (Name, address, and phone no.):
    Physician _____
    _____
    Clinic _____
    _____
    Hospital ER_____
    _____
    Other _____
    _____
    Dentist _____
    _____

13. IN CASE OF EMERGENCY NOTIFY
    (1) _____
    Relationship _____
    Phone _____ or _____
    (2) _____
    Relationship _____
    Phone _____ or _____
    (3) _____
    Relationship _____
    Phone _____ or _____

14. CONDITIONS WHICH COULD BE IMPORTANT IN AN EMERGENCY: *(Transfer from Form 2A)*
    - ☐ Severe Asthma
    - ☐ Diabetes
    - ☐ Seizures, Convulsions
    - ☐ Allergy, Bites_____
    - ☐ Allergy, Medication_____
    - ☐ Other_____
      _____

15 HOUSEHOLD INFORMATION *(Please complete for family and household members)*

	BIRTH DATE	LIVES WITH CHILD YES	LIVES WITH CHILD NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER				
MOTHER				
BROTHERS & SISTERS *(oldest first)*				
(1)				
(2)				
(3)				
OTHER *(Specify relationship)*				
(1)				
(2)				
(3)				

(Use additional page if needed)

INTERVIEWER: GO TO FORM 2A

CHAMBERS-TALLAPOOSA HEAD START

Child's Name: _____

Head Start Center: _____ Application #: _____

AUTHORIZATIONS

Please initial all blanks and sign/date the bottom of the form.

HEALTH SERVICES

_____ This is consent for child and/or myself to receive medical or dental services, or any screening done by program selected health care providers. This may include examinations, emergency treatment, testing screening, or therapy treatments when necessary. This also includes consent to transport my child and/or myself to receive these services. This does not include consent for surgical operation without my specific additional consent, except in the case of an emergency, and only after an effort has been made to locate me or my next of kin. This consent is valid for (1) year after the date signed. The purpose of this consent form has been explained to me.

TRANSPORTATION

I, hereby, give my permission for the Chambers-Tallapoosa Head Start Program to transport my child as follows:

_____ To and from the center for field trips, screening, emergency treatments, and any other services provided by Head Start.

_____ To and from center on a daily basis as a child with disability. I understand that transportation for a disabled child must be approved by the Health Coordinator.

I agree to have my child ready at the appointed time in the morning and to be available at the appointed time in the afternoon to receive my child. I understand that the child will not be released to anyone other than those persons listed on this form and that it is my responsibility to keep this list up-to-date.

INDIVIDUAL TRANSPORTATION

_____ I agree that I, or a person authorized by me, will bring my child to his/her designated center each day by 8:00 a.m. and will pick up my child each day at the close of school. I understand that if arrangements are not made to pick up my child by 3:00 p.m., the police and/or child protection services may be notified and my child delivered to their custody.

FIELD TRIPS

_____ I, hereby, give my permission for my child to participate in all field trips planned for his/her classroom and/or center during the 20 ___/20 ___ school year, unless I specifically decline my child's participation in writing at least two (2) days before the trip is scheduled. I understand that I will be notified of my field trip from the center a week in advance of the trip/walk.

PICTURE/PUBLICATIONS

_____ I, hereby, give my consent for any pictures taken of my child to be used in newspaper, displays, bulletin boards, slide presentations, or any other type of educational/public relations materials or publications.

The following is a list of designated persons who have permission to deliver or receive my child:

NAME	PHONE #	RELATION TO CHILD

_____ _____

Signature of Parent or Guardian Date

HILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

HILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
EAD START CENTER: _____ PHONE: _____
DDRESS: _____

. RELEVANT INFORMATION *(from Health History, Parent/Teacher Observations):*

SECTIONS BELOW TO BE COMPLETED BY PHYSICIAN

. SCREENING TESTS. **(*) REQUIRED by Head Start. Enter dates if done previously.**

TEST	DATE	RESULTS
. PRESENT AGE*		____Yrs.____Mos.
. HEIGHT (no shoes, to nearest 1/8 in.)*		
. WEIGHT (light clothing to nearest ¼ lb.)*		
. BMI		
. BLOOD PRESSURE*		
. TEMPERATURE		
. RESPIRATION		

j. VISION (Type of test): _____
* DATE: _____
ACUITY, R/L: _____
STRABISMUS: _____
COMMENTS: _____

k. HEARING (Type of test): _____
* DATE: _____
RESULTS, R/L: _____
COMMENTS: _____

(*) REQUIRED by Head Start. Enter dates if done previously.

TEST	DATE	RESULTS
l. OTHER TESTS (if indicated)		
(1) TB		
(2) SICKLE CELL		
(3) OVA & PARASITES		
(4) URINALYSIS		
(5) OTHER: _____		

. HGB/HCT: _____ DATE: _____
□ Normal □ Abnormal
TX: _____

LEAD: _____ DATE: _____
□ Normal □ Abnormal
TX: _____

. PHYSICAL EXAMINATION/ASSESSMENT.

	NORMAL	ABNORMAL	NOT EVAL.	COMMENTS *(Use Additional sheet if necessary)*
a. GENERAL APPEARANCE				
b. POSTURE, GAIT				
c. SPEECH				
d. HEAD				
e. SKIN				
f. EYES: (1) External Aspects				
(2) Optic Fundiscopic				
(3) Cover Test				
g. EARS: (1) External Aspects				
(2) Tympanic				
h. NOSE, MOUTH, PHARYNX				
i. TEETH				
j. HEART				
k. LUNGS				
l. ABDOMEN (include hernia)				
m. GENITALIA				
n. BONES, JOINTS, MUSCLES				
o. NEUROLOGICAL/SOCIAL				
(1) Gross Motor _____				
(2) Fine Motor _____				
(3) Communication Skills _____				
(4) Cognitive _____				
(5) Self-Help Skills _____				
(6) Social Skills _____				
p. GLANDS (Lymphatic/Thyroid)				
q. MUSCULAR COORDINATION				
r. OTHER				

Does the child have a diagnosed chronic condition? YES NO
Diagnosis _____
Date of Diagnosis _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS *(Initial when complete)*	DATE
a.			
b.			
c.			

5. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

By signing below and according to the information provided above, the child is determined to be up-to-date on a schedule of age appropriate preventative and primary health care which includes medical, dental, and mental health.

Physician's Signature: _____ Health Determination Date: _____

NATIONAL CENTER ON
Early Childhood Health and Wellness

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____

Next recall date: _____ / _____ (month/year)

Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

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