Applicant & Family Member Information

Date:

Applicant

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐Asian
☐Black
☐White
☐Other:
☐American Indian/Alaska Native
Tribal Affiliation:_____
Tribal Role#: _____
☐Hawaiian/Pacific Islander
☐Multi-Racial

Hispanic
☐Yes
☐No

English Proficiency
☐None
☐Little
☐Moderate
☐Proficient

Other Language

Other Language Proficiency
☐Poor
☐Moderate
☐Proficient

Primary Health Coverage | Other Health Coverage | Insurance# | Medicaid | Medicaid# | Doctor | Dentist

Medicaid
☐Not Eligible
☐On Medicaid
☐Potentially Eligible

Adult Caretaker 1

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐Asian
☐Black
☐White
☐Other:_____
☐American Indian/Alaska Native
☐Hawaiian/Pacific Islander
☐Multi-Racial

Hispanic
☐Yes
☐No

English Proficiency
☐None
☐Little
☐Moderate
☐Proficient

Other Language

Other Language Proficiency
☐Poor
☐Moderate
☐Proficient

Highest Grade Completed
☐Associate's
☐Bachelor's
☐Col Deg/Train
☐Col or Adv Train
☐GED
☐Grade 10
☐Grade 11
☐Grade 12
☐<Grade 9
☐HS Graduate
☐Master's

Employment Status
☐Full Time
☐Part Time
☐Seasonal
☐Unemployed
☐Full Time & Training
☐Part Time & Training
☐Training or School
☐Retired or Disabled

Child's Relationship
☐Natural/Adopted/Step
☐Grandchild
☐Niece/Nephew
☐Foster
☐Other

Custody
☐Yes
☐No

Check all that apply:
☐Lives with Family
☐Provides Financial Support
☐Teen Parent

If teen parent, subsidized?
☐Yes ☐No

E-mail Address:

Adult Caretaker 2

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐Asian
☐Black
☐White
☐Other:_____
☐American Indian/Alaska Native
☐Hawaiian/Pacific Islander
☐Multi-Racial

Hispanic
☐Yes
☐No

English Proficiency
☐None
☐Little
☐Moderate
☐Proficient

Other Language

Other Language Proficiency
☐Poor
☐Moderate
☐Proficient

Highest Grade Completed
☐Associate's
☐Bachelor's
☐Col Deg/Train
☐Col or Adv Train
☐GED
☐Grade 10
☐Grade 11
☐Grade 12
☐<Grade 9
☐HS Graduate
☐Master's

Employment Status
☐Full Time
☐Part Time
☐Seasonal
☐Unemployed
☐Full Time & Training
☐Part Time & Training
☐Training or School
☐Retired or Disabled

Child's Relationship
☐Natural/Adopted/Step
☐Grandchild
☐Niece/Nephew
☐Foster
☐Other

Custody
■Yes
☐No

Check all that apply:
☐Lives with Family
☐Provides Financial Support
☐Teen Parent

If teen parent, subsidized?
☐Yes ■No

E-mail Address:

Additional Child (Non-Applicant)*

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐Asian
☐Black
☐White
☐Other:_____
☐American Indian/Alaska Native
☐Hawaiian/Pacific Islander
☐Multi-Racial

Hispanic
☐Yes
☐No

English Proficiency
☐None
☐Little
☐Moderate
☐Proficient

Other Language

Other Language Proficiency
☐Poor
☐Moderate
☐Proficient

Additional Child (Non-Applicant)*

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐Asian
☐Black
☐White
☐Other:_____
☐American Indian/Alaska Native
☐Hawaiian/Pacific Islander
☐Multi-Racial

Hispanic
☐Yes
☐No

English Proficiency
☐None
☐Little
☐Moderate
☐Proficient

Other Language

Other Language Proficiency
☐Poor
☐Moderate
☐Proficient

Family Information, Income & Contacts

This section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information

Living Address	Address Line 2	Zip	City	State	County
Mailing Address (if different)	**Address Line 2**	**Zip**	**City**	**State**	**County**

Phone Numbers	Type (check one)				Note (for example, an extension or best time to call)
	☐Cell	☐home	☐Work	☐Other	
	☐Cell	☐home	☐Work	☐Other	
	☐Cell	☐home	☐Work	☐Other	
	☐Cell	☐home	☐Work	☐Other	

Number of Adults in Household	Number of Children in Household	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (if applicable)
		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Family Income

TANF ☐Yes ☐No ☐Formerly

Supplemental Security Income ☐Yes ☐No

Date Verified (agency use only _____ *Verified by (agency use only)* _____

Family Member	Amount	Per (for example: Week, month, year)	Annual Amount	Description (for Example: SSI, Job, Child Support)	Verification (for example: W2, check stub)	Notes
	$		$			
	$		$			
	$		$			

Income Notes

Emergency Contacts

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐Yes ☐No	☐Yes ☐No

Address	Zip	City	State

Phone # 1	Phone # 2	Phone # 3
☐Cell ☐Home ☐Work	☐Cell ☐Home ☐Work	

Contact 2

Name	Relationship	Emergency Contact	Release To
		☐Yes ☐No	☐Yes ☐No

Address	Zip	City	State

Phone # 1	Phone # 2	Phone # 3
☐Cell ☐Home ☐Work	☐Cell ☐Home ☐Work	

Contact 3

Name	Relationship	Emergency Contact	Release To
		☐Yes ☐No	☐Yes ☐No

Address	Zip	City	State

Phone # 1	Phone # 2	Phone # 3
☐Cell ☐Home ☐Work	☐Cell ☐Home ☐Work	

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 Signature _____ **Date** _____

This Section for Agency Use Only

Applicant

Applicant Name: _____ Birthday _____

Enrollment Information

Eligibility

Program Team

Classroom

Application Status
☐Complete & Verified
☐Incomplete
☐Incomplete, info not returned
☐Other – specify in notes

Application Number

Application Date

Waitlisted Date

Accepted Date

Releases Signed
☐Yes ☐No

Date Signed

Child will transition to

Eligibility Date

Eligibility Income

Number in Family

Income Status
☐101-130%
☐Eligible
☐
☐Homeless
☐Over Income
☐Public assistance

Participation Year

Sibling Eligible Next Year
☐Yes ☐No

Eligibility Notes:

Family Situations

Extenuating Circumstance	Concern	Other
Recent Change in family situation Due to:	☐ Separation ☐ Divorce ☐ Death of a family member	
Parent/Guardian recently Unemployed:	☐ Seeking job opportunities ☐ Seeking job training	
Parent Chronically Unemployed	☐ Seeking job opportunities ☐ Seeking job training	
Parent current working towards:	◉ High School Diploma ○ GED	
Parent in Drug or Alcohol Program:	☐ Currently enrolled ☐ Seeking placement	
Current Dwelling	☐ Homeless ☐ Currently without permanent residence	
Other family concerns or Circumstances that may exist in Your family:		

CHILD'S PREADMISSION HEALTH HISTORY-PARENT'S REPORT

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S/FATHER/S DOMESTIC PARTNER'S NAME		DOES FATHER/FATHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
MOTHER'S/MOTHER'S DOMESTIC PARTNER'S NAME		DOES MOTHER/MOTHER'S DOMESTIC PARTNER LIVE IN HOME WITH CHILD?
IS/HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?		DATE OF LAST PHYSICAL/MEDICAL EXAMINATION

DEVELOPMENTAL HISTORY (FOR INFANTS AND PRESHOOL-AGE CHILDREN ONLY)

WALKED AT*	BEGAN TALKING AT*	TOILET TRAINING STARTED AT*
MONTHS	MONTHS	MONTHS

PAST ILLNESSES – Check illnesses that child has had and specify approximate dates of illnesses:

	DATES		DATES		DATES
☐Chicken Pox		☐Diabetes		☐Poliomyelitis	
☐Asthma		☐Epilepsy		☐Ten-Day Measles (Rubeola)	
☐Rheumatic Fever		☐Whooping Cough		☐Three-Day Measles (Rubella)	
☐Hay Fever		☐Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? ☐ YES ☐ NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERFIES STAFF SHGOULD BE AWARE OF

DAILY ROUTINES (*For Infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*

DIET PATTERN: (What does child usually eat for these meals?)
BREAKFAST
LUNCH
DINNER

WHAT ARE USUAL EATING HOURS?
BREAKFAST _____
LUNCH _____
DINNER _____

ANY FOOD DISLIKES?	ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?* ☐ YES ☐ NO	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?* ☐ YES ☐ NO	WHAT IS USUAL TIME?*

WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*

PARENTS EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENLTY UNDER A DOCTOR'S CARE? ☐ YES ☐ NO	IF YES, NAME OF DOTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)? ☐ YES ☐ NO	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
DOES CHILD USE ANY SPECIAL DEVICE(S): ☐ YES ☐ NO	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME? ☐ YES ☐ NO	IF YES, WHAT KIND:

PARENTS EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHER, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENTS SIGNATURE	DATE

Pinoleville Native American Head Start
500 A Pinoleville Drive
Ukiah, CA 95482
707.468.3835
707.463.6601

Pinoleville Native American Head Start/Early Head Start

Authorization for Services Consent

Child's Name:_____ Date of Birth:_____

WELCOME TO PINOLEVILLE NATIVE AMERICAN HEAD START/EARLY HEAD START! Our mission at PNAHS/EHSP is to be the pathway to cultural preservation and a place for all to grow in body, mind, and spirit. The following evaluations and screenings are helpful in identifying a child in need of further examination or treatment and are a requirement under the Federal Performance Standards. Some will be done at school, while others will require you to take your child to a licensed professional.

1. A complete physical examination (including a blood test called a hematocrit or hemoglobin, for iron levels) no later than 30 days after the first day of school (required annually)
2. A dental examination no later than 30 days after the first day of school (required annually)
3. Health screens including: hearing, vision, blood pressure, height and weight
4. Speech and language
5. Behavioral and developmental screenings

Must be performed by a licensed professional.

We will assist you in locating a doctor or dentist if needed. These medical and dental exams and tests will help us in determining you child's individual needs, as well as helping us in developing an individualized learning program for your child. The results of the tests and screenings performed at the school will be shared with you.

6. In order to maintain balance to our community, Pinoleville Pomo Nation takes pride in teaching and practicing Pomo culture and tradition. Our children here at PNAHS/EHSP will be participating in numerous cultural events and activities. Pomo language, Dance and Values will be incorporated into the PNAHS/EHSP curriculum.
7. Occasionally, pictures or videotapes of children are taken and released for newspaper publications, for community events, TV and Social Media (Private Facebook Group) to be implemented into our Cultural Curriculum, and for staff and parent training.

I agree to take my child to receive a physical examination and a dental examination (each year), as indicated in #1 and #2 above. ☐ Yes ☐ No

I agree for my child to participate in required screenings and tests at the school, as indicated in #3, #4, and #5. ☐ Yes ☐ No

If you refuse to have your child participate in required health screenings (as indicated in #3), it is your responsibility to have your child screened by their doctor. Results must be submitted to program staff.

I give my child permission to participate in all cultural events, activities, and curriculum as stated in #6. ☐ Yes ☐ No

I give permission for my child's picture's and video's to be used for class curriculum, and/or to be published and/or televised, as indicated in #7. ☐ Yes ☐ No

Signature:_____ Date:_____

Print Name:_____

Relationship to Child:_____

Staff Signature:_____ Date:_____

IDENTIFICATION AND EMERGENCY INFORMATION

CHILD CARE CENTERS/FAMILY CHILD CARE HOMES

To Be Completed by Parent or Authorized Representative

CHILD'S NAME	LAST	MIDDLE	FIRST	SEX	TELEPHONE ( )

ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	BIRTHDATE

FATHERS/GUARDIAN'S/MOTHER'S DOMESTIC PARTNERS NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )

MOTHER'S/GUARDIAN'S/MOTHER'S DOMESTIC PARTNER'S NAME	LAST	MIDDLE	FIRST	BUSINESS TELEPHONE ( )

HOME ADDRESS	NUMBER	STREET	CITY	STATE	ZIP	HOME TELEPHONE ( )

PERSON RESPONSIBLE FOR CHILD	LAST NAME	MIDDLE	FIRST	HOME TELEPHONE ( )	BUSINESS TELEPHONE ( )

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

PHYSICIAN OR DENTIST TO BE CALLED IN AN EMERGENCY

PHYSICIAN	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

DENTIST	ADDRESS	MEDICAL PLAN AND NUMBER	TELEPHONE ( )

IF PHYSICIAN CANNOT BE REACHED, WHAT ACTION SHOULD BE TAKEN?

☐CALL EMERGENCY HOSPITAL ☐OTHER EXPLAIN:_____

NAMES OF PERSONS AUTHORIZED TO TAKE CHILD FROM THE FACILITY

(CHILD WILL NOT BE ALLOWED TO LEAVE WITH ANY OTHER PEROSN WITHOUT WRITTEN AUTHORIZATION FROM PARENT OR AUTHORIZED REPRESENTATIVE)

NAME	RELATIONSHIP

TIME CHILD WILL BE CALLED FOR

SIGNATURE OF PARENT/GAURDIAN OR AUTHORIZED REPRESENTATIVE	DATE

TO BE COMPLETED BY FACILITY DIRECTOR/ADMINISTRATOR/FAMILY CHILD CARE HOMES LICENSEE

DATE OF ADMISSION	DATE LEFT

CONSENT FOR EMERGENCY MEDICAL TREATMENT-
Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

PINOLEVILLE NATIVE AMERICAN HEAD START TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE
FACILITY NAME
PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

_____ . THIS CARE MAY BE GIVEN UNDER
NAME
WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD

NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

_____ _____
DATE PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

HOME ADDRESS

HOME PHONE	WORK PHONE
( )	( )

RISK FACTORS FOR TB IN CHILDREN:

- Have a family member or contacts with a history of confirmed or suspected TB.
- Are in foreign-born families and from high prevalence countries (Asia, Africa, Central and South America).
- Live in out-of-home placements.
- Have, or are suspected to have, HIV infection.
- Live with an adult with HIV seropositivity.
- Live with an adult who has been incarcerated in the last five years.
- Live among, or are frequently exposed to k individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- Have abnormalities on chest X-ray suggestive of TB.
- Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

Evidence of Blood Lead Testing

Print Child's Full Name _____

Child's Date of Birth: _____

Receipt of Test

Received a Venous / Capillary blood lead test on _____(date).
(Circle One)

Test was administered by: _____
(Signature of Health Care Professional who administered the test)

Health Care Professional's Complete Address:

_____
City State Zip

Health Care Professional's Phone Number _____

Parent/guardian refusal of Blood Lead Testing:

I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under age of six years. I do object to my child being blood tested in order to determine if he/she is lead poisoned, and hereby refuse blood lead testing.

Reason for Refusal: _____

Signed _____ Relation to Child: _____
(parent or guardian)

Parent/Guardian Address:

_____
City State Zip

Parent/Guardian Phone Number: _____

Date: _____

Infant & Toddler Needs and Services Plan
Family Information Form

Name of Child:_____ **Date of Birth**:_____

Arrival:

What time will you usually arrive at the center?

What will help you and your child say goodbye to each other in the morning?

Diapering and Toileting:

What type of diapers do you use?

How often do you change your child's diaper? When does your child usually need a diaper change?

Is your child beginning to use the toilet? If so, are there any special instructions for toileting?

Sleeping:

How will we know that your child is tired and needs to sleep?

When does your child usually sleep? For how long does he or she usually sleep?

What helps your child to fall asleep?

We put babies to sleep on their backs. Is your baby used to sleeping on his or her back? Y / N

How does your child wake up? Does he or she wake up quickly or slowly? Does your child like to be taken out of the crib or bed immediately, or to lie alone in the crib or bed for a few minutes before being held?

Eating:

Babies:

Are you breast-feeding or bottle-feeding your baby?

If breast-feeding, will you come to the center to breast-feed? Y / N

If yes, at what time(s)?

If no, will you send expressed breast milk? Y / N

If bottle-feeding:

What kind of formula do you use?

How do you prepare the bottles?

How much do you prepare at one time?

How much does your baby drink at one time?

Does your baby drink bottles of water during the day? /

If yes, when and how much?

Is your baby eating solid foods? ☐/☐

If yes, which ones?

When?

How do you prepare your baby's solid foods?

How much does your baby eat at one time?

How is your baby used to being fed (in what position)?

Does your baby eat any finger foods? If yes, which ones?

All Children:

What are some of your child's favorite foods?

What foods does your child dislike?

Is your child sensitive or allergic to any foods? If yes, please list them.

Are there any foods that you don't want your child to eat?

Dressing:

Is there anything special that we should know about dressing and undressing your child?

Awake Time:

How does your baby like to be held? What position does your baby prefer when awake?

In what language(s) do you speak and sing with your child at home?

What language(s) does your child use when talking and singing with family member?

What does your child like to do when awake?

How do you play with your child?

Departure:

What time will you usually come to pick up your child?

What will help you and your child say hello to each other at the end of the day?

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

NUTRIONAL ASSESMENT

Child's Name: _____ Date: _____

Gender: ■M ☐F Birthdate: _____ Age: _____
(years) (months)

Child's appetite? ☐Excellent ☐Good ☐Fair ☐Poor ☐*Recent Change in _____

Child's favorite foods? _____

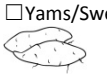
Child's normal eating times? _____ Breakfast _____ Lunch _____ Dinner

	NO	YES	EXPLANATIONS/COMMENTS:
Child Currently enrolled in WIC	☐	☐	
*Child takes a bottle:	☐	☐	☐milk ☐juice ☐water ☐other? _____
*Child has trouble chewing/swallowing:	☐	☐	if yes, specify: _____
*Child often has diarrhea/constipation:	☐	☐	if yes, specify: _____
*Child eats/chews non-food items:	☐	☐	if yes, specify: _____
Ever told child was anemic?	☐	☐	if yes, specify: _____
Child currently taking supplements?	☐	☐	if yes, specify: _____
Child has food allergies:	☐	☐	if yes, specify: _____
*Foods to be avoided for medical, religious, or personal reasons:	☐	☐	if yes, specify: _____
*Child on special diet:	☐	☐	if yes, specify: _____

*Do you have any concerns/comments about your child's eating habits or nutritional status?

_____

_____

DIETARY HABITS Check the foods your child eats and check the box that applies to how often they eat from each food group	1-3 day	2-3 day	Once/wk	Rarely
☐Milk (any kind)  ☐Cheese (except cream or cottage cheese  ☐Yogurt 				
☐Meat/Poultry (any kind)  ☐Fish  ☐Eggs  ☐Beans (not green)  ☐Cottage Cheese  ☐Peanut Butter 				
☐Cereal (any kind)  ☐Bread (any kind)  ☐Rice  ☐Noodles/Spaghetti  ☐Crackers  ☐Tortilla 				
☐Orange (or juice)  ☐Tomato (or juice)  ☐Grapefruit (or juice)  ☐Broccoli  ☐Cabbage 				
☐Dark Leafy Greens  ☐Carrots  ☐Apricots  ☐Yams/Sweet Potatoes  ☐Cantaloupe  ☐Squash (dark yellow) 				
☐Apples/Bananas/Pears  ☐Peas  ☐Potatoes (White)  ☐Peaches  ☐Squash(zucchini)  ☐Green Beans  ☐Lettuce  ☐Grapes  ☐Corn 				
☐Candy  ☐Chips  ☐Donuts/Cakes/Pies/Cookies  ☐Jell-O  ☐Popsicles/ Tang/Hi-C/Kool-Aid  ☐Sodas ☐Sugary Cereals				

Release of Information and Records

I/We the undersigned hereby authorize and consent to the release of information and/or records identified below for use in planning for this individual:

Information and Records Pertaining to:

Child's Name: _____ DOB: _____

Address: _____

May be [ ] Sent to [ ] Shared with _____Obtained From

Pinoleville Naitve American Head Start Program
500 A Pinoleville Dr.
Ukiah, CA 95482
Phone: 707-468-3835

And [ ] Sent to [ ] Shared with _____ Obtainded From

Check and Initial

- ☐ Pinoleville Native American Head Start Nutrition Consultant _____
- ☐ Pinoleville Native American head Start Mental health Consultant _____
- ☐ Consolidated Tribal Health project – 6991 North State St. Calpella _____
- ☐ Ukiah Valley Primary Care Medical Group-1050 North State St. Ukiah _____
- ☐ Mendocino County Public Health Department-890 North Bush St. Ukiah _____
- ☐ Redwood Coast Regional Center-1116 Airport Park Blvd. Ukiah _____
- ☐ Ukiah Unified School District-925 North State St. Ukiah _____
- ☐ Other: _____ _____
  Address: _____ _____

Regarding the Following Information and/or Records:

- o Medical Records From: _____to _____
- o Dental Records From: _____to _____
- o All Medical, dental, health, development, speech, language, psychological, social and financial information.
- o Other: _____

Parent/Guardian Authorization

This authorization shall remain effective for one year unless otherwise stated. I understand that I have the right to revoke this release at any time and the right to receive a copy of this authorization. If so indicated above, I agree to the sharing of information between agencies/individuals and/or persons who represent them. I understand that I may limit information to be exchanged as noted.

Parent/Guardian Signature: _____ Date: _____

PARENT PARTICIPATION SURVEY

Child's Name: _____ Date: _____

Parent/Guardian's Name: _____

Please Check all that Apply:

Best Days for me/us to participate:
Monday: ☐ Tuesday: ☐ Wednesday: ☐ Thursday: ☐ Friday: ☐

I/We are willing to:

- ☐ Observe Children
- ☐ Set up play year
- ☐ Work in kitchen
- ☐ Help with children's projects
- ☐ Help on field trips
- ☐ Read to Children
- ☐ Pick up play yard
- ☐ Help with meal set up/cleanup
- ☐ Work on projects at home
- ☐ Set up classroom parties
- ☐ Supervise the play yard
- ☐ Help with special projects
- ☐ Make phone calls
- ☐ Music and dance
- ☐ Field trips

☐ Share an interest, hobby or custom, with the children: _____

I understand that parent involvement and participation is a vital part of my family's experience in Head Start. For the continued success of my child, I am interested and willing to attend:

- ☐ Parent meetings
- ☐ Parent support groups
- ☐ Attend socials
- ☐ Educational trainings/workshops
- ☐ Classroom special activities
- ☐ Health Advisory Committee meetings
- ☐ Policy Council meetings
- ☐ Fatherhood Groups
- ☐ Cultural Committee Meetings
- ☐ Recruitment Events

The best times/days for me to attend meetings and other events are:

Monday: ☐ Tuesday: ☐ Wednesday: ☐ Thursday: ☐ Friday: ☐

☐ 8:00 A.M. (before school) ☐ 3:30-5:30 P.M. ☐ 5:30-7:30 P.M. Other: _____

Parent/Guardian Signature: _____ Date: _____