TUSKEGEE-MACON COUNTY HEAD START

103 West Martin Luther King Highway
Tuskegee, Alabama 36083-2225
Telephone #: 334-720-0600 Fax #: 334-724-2118

ENROLLMENT REQUIREMENTS

The child must be 3 years old on or before September 1st, 4 years old or 5 years old after September 1st.

To be officially accepted into the program, applicants must submit the following three main requirements and an enrollment application. You must bring all of the following items to begin the application process:

☐ **Proof of Age** (Child's original birth certificate)

☐ **Proof of Income** (Examples: W-2, Income Tax Form, check stub showing gross amount for year requested, letter from employer, SSI documentation/letter, letter from DHR, child support statement, veterans benefits, TANF, unemployment letter...etc)

20_____

☐ **Child's Original, Updated Immunization Record** (Blue Slip)

The following documents must also be obtained from the applicant:

☐ **Social Security Card** (For child being enrolled only)

☐ **Physical Examination** (Form will be provided by Tuskegee-Macon County Head Start, to be completed by your child's doctor)

☐ **Dental Examination** (Form will be provided by Tuskegee-Macon County Head Start, to be completed by your child's dentist)

☐ **Health/Medical Insurance** (Medicaid card, Allkids card, or any other private insurance)

☐ **Documentation of Child's Special Needs** (From the child's medical doctor, referral letter and/or IEP)

Notes:

_____

_____

_____

_____

_____

Website: http://tmcheadstart.com
Business Hours: 8:00 am – 4:30 pm

"Touching Children, Reaching Families"
AN EQUAL OPPORTUNITY EMPLOYER

Family ID #:_____ Application #:_____

Applicant & Family Member Information

Head Start Tuskegee-Macon County

__/__/__ Entered __/__/__ Scanned

Primary Site(s): _____

Applicant (Child Applying for Services)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)	Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ None ☐ Little ☐ Moderate ☐ Proficient

Primary Health Coverage	Other Health Coverage	Insurance #	Medicaid Eligibility	Medicaid #
			☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible	

Doctor/Medical Home	Dental Coverage	Dental Coverage #	Dentist/Dental Home

Primary Adult

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)	Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ None ☐ Little ☐ Moderate ☐ Proficient

Highest Grade Completed	Employment Status at Enrollment	Child's Relationship	Check all that apply:
☐ Associate's ☐ Grade 10 ☐ Bachelor's ☐ Grade 11 ☐ Col Deg/Train ☐ Grade 12 ☐ Col or Adv Train ☐ < Grade 9 ☐ GED ☐ HS Graduate ☐ Some College ☐ Master's	☐ Full Time ☐ Full Time & Training ☐ Part Time ☐ Part Time & Training ☐ Seasonal ☐ Training or School ☐ Unemployed ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Foster ☐ Grandchild ☐ Other _____ ☐ Other Relative _____	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent If teen parent, subsidized? ☐ Yes ☐ No ☐ Subsidized (Low income housing, Section 8, etc.…)

E-mail Address:_____

Custody ☐ Yes ☐ No

Secondary or ☐ Other Adult →

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)	Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ None ☐ Little ☐ Moderate ☐ Proficient

Highest Grade Completed	Employment Status	Child's Relationship	Check all that apply:
☐ Associate's ☐ Grade 10 ☐ Bachelor's ☐ Grade 11 ☐ Col Deg/Train ☐ Grade 12 ☐ Col or Adv Train ☐ < Grade 9 ☐ GED ☐ HS Graduate ☐ Some College ☐ Master's	☐ Full Time ☐ Full Time & Training ☐ Part Time ☐ Part Time & Training ☐ Seasonal ☐ Training or School ☐ Unemployed ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Foster ☐ Grandchild ☐ Other ☐ Other Relative _____	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent If teen parent, subsidized? ☐ Yes ☐ No ☐ Subsidized (Low income housing, Section 8, etc.…)

E-mail Address:_____

Custody ☐ Yes ☐ No

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)	Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ None ☐ Little ☐ Moderate ☐ Proficient

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)	Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ None ☐ Little ☐ Moderate ☐ Proficient

Received By (Agency Use Only): _____ Date: __/__/__

Family Member Information Continue

Applicant Name: ______________________________

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ None
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Little
☐ White	☐ Multi-Racial		☐ Moderate		☐ Moderate
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ None
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Little
☐ White	☐ Multi-Racial		☐ Moderate		☐ Moderate
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ None
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Little
☐ White	☐ Multi-Racial		☐ Moderate		☐ Moderate
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ None
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Little
☐ White	☐ Multi-Racial		☐ Moderate		☐ Moderate
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ None
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Little
☐ White	☐ Multi-Racial		☐ Moderate		☐ Moderate
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ None
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Little
☐ White	☐ Multi-Racial		☐ Moderate		☐ Moderate
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant)

First	Middle	Last	Birthday	Gender	SSN
				☐Female ☐Male	

Race (Check all that apply)		Hispanic/Latino	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ None		☐ None
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Little		☐ Little
☐ White	☐ Multi-Racial		☐ Moderate		☐ Moderate
☐ Other: ____________			☐ Proficient		☐ Proficient

Parent/Guardian Signature ______________________________ Date: ____/____/____

Family Information & Income

Applicant Name: _____

Family Information

Living Address Start Living At Date	Living Address	Address Line 2	Zip	City	State	County
/ /					Alabama	Macon

Mailing Address Same as living?	Mailing Address (if different)	Address Line 2	Zip	City	State
☐ Yes ☐ No					Alabama

Phone Numbers	Type (*check one*)	Other (*for example, an extension or best time to call*)	Opt in for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other _____		☐ Yes ☐ No
( )	☐ Cell ☐ Home ☐ Work ☐ Other _____		☐ Yes ☐ No
( )	☐ Cell ☐ Home ☐ Work ☐ Other _____		☐ Yes ☐ No

Parental Status (check one)	Primary Language at Home	Homeless Family	Active Military (active duty only)	Military Veteran	Referred by Child Welfare Agency	Receiving SNAP
☐ One ☐ Two		☐ Yes (If yes, answer Residency Status) ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

WIC	WIC ID (*if applicable*)	TANF Status	Supplemental Security Income
☐ Yes ☐ No		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ No

Residency Status (If possible, request supporting documentation or letter from shelter or other third party verification.)

Do you lack a fixed, regular, and adequate nighttime residence? ☐ Yes ☐ No
If yes, please complete the remainder questions. If not, **STOP** here.

Check all that apply:

☐ Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason? (Examples: Eviction, foreclosure, unemployment, fire, domestic violence, utilities disconnected etc…)

☐ Living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations? What is the name of motel/hotel/trailer park or camping ground?

☐ Living in emergency or transitional shelters?

Is your primary nighttime residence a private or public place not designed for or ordinarily used as a regular sleeping accommodation for human beings?
☐ Yes ☐ No

Are you living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings? ☐ Yes ☐ No

Child's Health Information and Concerns (Attach documentation)

Does your child have any current or chronic medical conditions? ☐ Yes ☐ No
☐ asthma ☐ bronchitis ☐ diabetes ☐ eczema ☐ anemia ☐ bowel disorder ☐ seizures ☐ sickle cell disease ☐ sickle cell trait ☐ liver disorder ☐ cancer
☐ heart problems ☐ high lead ☐ Other:_____

Does your child have any health or developmental issues? ☐ Yes ☐ No
☐ food allergies ☐ injuries ☐ speech ☐ hearing ☐ vision ☐ autism ☐ developmental delay ☐ Other: _____
Please explain:_____

Does your child have an active Individualized Education Plan (IEP)? ☐ Yes, please attach documentation ☐ No

Family Income (Agency Use Only)

Income Verified By (Agency Use Only)	Date Verified	Income Notes
	/ /	

Family Member (Agency Use Only)	Amount	Per (week, month, year)	Annual Amount	Description (SSI, Job, Child Support)	Verification (W2, check stub)
	$		$		
	$		$		
	$		$		
	$		$		
	Total Amount of Annual Income		$		

Parent/Guardian Signature _____ Date: ____/____/____

Emergency Contacts

Applicant Name: _____

Emergency Contacts

	Name	Relationship (to child)	Emergency Contact	Release To
Contact 1			☐ Yes ☐ No	☐ Yes ☐ No
	Address	**Zip**	**City**	**State**
	Phone # 1	**Phone # 2**	**Phone # 3**	
	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	
Contact 2	**Name**	**Relationship** (to child)	**Emergency Contact**	**Release To**
			☐ Yes ☐ No	☐ Yes ☐ No
	Address	**Zip**	**City**	**State**
	Phone # 1	**Phone # 2**	**Phone # 3**	
	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	
Contact 3	**Name**	**Relationship** (to child)	**Emergency Contact**	**Release To**
			☐ Yes ☐ No	☐ Yes ☐ No
	Address	**Zip**	**City**	**State**
	Phone # 1	**Phone # 2**	**Phone # 3**	
	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	
Contact 4	**Name**	**Relationship** (to child)	**Emergency Contact**	**Release To**
			☐ Yes ☐ No	☐ Yes ☐ No
	Address	**Zip**	**City**	**State**
	Phone # 1	**Phone # 2**	**Phone # 3**	
	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	
Contact 5	**Name**	**Relationship** (to child)	**Emergency Contact**	**Release To**
			☐ Yes ☐ No	☐ Yes ☐ No
	Address	**Zip**	**City**	**State**
	Phone # 1	**Phone # 2**	**Phone # 3**	
	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	
Contact 6	**Name**	**Relationship** (to child)	**Emergency Contact**	**Release To**
			☐ Yes ☐ No	☐ Yes ☐ No
	Address	**Zip**	**City**	**State**
	Phone # 1	**Phone # 2**	**Phone # 3**	
	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	
Contact 7	**Name**	**Relationship** (to child)	**Emergency Contact**	**Release To**
			☐ Yes ☐ No	☐ Yes ☐ No
	Address	**Zip**	**City**	**State**
	Phone # 1	**Phone # 2**	**Phone # 3**	
	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	( ) ☐C ☐H ☐W	

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: ____/____/____

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

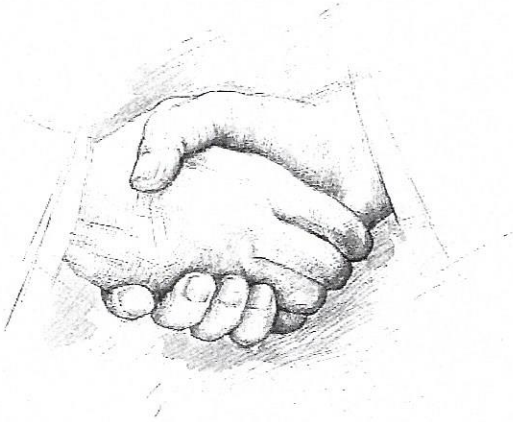
FAMILY PARTNERSHIP AGREEMENT
STATEMENT OF UNDERSTANDING

Tuskegee-Macon County Head Start is a family focused program. We are here to assist not only your child, but your entire family. The purpose of the **Family Partnership Agreement** is to assist families in taking steps towards personal and economic independence.

The information shared in interviews and home visits will be kept confidential within the Head Start Program with the exception of child and/or elder abuse as mandated by the State Law to report. Any other information will only be release to outside agencies with written authorization by the legal guardian.

Tuskegee-Macon County Head Start can provide assistance in the following ways: Written materials, parent training and referrals to community agencies. We may not be able to assist you in meeting all your needs, but we will try our best to work closely with you, your family and the community.

The home visit shall be made as early as possible, after the child's enrollment. Additional home visits will be conducted as needed.



As a parent of the Tuskegee-Macon County Head Start Program, I have read and understand the statements printed above. I agree to share information with the appropriate Head Start Staff in order for them to assist me and my family.

Parent's/Guardian's Signature: _____ Date: _____

Family Services Advocate's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

FAMILY PARTNERSHIP INITIAL ASSESSMENT

CHILD'S NAME: _____ **PARENT'S NAME:** _____

All information given is completely confidential and will not be shared without your permission. Please answer all questions.

EDUCATION

Please check your educational needs.

	GED		Vocation		Technical		College		Other

EMPLOYMENT

Are you currently employed? ___Yes ___No If yes, ____Full Time ___Part Time ___Seasonal
What type of work do you do? _____

Are you currently having job training or placement problems? ___Yes ___No
If yes, please explain: _____

HEALTH

Who is your Medical Doctor? _____ City _____

If you do not have a health care provider, where do you go for medial help?
_____ City _____

Does your family have Health Insurance? ___Yes ___No

Briefly describe any medical care need you have: _____

FAMILY & COMMUNITY

What are the most pressing problems for you and your family? Check all that apply.

	Safety		Family Violence		Unemployment		Health
	Drug/Alcohol Abuse		Poor Housing		Paying Bills		Other

Specify: _____

Are you involved with any social services agency, including mental health, courts, etc.? Please list.

Agency	Contact Person	Brief Description of Services

PARENTING

Would you like information on the following? Check all that apply.

	Single Parenting		Parenting Skills		Stage of Growth
	Positive Behavior		Parent/Child Conflicts		Child/Family Health

Other: _____

Parent's/Guardian's Signature: _____ Date: _____

Staff's Signature: _____ Date: _____
(Initial Assessor)

Assigned Family Service Worker Signature: _____ Date: _____

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

AUTHORIZATIONS

CHILD'S NAME: _____ **PARENT/GUARDIAN:** _____

Parent/Guardian, please place your initials on each blank.

TRANSPORTATION

I, hereby, give permission for the Tuskegee-Macon County Head Start Program to transport my child as follows:

____ To and from the center for transition field trips, screenings, emergency treatment, and any other services provided by Tuskegee-Macon County Head Start.

____ 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 my child will not be released to anyone other than those persons listed on my child's Pre-Admission Record and that it is my responsibility to keep this record 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 7:30a.m. and I or the person listed on the release list 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 2:30p.m.; the police and/or child protection services may be notified and my child will be delivered into their custody.

PICTURES AND PUBLICATIONS

___ I, hereby, give permission for any picture taken of my child to be used in newspapers, displays, bulletin boards, slide presentations or any other type of educational/public relations materials or publications.

Parent's/Guardian's Signature: _____ **Date:** _____

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

EDUCATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

In order to accurately assess your child and provide the necessary opportunities for him/her, please complete the section below as truthfully as possible. Please sign and date after completion.

DEVELOPMENTAL HISTORY (PARENT'S OBSERVATION)

Below are some common childhood problems. Please indicate your observation(s) of any of these problems by checking YES or NO.

PROBLEM	YES	NO		PROBLEM	YES	NO
Shyness				Selfishness		
Nightmares				Thumb Sucking		
Nervousness				Temper Tantrums		
Showing Off				Fainting		
Fighting				Destructiveness		
Rudeness				Stealing		
Refusal to Obey				Whining		
Jealousy				Running Away		
Untruthfulness				Impatience		

Please list any other problems(s) or fear(s)_____

CHECK CHILD'S GROUP EXPERIENCES:

Nursery School			Day Care	
Sunday School			Other	

Specify Other _____

Parent's/Guardian's Signature: _____ Date: _____

TUSKEGEE-MACON COUNTY HEAD START
CHILD NUTRITION RECORD (AGES 3 – 5)

Date: _____ Center: _____

Child's Name: _____ Date of Birth: _____ Sex: ____

Relationship to child: _____

1. How is your child's appetite? (Circle one) excellent good fair poor
2. What food(s) does your child like best? _____
3. What food(s) does your child dislike? _____

Please check "yes" or "no" for each question. Some questions ask for additional information. Please respond by providing such information if it applies to your child.

		Yes	No
4.	Does your child eat at least 3 meals a day?		
5.	Does your child drink water each day?		
6.	Does your child participate in the WIC program?		
7.	Does your family receive food stamps?		
8.	Is your child following a special diet? If yes, please describe: Type of diet: _____ Reason for diet: _____		
9.	Has there been a big change in your child's appetite recently? If yes, has it increase of decreased? (Please circle one)		
10.	Does your child take a nutritional supplement? If yes, circle which one(s): Vitamins/minerals/combination wits & min./iron/high calorie supplement/other		
11.	Is your water supply city water? If not, what is your water source?		
12.	Does your child chew or eat things that are not food? If so, what?		
13.	Does your child have diet related allergies? If so, what?		
14.	Does your child take a baby bottle? If yes, how often?		
15.	Is your child on any prescription medication? If yes, please describe:		
16.	Does your child have problems chewing and/or swallowing? (Please circle)		
17.	Does your child often have diarrhea / constipation / nausea? (Please circle)		
18.	Does your child use special eating utensils? If so, describe:		
19.	Does a blood relative of your child have any of the following conditions? Circle all that apply: Heart disease, blood pressure, diabetes, high cholesterol		
20.	Does your child have any special dietary needs that Head Start Nutrition Services should be aware of in planning his/her meals and snacks? Please explain:		

TUSKEGEE-MACON COUNTY HEAD START
FOOD FREQUENCY INTAKE

About how often does your child eat a food from each of the following groups:	Approximate number of times a week (circle the number(s) nearest to parent's answer
(a) Milk, cheese, yogurt	0* 1* 2* 3 4 5 6 7+
(b) Meat, poultry, fish, eggs, dried beans/peas, peanuts butter	0* 1* 2* 3 4 5 6 7+
(c) Rice, grits, bread, cereal, tortillas	0* 1* 2* 3 4 5 6 7+
(d) Greens, carrots, broccoli, winter squash, Pumpkin, sweet potatoes	0* 1* 2 3 4 5 6 7+
(e) Oranges, grapefruit, tomatoes (fruit/juice)	0* 1* 2* 3 4 5 6 7+
(f) Other fruits and vegetables	0* 1* 2 3 4 5 6 7+
(g) Oil, butter, margarine, lard	0* 1* 2 3 4 5 6 7+
(h) Cakes, cookies, sodas, fruit, drink, Candy	0* 1 2 3 4 5 6 7+
(i)Water	0* 1* 2* 3 4 5 6 7+

TUSKEGEE-MACON COUNTY HEAD START
CHILD'S HEALTH HISTORY

Child's Name _____

Date of Birth _____ Sex ___M ___F

Parent's/Guardian's Name _____

Child's Health History

	Asthma		Liver Disorder
	Eczema		Obesity
	Diabetes		Sickle Cell Disease/Trait
	Heart Disease		Anemia
	Seizures		High Lead
	Bowel Disorder		Cancer
	Learning Disorder		Other:

Have your child had Chicken Pox? □ No □ Yes

Does child have regular habit of eating dirt, ice, starch or paper? No Yes

List the name, dosage, amount and frequency of any medication or vitamin your child takes regularly.

Name	Dosage	Amount	Frequency

Why? _____

List the name of any medication, food or other allergies your child has: _____

What is the reaction and treatment used for the allergy listed above? _____

_____

Physical/Psychological/Social Development

Name two things child does well:

1. _____ 2. _____

Does child sleep less than 8 hours per night or have trouble falling or remaining sleep? No Yes

Does child relate poorly with children? No Yes

Does child relate poorly with adults? No Yes

Is child afraid of anything? No Yes

Is child easily upset, disturbed or angry? No Yes

Does child have trouble expressing self? No Yes

Do you have trouble understanding child? No Yes

Does child have problems with toileting? No Yes

If yes, explain _____

Family Health History

Are there any health problems in the immediate family? (mother/father) ____yes ____no

If yes, explain _____

Pregnancy/Birth History

Did the child's mother see a doctor less than two (2) times during the pregnancy?

No Yes

Were there problems during or after the pregnancy?

No Yes

Was the child born prematurely?

No Yes

Was anything wrong at birth or in the nursery?

No Yes

If yes, explain _____

Tuberculosis Risk (TB)

Do you and your family have yearly TB Skin Tests?

No Yes

Has the child been around an adult who has a positive TB skin test or had tuberculosis/TB?

No Yes

Is there anyone in the family on medication for TB?

No Yes

Lead Risk

Does child:

Live in or regularly visit a house built before 1960 with peeling/chipping paint? No Yes

Have sibling who has been treated for lead poisoning? No Yes

Live with an adult whose job or hobby results in lead exposure? No Yes

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date

TUSKEGEE-MACON COUNTY HEAD START

PARENTAL AGREEMENT FOR HEALTH SERVICES

I understand it is my responsibility to obtain a physical and dental examination for my child, _____. However, in the case that my child's physical is incomplete and does not include the entire following element, I grant permission for Tuskegee- Macon County Head Start Program to conduct or arrange for the following screenings for my child **(Please circle yes or no for each screening return form to center).**

Growth Assessment (height/weight)	Yes	No
Hemoglobin/Hematocrit	Yes	No
Blood Pressure	Yes	No
Pulse	Yes	No
Lead	Yes	No
Physical Examination	Yes	No
Dental Examination	Yes	No
Vision Screening	Yes	No
Social and Emotional Well-Being	Yes	No

I have received a description of each of the above screenings and understand the importance of each screening.

_____ _____

Parent's Signature Date

_____

Head Start Staff's Signature

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

CONSENT FOR **EMERGENCY** MEDICAL TREATMENT

In Case of Accident or Illness:

Should _____ (my child) become ill during the time that he/she is in the care of the Tuskegee-Macon County Head Start Program or suffer an accident of any nature the Program shall undertake to contact me immediately.

In the event the Program is unable to reach me immediately, it is authorized to secure such medical attention and care for my child, as deemed necessary.

_____ _____

Parent/Guardian's Authorized Signature **Date**

CONSENT FOR **EMERGENCY** DENTAL TREATMENT

Should _____ (my child) need emergency dental care, due to an accident of any nature, during the time that he/she is in the care of the Tuskegee-Macon County Head Start Program the Program shall undertake to contact me immediately.

In the event the Program is unable to reach me immediately, it is authorized to secure such dental attention and care for my child, as deemed necessary, without further consent.

_____ _____

Parent/Guardian's Signature **Date**

I. Authorization for administering medication

DHR-CDC-1949

Authorization for Medication Administration/Medical Procedures

Dear Parent /guardian,

Your written permission is required to administer medication or medical procedures to your child. Any prescription drug or over- the- counter drug sent to the center must be in its original container and must be clearly labeled with your child's name, the name of the drug, and directions for administering the drug. **A new authorization form is needed each week.** If it is absolutely necessary for your child to be given medication while at the center, **please complete the following information.**

Child's Name: _____

Prescription Number: NOT APPLICABLE

Name of medication: FLUORIDE TOOTHPASTE

Amount of medication to be given at each dosage: PEA SIZE

Instructions (how *to give or apply, such as give by mouth, apply to skin, inhale, drops in eyes, etc)* GIVE TO CHILD IN A 3 OZ. CUP TO USE FOR TOOTHBRUSHING.

Time of last dosage given at home: NOT APPLICABLE

Time(s) of dosage(s) to be given at the child care facility AFTER MEALS

Please give my child the above-named medication at the time(s) and in the amount(s) indicated.

_____

Signature of parent/guardian **Date**

To be completed by licensee/staff/caregiver

Date Medication Given	Time Medication Given	Signature of person giving medication

Effective January 22, 2001/Reprinted January 2006

THE NATIONAL CENTER ON Health

Tuskegee-Macon County Head Start
103 W. Martin Luther King Highway
Tuskegee, Alabama 36083
(334) 720-0600 office
(334) 724-2118 fax

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

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ 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 _____

This document was prepared under grant #90HC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Health.

Medical Home
Screenings/Physical Examination/Assessment Record

Child's Name: _____ Sex: M F Birthdate: _____

Child Development Center: _____ Address: _____ Phone: _____

PART A: To be completed by staff or health care provider before physical examination/assessment

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

PART B: Starred items (*) are recommended by the EPSDT for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", "A" for NORMAL, SUSPECT, ATYPICAL/ABNORMAL, respectively.

TEST	DATE	RESULTS
Present Age*		Yrs. Mos.
Height (no shoes, to nearest 1/8 in.)*		
Weight (light clothing, to nearest 1/4 lb.)*		
Blood Pressure/Pulse		
Temperature, Respiration and Circulation		

TEST	DATE	RESULTS
Hearing (type of test)* Screening		
Results, R/L		
Vision (type of test)*		
Acuity, R/L		
Strabismus		

TEST	DATE	RESULTS
Other tests (if indicated) (1) Lead		
(2) Urinalysis (Age 5)		
(3) Hematocrit or Hemoglobin		

	Normal For Age	Abnormal	Not Eval.
General Appearance			
Posture, Gait			
Speech			
Skin			
Head			
Eyes (1) External Aspects			
(2) Optic Fundiscopic			
(3) Cover Test			
Ears (1) External &			
(2) Tympanic membranes			

	Normal For Age	Abnormal	Not Eval.
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen (include hernia)			
Nutrition			
Genitalia			
Bones, Joints, Muscles			
Neurological/Social			
(1) Gross Motor			
(2) Fine Motor			

	Normal For Age	Abnormal	Not Eval.
(3) Communication Skills			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
Glands (lymphatic/thyroid)			
Muscular Coordination			
Other			

Medication Administration (Use additional sheet if necessary)

Special Conditions:

Allergies: Yes _____ or No _____. If yes, indicate: _____

General statement on child's physical status:

Signature _____ Date: _____

PART C: FINDINGS, TREATMENT, AND RECOMMENDATIONS:

Abnormal Findings/Diagnosis	Treatment Plan	Recommended Follow-up or Results	Date

Circle Appropriate Payment: M - Medicaid H - HeadStart P - Private O - Other C - CHIP