

Frequently Asked Questions

YVEDDI Head Start Application Process

Please visit www.yveddi.com/head-start to download the Application Download and Save on your computer.

Please **print one-sided** if you print and mail in application

Questions while completing the application?

Feel free to contact a Family Advocate from your area (listed below) or Lindsey Huttar if you have any questions while filling out the application. We would be happy to help you!

ATTENTION:

Sections that should not be filled out by families:

- **Page 2 – SSN (Social Security Number) is not required**
- **Page 3 – Family Income section – Office use only (Fill out Family Information and Emergency Contact only)**

I was unable to sign the application on the computer before emailing it, what should I do?

- Complete the rest of the application and leave signature blank, or type your name.
- If you type your name on the application, we will assume that will take place of your signature until we can contact you for an in person appointment.

I have more than 3 children, where do I list their information?

- On page 2 of the application it requests information on your additional children (that are not applicants) in the household.
- We have included an additional page for households with more than 3 children, please add any children you were unable to place on page 2.
- If page 2 had enough space to list your children in the household please leave page 4 blank and skip to page 5.

What do I do next with my completed Head Start application?

- Email
 - Print & Mail
 - Print & Drop it off at the Head Start center
- (If you are unsure what location to drop off your application please call Lindsey Huttar at (336) 367-4993 ext. 246)
- Call the Family Advocate for your designated area, address, and when to drop it off the application
 - Print & Fax it
 - Ensure you have signed and dated each section that has a signature line
 - Once we have received the application we will contact you with additional information.
- (Please see contact list below for your Family Advocate's contact information)

Where do I send my application?

Davie County	Surry County	Stokes County	Yadkin County
<p>Patricia Hernandez Ph.#: 336-284-2374 Fax #: 336-284-2361 Email: phernandez@yveddi.com</p>	<p>Clara Urquiza Ph. #: 336-786-6155 x508 Fax #: 336-786-1514 Email: curquiza@yveddi.com</p> <p>Lashonda Griffith Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: lgriffith@yveddi.com</p> <p>Michael Lineback Ph. #: 336-786-6155 x507 Fax #: 336-786-1514 Email: mlineback@yveddi.com</p>	<p>Angelina Melvin – London/Mt Olive/Sandy Ridge Ph. #: 336-871-5022 (Sandy Ridge) Fax #: 336-871-5023 (Sandy Ridge)</p> <p>Ph. #: 336-983-2344 (King) Fax#: 336-985-3302 (King) Email: amelvin@yveddi.com</p> <p>Lashonda Griffith - Danbury Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: lgriffith@yveddi.com</p>	<p>Marissa Harris – Boonville/Jonesville/Oak Grove Ph. #: 336-367-4993 x246 Fax #: 336-367-4997 or 336-367-7146 Email: lhuttar@yveddi.com</p> <p>Cristina Alonzo – Yadkinville Ph. #: 336-367-4993 x239 Fax #: 336-367-4997 Email: calonzo@yveddi.com</p>

**Reminder: Please call the designated Family Advocate in or close to your area to get a drop off address.*

Mailing address: YVEDDI Head Start

P. O. Box 309

Boonville, NC 27011

Attention: (please include Family Advocate's name)

Is there anything else I need to do?

If you are able, please send copies of the following with your application or once you have spoken to your location's Family Advocate:

- Child's Birth Certificate
- Most recent Shot Records
- Child's Insurance/Medicaid card
- Proof of income for each parent/caregiver
 - 2019 W2s/1040s
 - One month's worth of paystubs from the month prior to application date
(example: Application filled out in June would need May paystubs)
 - Child Support
 - Self Employed – 1099 Tax form/Self-declaration letter
 - SSI (Supplemental Security Income) – Letter w/ amount per month
 - TANF (Temporary Assistance for Needy Families) – Letter w/ amount per month
 - SSA (Social Security Administration) – Letter w/amount per month

If you are unsure of what income to provide; contact your advocate.

Thank you for completing an application with YVEDDI Head Start! We look forward to working with you further.

Date Application Completed _____

Date of Enrollment _____

Classroom

NCPK



CHILD'S APPLICATION FOR ENROLLMENT



To be completed, signed, and placed on file in the facility on the first day and updated as changes occur and at least annually

How did you hear about us? _____

CHILD INFORMATION

Date of Birth: _____

Full Name: _____

Last

First

Middle

Nickname

Child's Physical Address: _____

FAMILY INFORMATION

Child lives with: _____

Father/Guardian' Name: _____ Home Phone: _____

Address (if different from child's): _____

Employer _____ Occupation _____

Work Phone: _____ Cell Phone: _____

Mother/Guardian's Name: _____ Home Phone: _____

Address (if different from child's): _____

Employer _____ Occupation _____

Work Phone: _____ Cell Phone: _____

CONTACTS

Child will be released only to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this application. In the event of an emergency, if the parents/guardians cannot be reached, the facility has permission to contact the following individuals.

Name Relationship Address Phone Number

Name Relationship Address Phone Number

Name Relationship Address Phone Number

HEALTH CARE NEEDS

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care professional. Is there a medical action plan attached? Yes No

List any allergies and symptoms and type of response required for allergic reactions. _____

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns. _____

List any particular fears or unique behavior characteristics the child has. _____

List any type of medication taken for health care needs. _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child. _____

EMERGENCY MEDICAL CARE INFORMATION

Name of health care professional _____ Office Phone _____

Hospital preference _____ Phone _____

I, as the parent/guardian, authorize the center to obtain medical attention for my child in an emergency.

Signature of Parent/Guardian _____ Date _____

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or any medication without specific instructions from the physician or the child's parent, guardian, or full-time custodian.

Signature of Administrator _____ Date _____

Additional Child (Non-Applicant) CONTINUED						
First Name	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient

Additional Child (Non-Applicant)						
First Name	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient

Additional Child (Non-Applicant)						
First Name	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient

Additional Child (Non-Applicant)						
First Name	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
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<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient

Additional Child (Non-Applicant)						
First Name	Middle	Last	Suffix	Nickname	Birthday	Gender
Race		Hispanic	English Proficiency		Other Language	Other Language Proficiency
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little			<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate			<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None			<input type="checkbox"/> None
	<input type="checkbox"/> Other _____		<input type="checkbox"/> Proficient			<input type="checkbox"/> Proficient

Applicant & Family Member Information

Applicant									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little					<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate					<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None					<input type="checkbox"/> None	
	<input type="checkbox"/> Other:		<input type="checkbox"/> Proficient					<input type="checkbox"/> Proficient	
Primary Health Coverage		Other Coverage		Insurance #		Medicaid Eligibility		Medicaid #	
						<input type="checkbox"/> Not Eligible			
						<input type="checkbox"/> On Medicaid			
						<input type="checkbox"/> Potentially			
Dental Coverage			Dental Coverage #			Dentist/Dental Home			

Primary Adult									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little					<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate					<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None					<input type="checkbox"/> None	
	<input type="checkbox"/> Other:		<input type="checkbox"/> Proficient					<input type="checkbox"/> Proficient	
Highest Grade Completed		Employment Status		Child's Relationship		Custody		Check all that apply:	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes			<input type="checkbox"/> Lives with Family	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No			<input type="checkbox"/> Provides Financial Support	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative					<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster					
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other					If teen parent, subsidized
	<input type="checkbox"/> Master's								<input type="checkbox"/> Yes <input type="checkbox"/> No

Email Address:

Secondary or Other Adult									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little					<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate					<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None					<input type="checkbox"/> None	
	<input type="checkbox"/> Other:		<input type="checkbox"/> Proficient					<input type="checkbox"/> Proficient	
Highest Grade Completed		Employment Status		Child's Relationship		Custody		Check all that apply:	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological/Adopted/Step	<input type="checkbox"/> Yes			<input type="checkbox"/> Lives with Family	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No			<input type="checkbox"/> Provides Financial Support	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Other Relative					<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster					
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other					If teen parent, subsidized
	<input type="checkbox"/> Master's								<input type="checkbox"/> Yes <input type="checkbox"/> No

Email Address:

Additional Child (Non-Applicant) *									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN		
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little					<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate					<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None					<input type="checkbox"/> None	
	<input type="checkbox"/> Other:		<input type="checkbox"/> Proficient					<input type="checkbox"/> Proficient	

Additional Child (Non-Applicant) *									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN		
Race		Hispanic		English Proficiency		Other Language		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little					<input type="checkbox"/> Little	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate					<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> None					<input type="checkbox"/> None	
	<input type="checkbox"/> Other:		<input type="checkbox"/> Proficient					<input type="checkbox"/> Proficient	

* If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Physical Address

Started Living At Date	Physical Address	Address Line 2	ZIP	City	State	County

Family Mailing Address

Same as Physical?	Started Using Date	Mailing Address	Address Line 2	ZIP	City	State
<input type="checkbox"/> Yes <input type="checkbox"/> No						

Phone Number(s)	Type (check one)	Note (extension or best time to call)	Opt In for Text Messages
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other		<input type="checkbox"/> Yes <input type="checkbox"/> No

Parental Status (check one)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (if applicable)
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family Income

Income Verified by	Verification Date	TANF Status	SSI
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly on TANF/Not now	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family Member	Amount	Per (for example: week, month, year)	Annual Amount	Description (for example: SSI, Job, Child Support)	Verification (for example: W2, check stub)	Note
	\$		\$			
	\$		\$			
	\$		\$			

Income Notes

Emergency Contacts

Contact 1	Name	Relationship	Emergency Contact	Release To
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	ZIP	City	State
Contact 2	Phone Number 1	Phone Number 2	Phone Number 3	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
	Name	Relationship	Emergency Contact	Release To
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact 3	Address	ZIP	City	State
	Phone Number 1	Phone Number 2	Phone Number 3	
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> 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 _____

Child Health History

Child's Name: _____ Child's DOB: _____ Date: _____ Center: _____

Health Issues: Does child have any:				
Allergies: – Allergy Form/Med Form required	Yes	No	If Yes, Explain	Medication?
Food allergies?	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy to bees?	<input type="checkbox"/>	<input type="checkbox"/>		
Environmental, medications or other?	<input type="checkbox"/>	<input type="checkbox"/>		
Illnesses/Conditions:				
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>		
Eczema/Rashes?	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>		
Heart murmur/disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
Constipation/Stomach pain?	<input type="checkbox"/>	<input type="checkbox"/>		
1. Has Child ever had a seizure/febrile seizure?	<input type="checkbox"/>	<input type="checkbox"/>		
Last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>		
Currently on medication?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Frequent symptoms of any conditions not listed above?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Ear/hearing problems? Tubes?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Eye/vision problems?	<input type="checkbox"/>	<input type="checkbox"/>		
Glasses prescribed/worn? If so, date of last checkup?	<input type="checkbox"/>	<input type="checkbox"/>		
History of:				
Whooping cough/severe coughing?	<input type="checkbox"/>	<input type="checkbox"/>		
Hospitalization/surgery/serious accident?	<input type="checkbox"/>	<input type="checkbox"/>		
Premature birth?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Concerns about development?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Diagnosed with a disability?	<input type="checkbox"/>	<input type="checkbox"/>		
IEP?	<input type="checkbox"/>	<input type="checkbox"/>		
Therapist/Specialist: _____	<input type="checkbox"/>	<input type="checkbox"/>		
Phone number: _____	<input type="checkbox"/>	<input type="checkbox"/>		
7. Is your child on a special diet?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Does your child currently have any of these problems daily, weekly or monthly? If so, please indicate which. <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Dental pain <input type="checkbox"/> Pain with chewing <input type="checkbox"/> Difficulty swallowing				
12. Please check if your child: <input type="checkbox"/> Does not feed him/herself <input type="checkbox"/> Uses a baby bottle/sippy cup				
10. Does your child have any special needs when it comes to mealtimes?	<input type="checkbox"/>	<input type="checkbox"/>		
11. Do you have any concerns regarding your child's weight and/or their eating habits?	<input type="checkbox"/>	<input type="checkbox"/>		
15. Is your child/family receiving WIC?	<input type="checkbox"/>	<input type="checkbox"/>		
Are there any other medical or dental conditions that we have NOT discussed which interfere with activities?	<input type="checkbox"/>	<input type="checkbox"/>		

I have answered the questions above to the best of my knowledge:

Parent Signature

Date

I have staffed the above areas highlighted and completed necessary forms/follow-up as required:

Family Advocate

Date



Child's Name _____
Date of Birth _____
Classroom _____
Program Year _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name (Last, First, MI)			
Date of Birth			
Parent/Legal Guardian Full Name			
Street Address			
City/State/Zip Code			
Home Phone		Cell Phone	

AUTHORIZES: Release of information to: or Exchange of information with: (must select one or both)

Name of Health Care Provider, Clinic, Other

Street Address

City State Zip Code

Phone Number Fax Number

YVEDDI Head Start
PO Box 309
Boonville, NC 27011
Phone: (336)-367-4993
Fax: (336)-367-4997

DISCLOSURE OF MEDICAL RECORD COPIES

Information to be disclosed:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Physical Exams/Summary | <input type="checkbox"/> History/Consultations | <input type="checkbox"/> Immunization | <input type="checkbox"/> Lead Screenings |
| <input type="checkbox"/> Dental Exam/Treatment | <input type="checkbox"/> PT/SP/OT | <input type="checkbox"/> Labs - EKG/EEG/EMG | |
| <input type="checkbox"/> Mental Health/Psychology/Neuropsychology | | <input type="checkbox"/> Other: _____ | |

VERBAL COMMUNICATION

- Communication between those listed in Section 2 (includes any information unless limited below), or
- Limited communication (specified): _____

PURPOSE OF DISCLOSURE:

- Required for enrollment Further medical care Coordination of health services Other: _____

EXPIRATION DATE: This authorization will remain in effect for the duration of the child's enrollment in YVEDDI Head Start. Note: This authorization will apply to medical information generated during the extended time period.

RE-RELEASE: I understand the information used or disclosed based on this authorization may possibly be re-disclosed by the recipient and/or no longer protected by Federal Privacy standards.

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT MEDICAL INFORMATION

- **Right to Receive Copy of this Authorization:** I understand that if I agree to sign this authorization, I can receive a copy of it.
- **Right to Inspect or Copy the Health Information to be Used or Disclosed:** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed per this authorization.
- **No Obligation to Sign:** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefit on my decision to sign this authorization.
- **Revocation:** I have the right to revoke this authorization by notifying the YVEDDI Head Start Administrative Office in writing of my desire to revoke it. However, I understand that any action already taken in reliance to this authorization, cannot be reversed and my revocation will not affect those actions.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes for the minor child listed above.

Print Name _____ Date: _____

Signature _____

Authority to sign: Parent Guardian

Head Start Consent Form

Child's Name											
Center Name											
(Please <i>initial</i> each and sign below)											
	I understand that my child has been selected to participate in Head Start. The parent involvement will be critical to the success of my child. I commit to participate as much as possible at the Head Start/NCPK site.										
	I understand there may be a waiting list for Head Start/NCPK services.										
	I understand that transportation to and from Head Start/NCPK sites may be the responsibility of the family										
	<p>I give permission for my child to receive the following screenings while attending Head Start:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 2px 0;"><input type="checkbox"/> Developmental</td> <td style="width: 50%; padding: 2px 0;"><input type="checkbox"/> Hearing</td> </tr> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> Vision</td> <td style="padding: 2px 0;"><input type="checkbox"/> Dental exam</td> </tr> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> Behavioral</td> <td style="padding: 2px 0;"><input type="checkbox"/> Weight</td> </tr> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> Speech and language screening</td> <td style="padding: 2px 0;"><input type="checkbox"/> Height</td> </tr> <tr> <td style="padding: 2px 0;"><input type="checkbox"/> Mental health classroom observation</td> <td></td> </tr> </table>	<input type="checkbox"/> Developmental	<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental exam	<input type="checkbox"/> Behavioral	<input type="checkbox"/> Weight	<input type="checkbox"/> Speech and language screening	<input type="checkbox"/> Height	<input type="checkbox"/> Mental health classroom observation	
<input type="checkbox"/> Developmental	<input type="checkbox"/> Hearing										
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<input type="checkbox"/> Speech and language screening	<input type="checkbox"/> Height										
<input type="checkbox"/> Mental health classroom observation											
	I understand that if there is any change in my child's status of address, attendance in any type of licensed care, phone numbers, guardianship, etc. I will contact my child's teacher and/or Family Advocate immediately and inform them of the changes.										
	I understand that if my child participates in Head Start he/she may be photographed and the pictures may be used in the following ways: center display, center scrapbook, newspaper, TV broadcasts, School website, and Head Start/NCPK related publications, etc.										
	I give permission for Head Start to access my child's information on NC Tracks (for Medicaid/NC Health Choice verification), NC Immunization Registry (for updated immunization records), and NC Lead (for lead testing results).										

Parent/Guardian Signature:	Date:

* PARENT/GUARDIAN SIGNATURE IS REQUIRED *

This form is valid for the current school year