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.

Questions while completing the application?
Feel free to contact a Family Advocate from your area (listed below) or **Jessicca Smith** 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: **jsmith@yveddi.com**
- Print & Mail to: **YVEDDI Head Start ▪ P.O. Box 309 Boonville, NC 27011**
- Print & Drop it off at the Head Start center

(If you are unsure what location to drop off your application please call **Jessicca Smith at (336) 367-4993 ext. 246)**
- Call the Family Advocate for your area
- Print & Fax it: **(336) 367-4997**
- Ensure you have signed and dated each section that has a signature line
- Once the application is received and reviewed, a staff member will contact you regarding the status.

**Reminder: Please call the Family Advocate in your county to get a drop off address.*

Where do I send my application?
Please see contact list below for your Family Advocate's contact information)

Davie County	Surry County	Stokes County	Yadkin County
Patricia Hernandez Ph.#: 336-284-2374 Fax #: 336-284-2361 Email: phernandez@yveddi.com	**Clara Urquiza** Ph. #: 336-786-6155 x508 Fax #: 336-786-1514 Email: curquiza@yveddi.com **Lashonda Griffith** Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: lgriffith@yveddi.com **Sharon Branch** Ph. #: 336-786-6155 x507 Fax #: 336-786-1514 Email: sbranch@yveddi.com	**London/Mt Olive/Sandy Ridge** **Melissa Graham** Ph. #: 336-871-5022 (Sandy Ridge) Fax #: 336-871-5023 (Sandy Ridge) Ph. #: 336-983-2344 (King) Fax#: 336-985-3302 (King) Email: mgraham@yveddi.com **Sharon Branch - Danbury** Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: sbranch@yveddi.com	**Boonville/Jonesville/Oak Grove** Maria "Lulu" Galicia Ph. #: 336-367-7175 Fax #: 336-367-7146 Email: mgalicia@yveddi.com **Cristina Alonzo – Yadkinville** Ph. #: 336-367-4993 x239 Fax #: 336-367-4997 Email: calonzo@yveddi.com

Is there anything else I need to do?
If you are able, please send copies of the following with your application:

- Child's Birth Certificate (for age verification)
- Most recent Shot Records
- Child's Insurance/Medicaid card
- Proof of income for each parent/guardian living in the household
  - W2s/1040s (most recent)
  - 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
  - SNAP/Food Stamp Card

If you are unsure of what income to provide, please contact us.

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

YVEDDI
YADKIN VALLEY ECONOMIC DEVELOPMENT DISTRICT, INC.

CHILD'S APPLICATION FOR ENROLLMENT

Head Start

To be completed, signed, and placed on file in the facility by the first day of enrollment 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: mother

Father/Guardian' Name: _____ Home Phone: _____

Address (if different from child's): _____

Employer_____ Occupation_____

Work Phone: _____ Cell Phone: _____

Email:_____

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

Address (if different from child's): _____

Employer_____ Occupation_____

Work Phone: _____ Cell Phone: _____

Email: _____

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_____

Applicant & Family Member Information

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
	☐ Other:		☐ Proficient		☐ Proficient

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
			☐ Not Eligible ☐ On Medicaid ☐ 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
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
	☐ Other:		☐ Proficient		☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Biological/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Other Relative		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐ Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized
	☐ Master's					☐ Yes ☐ 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
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
	☐ Other:		☐ Proficient		☐ Proficient

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

Email Address:

Additional Child (Non Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
	☐ Other:		☐ Proficient		☐ Proficient

Additional Child (Non Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
	☐ Other:		☐ Proficient		☐ Proficient

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

This Section for Agency Use Only:

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
☐ Yes ☐ No						

Phone Number(s)	Type (*check one*)	Note (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 Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Family Income (This section is for Agency Use Only)

Income Verified by	Verification Date	TANF Status	SSI
		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ 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
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

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

Contact 2

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

Address	ZIP	City	State

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

Contact 3

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

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ 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 _____

To Be completed ONLY if you have more than 3 children

Additional Child (Non-Applicant) CONTINUED

First Name	Middle	Last	Suffix	Nickname	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
❒ Asian ❒ Black ❒ White	❒ American Indian/Alaska Native ❒ Hawaiian Pacific Islander ❒ Multi-Racial ❒ Other ____________________	❒ Yes ❒ No	❒ Little ❒ Moderate ❒ None ❒ Proficient		❒ Little ❒ Moderate ❒ None ❒ Proficient

Additional Child (Non Applicant)

First Name	Middle	Last	Suffix	Nickname	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
❒ Asian ❒ Black ❒ White	❒ American Indian/Alaska Native ❒ Hawaiian Pacific Islander ❒ Multi-Racial ❒ Other ____________________	❒ Yes ❒ No	❒ Little ❒ Moderate ❒ None ❒ Proficient		❒ Little ❒ Moderate ❒ None ❒ Proficient

Additional Child (Non Applicant)

First Name	Middle	Last	Suffix	Nickname	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
❒ Asian ❒ Black ❒ White	❒ American Indian/Alaska Native ❒ Hawaiian Pacific Islander ❒ Multi-Racial ❒ Other ____________________	❒ Yes ❒ No	❒ Little ❒ Moderate ❒ None ❒ Proficient		❒ Little ❒ Moderate ❒ None ❒ Proficient

Additional Child (Non Applicant)

First Name	Middle	Last	Suffix	Nickname	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
❒ Asian ❒ Black ❒ White	❒ American Indian/Alaska Native ❒ Hawaiian Pacific Islander ❒ Multi-Racial ❒ Other ____________________	❒ Yes ❒ No	❒ Little ❒ Moderate ❒ None ❒ Proficient		❒ Little ❒ Moderate ❒ None ❒ Proficient

Additional Child (Non Applicant)

First Name	Middle	Last	Suffix	Nickname	Birthday	Gender

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
❒ Asian ❒ Black ❒ White	❒ American Indian/Alaska Native ❒ Hawaiian Pacific Islander ❒ Multi-Racial ❒ Other ____________________	❒ Yes ❒ No	❒ Little ❒ Moderate ❒ None ❒ Proficient		❒ Little ❒ Moderate ❒ None ❒ Proficient

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?	☐	☐		
Allergy to bees?	☐	☐		
Environmental, medications or other?	☐	☐		
Illnesses/Conditions:				
Asthma?	☐	☐		
Eczema/Rashes?	☐	☐		
Diabetes?	☐	☐		
Heart murmur/disorder?	☐	☐		
Constipation/Stomach pain?	☐	☐		
1. Has Child ever had a seizure/febrile seizure?	☐	☐		
Last 12 months?	☐	☐		
Currently on medication?	☐	☐		
2. Frequent symptoms of any conditions not listed above?	☐	☐		
3. Ear/hearing problems? Tubes?	☐	☐		
4. Eye/vision problems?	☐	☐		
Glasses prescribed/worn? If so, date of last checkup? _____	☐	☐		
History of:				
Whooping cough/severe coughing?	☐	☐		
Hospitalization/surgery/serious accident?	☐	☐		
Premature birth?	☐	☐		
5. Concerns about development?	☐	☐		
6. Diagnosed with a disability?	☐	☐		
IEP?	☐	☐		
Therapist/Specialist: _____ Phone number: _____	☐	☐		
7. Is your child on a special diet?	☐	☐		
8. Does your child currently have any of these problems daily, weekly or monthly? If so, please indicate which. ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Dental pain ☐ Pain with chewing ☐ Difficulty swallowing				
12. Please check if your child: ☐ Does not feed him/herself ☐ Uses a baby bottle/sippy cup				
10. Does your child have any special needs when it comes to mealtimes?	☐	☐		
11. Do you have any concerns regarding your child's weight and/or their eating habits?	☐	☐		
15. Is your child/family receiving WIC?	☐	☐		
Are there any other medical or dental conditions that we have NOT discussed which interfere with activities?	☐	☐		

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**

YVEDDI
YADKIN VALLEY ECONOMIC DEVELOPMENT DISTRICT, INC.

Head Start

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:

❒ Physical Exams/Summary ❒ History/Consultations ❒ Immunization ❒ Lead Screenings
❒ Dental Exam/Treatment ❒ PT/SP/OT ❒ Labs - EKG/EEG/EMG
❒ Mental Health/Psychology/Neuropsychology ❒ 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

YVEDDI
YADKIN VALLEY ECONOMIC DEVELOPMENT DISTRICT, INC.

Head Start

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

AUTHORIZATION FOR RELEASE OF DENTAL 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:
❒ Dental Exam/Treatment
❒ History/Consultations
❒ 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	

INITIAL ALL	**(Please INITIAL 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
Initial Beside Each Screening	I give permission for my child to receive the following screenings while attending Head Start: _____ Developmental _____ Vision _____ Behavioral _____ Speech and language screening _____ Mental health classroom observation _____ Hearing _____ Dental exam _____ Weight _____ Height
	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