



YVEDDI HEAD START APPLICATION PROCESS

Please visit www.yveddi.com/head-start to download and save the Head Start Application Packet onto your computer.

ATTENTION:

Sections of the application that should not be filled out by families:

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

Questions while completing the application?

Please see the frequently asked questions answered below. If your questions are not addressed, feel free to contact a Family Advocate from your area or reach out to either the Family and Community Partnerships Coordinator, Yolanda Lytton, at (336) 367-4993 ext. 232 or the Family and Community Partnerships Supervisor, Katy Riojas, at (336) 367-4993 ext. 246.

We would be happy to help you!

Frequently Asked Questions?

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

If you can't sign the application on the computer:

- Finish filling it out and leave the signature blank, **or** type your name.
- If you type your name, it will count as your signature until we meet with you in person.

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

There is an additional page provided with the wording "To be completed ONLY if you have more than 3 children." This is where you will list children who are not applicants but who still reside in the household.

What do I do with my completed Head Start application?

You have the following delivery options:

Email- To either the Family and Community Partnerships Coordinator, Yolanda Lytton, at ylytton@yveddi.com **or** the Family and Community Partnerships Supervisor, Katy Riojas, at kriojas@yveddi.com

Mail- Print the packet and mail it to **YVEDDI Head Start, P.O. Box 309 Boonville, NC 27011**. Ensure you have signed and dated each section that has a signature line.

Fax it: Send the entire completed packet to **(336) 367-4997**. Ensure you have signed and dated each section that has a signature line.

Drop off- Print the packet and hand deliver it to the Head Start center. If you are unsure what location to drop off your application, please call either Yolanda Lytton at (336) 367-4993 ext. 232, Katy Riojas at (336) 367-4993 ext. 246, or the assigned Family Advocate for your area, using the directory listed below.

Davie County	Surry County	Stokes County	Yadkin County
Jack G Koontz / Mocksville Patricia Hernandez Ph.#: 336-284-2374 Fax #: 336-284-2361 Email: phernandez@yveddi.com	Granite City 4 / Paynetown Clara Urquiza Ph. #: 336-786-6155 x508 Fax #: 336-786-1514 Email: curquiza@yveddi.com Granite City 2 & 3 Lashonda Griffith Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: lgriffith@yveddi.com	Mt Olive / Sandy Ridge Ph. #: 336-871-5022 (Sandy Ridge) Fax #: 336-871-5023 (Sandy Ridge) Morgan Lang Ph. #: 336-983-2344 (King) Fax#: 336-985-3302 (King) Email: mlang@yveddi.com London Lashonda Griffith Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: lgriffith@yveddi.com	Boonville/Jonesville Sharon Branch Ph. #: 336-469-4563 Email: sbranch@yveddi.com Yadkinville 1 & 3 Cristina Alonzo Ph. #: 336-367-4993 x239 Fax #: 336-367-4997 Email: calonzo@yveddi.com

Is there anything else I need to do?

Once the application is received and reviewed, a staff member will contact you regarding the status.

Please send copies of the following documents 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



CHILD'S APPLICATION FOR ENROLLMENT



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: _____

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	
							[REDACTED]		
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	
							[REDACTED]		
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					If teen parent, subsidized
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Master's									

Email Address:

Secondary or Other Adult									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
							[REDACTED]		
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					If teen parent, subsidized
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Master's									

Email Address:

Additional Child (Non-Applicant) *									
First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID	
							[REDACTED]		
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	Alt ID	
							[REDACTED]		
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					

Family Income (This section is for Agency Use Only)

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
Contact 3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	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 _____

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
<input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <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"/> Black <input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <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"/> Black <input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <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"/> Black <input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <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"/> Black <input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian Pacific Islander <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient			<input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> None <input type="checkbox"/> Proficient

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: (I will review this form and update Family Advocate of any changes that occur)

Parent Signature

Date

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

Family Advocate

Date

This form is valid for the duration of enrollment



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.

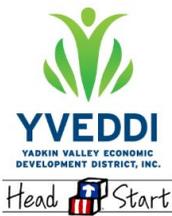
I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes for the minor child listed above.

Print Name _____ Date: _____

Signature _____

Authority to sign: Parent Guardian

This form is valid for the duration of enrollment



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

This form is valid for the duration of enrollment

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	<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%;">_____ Developmental</td> <td style="width: 50%;">_____ Hearing</td> </tr> <tr> <td>_____ Vision</td> <td>_____ Dental exam</td> </tr> <tr> <td>_____ Behavioral</td> <td>_____ Weight</td> </tr> <tr> <td>_____ Speech and language screening</td> <td>_____ Height</td> </tr> <tr> <td>_____ Mental health classroom observation</td> <td></td> </tr> </table>	_____ Developmental	_____ Hearing	_____ Vision	_____ Dental exam	_____ Behavioral	_____ Weight	_____ Speech and language screening	_____ Height	_____ Mental health classroom observation	
_____ Developmental	_____ Hearing										
_____ Vision	_____ Dental exam										
_____ Behavioral	_____ Weight										
_____ Speech and language screening	_____ Height										
_____ 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 duration of enrollment

AUTHORIZATION TO RELEASE INFORMATION

Parent name: _____

Child(ren) name(s): _____

I understand that the State of North Carolina has created a system that combines limited information about children and families who receive services from publicly-funded programs like the Head Start and Early Head Start programs into a single, statewide system called the NC Early Childhood Integrated Data System (NC ECIDS).

I understand that the purpose of NC ECIDS is to help provide answers to important policy and program questions about publicly-funded programs administered in North Carolina; as well as those questions that my local Head Start or Early Head Start program may have about the services offered in the county(ies) in which it operates.

I understand that NC ECIDS is requesting my permission to receive the following information about my child(ren) and family to be included in NC ECIDS:

Child's Name*	Primary Language
Child's Date of Birth	Category of enrollment eligibility
Child's Gender	Health insurance status
Child's Race	

**I understand that my child's name will never be released publicly in any report.*

I understand that allowing data about my child(ren) and family to be released to NC ECIDS is voluntary and is not a requirement for my child to be enrolled in the Head Start or Early Head Start program.

_____ I authorize YVEDDI Head Start to release the information about my child(ren) / family noted above to NC ECIDS

_____ I **DO NOT** authorize YVEDDI Head Start to release the information about my child(ren) / family noted above to NC ECIDS

Parent/Guardian signature: _____ Date: _____

Relationship to child(ren): _____

Staff signature: _____ Date: _____

I understand that I may revoke the release of information at any time, in writing, except where the agency has already made disclosures in reliance upon my prior authorization.



Family Needs Assessment

Child's Name:		Classroom:	
Employment/Income			
1. Is someone in the household receiving other sources of assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check all that apply:			
<input type="checkbox"/> Foster Care <input type="checkbox"/> WIC <input type="checkbox"/> Food Stamps <input type="checkbox"/> Unemployment <input type="checkbox"/> Public Housing <input type="checkbox"/> Child Support <input type="checkbox"/> Temporary Housing			
2. Are any unemployed adults seeking a job, or if employed, seeking a new job? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. What are the main barriers to finding employment? <i>Check all that apply</i>			
<input type="checkbox"/> Transportation <input type="checkbox"/> Child Care <input type="checkbox"/> Health <input type="checkbox"/> Education/Training <input type="checkbox"/> Other: _____			
Education/Training			
<u>Mother</u>		<u>Father</u>	
Currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently in school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like to gain any of the following?		Would you like to gain any of the following?	
<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> College degree		<input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> College degree	
Have you had a child in Head Start before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Basic Needs			
1. Does your family have enough food? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Does your family have enough clothing? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Are you able to pay your power/water bills? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Is your current housing satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Do you own or rent your own home? <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other; explain:			
6. Check below any items that apply to you:			
<input type="checkbox"/> Moved during past year <input type="checkbox"/> Would like to move to better housing <input type="checkbox"/> Lived in a shelter or temporary housing during the past year <input type="checkbox"/> Have an application pending with public housing <input type="checkbox"/> Would like to own your own home			
7. Does anyone in your home have a disability condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
8. Are there any needs or that have not been noted regarding your family? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
Parent/Guardian Signature:			
Date:			



Parent Interest Survey

Head Start is committed to providing information, workshops, and training opportunities that meet the needs of parents and caregivers. Please check any area of interest that you would like more information about.

Parenting

- | | | |
|--|----------------|--|
| | Date Discussed | |
| 1. <input type="checkbox"/> Discipline issues | _____ | |
| 2. <input type="checkbox"/> Child development | _____ | |
| 3. <input type="checkbox"/> Communicating with children | _____ | |
| 4. <input type="checkbox"/> Anger Management | _____ | |
| 5. <input type="checkbox"/> Custody/legal issues | _____ | |
| 6. <input type="checkbox"/> Fun family activities | _____ | |
| 7. <input type="checkbox"/> Reading to children | _____ | |
| 8. <input type="checkbox"/> How to speak for yourself and others | _____ | |
| 9. <input type="checkbox"/> Single Parent / Shared Parent Issues | _____ | |
| 10. <input type="checkbox"/> Father/ Men in your child's life | _____ | |
| 11. <input type="checkbox"/> Grandparents raising children | _____ | |
| 12. <input type="checkbox"/> Self esteem | _____ | |
| 13. <input type="checkbox"/> Developmental concerns or delays | _____ | |
| 14. <input type="checkbox"/> Advocating with schools | _____ | |

Education and Employment

- | | |
|--|----------------|
| | Date Discussed |
| 15. <input type="checkbox"/> GED classes | _____ |
| 16. <input type="checkbox"/> ESL classes | _____ |
| 17. <input type="checkbox"/> Learning about computers/internet | _____ |
| 18. <input type="checkbox"/> Obtaining a job | _____ |
| 19. <input type="checkbox"/> Keeping my job | _____ |
| 20. <input type="checkbox"/> Advancing my skills and salary | _____ |
| 21. <input type="checkbox"/> Exploring a new career | _____ |

Health / Nutrition

- | | |
|---|----------------|
| | Date Discussed |
| 22.. <input type="checkbox"/> Family Planning (birth control) | _____ |
| 23. <input type="checkbox"/> CPR / First Aid | _____ |
| 24. <input type="checkbox"/> Home Safety / gun safety | _____ |
| 25. <input type="checkbox"/> Stress Management / Self-care | _____ |
| 26. <input type="checkbox"/> Family violence prevention | _____ |
| 27. <input type="checkbox"/> Preparing for an emergency | _____ |
| 28. <input type="checkbox"/> Finding / using health services | _____ |
| 29. <input type="checkbox"/> Drug and Alcohol information | _____ |
| 30. <input type="checkbox"/> Taking care of children's teeth | _____ |
| 31. <input type="checkbox"/> Immunizations | _____ |
| 32. <input type="checkbox"/> Adult Health Issues | _____ |

- | | |
|---|----------------|
| | Date Discussed |
| 33. <input type="checkbox"/> Quit Smoking / Quit Tobacco | _____ |
| 34. <input type="checkbox"/> Talking to my doctor | _____ |
| 35. <input type="checkbox"/> Exercise programs | _____ |
| 36. <input type="checkbox"/> Getting children to eat | _____ |
| 37. <input type="checkbox"/> Budgeting for food | _____ |
| 38. <input type="checkbox"/> Healthy meals and snacks | _____ |
| 39. <input type="checkbox"/> Cooking | _____ |
| 40. <input type="checkbox"/> Eating disorders | _____ |
| 41. <input type="checkbox"/> Using mental health services | _____ |
| 42. <input type="checkbox"/> Childhood illnesses | _____ |

Other

- | | |
|---|----------------|
| | Date Discussed |
| 43. <input type="checkbox"/> Other: _____ | _____ |
| 44. <input type="checkbox"/> I do not have any interests at this time | _____ |

Preferred teaching method:

- Conversation Video Books/Written Instruction Group Lecture/Meeting Internet

Parent/Guardian's Name: _____ Date: _____

YVEDDI HEAD START OFFICE USE	
Resource follow-up (detail what information was provided): _____	

Advocate's Name: _____ Date: _____	