



## YVEDDI HEAD START APPLICATION PROCESS

Please visit [www.yveddi.com/head-start](http://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](mailto:ylytton@yveddi.com) **or** the Family and Community Partnerships Supervisor, Katy Riojas, at [kriojas@yveddi.com](mailto: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
<b>Jack G Koontz / Mocksville</b> Patricia Hernandez Ph.#: 336-284-2374 Fax #: 336-284-2361 Email: <a href="mailto:phernandez@yveddi.com">phernandez@yveddi.com</a>	<b>Granite City 4 / Paynetown</b> Clara Urquiza Ph. #: 336-786-6155 x508 Fax #: 336-786-1514 Email: <a href="mailto:curquiza@yveddi.com">curquiza@yveddi.com</a>  <b>Granite City 2 &amp; 3</b> Lashonda Griffith Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: <a href="mailto:lgriffith@yveddi.com">lgriffith@yveddi.com</a>	<b>Mt Olive / Sandy Ridge</b> 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: <a href="mailto:mlang@yveddi.com">mlang@yveddi.com</a>  <b>London</b> Lashonda Griffith Ph. #: 336-786-6155 x506 Fax #: 336-786-1514 Email: <a href="mailto:lgriffith@yveddi.com">lgriffith@yveddi.com</a>	<b>Boonville/Jonesville</b> Sharon Branch Ph. #: 336-469-4563 Email: <a href="mailto:sbranch@yveddi.com">sbranch@yveddi.com</a>  <b>Yadkinville 1 &amp; 3</b> Cristina Alonzo Ph. #: 336-367-4993 x239 Fax #: 336-367-4997 Email: <a href="mailto:calonzo@yveddi.com">calonzo@yveddi.com</a>

**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	
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 #	Doctor/Medical Home		
				<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		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	
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	
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	
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 (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

<b>Contact 1</b>	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
<b>Contact 2</b>	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
<b>Contact 3</b>	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"/>		
<b>Illnesses/Conditions:</b>				
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"/>		
<b>1. Has Child ever had a seizure/febrile seizure?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>		
Currently on medication?	<input type="checkbox"/>	<input type="checkbox"/>		
<b>2. Frequent symptoms of any conditions not listed above?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>3. Ear/hearing problems? Tubes?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>4. Eye/vision problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Glasses prescribed/worn? If so, date of last checkup? _____	<input type="checkbox"/>	<input type="checkbox"/>		
<b>History of:</b>				
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"/>		
<b>5. Concerns about development?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>6. Diagnosed with a disability?</b>	<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"/>		
<b>7. Is your child on a special diet?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>8. Does your child currently have any of these problems daily, weekly or monthly? If so, please indicate which.</b> <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				
<b>12. Please check if your child:</b> <input type="checkbox"/> Does not feed him/herself <input type="checkbox"/> Uses a baby bottle/sippy cup				
<b>10. Does your child have any special needs when it comes to mealtimes?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>11. Do you have any concerns regarding your child's weight and/or their eating habits?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>15. Is your child/family receiving WIC?</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Are there any other medical or dental conditions that we have NOT discussed which interfere with activities?</b>	<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





## Head Start Consent Form

<b>Child's Name</b>											
<b>Center Name</b>											
<b>INITIAL ALL</b>	<b>(Please INITIAL each and sign below)</b>										
	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										
<b>Initial Beside Each Screening</b>	<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).										

<b>Parent/Guardian Signature:</b>	<b>Date:</b>

**\* 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 Eligibility and Needs Assessment



Child's Name: \_\_\_\_\_ Classroom: \_\_\_\_\_

### Child Information

- Child's age as of August 31 of this year:
  - 3 years 0 months – 3 years 5 months
  - 3 years 6 months – 3 years 11 months
  - 4 years 0 months – 4 years 5 months
  - 4 years 6 months or older
- Is the child being raised by a grandparent, guardian, or kinship caregiver?  Yes  No
- Is the child currently in foster care or kinship care (documented)?  Yes  No
- Was the child adopted through foster care?  Yes  No
- Has the applicant child been a victim of documented child abuse or neglect?  Yes  No
- Does the child have a documented diagnosed disability?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Has the child been referred for a potential or suspected disability evaluation?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Does the child have documented health or nutritional care needs? (Asthma, allergies, diabetes, seizures, vision or hearing impairments, treatment plans, special diets or eating disorders)  Yes  No  
If yes, please explain: \_\_\_\_\_
- Is the child repeating the program for a third year?  Yes  No
- Is the child on the waiting list in the previous program year?  Yes  No

### Parent / Guardian Information

<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
Currently Deployed in the Military? <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Deployed in the Military? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were you a teen parent? (Applicant child's birth) <input type="checkbox"/> Yes <input type="checkbox"/> No	Were you a teen parent? (Applicant child's birth) <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Unemployed within the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Unemployed within the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Seeking employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Seeking employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what are barriers to finding employment? <i>Check all that apply</i>	If yes, what are 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"/> Transportation <input type="checkbox"/> Child Care <input type="checkbox"/> Health <input type="checkbox"/> Education/Training
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

### Family Information

- Does the applicant child have siblings currently enrolled in the Head Start program?  Yes  No
- Is the family considered a large family (more than 4 individuals)?  Yes  No
- Does your family have enough food?  Yes  No
- Does your family have enough clothing?  Yes  No
- Are you able to pay your power/water bills?  Yes  No
- Is your current housing satisfactory?  Yes  No
- Is the family experiencing homelessness?  Yes  No
- Do you own or rent your own home?  Own  Rent  Other; explain: \_\_\_\_\_
- Check all that apply to you:  Moved during past year  Lived in a shelter/temporary housing during the past year  
 Would like to move to better housing  Application pending with public housing  Would like to own your own home
- Does the family currently receive SSI, TANF, or SNAP/Food Stamps benefits?  Yes  No
- Has an immediate family member of the applicant child died within the past 12 months?  Yes  No
- Is there a documented disability in the home (not the applicant child)?  Yes  No
- Is there a documented mental or physical illness in the household (not the applicant child)?  Yes  No
- Is someone in the household receiving other sources of assistance?  Yes  No If yes, check all that apply:  
 Foster Care  WIC  Unemployment  Public Housing  Child Support  Temporary Housing  Other: \_\_\_\_\_
- Are there any needs or that have not been noted regarding your family?  Yes  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: \_\_\_\_\_