

**Chugachmiut Head Start Program**

**Instruction Sheet for Enrollment Application**

This page is to help you fill out the Head Start Enrollment Application. One application is required per child interested in enrolling into Head Start. All required documents listed below must be received with the child’s application in order to process. Once all documents are received, the child will be enrolled or placed on a wait list. (Age and income eligible have priority for enrollment and other eligibility criteria are followed as well.)

## Child Application

(Complete using child’s legal name as is appears on the birth certificate, sign and date in all applicable areas. Questions that do not pertain to your family put “N/A” (not applicable) DO NOT LEAVE ANY BLANK AREAS.

## Birth Certificate

* **Proof of Legal/Foster/Relative Guardianship** (If not the child’s biological parent)

## Last 12 months Income

(ATAP/TANF; copies of W-2, 1040 Tax Return (most recent), Pay stubs, Social Security Benefits, Unemployment documents, child support, etc.)

A child that is homeless\* or is in foster care is eligible even if the family income exceeds the income guidelines. (\*Homeless means any individual who lack fixed, regular and adequate residence.)

## Release of Information

Priority is given to those that meet the 2017 Poverty Guidelines for Alaska.

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2017 Poverty Guidelines for Alaska

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Persons in family/household guideline

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1........................................................... $15,060

2........................................................... 20,290

3........................................................... 25,520

4........................................................... 30,750

5........................................................... 35,980

6........................................................... 41,210

7........................................................... 46,440

8........................................................... 51,670

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For families/households with more than 8 persons, add $5,230 for each additional person.

Applications may be turned in to Head Start in the following ways:

|  |  |
| --- | --- |
| In Person | At your local Head Start center |
| Mail | Chugachmiut Head Start 1840 Bragaw Suite 110, Anchorage, AK 99508 |
| Fax | 1-800-793-2891Attn: Head Start |
| E-mail | [headstart@chugachmiut.org](mailto:headstart@chugachmiut.org) |

For more information or to apply, please call the Central Office at: 1(800)478-4155 ext: 144, or visit our website: [www.chugachmiut.org](http://www.chugachmiut.org)

Parent Checklist

## Child’s Name: Date of Birth: Site:

**Required for Head Start enrollment:**

* Verification of income
* Child’s birth certificate
* Individual Education Plan or Individual Family Service Plan (if applicable) **Records/Information required for attendance:**
* **Immunizations**: A series of vaccinations to protect children from the spread of disease. This includes DTaP, IPV, MMR, HIB, Hep A, Hep B, & Varicella.
* **Physical Exam**: A “well child” check-up to ensure everything is okay. The exam must be done by a doctor, public health nurse, nurse practitioner or physician’s assistant.
  + **Hemoglobin Test**: This shows if the individual has anemia (low iron). When anemia is present the person is more likely to get sick with colds or disease. If receiving WIC services the results may be in child’s health record.
  + **Height and Weight**: This shows if a child is growing and gaining weight normally. Poor growth and weight gain can indicate health problems or disease.
  + **Blood Pressure**: This determines heart and blood pressure. Abnormal blood pressure can indicate possible health problems.
  + **Vision Exam**: This shows if a child can see normally. If a child cannot see well he or she will have difficulty learning.
  + **Hearing/Audiology Exam**: This measures how well a child can hear certain sounds. Hearing problems can lead to speech, language and other learning difficulties.
  + **PPD Test**: This identifies people who have been exposed to Tuberculosis and helps prevent the spread of Tuberculosis to others. All children must have a PPD test before beginning school.
* **Dental Exam**: This is a check-up by the dentist to look for decay in the teeth and disease in the mouth. Severe tooth decay and gum disease can cause poor appetite and nutritional or speech problems. We recommend a dental check up every 6 months for your child beginning at 6-months of age.
* **Lead Screen Test\***: This screen detects the risk for lead poisoning by measuring the amount of lead in the blood stream. Lead exposure can cause impaired learning ability.

\*The Lead Screen Test is recommended, but not required for attendance. If you would like your child screened, please see Head Start staff for the State of Alaska “Blood Lead Testing Consent Form.” Lead screens for children must take place at the local clinic.

**Chugachmiut Head Start Enrollment Application**

**Program applying for:  Nanwalek  Port Graham  Seldovia**

## Selection 1: Applicant Information

Child’s Name (Last, First Middle): Date of Birth: Male Female

Mailing Address:

Street or P.O. Box City State Zip Code

Physical Address (if different from mailing address):

Street

Email Address: Alt. Email Address: How would you like to receive information from the Anchorage Office? Mail Email Both (mail & email)

Primary Phone: Alternate Phone:

* + Home Work Cell Message Home Work Cell Message

## Race/Ethnicity:

* Alaska Native or American Indian Asian Black/African American Native Hawaiian/Pacific Islander
* White Biracial/Multi-racial Other Please explain:
* Hispanic or Latino **or** Non-Hispanic or Non-Latino
* Other Please specify: N/A

## Language:

What is the primary language of the family at home? English Other Please specify: Is there a second language spoken at home? Yes No If yes, please specify:

**Section 2: Family Information**

Indicate Family Type: Two Parent Family Single Parent Family Foster Family Teen Parent(s)

* + Other Family Type

Please list below everyone living in your household beginning with the head of household. Please include the child that you are applying for:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name (Last, First)** | **Date of Birth** | **Relationship to Child** | **Employed**  **(FT/PT)** | **In school**  **(FT/PT)** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6. |  |  |  |  |

\*Please attach additional page if necessary

Total number of adults: Total number of children:

## Child’s Name: Date of Birth: Site:

**Section 3: Assistance Information**

Is there any other assistance that your family is currently receiving? (check all that apply)

* TANF/ATAP SNAP/Food Stamps WIC Unemployment Insurance SSI-Disability/Survivors
* HUD Medicaid Denali Kid Care Other Please specify: N/A

Do you have any existing plans with other agencies? Yes No If yes, please explain: Was your family referred for services by a child welfare agency (OCS, CIT, ICWA, etc.)? Yes No

Are you currently homeless (lack of fixed, regular, and adequate nighttime residence)? Yes No

Are you experiencing any other crisis? Yes No If yes, please describe:

|  |  |
| --- | --- |
| **Section 4: Education/Employment Information** | |
| Primary Parent/Legal Guardian Name: | Secondary Parent/Legal Guardian Name: |
| Highest level of education obtained:   * High school graduate or GED * Less than high school graduate Grade: * Advanced degree or baccalaureate degree * Associate degree, vocation school or some college * Employed Unemployed Name of employer: * Full Time Part Time Seasonal Temp Part of the U.S. Military? Yes No | Highest level of education obtained:   * High school graduate or GED * Less than high school graduate Grade: * Advanced degree or baccalaureate degree * Associate degree, vocation school or some college * Employed Unemployed Name of employer: * Full Time Part Time Seasonal Temp Part of the U.S. Military? Yes No |

**Section 5: Family Income** (Verification of Income Must Be Included)

Type of Income Verified: Tax Form W-2 Check Stubs (Previous 12 months) TANF/ATAP SSI

* Unemployment Statements Other: No Income (Provide written statement)

Annual income amount for Primary Parent/Legal Guardian: $

Annual income amount for Secondary Parent/Legal Guardian: **+** $

**Total** annual income of family: **=** $

I certify that I have reviewed all information and documentation that the above calculations were completed accurately, and to the

best of my ability and that the information on this form represents the family’s current situation.

**Verifying Head Start Staff Printed Name/Signature**

**Date**

## Child’s Name: Date of Birth: Site:

**Section 6: Disabilities/Health Information Disabilities:**

Has your child been diagnosed or suspected of a disability or developmental delay? Yes No

If yes, please explain:

|  |  |  |
| --- | --- | --- |
| Does your child have either of the following: | Individualized Education Plan (IEP) | * Yes No |
|  | Individualized Family Service Plan (IFSP) | * Yes No |

If yes, with which program: KPBSD SPROUT Other: Please attach copies of the IEP **or** IFSP **and** signed Release of Information form

Does your child wear diapers, pull ups or need assistance using the bathroom? Yes No

If yes, please describe:

## Health History:

Primary Health Coverage: IHS DKC/Medicaid Private Other: None

Doctor/Medical Clinic Name: Phone:

Dentist/Dental Clinic Name: Phone: Were there any complications during pregnancy or newborn period? Yes No Birth weight: Has your child ever been hospitalized? Yes No If yes, please explain: Is your child being treated by a physician, PA, RN or PHN? Yes No

If yes, list provider: diagnosis details:

Does your child receive medical treatment for the following health conditions (check all that apply):

* Anemia  Asthma  Hearing Difficulties  Overweight/Underweight  Vision Problems  Diabetes
* High Lead Levels  Eczema/dry skin  Epilepsy  Hepatitis A  Hepatitis B  Impetigo  Meningitis
* Rheumatic Fever  RSV  Scarlet Fever  Seizures  Sickle Cell Anemia  Tuberculosis (TB)  N/A
* Other (please explain):

If you checked any of the above conditions, please describe:

Does your child frequently have any of the following health concerns (check all that apply):

* Constipation  Cough  Diarrhea  Sore Throat  Urinary Tract Infections  Vomiting  N/A
* Other: If yes, please describe:

Has your child ever had chicken pox? Yes No

Does your child use any assistive devices (glasses, hearing aids or other)? Yes No If yes, list devices:

## Nutrition/Dental Health:

How many times a day does your child like to eat? How much? Does your family eat “family style” (where everyone sits together)? Yes No

Does your family use food from hunting, gathering, gardening or fishing? Yes No

## Child’s Name: Date of Birth: Site:

Does your child eat or chew things that are not food? Yes No If yes, provide details: Does your child have cavities or other dental problems? Yes No

Has your child ever received fluoride treatment? Yes No If yes, date of treatment: Is tobacco used in the home? Yes No If yes, type of tobacco used:

## Allergies:

Does your child have any allergies (food, seasonal or other)? Yes No If yes, please specify: Is there any food your child should not eat for the following reasons: Medical Religious Personal

* Other: If applicable, please describe: N/A

Is your child under a medically prescribed diet? Yes No If yes, provide diet:

\*If your child requires a food substitution, a completed *“Medical Statement for Food Substitutions”* form must be signed by a recognized Medical Authority and should include recommended alternate foods before we can make any accommodations.

## Medications:

Does your child take any medications? Yes No If yes, list medications: Does your child take vitamin or mineral supplements? Yes No Containing iron or fluoride? Yes No If yes, list supplements: Do you have any other health or developmental concerns about your child? Yes No

If yes, please explain:

**Section 7: Parent Authorizations (Please INITIAL each space)**

The following is a list of Head Start services that require parental consent. These services are completed by qualified specialists and/or trained Head Start staff. Unless revoked in writing, authorization is valid for up to 3 years while enrolled in the Head Start program. Please initial all applicable areas:

## For Basic First Aid:

I authorize Head Start staff to administer basic first aid to my child during program hours.

## For Health Screenings:

I authorize Head Start or other qualified specialist to conduct hearing, vision, height and weight screens.

## For Developmental Screenings:

I authorize Head Start staff to conduct developmental screenings on my child to assess their development.

## For Classroom Observations:

I authorize my child to participate in behavioral observations in a group setting. If an individual child observation is indicated, parental authorization will be requested.

## For Pictures:

I authorize that pictures of my child taken during Head Start activities may be used in newspapers, books, displays, brochures or posters for educational and/or publicity purposes.

## For Video Recording:

I authorize Head Start staff to video my child for classroom purposes, child observations and staff trainings.

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## Child’s Name: Date of Birth: Site:

**For Field Trips:**

I authorize my child to attend all Head Start field trips outside the Head Start facility.

## For Exchange of Information:

I agree to allow Head Start to share my information within Chugachmiut .

## For Release of Contact Information:

I authorize for my phone number and email address to be released to the local Parent Committee for Head Start activities.

## For Records:

I agree to provide Head Start a copy of my child’s immunization record, TB screening with results, Medical Statement for allergies (if applicable), well-child check/physical exam, including blood pressure & hemoglobin results, lead screen and dental exam prior to enrollment.

## For Lead Screen:

Lead is a natural metal found in the environment. Exposure can occur through ingestion, breathing in lead dust and water from lead based pipes. Lead can affect speech and language, cause poor muscle and bone development and learning problems. Blood lead screens are provided FREE to Medicaid eligible children by the State of Alaska Department of Public Health.

* Decline Screen Accept Screen (State of Alaska Childhood Lead Risk Questionnaire)

\*\*If you would like to have your child screened for blood lead levels, please see Head Start staff for the State of Alaska “Blood Lead Testing Consent Form.” Lead screens for children must be completed at the local clinic by a healthcare provider.

**The Chugachmiut communities water isn’t fluoridated. Would you like information on fluoride supplements? Yes  No**

I cert if y t h at t he ab ove in f or mat ion is t ru e t o t he b est of my kn owled ge. If an y p art is f alse, you r ch ild may not qualify for services and will lose their slot.

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/Legal Guardian Signature Date

Head Start Staff Signature Date

*Chugachmiut Head Start 3-5 program does not discriminate (AS 18.80.230). Preference is given to Alaska Native and American Indian children living in the service area.*

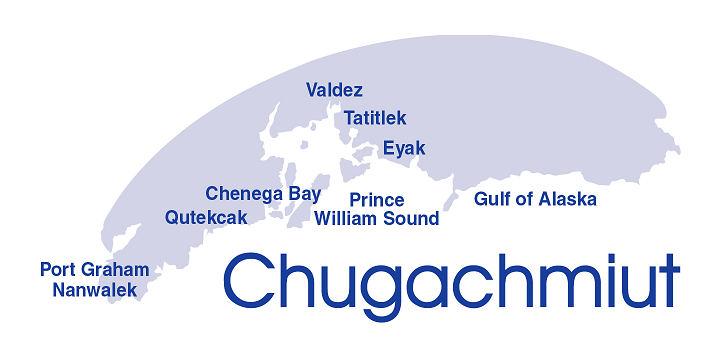
*The program is funded through the Alaska Native/American Indian Program Branch for Alaska Native and American Indian children living in the service area.*

*USDA and the State of Alaska are equal opportunity providers and employers.*

**For Office Use Only**

* Application complete Birth Certificate Income documentation Release of Information
* Proof of Legal, Foster or Relative Guardianship (if not the child’s biological parent) IEP or IFSP (if applicable)
* Physical Exam Immunizations (including TB results) Dental Exam

CACFP Enrollment form Medical Statement for Food Substitutions (if applicable)



Chugachmiut Head Start Program

**EMERGENCY RECORD CARD**

**CHILD’S INFORMATION**

|  |  |
| --- | --- |
| **Last Name:** | Date of Birth: |
| **First Name:** | First Day in Care: |
| Siblings enrolled Yes No | Any Custody Arrangements? Yes No NA |

**NAMES OF PARENT(S) OR LEGAL GUARDIAN(S) CONTACT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Relationship:** | **Name:** | **Relationship:** |
| Place of Employment/Other: | | Place of Employment/Other: | |
| Phone: | | Phone: | |
| Physical Home Address: | | Physical Home Address: | |
| Cell Phone: | Home Phone: | Cell Phone: | Home Phone: |
| E-mail Address: | | E-mail Address: | |

**PERSONS AUTHORIZED TO PICK-UP CHILD – Emergency / Routine**

|  |  |  |  |
| --- | --- | --- | --- |
| List the names and phone numbers of persons who can pick up your child. You must include at least one name and phone number of an individual who can assume responsibility of your child if you cannot be reached immediately in an emergency. Clarify whether these individuals can pick up the child in emergency situations only or at other times. Individuals cannot be under the age of 16. | | | |
| Name: | Daytime Phone: | Cell: | * Emergency Routine |
| Name: | Daytime Phone: | Cell: | * Emergency Routine |
| Name: | Daytime Phone: | Cell: | * Emergency Routine |
| Name: | Daytime Phone: | Cell: | * Emergency Routine |

# MEDICAL INFORMATION and RELEASE FOR MEDICAL CARE

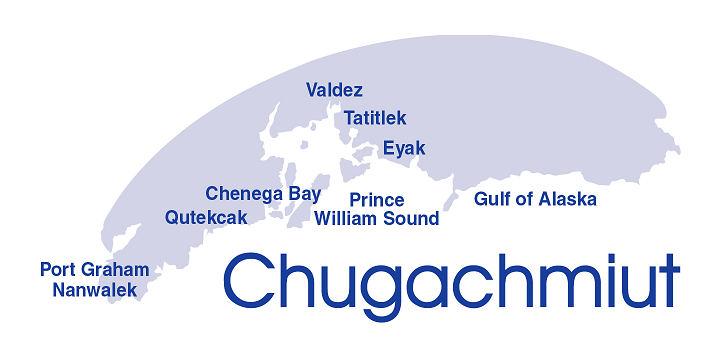
|  |  |  |  |
| --- | --- | --- | --- |
|  | **Child’s Name:** | **Child Care Facility:**   * Nanwalek Port Graham Seldovia |  |

|  |  |
| --- | --- |
| * **My child has NO ongoing health concerns**, including allergies or ongoing medications | |
| **-OR-** | |
| * **My child has the following chronic health concerns:** allergies (list all): * Asthma Diabetes Seizures or epilepsy Other (list): * My child takes the following ongoing medications: * I **give my consent** for my child to receive the above medications, if needed, by Head Start Staff or other Emergency Personnel. | |
| **PREFERRED MEDICAL FACILITY INFORMATION** | |
| Physician’s Name: | Physician’s Phone (recommended): |
| Medical Clinic: Nanwalek Clinic Port Graham Clinic Seldovia Clinic Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

I, the parent or legal guardian of , am verifying that this medical information is correct and complete. I hereby give the above named facility permission to seek emergency medical treatment, including necessary emergency paramedic transport for my child. I understand that every effort will be made to locate me or my child’s other parent or legal guardian as soon as possible. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care and any related medical transportation costs.

Signature of Parent or Legal Guardian Date Signed

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Information on this Emergency Record Card must be Reviewed and Updated Semi-annually*** | | | | | | | | | |
| **Date & Initial** | | **Date & Initial** | | **Date & Initial** | | **Date & Initial** | | **Date & Initial** | |
|  |  |  |  |  |  |  |  |  |  |



**Authorization to Release & Exchange Confidential Information**

Child’s Name (Last, First Middle): Date of Birth:

Address:

Street or P.O. Box City State Zip Code

Telephone: Parent/Legal Guardian:

I (we) the undersigned do hereby authorize the following person(s)/organization(s) to release and/or exchange the type of information requested below:

* Nanwalek Clinic  Port Graham Clinic  Seldovia Clinic  Alaska Native Medical Center

 State of Alaska Public Health **and/or** WIC Kenai Peninsula Borough School District Sprout

|  |  |  |  |
| --- | --- | --- | --- |
|  | Information to be released FROM: (If not listed above) Person(s): Organization:  Address: City, State, Zip: Phone No: | Information to be release TO:  Person(s): Organization: Chugachmiut Head Start Program Address: 1840 Bragaw Street Suite 110  City, State, Zip: Anchorage, AK 99508  Phone No: (907) 562-4155 Fax No: (907) 563-2891 |  |

Type of Information to be exchanged: **(Please INITIAL each space)**

Date of Service Date of Service

|  |  |
| --- | --- |
| Well Child/Physical Exam:  Immunization Record  Dental Exam/Treatment:  Hearing/Vision Treatment: | Behavioral Health Screen:  Educational Assessment(s):  Other: Kindergarten Transition Portfolio  Other: |

I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party. I also understand that it is my right to request a copy of all information and question any information that I feel is incorrect.

If this authorization is to be used for a referral to Special Education or Infant Learning, I have received

(Initials) a copy of the Alaska Parent Guide.

This permission is valid for Current School Year **or** until (date or event). I may revoke or withdraw my permission in writing at any time; however this will not affect information already disclosed.

Parent/Legal Guardian Signature Date

*If for any reason you wish to discontinue the exchange of information between the parties listed above:*

Date Release Withdrawn Parent/Legal Guardian Signature

CH 04182017