Chugachmiut Head Start &Early 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. **(Data will be entered into National Database with no names attached.)**

- **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, 2014 1040 Tax Return, 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 lacks fixed, regular and adequate residence.)

- **Release of Information**

Priority is given to those that meet the 2019 Poverty Guidelines for Alaska.

2019 Poverty Guidelines for Alaska

Persons in family/household	guideline
1	$15,600
2	21,130
3	26,660
4	32,190
5	37,720
6	43,250
7	48,780
8	54,310

For families/households with more than 8 persons, add $5,530 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

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

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CW 1.16.19

Parent Checklist

Child's Name:_____ **Date of Birth:**_____ **Site:** _____

Submit Required Documents with Complete Application:

☐ Verification of income (required with application)

☐ Child's birth certificate(required with application)

☐ Any Legal Guardianship Documents (if applicable)

☐ 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.
(As immunizations are updated, give a copy to Teacher.)

☐ **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. **(12 mos. and older.)**
- ☐ **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. **(3 years and older.)**
- ☐ **Vision Screen**: This shows if a child can see normally. If a child cannot see well he or she will have difficulty learning. **(Copy of screen or obtain within 45 days.)**
- ☐ **Hearing Screen/Audiology Exam**: This measures how well a child can hear certain sounds. Hearing problems can lead to speech, language and other learning difficulties. **(Copy of screen or obtain within 45 days.)**
- ☐ **TB Screen**: 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.

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Chugachmiut Head Start Enrollment Application

Program applying for: ☐ Nanwalek ☐ Port Graham

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 program information? ☐ Mail ☐ Email ☐ Text/FB Message ***(msg. & data rates apply)***

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)
☐ Grandparent (s) ☐ Other Relative ☐ Other: _____

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: _____

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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

Is your child in OCS or State custody? ☐ Yes ☐ No If yes please provide a copy.

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

Single Parent/Legal Guardian Name:	Two Parent Family/Legal Guardian Name:
Highest level of education obtained: ☐ High school graduate or GED ☐ Less than high school graduate Grade: _____ ☐ Enrolled in Job Training or School ☐ Advanced degree or baccalaureate degree ☐ Associate degree, vocation school or some college ☐ Employed ☐ Unemployed Name of Employer, Training or School: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temp Active Military? ☐ Yes ☐ No Veteran? ☐ Yes ☐ No	Highest level of education obtained: ☐ High school graduate or GED ☐ Less than high school graduate Grade: _____ ☐ Enrolled in Job Training or School ☐ Advanced degree or baccalaureate degree ☐ Associate degree, vocation school or some college ☐ Employed ☐ Unemployed Name of Employer, Training or School: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Temp Active Military? ☐ Yes ☐ No Veteran? ☐ 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: + $_____

Alaska Permanent Fund Dividend or other Income Source: +$_____

Total annual income of family: = $_____

I have received all Parent Financial Information.

_____ _____

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

Our Medical Service Provider (Medical Home): ☐ Port Graham Clinic ☐ Nanwalek Clinic ☐ Other: _____

Our Dental Service Provider (Dental Home): ☐ Port Graham Clinic ☐ Nanwalek Clinic ☐ Other: _____

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

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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.

_____**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 & Video Recordings:**
I authorize that pictures and/or video recordings of my child taken during Head Start activities are used for the purposes of Educational Observations (school readiness observations) and/or may be used in print media-online media and social media and marketing material or other Chugachmiut publications.

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 Screens:**
I agree to permit Head Start to obtain a copy of the lead screen results from the clinic or provider.

The Chugachmiut community water isn't fluoridated. Would you like information on fluoride supplements? ☐Yes ☐ No

I certify that the above information is true to the best of my knowledge. If any part is false, your child 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 0-5 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 & Lead Screen results) ☐ Dental Exam
☐ CACFP Enrollment form ☐ Medical Statement for Food Substitutions (if applicable)

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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

☐ **My child has <u>NO</u> 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 **<u>give my consent</u>** 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 ☐	☐ 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**	

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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 ☐ 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)**

Well Child/Physical Exam: _____
Immunization Record: _____
Dental Exam/Treatment: _____
Hearing/Vision Treatment: _____

ASQ Scores: _____
Lead and/or TB Screen Result:_____
Behavioral Health Screen: _____
Educational Assessment(s): _____
Kindergarten Transition Portfolio:_____

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 is effective for the whole time my child is enrolled in Head Start.

_____ _____
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

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