# Early Childhood Application



## CHILD INFORMATION: Fill out information about your child

| Last: | First/Middle: | |
|---|---|---|
| Birth Date: | Male ☐ Female ☐ | U.S. Citizen Yes ☐ No ☐ |

## CHILD DEMOGRAPHICS: Fill out information about your child

**Race** *(check all that apply):* ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Hawaiian/Pacific Islander ☐ White ☐ Other: _____

**Ethnicity:**

**Nationality:**

**Primary Language**

English Yes ☐ No ☐ Speak English at home Yes ☐ No ☐

Spanish Yes ☐ No ☐ Speak Spanish at home Yes ☐ No ☐

Other-Explain:

## FAMILY INFORMATION: Fill out information about parents/guardians and family

**PARENT/GUARDIAN** Name:

Race: Birth Date: Primary Language: 2nd Language:

Living Address: Apt. #_____ Level 1___2___3___ Rent_____Own_____ Shelter_____

City State Zip

E-mail Address:

| Phone Number | Primary Phone? | Phone Type (Work, Home, Cell) | Notes (when not to call, etc.) |
|---|---|---|---|
| | Yes ☐ No ☐ | | |
| | Yes ☐ No ☐ | | |

Teen Parent (19 or younger): Yes ☐ No ☐ Custody: Yes ☐ No ☐ Lives with Child: Yes ☐ No ☐

| Child's Relationship to Adult: | Marital Status | Education: | Employment Status: |
|---|---|---|---|
| Natural/Adopted/Step-Child ☐<br>Grandchild ☐<br>Niece/Nephew ☐<br>Foster Child ☐<br>Other ☐ | Single ☐<br>Married ☐<br>Separated ☐<br>Divorced ☐<br>Widow ☐ | Some College ☐ <Grade 9 ☐<br>Certificate ☐ Grade 10 ☐<br>High School Grad ☐ Grade 11 ☐<br>GED ☐ Grade 12 ☐<br>Master's Degree ☐ Associate's ☐<br>BA ☐<br>**currently in school** Yes_____No_____<br>**currently in training** Yes_____No_____ | Full Time (35+hours) ☐ Full Time & Training ☐<br>Part Time ☐ Part Time & Training ☐<br>Retired/Disabled ☐ Seasonally Employed ☐<br>Unemployed ☐ |

**PARENT/GUARDIAN** Name:

Race: Birth Date: Primary Language: 2nd Language:

Is either parent in the military? Yes ☐ No ☐ which one? Lives with Child: Yes ☐ No ☐

Living Address: Apt. #_____ Level 1___2___3___ Rent_____Own_____ Shelter_____

E-mail Address:

| Phone Number | Primary Phone? | Phone Type (Work, Home, Cell) | Notes (when not to call, etc.) |
|---|---|---|---|
| | Yes ☐ No ☐ | | |
| | Yes ☐ No ☐ | | |

| Child's Relationship to Adult: | Marital Status | Education: | Employment Status: |
|---|---|---|---|
| Natural/Adopted/Step-Child ☐<br>Grandchild ☐<br>Niece/Nephew ☐<br>Foster Child ☐<br>Other ☐ | Single ☐<br>Married ☐<br>Separated ☐<br>Divorced ☐<br>Widow ☐ | Some College ☐ <Grade 9 ☐<br>Certificate ☐ Grade 10 ☐<br>High School Grad ☐ Grade 11 ☐<br>GED ☐ Grade 12 ☐<br>Master's Degree ☐ Associate's ☐<br>BA ☐<br>**currently in school** Yes_____No_____<br>**currently in training** Yes_____No_____ | Full Time (35+hours) ☐ Full Time & Training ☐<br>Part Time ☐ Part Time & Training ☐<br>Retired/Disabled ☐ Seasonally Employed ☐<br>Unemployed ☐ |

# Early Childhood Application



**HOUSEHOLD MEMBERS who live with the family and supported by your income:**

| | | |
|---|---|---|
| Name: | Relationship to Child: | Date of Birth: |
| Name: | Relationship to Child: | Date of Birth: |
| Name: | Relationship to Child: | Date of Birth: |
| Name: | Relationship to Child: | Date of Birth: |
| Name: | Relationship to Child: | Date of Birth: |

**OTHER MEMBERS who live with the family and not supported by your income**

| | | |
|---|---|---|
| Name: | Relationship to Child: | Date of Birth: |
| Name: | Relationship to Child: | Date of Birth: |
| Name: | Relationship to Child: | Date of Birth: |
| Name: | Relationship to Child: | Date of Birth: |

**Total # of people (including the child and adults listed on front, and all listed above) who live in child's household : _____**

**CHILD'S NEEDS ****

Does your child have a disability (diagnosed by a doctor or specialist)? ___Yes ___No Does s/he have an IEP or IFSP? ___Yes ___No

If yes, please list the specific disability:

**SERVICES: What services are your family receiving?**

**DO YOU HAVE? WIC____ YES_____NO Previously_____ FOOD STAMPS_____YES_____NO CARE 4 KIDS _____YES_____NO TANF _____Yes____N0**

**HUSKY FOR CHILD____YES_____NO HUSKY FOR MOM____YES____NO DAD ___YES____NO PRIVATE INS. MOM___YES ____NO DAD___YES___NO**

Is your family currently dealing with legal issues such as family court, divorce, probation, custody, restraining orders, etc.? ___ Yes ___ No

If yes, please clarify: _____

**Additional Information**

Has your child previously been enrolled in Head Start or another preschool program?
Yes ☐ No ☐
If yes, what program? _____

Has your child had a sibling previously enrolled in this Head Start program?
Yes ☐ No ☐
If yes, is he or she currently enrolled? ___ Yes ___ No
Specify dates of attendance? _____to_____

How did you hear about our program?

____Word of mouth (friend, family)
____Saw/received a flyer
____Saw/passed the center
____Know someone who works here
____Referred by agency (WIC, child support services, child care subsidy, etc.)
*Please specify:* _____
____Other
*Please specify:* _____

***PLEASE SIGN HERE to verify that you have completed this application and provided true information.***

Signature of Parent/Guardian:

Print Name: Date:

**OFFICE USE ONLY:**

**COMMENTS:**

# Head Start Attendance and Home Visits Policy Agreement
# Early Childhood Registration Office

Date: _____

Head Start is required to make sure that children attend school at all times. The minimum allowable attendance is eighty-five percent (85%). Therefore, it is very important that all children attend school on a regular basis. Children who do not attend on a regular basis will not achieve school readiness skills. When your child is absent you are responsible for notifying: The teacher(s), family service/social worker, or if attending the Dr. Mayo School, you may also contact the main office. Children with irregular or extended absences due to illness will need a doctor's excuse upon return to school. Parents of children with multiple unexcused absences will be counseled and required to sign an attendance agreement which states that the child will be terminated from the Head Start program if attendance does not improve.

*Due to our Federal Head Start Performance Standards we are required to make contact with families within one (1) hour of the program's arrival time. Please expect to be contacted by your family service/social worker every day that your child is absent (IF we have not heard from you).*

Attendance habits are developed at a very early age. If your child arrives later than the expected arrival time more than three (3) times, counseling will be provided. Children who attend Head Start on a regular basis and arrive on time will be more inclined to attend school on a regular basis therefore becoming more productive. If needed your family service/social worker or project site director will assist you with this process.

Home Visits Requirement: Home visits are mandated by the Head Start Program to engage the parents in their child's learning and development. Teachers and Family Service/Social Workers conduct 2 visits each per program year, including a mandated visit prior to the child entering the program. Home visits can be conducted at the Family Home, Program Site or a private location convenient to the family. Staff will be making arrangements with you to conduct these visits.

I _____have read the above attendance and home visits policy agreement. I will make every effort for my child to be in school on a regular basis. If not my child is subject to returning to the waiting list and letting another child benefit from the free program.

_____ _____

Parent(s)/Guardian(s) Signature Enrolling Student Name

_____

Intake/Family Service/Social Worker Signature

***Reg./FSW/Admin/ 04/02/19***

***White-Registration Office*** ***Yellow-Social Services*** ***Pink-Parent***

New Haven Public Schools
Early Childhood Registration Office

# Child Support Statement

**Date: _____**

**Child Name: _____**

**Parent/Guardian Name: _____**

**Parent responsible for paying child support Name: _____**

**Are you receiving Child Support at this time? ____Yes / No____**

***Please explain in Your Own Words* your Child Support Status:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
**Parent /Guardian Signature**

*ERPP 2/6/2019*

# Early Childhood Registration Office

## Declaración de manutención infantil

**Fecha: _____**

**Nombre de niño(a): _____**

**Nombre del padre/guardian: _____**

**Responsable de pagar manutención infantile nombre: _____**

**Estás recibiendo manutención infantil en este momento? __Si/No___**

**En sus propias palabras explique su estado de manutención infantil:**
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____
**Firma de padre/guardian**

# CONNECTICUT DENTAL HEALTH INFORMATION FORM
SCHOOL YEAR _____

*Part I: To be completed by parent/caregiver and returned to the child's school*

## CHILD INFORMATION

**Name: _____ DOB: ___/____/_____**
**School: _____ Classroom/Grade: _____**

I give consent for my child's dental health care provider and the school's health care provider to exchange information for confidential use in meeting my child's health and educational needs.

_____
Signature of Parent/Guardian Date

*Part 2: To be completed by dental provider*

## PREVENTATIVE CARE: Recommended every six months or bi-annually

**This child is up to date on a schedule of age and risk appropriate preventative dental care:** YES NO
**Most recent periodic exam by licensed dentist**: ____/_____/_____
**Next scheduled recall appointment:** ____/_____/_____

## DENTAL TREATMENT

**This child has received previous dental treatment (beyond preventative care):** YES NO
Please indicate previous treatment: sealants fillings/crowns extractions pulp therapy other: _____
**This child has further unmet dental care needs:** YES NO
Please indicate needs: sealants fillings/crowns extractions pulp therapy other: _____
Date of next treatment appointment: ____/_____/_____

## REFERRAL (if applicable)

**This child needs a referral for care:** YES NO Date of referral: ____/_____/_____
Referred to: _____ Appointment date (if known): ____/_____/_____
Address: _____ Phone: _____

## DENTAL PROVIDER INFORMATION

**Name of Licensed Dental Provider:** _____
Address: _____
Phone: _____
**This is the child's dental home:** YES NO

*A dental home is a source of oral healthcare that is comprehensive and continuously accesible that includes treatment, referral and coordination with dental specialists when appropriate.*

## ADDITIONAL COMMENTS

_____
Print Provider Name Signature Date

Provider's Stamp

*If this child is not up to date on preventive care, he/she must be seen by a dental provider for care. If this child has outstanding dental needs and no scheduled treatment appointment, please make arrangements with a dental provider immediately.*

CONNECTICUT DENTAL HEALTH INFORMATION FORM
SCHOOL YEAR _____

# State of Connecticut Department of Education

# Early Childhood Health Assessment Record

(For children ages birth – 5)

**To Parent or Guardian:** In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

*Please print*

| Child's Name (Last, First, Middle) | Birth Date (mm/dd/yyyy) | ☑ Male ☐ Female |
|---|---|---|
| Address (Street, Town and ZIP code) | | |
| Parent/Guardian Name (Last, First, Middle) | Home Phone / Cell Phone | |
| Early Childhood Program (Name and Phone Number) | Race/Ethnicity<br>☐ American Indian/Alaskan Native ☐ Hispanic/Latino<br>☐ Black, not of Hispanic origin ☐ Asian/Pacific Islander<br>☐ White, not of Hispanic origin ☐ Other | |
| Primary Health Care Provider:<br>Name of Dentist: | | |
| Health Insurance Company/Number* or Medicaid/Number* | | |

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

## Part I — To be completed by parent/guardian.

## Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Any health concerns | Y N | Frequent ear infections | Y N | Asthma treatment | Y N |
| Allergies to food, bee stings, insects | Y N | Any speech issues | Y N | Seizure | Y N |
| Allergies to medication | Y N | Any problems with teeth | Y N | Diabetes | Y N |
| Any other allergies | Y N | Has your child had a dental examination in the last 6 months | Y N | Any heart problems | Y N |
| Any daily/ongoing medications | Y N | | | Emergency room visits | Y N |
| Any problems with vision | Y N | Very high or low activity level | Y N | Any major illness or injury | Y N |
| Uses contacts or glasses | Y N | Weight concerns | Y N | Any operations/surgeries | Y N |
| Any hearing concerns | Y N | Problems breathing or coughing | Y N | Lead concerns/poisoning | Y N |
| **Developmental — Any concern about your child's:** | | | | Sleeping concerns | Y N |
| 1. Physical development | Y N | 5. Ability to communicate needs | Y N | High blood pressure | Y N |
| 2. Movement from one place to another | Y N | 6. Interaction with others | Y N | Eating concerns | Y N |
| | | 7. Behavior | Y N | Toileting concerns | Y N |
| 3. Social development | Y N | 8. Ability to understand | Y N | Birth to 3 services | Y N |
| 4. Emotional development | Y N | 9. Ability to use their hands | Y N | Preschool Special Education | Y N |

**Explain all "yes" answers or provide any additional information:**

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

**New Haven Public Schools**
**Early Childhood/Head Start Program**

PowerSchool No. _____
Enrollment Date

# EMERGENCY /CONTACT & RELEASE CHILD FORM

Formulario de emergencia y contacto para dejar salir a su hijo(a)

**Child's Name** _____ **Date of Birth** _____
*Last (Apellido del niño)* *First (Nombre)* *Mo/Day/Yr (Mes/Día/Año)*

**Parent/Guardian** _____
*Name (Nombre y Apellido)* *Home Phone (Teléfono)/ Cell Phone (Teléfono celular)*

**Address** _____
*Street (Dirección)* *Zip Code (Código Postal)*

**Employer** _____
*Name (Empleador)* *Address (Dirección)* *Work Phone (Teléfono de trabajo)*

**Parent/Guardian** _____
*Name (Nombre y Apellido)* *Address (Dirección)* *Home Phone (Teléfono)/ Cell Phone (Teléfono celular)*

**Employer** _____
*Name (Empleador)* *Address (Dirección)* *Work Phone (Teléfono de trabajo)*

**IN CASE OF EMERGENCY AND WE CANNOT REACH EITHER PARENT/GUARDIAN LISTED ABOVE, WE WILL CONTACT AND/OR RELEASE YOUR CHILD TO THE FOLLOWING PERSONS LISTED ONLY-- En caso de emergencia y no podemos llegar a cualqueria de los padres arriba mencionado, nos podremos en contacto y/o liberar a su hijo a las siguientes personas en la lista solamente:**

1. _____
*Name (Nombre y Apellido) Speaks (Habla) ____English or ____Spanish Home Phone (Teléfono)/ Cell Phone (Teléfono celular) Relationship/Relación*

2. _____
*Name (Nombre y Apellido) Speaks (Habla) ____English or ____Spanish Home Phone (Teléfono)/ Cell Phone (Teléfono celular) Relationship/Relación*

3. _____
*Name (Nombre y Apellido) Speaks (Habla) ____English or ____Spanish Home Phone (Teléfono)/ Cell Phone (Teléfono celular) Relationship/Relación*

4. _____
*Name (Nombre y Apellido) Speaks (Habla) ____English or ____Spanish Home Phone (Teléfono)/ Cell Phone (Teléfono celular) Relationship/Relación*

**RESTRICTED FROM PICK-UP_____Documentation Provided (documentacion por orden judicial)_____**
**Honored only with court ordered documentation (Restriccion/Personas que no pueden recoger a su hijo(a))** ***Staff initials***

## Child's Medical Information/Niño Médica Información

**Medical Problems/Médica Problema:**_____
**Primary Health Care Provider/Medico de Cabecera:**_____
**Name of Dentist/ Nombre del Dentista:**_____
**Health Insurance Company/compania de seguro médico:**_____
**Preferred Hospital/Hospital preferido:**_____

**Allergies/Alergia:**_____
**Telephone Number/Teléfono:**_____
**Telephone Number/Teléfono:**_____
_____
**Health insurance number/ numero de identificacion de seguro medico**

**IN CASE OF AN EMERGENCY, I GIVE PERMISSION TO THE SCHOOL STAFF TO TAKE MY CHILD TO THE ABOVE HOSPITAL.**
**I UNDERSTAND THAT A STAFF MEMBER WILL ACCOMPANY MY CHILD AND THAT I WILL BE NOTIFIED IMMEDIATELY—En caso de una emergencia, yo doy permiso al personal de la escuela llevar a mi hijo al hospital superior. Entiendo que un miembro de personal acompañará mi hijo y que me sera notificado de inmediato.**

**SIGNATURE** _____ **DATE** _____
*Parent/Guardian* *Firma del padre, la madre o del tutor* *Fecha*

**SIGNATURE** _____ **DATE** _____
*Parent/Guardian* *Firma del padre, la madre o del tutor* *Fecha*

*White – Classroom* *Yellow – Social Services* *Pink – Nursing* *Revised 2/2019 ERPP*

NEW HAVEN PUBLIC SCHOOLS

# Early Childhood/Head Start Program

## Autorización conforme a HIPAA para Intercambio de Salud y Liberación de Información

Yo, _____(nombre del padre) le doy permiso al programa de primera infancia / Head Start de las escuelas públicas de New Haven para que libere /reciba información de cualquier proveedor / agencia / persona que brinde servicio para mí y/o mi hijo/a _____(nombre del estudiante). Fecha de nacimiento _____ para la siguiente información.

***DESCRIPCIÓN:*** **El estado y la divulgación de la información que se divulgará consiste en:**

- Los resultados más recientes de Well-Child Medical / EPSDT Exam
- Hemoglobina/Hematocrito, Nivel (es) de Plomo, Evaluación de Riesgo de TB
- Cartilla de vacunación
- Resultados de exámenes dentales más recientes y estado de tratamiento
- Estado de Medicaid / Husky
- Servicios de Ciudadanía, Pasaporte / Visa e Inmigración de los EE.UU.
- Información financier
- Prueba de residencia en New Haven
- WIC (Si es elegible)
- Otros (especificar) _____

***PROPÓSITO:*** La información se usará para el (los) siguiente(s) propósito (es):

1. Requisitos del programa de primera infancia Head Start
2. Evaluación de salud y planificación de servicios de atención médica y tratamiento en la escuela.
3. Evaluación médica y tratamiento.
4. Determinar la elegibilidad para los servicios, la asistencia, las necesidades educativas en el programa para la primera infancia y los objetivos familiares.
5. Otro (por favor especifique): _____

***AUTORIZACIÓN***

Esta autorización es válida durante la duración de mi hijo/a en el programa de niñez temprana de las escuelas públicas de New Haven. Entiendo que esta información se puede compartir através de un intérprete, teléfono, fax, escáner, correo electrónico o en persona para satisfacer las necesidades de la familia. Entiendo que puedo revocar esta autorización en cualquier momento mediante el envío de un aviso por escrito de la retirada de mi consentimiento. También entiendo que si rehuso firmar esto no interferirá con obtener servicios que Head Start ofrece para mi hijo (a).

_____ _____
Firma del Padre / Tutor Fecha

_____ _____
Firma del intérprete (si corresponde) Fecha

**COPIES:** White – Health Coordinator Yellow – Family Services Worker Pink – Registration Office

NEW HAVEN PUBLIC SCHOOLS

# Early Childhood/Head Start Program

## HIPAA-Compliant Authorization for Exchange of Health and Release of Information

I, _____ (name of parent) give permission to the New Haven Public Schools Early Childhood/Head Start Program to release/receive information from any provider/agency/person providing service to myself and /or my child _____ (student's name) Date of Birth _____ for the following information.

**DESCRIPTION: The health and release of information to be disclosed consists of:**

- Most Recent Well-Child Medical/EPSDT Exam Results
- Hemoglobin/Hematocrit, Lead Level(s), TB Risk Assessment
- Immunization Record
- Most Recent Dental Exam Results and Treatment Status
- Medicaid/Husky Status
- US Citizenship, Passport/Visa and Immigration Services
- Financial Information
- Proof of New Haven Residency
- WIC (If eligible)
- Other (Please Specify) _____

**PURPOSE: The information will be used for the following purpose(s):**

1. Head Start Requirements
2. Health assessment and planning for health care services and treatment in school.
3. Medical evaluation and treatment.
4. Determining eligibility for services, assistance, educational needs in the early childhood program and family goals.
5. Other (Please Specify): _____

**AUTHORIZATION**

This authorization is valid during my child's duration in the New Haven Public Schools Early Childhood /Head Start Program. I understand that this information may be shared through a translator, telephone, fax, scan, mail, email or in person to meet the needs of the family. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that if I refuse to sign, such refusal will not interfere with any services provided by the New Haven Public Schools Early Childhood/Head Start Program.

_____ _____

*Parent/Guardian Signature* *Date*

_____ _____

*Signature of Interpreter (if applicable)* *Date*

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8/2017

**NEW HAVEN PUBLIC SCHOOLS** **English/Spanish**

New Haven, Connecticut

## HOME LANGUAGE SURVEY

Welcome to New Haven Public Schools!
We have a few questions about languages spoken at home. We are required by the US Department of Education to ask for this information because it will help us know how we can best support your child. The language information also helps us know how we can best communicate with you. Please share with us the language(s) spoken by your family and in your home.

**Student Information:**

| **Student First Name** | **Student Last Name** | **Date of Birth** | **Grade** |
|---|---|---|---|

Address: _____ Phone: _____

1) What is the primary language used in the home, regardless of the language spoken by the student?
_____
2) What is the language most often spoken by the student? _____
3) What is the language the student first acquired? _____

_____
**Print** Parent/Guardian Name

_____ Date: _____
Parent's Signature

Thank you for answering the questions. We look forward to working with your child.

## CUESTIONARIO SOBRE EL IDIOMA DEL HOGAR

¡Bienvenidos a nuestra escuela! Tenemos algunas preguntas acerca de los idiomas que se hablan en el hogar. El Departamento de Educación de EE.UU. nos exige pedir esta información porque nos ayudará a saber la mejor forma de ayudar a su hijo. La información sobre los idiomas también nos ayuda a saber la mejor forma de comunicarnos con ustedes. Por favor compartan con nosotros el o los idiomas que habla su familia y en su hogar.

**Información del alumno:**

| **Nombre del alumno** | **Apellido del alumno** | **Fecha de nacimiento** | **Grado** |
|---|---|---|---|

Dirección: _____ Teléfono: _____

1) ¿Cuál es el principal idioma que se usa en el hogar, independientemente del idioma que habla el alumno?
_____
2) ¿Qué idioma habla con mayor frecuencia el alumno? _____
3) ¿Cuál fue el primer idioma que adquirió el alumno? _____

_____
Nombre del padre/madre/tutor **(escribe en letra de molde)**

_____ Fecha: _____
Firma del padre/madre/tutor

Gracias por contestar las preguntas. Estamos deseosos de trabajar con su hijo.

*Original – Student Packet * Yellow – Bilingual Examiner * Pink – Bilingual Office*