

\*\*\* Must be checked for application to be valid, if applying for Early Head Start you must circle Center or Home base (check all that apply)

**Head Start**     **Childcare**     **Early Head Start (Center or Home)**     **Pre-School**

**Section VII - Child to be enrolled**

Last Name:		First Name:		Middle IN:	Preferred Name:
Date of Birth:		Gender:		Social Security Number:	
Race (check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other		Language(s) spoken in home:		Tribal Affiliation: <input type="checkbox"/> PBP Enrolled Tribal Member <input type="checkbox"/> PBP Tribal Descendent <input type="checkbox"/> Member of Another Tribe <input type="checkbox"/> Native American Descendent	
		CDIB #:			

**Pregnancy History of Mother:**

While pregnant, did the child's mother have any of the following:

German Measles	Yes	No	Vaginal infection or Bleeding	Yes	No
Anemia	Yes	No	Have a high fever	Yes	No
Diabetes	Yes	No	Smoke cigarettes	Yes	No
Kidney Problems	Yes	No	Drink alcohol	Yes	No
High Blood Pressure	Yes	No	Use drugs	Yes	No

Were there any other complications or unusual circumstances during pregnancy? (describe)

What medications did the mother take during pregnancy? (include vitamins and iron)

Please list all Health Professionals working with the child:

- |   |   |
|---|---|
| <input type="checkbox"/> Health Department      | <input type="checkbox"/> Occup. Therapist   |
| <input type="checkbox"/> Family Practice        | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> IHS                    | <input type="checkbox"/> Pediatrician       |
| <input type="checkbox"/> Speech/Lang. Therapist | <input type="checkbox"/> Other (Specify):   |

**Child's Birth History:**

Was child born early?      How early?      Late?       On Time  
 Was child born C-Section?      Yes       No       If yes, please give reason:

How much did child weigh when he/she was born? \_\_\_\_\_ Length of child? \_\_\_\_\_

What was child's birth condition?

**Child's General Medical History:**

Has he/she ever had the following?

Ear or Hearing Problem	Yes	No	Eye or vision Problems	Yes	No
Allergies	Yes	No	Asthma	Yes	No
Convulsions	Yes	No	Meningitis	Yes	No
Exposure to lead	Yes	No	Anemia	Yes	No
Vomiting Spells	Yes	No	Frequent diarrhea	Yes	No
Frequent colds-coughs	Yes	No	Head Injury	Yes	No
Frequent ear infections	Yes	No	High fevers(over 104)	Yes	No
Dental problems	Yes	No	Sore throats	Yes	No
Chicken Pox	Yes	No	Measles	Yes	No
Mumps	Yes	No	Boils	Yes	No
Hives	Yes	No	Eczema	Yes	No
Constipation	Yes	No	Headaches	Yes	No
Bladder infections	Yes	No	Stomach aches	Yes	No

Other: (please explain)

Does the child take medication on a regular basis? Y N Please list medications and reason for taking:

**\*\*Please circle one number in each category in one or all programs that your child is applying for.**

Prairie Band Potawatomi <b>Head Start</b>			
Child Eligibility Priority Criteria			
<b>Tribal Affiliation</b>		<b>Residence Location</b>	
PBP Enrolled Tribal Member	50	Reservation	10
PBP Tribal Descendent	45	Off Reservation	5
Member of Another Tribe	40	<b>Income Status</b>	
Native American Descendent	10	Income Eligible	50
Non-Native American	5	Over Income	5
<b>Age of the Child</b>		<b>Continuity of Care</b>	
4-Year-Old	20	Past Head Start Family	10
3-Year-Old	10	Early Head Start Transition	40
<b>Special Circumstances</b>			
Special Needs (IEP)	50		
Special Circumstances	10		
<small>(Foster child, single parent, teenage parent, childcare, returning, etc.)</small>			
<b>**Office Use Only</b>		<b>Application No.</b> _____	<b>Total Points</b> _____

Prairie Band Potawatomi <b>Early Head Start</b>			
Child Eligibility Priority Criteria			
<b>Tribal Affiliation</b>		<b>Parental Status</b>	
PBP Enrolled Tribal Member	50	Teenage Expectant Parent	50
PBP Tribal Descendent	45	Teenage Parent	40
Member of Another Tribe	40	Single Parent	10
Native American Descendent	10	Attending School or Training	10
Non-Native American	5	Two Member Household	5
<b>Age of the Child</b>		<b>Residence Location</b>	
Prenatal to 1 Year	30	Reservation	10
1-2 Year Old	20	<b>Income Status</b>	
2-3 Year Old	10	Income Eligible	50
<b>Special Circumstances</b>		Over Income	5
Special Needs (IFSP)	50		
Special Circumstances	10		
<small>(homeless, childcare, returning, foster care, etc.)</small>			
<b>**Office Use Only</b>		<b>Application No.</b> _____	<b>Total Points</b> _____

Prairie Band Potawatomi <b>Child Care</b>			
Child Eligibility Priority Criteria			
<b>Tribal Affiliation</b>		<b>Parental Status</b>	
PBP Enrolled Tribal Member	50	Teenage Parent	10
PBP Tribal Descendent	45	Single Parent	10
Member of Another Tribe	40	Two Member Household	5
Non- Native American	5	<b>Residence Location</b>	
<b>Age of the Child</b>		Reservation	10
4-5 Year Old	20	Off Reservation	5
0-1 Year Old	20	<b>Special Circumstances</b>	
1-2 Year Old	20	Special Circumstances	20
2-3 Year Old	10	<small>(foster care, homeless, special needs, etc.)</small>	
<b>**Office Use Only</b>		<b>Application No.</b> _____	<b>Total Points</b> _____

**Parent's Consent/Cooperation**

**Field Trips**

I give my consent for my child \_\_\_\_\_ to participate in field trips supervised by authorized staff of the Prairie Band Potawatomi Early Childhood Education Center. All precautions to ensure the health and safety of my child will be taken.

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian's Initial: \_\_\_\_\_

**Publicity**

I give my consent for my child's picture and name to be used in promotional ways to acquaint the community with the PBP ECEC (newspaper, newsletter, video recordings, website, and or parent lists).

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian's Initial: \_\_\_\_\_

**Health & Dental**

I agree to cooperate with PBP ECEC Staff in taking my child for a complete health assessment and dental exam. I further agree to cooperate for follow-up care as appropriate.

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian's Initial: \_\_\_\_\_

**Authorization to Treat Minor Injuries or Accidents**

I hereby authorize faculty of PBP ECEC to administer medical treatment and/or first aid for any minor injury or accident while my child is in their care.

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian's Initial: \_\_\_\_\_

**Child Protection Services Acknowledgement**

In the event that PBP ECEC Staff has reason to suspect the occurrence of physical, sexual, or emotional abuse, neglect, or exploitation of a child, PBP ECEC will, as required by law, report the incident immediately by telephone or writing to the appropriate agency ( PBP Social Service Program or Social and Rehabilitation Services).

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian's Initial: \_\_\_\_\_

**Confidentiality**

Children's records shall be confidential. Staff shall not disclose or discuss personal information regarding my child with any person not authorized. Each child's records shall be made available to the child's parent/guardian on request during normal working hours.

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian's Initial: \_\_\_\_\_

**Child Development**

I hereby give my permission for the PBP ECEC Staff to evaluate my child's development. The information will be used to provide my child with individual assistance when necessary.

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian's Initial: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Permission to Release Confidential Information**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize the release and/or exchange of information between the Prairie Band Potawatomi Early Childhood Education Center and the individual/agencies listed below. Parent/Guardian must **initial** appropriate item. Information requested from/to:

Individual/Agency	Examples of Information
<input type="checkbox"/> Royal Valley USD #337	*education, screening results, Transportation, and/or health information, kindergarten transition information
<input type="checkbox"/> Holton Special Ed Coop.	
<input type="checkbox"/> Infant/Toddler Prgm/Part C	
<input type="checkbox"/> Parents as Teachers Prgm	
<input type="checkbox"/> Even Start	
<input type="checkbox"/> FACE-Family and Child Education	*verification of DOB, TANF, food stamps, medical care, and other related information
<input type="checkbox"/> EHS Early Head Start	
<input type="checkbox"/> SRS-Social & Rehabilitation Services	
<input type="checkbox"/> Haskell Dental	*dental exam, treatment plan, and follow-ups
<input type="checkbox"/> Indian Public Health Services	*medical, health assessment, immunizations, and other related information
<input type="checkbox"/> WIC	
<input type="checkbox"/> Native American Family Services	
<input type="checkbox"/> PBP Family Health Center	
<input type="checkbox"/> Jackson County Health Dept.	*health and developmental screening results and/or Healthy Start visits
<input type="checkbox"/> Other	

Comments: \_\_\_\_\_

I understand the information obtained will not be transmitted to another party without specific written consent, or as otherwise permitted by federal regulation (42 D.F.R. Part 2). I understand I have the right to revoke this permission at any time.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_