

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		<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 <input type="checkbox"/> Non-Native	
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:			
		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:

Health Department Occup. Therapist
 Family Practice Physical Therapist
 IHS Pediatrician
 Speech/Lang. Therapist 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 number in each category in one or all programs that your child is applying for. unless otherwise noted****

Prairie Band Potawatomi Head Start					
Child Eligibility Priority Criteria					
Tribal Affiliation			Eligibility Continued		
PBP Enrolled Tribal Member	50	} _____	Public Assistance	50	} _____
PBP Tribal Descendent	30		Individual Ed. Plan (IEP)	50	
Member of Another Tribe	20		Residence Location		
Native American Descendent	10		PBPN Reservation	20	} _____
Non-Native American	5		Off Reservation	5	
Age of the Child			Family Status		
4-Year-Old	20	} _____	Single Parent	50	_____
3-Year-Old	10		Current teen parent/prenatal	30	_____
Eligibility (select all that apply-documentation must be provided)			Early Head Start Transition	10	_____
Income Eligible	50	} _____	Past EHS/HS Family	10	_____
Homeless	50		Prenatal Parent	10	_____
Foster Care	50		Two Parent Household	5	_____
Children must turn 3 before September 1st					

**Office Use Only	Application No.	Total Points
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Prairie Band Potawatomi Early Head Start					
Child Eligibility Priority Criteria					
Tribal Affiliation			Eligibility Continued		
PBP Enrolled Tribal Member	50	} _____	Public Assistance	50	} _____
PBP Tribal Descendent	30		Individual Family Service Plan	50	
Member of Another Tribe	20		Single Parent	50	
Native American Descendent	10		Residence Location		
Non-Native American	5		Reservation	15	} _____
Age of the Child			Off Reservation	5	
Prenatal to 1 Year	30	} _____			
1-2 Year Old	20				
2-3 Year Old	10				
Eligibility (select all that apply-documentation must be provided)					
Income Eligible	50	} _____			
Homeless	50				
Foster Care	50				

**Office Use Only	Application No.	Total Points
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Prairie Band Potawatomi Child Care					
Child Eligibility Priority Criteria					
Tribal Affiliation			Residence Location		
Enrolled Tribal Member	50	} _____	Reservation	15	} _____
Descendent of a Tribe	30		Off Reservation	5	
Non- Native American	10		Income Status		
Parental Status			Income Eligible	15	} _____
Teenage Parent	10				
Single Parent	10	} _____	Over Income	5	
Two Member Household	5		Special Circumstances (select all that apply)		
			Special Needs (IFSP/IEP)	30	} _____
			Homeless or Foster Child	30	

**Office Use Only	Application No.	Total Points
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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, tribal website, PBP ECEC Facebook, 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 Kansas Department of Children and Families).

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

Appendix 3

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
____ Royal Valley USD #337	*education, screening results, Transportation, and/or health information, kindergarten transition information
____ Holton Special Ed Coop.	
____ Infant/Toddler Prgm/Part C	
____ Parents as Teachers Program	
____ Even Start	
____ FACE-Family and Child Education	*verification of DOB, TANF, food stamps, medical care, and other related information
____ EHS Early Head Start	
____ Department of Child and Family Services	*dental exam, treatment plan, and follow-ups
____ Haskell Dental	
____ Indian Public Health Services	*medical, health assessment, immunizations, and other related information
____ WIC	
____ Child and Family Services	
____ PBP Family Health Center	
____ Jackson County Health Dept.	
____ Other	*health and developmental screening results and/or Kan Be Healthy visits

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: _____