



The Center
 Early Childhood Programs
 Lake County School District R-1

315 West 6th Street
 Leadville, CO 80461

Phone 719 486-6928
 Fax 719 486-9992

Head Start, Colorado Preschool Program, Tuition-Based Preschool and School Age Programs, Services for Children with Special Needs

Dear Parent,

Thank you for your interest in The Center Early Childhood Programs. Our program offers a school readiness preschool program and extended day high quality child care.

The following items must be included with your application in order for it to be processed.

- Child's Birth Certificate
- Child's Immunization Record - Must be up-to-date on immunizations
- Health Insurance Card - Private Insurance, Medicaid, or CHP+
 - If no health insurance - Please pick up an application from Mary in Room 9
- CACFP Child and Adult Food Care Program) Eligibility form
- If you wish to be considered for a Head Start preschool spot, you must include one of the following as evidence of eligibility:
 - * 1040 Tax Form from 2016 or W-2 forms from 2016 or
 - * Check stubs representing one year of income
 - * Statement from Employer for one year of income or
 - * Documentation of a TANF or SSI award or
 - * Documentation of foster care status.

If you not have one of these forms of evidence of income on file, your child will not be considered for Head Start enrollment, only for the other preschool programs. Please do not leave originals of these items - we will be happy to make copies if needed.

Once you have completed and signed this application, please bring it and the required supporting documents to The Center. We will evaluate your requests and let you know which programs you qualify for, which programs have openings, and work to create a schedule that will fit your family's needs. ***Please note:*** *This application is printed on the front and back of the page.*

Completion of this application does not guarantee your child a place in the program.

If you have any questions at all, or if you would like assistance completing this application, please call Lisa at 719-486-6928 or Jenny at at 719-486-6925 for Spanish.

Date and Time Received by Office:	Person receiving application:	Developmental Screening appointment

Child's Name _____ **Date of Application** _____

Our preschool program emphasizes school readiness, and includes family-style breakfast and lunch, group activities, formal lessons, child-directed activities, outdoor time, and lots of fun.

Some families may qualify for the preschool program free of charge or on a low-cost basis, based on the information you provide in this application packet.

In addition, we are open for child care before preschool at 7:00am and after preschool until 5:30pm. During those extra hours, we provide high-quality child care on a tuition basis.

Please provide the most accurate scheduling information possible to help us provide you with appropriate services.

1) Which daily schedule are you interested in (if available)?

Circle One - Preschool Only Extended Day Half Day

If you need an extended day, please list the days and times you would like your child to attend The Center.

2) How many days per week are you interested in having your child attend?

Circle One - 2 days 3 days 4 days 5 days

THANK YOU. We will evaluate your requests and your completed application. We will then let you know which programs you are eligible for that will also meet your needs.

Program Descriptions

All children receive the same quality preschool experience in all programs at The Center.

Based on your needs, we will evaluate your child for some or all of the programs below:

Head Start - This federally funded program provides a regular daily preschool schedule at no cost, according to the program's calendar. Head Start is a program for low income families, and your **child must be 3 or 4 by October 1, 2017**. Selection is based on age, income, and family size, as well as child and family needs. **TRANSPORTATION MAY BE PROVIDED TO THOSE WITHIN BUSSING AREA.**

Full Day Head Start - For families who qualify for Head Start. 40 hours a week of preschool at no cost for families who are in school or job training, or work full time. To be enrolled in Full Day Head Start, there must be no parent at home available to care for the child. **TRANSPORTATION MAY BE PROVIDED TO THOSE WITHIN BUSSING AREA.**

Colorado Preschool Program - This program is state funded and provides 10 hours of a regular preschool schedule at no cost. A special tuition rates may be available to extend your child's preschool day. CPP can be combined with Head Start, special education funding or tuition-based preschool for a longer day. **Children must be 3 or 4 by October 1, 2017**. There are no income requirements for this program. Selection is based on age and educational risk factors. **NO TRANSPORTATION PROVIDED.**

Tuition-Based Preschool - For a pre-paid monthly tuition fee, **children who are at least 3 years old by October 1, 2017**, can attend a regular daily preschool schedule and/or extend their hours to meet their family's needs for child care. A scale is available with reduced rates for families who qualify for the Free or Reduced Lunch Program. Tuition-Based Preschool can be combined with Head Start, special education services, or the Colorado Preschool Program. **NO TRANSPORTATION PROVIDED.**

Services for Children with Special Needs – Lake County School District is the local service provider for children with diagnosed disabilities. Hours and services are determined by the Special Education staff and the child's family. If you have concerns about your child's development, please ask for information about Child Find.



**The Center Early Childhood Programs
Lake County Schools
2017-2018 Application Form**



Revised 2/24/17

Please read the questions carefully and provide the most accurate information possible.

OFFICE USE ONLY
Enrollment Date _____ Entry Date _____

Child Information

Last Name	First Name	Middle Name	Nickname
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Date of Birth	Birthplace	<input type="checkbox"/> Male	
		<input type="checkbox"/> Female	

Lives with (check all that apply): <input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Both <input type="checkbox"/> Mom's Partner <input type="checkbox"/> Dad's Partner <input type="checkbox"/> Grandparents <input type="checkbox"/> Foster Parents <input type="checkbox"/> Other _____	If a parent does not live in the child's home, do we have permission to contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Is there a court order affecting your child? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, you must provide a copy Details of order-
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Language / Race / Ethnicity Questionnaire

Primary Language spoken at home :	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Both <input type="checkbox"/> Other : _____
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Primary Language for letters sent home :	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Both <input type="checkbox"/> Other : _____
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Ethnicity : Please mark one.	<input type="checkbox"/> Hispanic or Latino origin <input type="checkbox"/> Non-Hispanic or Latino origin
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Race : Please mark one or more.	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Pacific Islander or Native Hawaiian <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Other : _____
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Mother / Guardian Information

Name	Mailing Address
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Date of Birth	Physical Address
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Preferred daytime contact	Home Phone	Cell or Text Message	Email Address
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Employer	Employer Address	Work Phone
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Does Mother live with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Mother have legal custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Mother's Employment Information : <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Unemployed <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Homemaker <input type="checkbox"/> In job training or school <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Actively Deployed Military
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Mother's Education Information : <input type="checkbox"/> Less than High School Diploma <input type="checkbox"/> High School Diploma or GED <input type="checkbox"/> Some college, vocational, AA/AS degree <input type="checkbox"/> Bachelor or Advanced College degree
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Mother's Educational Goals : <input type="checkbox"/> GED classes <input type="checkbox"/> English classes <input type="checkbox"/> college classes <input type="checkbox"/> parenting classes <input type="checkbox"/> Other
--

Was mother under 18 at time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No

Was mother unmarried at the time of this child's birth? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Parent/Guardian Signatures

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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Father / Guardian Information

Name		Mailing Address	
Date of Birth	Physical Address		
Preferred daytime contact	Home Phone	Cell or text message	Email Address
Employer	Employer Address	Work Phone	

Does Father live with child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Father have legal custody? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Father's Employment Information : Full Time Part Time Seasonal Unemployed Seeking Employment
 Homemaker In job training or school Disabled Retired Actively Deployed Military

Father's Education Information : Less than High School Diploma High School Diploma or GED
 Some college, vocational, AA/AS degree Bachelor or Advanced College degree

Father's Educational Goals : GED classes English classes college classes parenting classes Other

Was father under 18 at time of this child's birth? Yes No
 Was father unmarried at the time of this child's birth? Yes No

Other Adult Caregiver in Home: <input type="checkbox"/> Guardian <input type="checkbox"/> Step Parent or <input type="checkbox"/> Live-in Partner Information (check one)

Is this person related to the applicant child by blood or through a marriage or adoption? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name		Date of Birth	
Preferred daytime contact	Home Phone	Cell or Message	Email Address
Employer	Address	Work Phone	

Caregiver's Employment Information : Full Time Part Time Seasonal Unemployed Seeking Employment
 Homemaker In job training or school Disabled Retired Actively Deployed Military

List all other family members not listed above who live in your household and for whom you are responsible for the care and welfare.

Name	Relationship to child	Date of Birth	Is this person related to the child's parent(s)	Is this person supported by the parent(s) income?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Total number of people living in the household (including you) for whom you provide financial support.	
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The Center respects and protects your family's privacy. The information you provide in this enrollment packet will be used to determine you eligibility for programs and services and will not be shared without your permission.

I understand this is an application for services that may be paid for with government funds and that intentionally providing misleading, inaccurate, or untruthful information may result in my child being terminated from the program.

*** I understand this is an application only and does not guarantee enrollment in the program ***

Parent/Guardian Signatures			
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Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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Special Considerations (Check all that apply to your household and add any extra information you would like to provide.)

<input type="checkbox"/> Developmental concerns	<input type="checkbox"/> Speech / language concerns
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Family member incarcerated
<input type="checkbox"/> Family violence / abuse	<input type="checkbox"/> Family in crisis
<input type="checkbox"/> Child in out of home placement	<input type="checkbox"/> Previously in Head Start
<input type="checkbox"/> Referral from agency Name of agency: _____	<input type="checkbox"/> Other- (Please describe):

Child Residency Questionnaire

This questionnaire is intended to address the McKinney-Vento Homeless Education Assistance Improvements Act 42 USC 11435. The answers to this residency information help determine the services the child may be eligible to receive.

1. How many times has your family / child moved in the last 3 years? _____

2. Is your current address a temporary living arrangement? Yes No

3. Is this temporary living arrangement due to loss of housing or economic hardship? Yes No

**If you answered YES to the above questions, please complete the remainder of this section.
If you answered NO, you may skip to the next section.**

Where is the child presently living? (Check one box)	<input type="checkbox"/> In a motel or hotel	<input type="checkbox"/> In an emergency or transitional shelter
	<input type="checkbox"/> Awaiting foster care placement	<input type="checkbox"/> With more than one family in a house or apartment
	<input type="checkbox"/> Abandoned in a hospital	<input type="checkbox"/> Moving from place to place
	<input type="checkbox"/> In a place not designed for ordinary sleeping accommodations, such as a car, park, abandoned building, or campsite	

Mandated Child Abuse and Neglect Reporting

This is to inform you that all employees of The Center Early Childhood Programs are required by State Law to report all instances of suspected child abuse/neglect to the Lake County Department of Human Services. This agency will visit The Center to evaluate the circumstances, and if abuse or neglect is determined, and if the child is felt to be in danger of further abuse or neglect, the Department of Human Services will call the legal authorities and request that they take the child into protective custody, and they will notify you of the steps you must take.

Parent's Initials _____

Payment for Child Care Services

The Center's tuition-based child care services must be pre-paid. The Head Start Program is federally funded, and Colorado Preschool Program is funded by the state. These programs do not charge for their services provided for enrolled children. I agree to pay all fees incurred by the attendance of my children which are not covered by the funding of these or other programs, before or after their hours of operation.

Parent's Initials _____

Parent/Guardian Signatures

*** I understand this is an application only and does not guarantee enrollment in the program ***

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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Child's Name

Enrollment Form

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Primary Emergency Contact and Authorized Pick Up Person – In case of illness or emergency, if we cannot reach parents or guardians, who is the next person we should try to contact?

Name		Relationship to child	
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Phone	Address	Note-	
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People Permitted to Pick Up Child or be contacted in case of emergency

(Do not list parents/guardians. All persons listed here must be over 18)

2017-2018

Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Name		Relationship to child	
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Phone	Address	Note-	
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Parent/Guardian Signatures

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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Health Screening Consent

2017-2018

I understand the following health screenings and examinations are required for my child's enrollment and participation in early childhood programs at The Center. I give my consent for my child named above to receive some or all of the following screenings, observations, and/or evaluations, and follow-up. This consent is valid for the program year immediately following the date it is signed. I understand that a parent or guardian must be present for Head Start dental and physical examinations. The results of these screenings and evaluations will be made available to me. I authorize release of information pertinent to any of these screenings, observations and evaluations to service providers deemed necessary by the Head Start, CPP, or Tuition based programs.

Health requirements for parents to complete:

*Required forms will be provided.
Assistance in making appointments is available upon request.*

- Physical exam
- Dental examination - *required for Head Start only*
- Blood Lead Screening
- Immunizations
- Ages & Stages social/emotional screening – *(paperwork will be provided by school)*

Health screenings to be completed at school by staff:

- Developmental screening
- Hearing screening
- Vision screening
- Heights & weights

Parent's Initials _____

Medical Treatment Authorization

I authorize staff members of The Center Early Childhood Programs to arrange for medical or surgical care for my child named above, and give consent for care and/or treatment in the event of an emergency. Staff members may use their judgment in deciding what an emergency is, and may request the services of our doctor named on the Health Information form or another if he/she is unavailable, and call the hospital, and/or an ambulance. I understand that an attempt will be made to reach me and/or the emergency contacts provided to The Center, but contact is not necessary for the above consent to be in effect. A copy of this form will be presented as medical treatment authorization, and will be considered valid as the original. This consent will be in effect until withdrawn in writing by the person(s) signing. I accept responsibility for related expenses incurred, which are not the responsibility of The Center Early Childhood Programs or its employees.

Parent's Initials _____

Information Release

I give permission for The Center Early Childhood Programs to exchange information with the following community partners for the purpose of providing the best services for my child and family. This authorization will continue in force until revoked by me in writing, and a copy or fax shall serve in its stead. This includes permission to copy, release, or discuss information with the purpose of facilitating interagency communication in providing services to myself and my family.

Parent's Initials _____

- | | |
|--|--|
| • Lake County School District | • Family Literacy Program |
| • Lake County Department of Human Services | • Disabilities Services Provider and Coordinator |
| • Lake County Public Health Agency | • WIC Nutrition Program |
| • My child's medical and dental care providers | • SolVista Health |

Photo and Video Release

Yes No I authorize The Center Early Childhood Programs to photograph or permit photographs to be taken and for the filming of video of my child named above. The photos or videos may be posted in The Center, published in the newsletter, on The Center's website or social media pages, news media, or used in promotional materials for these programs.

Transportation Permission

Yes No I give permission for my child named above, to be transported to The Center Early Childhood Programs and to be transported home or to an alternate location named by me. If necessary, this includes health or dental visits. I give permission for my child named above to walk or be transported to activities, programs, or field trips as part of participation in The Center Early Childhood Programs.

Parent/Guardian Signature

Mother/Guardian Signature	Date	Father/Guardian Signature	Date
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Child's Name _____

Date of Birth _____

Enrollment Form

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Medical and Dental Information

2017-2018

Health Provider and Coverage Information

Do you have a primary health care provider who provides your child's regular health care? Yes No

Provider's Name _____ Address _____ Phone _____

Do you have medical coverage or insurance? Yes (please bring the card to make a copy) No

If "Yes" what type Medicaid ID# _____

CHP+ ID# _____

Private insurance Company Name & Policy # _____

Does your insurance include dental coverage? Yes No

If "No", please request an application for Medicaid and CHP+. Assistance is available in completing this form.

Has your child been seen by a dentist before? Yes No

When was your child's last dental appointment? _____

Please list the preferred dentist for your child's dental care:

Dentist Name _____ Address _____ Phone _____

Please note : in case of an emergency, children will be transported to St. Vincent General Hospital.

Medical History and Special Concerns

Is your child seeing a medical specialist for any reason? Yes No

If yes, please explain : _____

Specialist's Name _____ Address _____ Phone _____

Has your child had a serious injury, accident, been hospitalized or had surgery? Yes No

If yes, please explain : _____

Is your child being treated for a medical, disabling or mental health condition? Yes No

If yes, please explain : _____

Is your child currently taking any medication or does he/she require any medical procedures? Yes No

If yes, what type? _____

Will this medicine or medical procedure be given at school? Yes No

(Note : Doctor's written authorization is needed before any medication/or procedure can be given at school.)

Are there health problems or conditions that will limit activities or affect your child at school? Yes No

If Yes, please explain : _____

Immunizations

Is your child up to date on their immunizations? Yes No

(Note : Either a copy of your child's immunization records or a signed Statement of Exemption must be on file before your child's first day of school.)

(Note : Colorado State policies require all children to be up to date on immunizations within 14 days of starting school)

Disability

Does your child have a diagnosed disability? Yes No

If yes, what is the disability? _____

Is your child on an Individual Education Plan (IEP)? Yes No

If yes, what is the IEP for? _____

Do you have other concerns about other children in your family who may have delays and or disabilities? Yes No

Would you like The Center to refer you to the Child Find early intervention program to help with your concerns? Yes No

Parent's Initials _____

Child's Name

Date of Birth

Enrollment Form

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Child's Medical Background and Health Concerns**2017-2018****Does your child now suffer from or have they suffered in the past from : (Please check all that apply.)**

<input type="checkbox"/> Asthma Will your child require an inhaler or nebulizer at school? <input type="checkbox"/> Yes <input type="checkbox"/> No What are the asthma triggers?	<input type="checkbox"/> Visual Problems (Difficulty seeing, headaches, wears glasses)	<input type="checkbox"/> Hearing Problems (Hearing aids, difficulty hearing, frequent earaches, tubes in ears)
<input type="checkbox"/> Skin Problems (Eczema, Hives, etc.)	<input type="checkbox"/> Bone, Joint or Muscle Injury Or Bone Disease	<input type="checkbox"/> Speech Problems (Hard to understand, Talked late)
<input type="checkbox"/> Pneumonia/RSV	<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Anemia or Sickle Cell Anemia	<input type="checkbox"/> Gastro Esophageal Reflux (GER)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Frequent fevers	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Frequent stomach aches, indigestion, or vomiting	<input type="checkbox"/> Constipation, diarrhea, frequent or painful urination	<input type="checkbox"/> Fainting Spells
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Trouble chewing or swallowing	<input type="checkbox"/> Second hand smoke
<input type="checkbox"/> Wears diapers or pull ups	<input type="checkbox"/> Other:	
Has this child ever passed out during extreme physical exertion?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone in the family suffered a sudden, unexplained death before the age of 50?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any concerns listed above:

Allergies

Medication Allergies	<input type="checkbox"/> Penicillin <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Other
Describe reactions and specify allergies if "other".	
Food Allergies	<input type="checkbox"/> Eggs <input type="checkbox"/> Fish <input type="checkbox"/> Milk/Milk Products <input type="checkbox"/> Nuts <input type="checkbox"/> Seeds <input type="checkbox"/> Gluten <input type="checkbox"/> Soy <input type="checkbox"/> Shellfish <input type="checkbox"/> Other
Describe reactions and specify allergies if "other".	
Environmental Allergies	<input type="checkbox"/> Bee stings <input type="checkbox"/> Insect bites <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Animals / Animal fur <input type="checkbox"/> Dust <input type="checkbox"/> Latex <input type="checkbox"/> Other
Describe reactions and specify allergies if "other".	
Does your child require any medication, such as an Epi Pen, to manage his/her allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No (Note : Doctor's written authorization is needed before any medication/or procedure can be given at school.)	
Special Diets	
Is your child on a special diet? (Diabetic, vegetarian, medical, religious, personal)	<input type="checkbox"/> Yes <input type="checkbox"/> No (Note : A special diet statement signed by a medical authority, including their recommendations, is required to substitute any food served at The Center.)

Parent's Initials _____

Date Completed _____

Child Development**2017-2018****Does Your Child:****Mark one****Please Explain :****Toileting**

Consistently use the bathroom on their own?

 Yes No

Need help going to the bathroom?

 Yes No

Ever have potty accidents?

 Yes No**Self Care**

Wash and dry hands?

 Yes No

Dress self with little help?

 Yes No

Know first and last name?

 Yes No**Self Esteem and Emotions**

Show aggression/inability to get along with others?

 Yes No

Have sudden mood changes or unexplained moodiness?

 Yes No

Act shy / withdrawn / fearful?

 Yes No

Separate from parents easily?

 Yes No

Have experience playing with other children?

 Yes No

Have any family changes or problems, which may affect him/her?

 Yes No**Sleep Habits**

Have any trouble sleeping?

 Yes No

Have discipline problems at bedtime?

 Yes No

Take a nap?

 Yes No

When is your child's bedtime?

How many hours per night does your child sleep?

Development

Did your child do any of these things later than expected, causing concerns about his/her development?

 Sit up Walk Talk Respond to directions**Child's Interests**

What is your child good at?

What does your child like to do when he/she plays?

Does your child....?

Show an interest in using new words?

 Always Often Every once in a while Never

Show an interest in books?

 Always Often Every once in a while Never

Listen and follow directions?

 Always Often Every once in a while Never

Show interest in counting, sorting, and numbers?

 Always Often Every once in a while Never

Get along / problem solve with other children?

 Always Often Every once in a while Never

Show interest in cutting, coloring, drawing, and writing?

 Always Often Every once in a while Never

Complete tasks that he/she starts?

 Always Often Every once in a while Never

Show an interest in nutritious foods and trying new foods?

 Always Often Every once in a while Never

Form attachments to new adults?

 Always Often Every once in a while Never**Parents Initials**

Date Completed

Family Strengths

2017-2018

How often do you read to your child? Every day Once a week Once a month Very rarely

Are you aware of community resources to help make your family even stronger (such as the public library, public health, recreation programs, or public assistance)?

Our family knows about and takes advantage of community resources.
 Our family knows about resources and connects to them as needed.
 Our family does not connect to community resources.
 I would like more information about :

How is your relationship to your child's school?

We actively participate. We know how to advocate for our child's needs. We have regular interactions with school staff. We attend events and meetings.
 We participate in Conferences and Home Visits as required. We sometimes come to events. We contact staff when there is a problem.
 We have minimal interaction with the school, beyond enrollment and attendance. Staff call us if there is a problem.
 We have no interest in our child's educational development and have no interactions with their school.

Are you interested in running for election to the Head Start Policy Council? Yes No

How do you feel about your parenting skills?

My family has warm interactions, shows affection to each other, and enjoys being together. Strongly Agree Agree Disagree Strongly Disagree I would like more information on more warmth and less stress in family interactions.

My family uses consistent, appropriate and effective discipline techniques. Strongly Agree Agree Disagree Strongly Disagree I would like more information on appropriate and effective discipline techniques

My family has consistent routines so everyone knows what to expect and transitions are easy. Strongly Agree Agree Disagree Strongly Disagree I would like more information on using routines to ease transitions.

I have knowledge about childhood development and am confident my child is growing and learning on track. Strongly Agree Agree Disagree Strongly Disagree I would like more information on childhood development.

I monitor my child's "screen time" and know that they are viewing only materials appropriate for their age and skill level. Strongly Agree Agree Disagree Strongly Disagree I would like more information on age appropriate media for preschool age children.

My family practices good nutrition habits, and we have enough food. Strongly Agree Agree Disagree Strongly Disagree I would like more information on healthy meals and eating habits.

My family has health coverage and a regular health care and dental care provider. Strongly Agree Agree Disagree Strongly Disagree I would like more information on applying for health coverage or using my existing coverage.

I provide a safe, regular, and comfortable home for my family. Strongly Agree Agree Disagree Strongly Disagree I would like more information on making my home even safer.

Both of my child's parents are connected to him/her and support his/her education. Strongly Agree Agree Disagree Strongly Disagree I would like more information on a father's role in child development and education.

Do you feel your child has the skills to be successful in school? (Examples: love of learning, following routines, interacting with adults and other children, specific concepts like colors, letters, numbers, shapes) Yes Getting there Not yet
 I would like my child to work on :

