The following items must be included with your application in order for it to be processed. Revised 2/12/15

- ☐ 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
- ☐ 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 2014 or W-2 forms from 2014 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 we do not have one of these forms of evidence of income on file, your child will not be considered for Head Start enrollment.

Please do not leave originals of these items - we will be happy to make copies if needed.

Date and Time Received by Office	☐ Scheduled developmental screening **Signature:** _____

Please return this entire packet to determine program eligibility
Only complete applications will be processed
* Completed applications do not guarantee a spot *

Revised 2/27/15

Child's Name _____ Date of Application_____

Our preschool program runs **Monday through Thursday from 9:30am – 1:30pm.** This 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 before preschool at 6:30am 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 information possible to help us provide you with appropriate services.

1) **Are you interested only in preschool hours, or do you need an extended day of child care?**
   Circle One **- Preschool Only Extended Day Don't know**

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

_____

2) **Can you pay tuition for extended hours or do you want extended hours only if they are free?** *Circle One* **- Yes No**

3) **Do you want a tuition-based child care spot on Fridays?**
   Circle One **- Yes No**

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 preschool from 9:30-1:30, Monday through Thursday, 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 of 2015**. Selection is based on age, income, and family size, as well as child and family needs. **TRANSPORTATION MAY BE PROVIDED TO THOSE WITHIN BUSING AREA.**

Full Day Head Start - For families who qualify for Head Start. 40 hours a week of preschool, that may include Fridays, 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. **MORNING TRANSPORTATION MAY BE PROVIDED TO THOSE WITHIN BUSING AREA.**

Colorado Preschool Program - This program is state funded and provides preschool from 9:15-12:00, Monday through Thursday at no cost. A special tuition rate is available to extend your child's preschool day until 1:30 for only $91 per month. CPP can be combined with Head Start or tuition-based preschool for more hours. **Children must be 3 or 4 by October 1, 2015**. 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 September 15, 2015**, can extend their hours, before and after the preschool experience 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 a morning Head Start spot or the Colorado Preschool Program. **NO TRANSPORTATION PROVIDED.**

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.

The Center Early Childhood Programs
Lake County Schools
2015-2016 Application Form

Revised 2/12/2015

Date of Intake Interview and staff initials	**OFFICE USE ONLY** Enrollment Date _____ Entry Date_____

Child Information

Last Name	First Name	Middle Name	Nickname

Date of Birth	Birthplace	☐ Male ☐ Female	Lives with: ☐ Mom ☐ Dad ☐ Both ☐ Other _____

Is there a court order affecting your child? ☐ Yes ☐ No	If yes, you must provide a copy Details of order-

Primary Language Questionnaire

Primary Language spoken at home :	☐ English ☐ Spanish ☐ Both ☐ Other :_____
Primary Language for letters sent home :	☐ English ☐ Spanish ☐ Both ☐ Other :_____
Ethnicity : Please mark one.	☐ Hispanic or Latino origin ☐ Non-Hispanic or Latino origin
Race : Please mark one or more.	☐ American Indian or Alaska Native ☐ Pacific Islander or Native Hawaiian ☐ Asian ☐ White ☐ Black or African-American ☐ Other :_____

Mother Information

☐ In home ☐ Not in home	Name	Mailing Address

Date of Birth	Physical Address		
Preferred daytime contact ☐ Home ☐ Work ☐ Cell	Home Phone	Cell or Message	Email Address

Employer	Address	Work Phone

Mother's Employment Information :	If not in home, do we have permission to contact / mail?	Was mother under 18 at time of this child's birth? ☐ Yes ☐ No
☐ Employed Full Time ☐ Employed Part Time ☐ Seasonal Employment ☐ Unemployed ☐ Seeking Employment ☐ Homemaker ☐ In job training or school ☐ Disabled ☐ Retired ☐ Actively Deployed Military	☐ Yes ☐ No Mother's Education Information : ☐ Less than High School Diploma ☐ High School Diploma or GED ☐ Some college, vocational, AA/AS degree ☐ Bachelor or Advanced College degree	Was mother unmarried at the time of this child's birth? ☐ Yes ☐ No Mother's Educational Goals : ☐ Interested in GED classes ☐ Interested in English classes ☐ Interested in college classes ☐ Interested in Parenting classes ☐ Other

Parent/Guardian Signatures

Mother/Guardian Signature	Date	Father/Guardian Signature	Date

Father Information

☐ In home ☐ Not in home	Name	Mailing Address	
Date of Birth	Physical Address		
Preferred daytime contact ☐ Home ☐ Work ☐ Cell	Home Phone	Cell or Message	Email Address
Employer	Address	Work Phone	

Father's Employment Information : ☐ Employed Full Time ☐ Employed Part Time ☐ Seasonal Employment ☐ Unemployed ☐ Seeking Employment ☐ In job training or school ☐ Disabled ☐ Retired ☐ Actively Deployed Military	If not in home, do we have permission to contact / mail? ☐ Yes ☐ No 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	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 Father's Educational Goals : ☐ Interested in GED classes ☐ Interested in English classes ☐ Interested in college classes ☐ Interested in Parenting classes ☐ Other

Other Adult Caregiver in Home: ☐ **Guardian** ☐ **Step Parent or** ☐ **Live-in Partner Information** (check one)

Is this person related to the applicant child by blood or through a marriage or adoption? ☐ Yes ☐ No

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

Other People in Your Home (please do not list applicant child or parents listed above)

Name	Relationship to child	Date of Birth	Name	Relationship to child	Date of Birth

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.

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

Please let us know if you have questions or require assistance in completing the application. We will be happy to help.

Parent/Guardian Signatures

Mother/Guardian Signature	Date	Father/Guardian Signature	Date

Statistical Information (Check all that apply to your household and add any extra information you would like to provide.)

☐ One parent home	☐ Family violence / abuse
☐ Substance abuse	☐ Family member incarcerated
☐ Out of home placement	☐ Family in crisis
☐ Previously in Head Start	☐ Other-
☐ Developmental concerns	☐ Speech / language concerns
☐ Receive public assistance (i.e. SSI or TANF) Types:_____	☐ Referral from agency Name of agency:_____

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)	☐ In a motel or hotel	☐ Awaiting foster care placement
	☐ In an emergency or transitional shelter	☐ With more than one family in a house or apartment
	☐ Abandoned in a hospital	☐ Moving from place to place
	☐ 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

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) **2015-2016**

Name	Relationship to child
Phone	Note-
Name	Relationship to child
Phone	Note-
Name	Relationship to child
Phone	Note-
Name	Relationship to child
Phone	Note-
Name	Relationship to child
Phone	Note-
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Name	Relationship to child
Phone	Note-
Name	Relationship to child
Phone	Note-
Name	Relationship to child
Phone	Note-

Parent/Guardian Signatures

Mother/Guardian Signature	Date	Father/Guardian Signature	Date

Health Screening Consent **2015-2016**

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.

Head Start Screenings and Follow-up	Tuition Preschool Colorado and Preschool Program
Dental examination	
Head Start physical -Physical exam -Hemoglobin/Lead -Height and weight -Blood pressure	Physical form provided for family physician to complete
Vision screening	Vision and Hearing screening
Hearing screening	Hemoglobin / Blood Lead Screening
DIAL developmental screening	DIAL developmental screening
DECA social/emotional screening - consultant contacts you	DECA social/emotional screening - consultant contacts you
Ages & Stages social/emotional screening	Ages & Stages social/emotional screening

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 _____

• All programs operating at Margaret J. Pitts School	• SolVista Health
• Lake County Department of Human Services	• Disabilities Services Provider/Coordinator
• My child's dental care provider	• WIC Nutrition Program
• My child's medical care provider	• Family Literacy Program - Lake County Schools
• Lake County Public Health Agency	• Lake County School District

Photo and Video Release

☐ Yes ☐ No	I authorize The Center Early Childhood Programs to photograph or permit photographs to be taken of my child named above, and for the filming of video. The photos/video 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/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

Medical Information **2015-2016**

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

Provider's Name_____Address_____ Phone_____

Date of last physical exam_____

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

If "Yes" what type ☐ Medicaid ID# _____

☐ CHP+ ID# _____

☐ Private insurance Company Name & Policy #_____

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

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 : _____

Did mom or child have any health problems during pregnancy, or delivery, or stay in the hospital longer than normal?
☐ Yes ☐ No If yes, please explain : _____

Was your child born 3 weeks early or late? ☐ Yes ☐ No What was the child's birth weight? _____

Are you pregnant now? ☐ Yes ☐ No Due date? _____ Do you have prenatal care? ☐ Yes ☐ No

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 : _____

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
What is the disability? _____

Is your child on an Individual Education Plan (IEP)? ☐ Yes ☐ No
What is the IEP for? _____

Do you have other concerns about other children in your family who may have delays and or disabilities?
Would you like The Center to make a referral to the free Child Find early intervention program to help you with your concerns? ☐ Yes ☐ No

Parent's Initials _____ Date Completed_____

Child's Current and Past Medical History Information **2015-2016**

Is your child exposed to second hand smoke? ☐ Yes ☐ No

Does your child suffer from, or has s/he suffered in the past from : (Please check all that apply.)

☐ Asthma Will your child require an inhaler or nebulizer at school? ☐ Yes ☐ No What are the asthma triggers?	☐ Visual Problems (Difficulty seeing, headaches, wears glasses)	☐ Hearing Problems (Hearing aids, diffuculty hearing, frequent earaches, tubes in ears)
☐ Seizures/Convulsions	☐ Bone, Joint or Muscle Injury Or Bone Disease	☐ Speech Problems (Hard to understand, Talked late)
☐ Pneumonia/RSV	☐ Cancer	☐ Kidney Disease
☐ Bleeding Disorder	☐ Anemia or Sickle Cell Anemia	☐ Gastroesophageal Reflux (GER)
☐ Diabetes	☐ Skin Problems (Eczema, Hives, etc)	☐ Meningitis
☐ Hepatitis	☐ Heart Disease	☐ Leukemia
☐ Rheumatic Fever	☐ Frequent fevers	☐ Sinus problems
☐ Orthopedic Problems	☐ Lead Poisoning	☐ Tuberculosis
☐ Whooping Cough	☐ Constipation, diarrhea, frequent or painful urination	☐ Fainting Spells
☐ Allergies to animals, fur, or dust	☐ Wears diapers or pull ups	☐ Other:

Please explain any concerns listed above:

Critical Health

Medication Allergies and reactions	☐ Penicillin ☐ Cephalosporins ☐ Other
Describe reactions, specify allergies if "other"	
Food Allergies and reactions	☐ Beef ☐ Eggs ☐ Fish ☐ Milk/Milk Products ☐ Nuts/Seeds ☐ Peanuts ☐ Gluten ☐ Soy ☐ Shellfish ☐ Other
Describe reactions, specify allergies if "other"	
Environmental Allergies	☐ Bee stings ☐ Insect bites ☐ Seasonal Allergies ☐ Latex ☐ Other
Describe reactions, specify allergies if "other"	
	Has this child ever passed out during extreme physical exertion? ☐ Yes ☐ No
	Has anyone in the family suffered a sudden, unexplained death before the age of 50? ☐ Yes ☐ No

Does your child require any medication, such as an Epi Pen, to manage his/her allergies? ☐ Yes ☐ No
(Note : Doctor's written authorization is needed before any medication/or procedure can be given at school.)

Parent's Initials_____ Date Completed_____

Dental **2015-2016**

Do you have dental coverage/insurance? ☐ Yes (please bring the card to make a copy) ☐ No

If "Yes" what type ☐ Medicaid ID# _____

☐ CHP+ ID# _____

☐ Private insurance Company Name & Policy #_____

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 _____

Is your child having pain now because of his/her teeth? ☐ Yes ☐ No

Does your child take a fluoride supplement? ☐ Yes ☐ No

Nutrition

Do you have questions or concerns about your child's eating habits? (Picky eater, under eating, over eating)	☐ Yes ☐ No
Would you like information on child nutrition?	☐ Yes ☐ No
Is your child on a special diet? (Diabetic, vegetarian, medical, religious, personal)	☐ Yes ☐ No (Note : A special diet statement signed by a medical authority, including their recommendations, is required to substitute any food served at The Center.)
Do you have enough food to feed your family?	☐ Yes ☐ No
Does your child have frequent stomachaches, indigestion, or vomiting?	☐ Yes ☐ No
Does your child have any trouble chewing or swallowing?	☐ Yes ☐ No
Do you participate in the following?	☐ WIC ☐ SNAP (Food Assistance) ☐ Food Pantry Referral date:
How does your child appear to you?	☐ Just Right ☐ Overweight ☐ Underweight ☐ Short ☐ Tall ☐ Lack of Energy
Does your child take a multivitamin?	☐ Yes ☐ No
What foods does your child like to eat?	
Are there any foods your child will not eat?	

How many times **per day** does your child eat foods from these categories :

Meals		Snacks	
Vegetables		Fruits	
Rice, Bread, Tortillas, Cereal		Protein (meat, poultry, eggs, beans. nut butters)	
Cheese, Yogurt			
Oils, Fats		Cakes, cookies, candy	

How many times **per day** does your child drink these items :

Water		Milk	
Juice		Soda	

How many hours per day does your child watch TV, play video games or computer games? _____

Parent's Initials_____ Date Completed_____

Social/ Emotional/Development **2015-2016**

Does Your Child:		**Please Explain :**
Dress self with little help?	☐ Yes ☐ No	
Consistently use the bathroom?	☐ Yes ☐ No	
Need help going to the bathroom?	☐ Yes ☐ No	
Ever have potty accidents?	☐ Yes ☐ No	
Separate from parents easily?	☐ Yes ☐ No	
Wash and dry hands?	☐ Yes ☐ No	
Know first and last name?	☐ Yes ☐ No	
Have discipline problems at bedtime?	☐ Yes ☐ No	
Have discipline problems at mealtime?	☐ Yes ☐ No	
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	
Have there been any family changes/problems, which may affect him/her?	☐ Yes ☐ No	
Did your child do any of these things late, causing concerns with his/her development? ☐ Sit up ☐ Walk ☐ Talk ☐ Respond to directions		
Does your child have any trouble sleeping?	☐ Yes ☐ No	
Does your child take a nap?	☐ Yes ☐ No	
When is your child's bedtime?		
How many hours per night does your child sleep?		
What is your child good at?		
What does your child like to do when he/she plays?		

Parents Initials_____ Date Completed_____

Thank you for taking the time to complete this enrollment packet for your child.
Please let us know if you have any questions at all about this packet.
ALL complete applications are considered for eligibility for all programs at The Center.