ENIPC Head Start Program Application

327 Eagle Drive ● P. O. Box 969, Ohkay Owingeh, NM 87566

505.747.1593 (voice) 505.747.1599 (fax)

Please fill all areas out, so a complete application may be reviewed

Please provide verification of **child's age** and **proof of family income** with Application

Please print, and use a black or blue pen when filling out the application. Selection for Enrollment will be based on: Income, Age, Employment, and Special Needs of a Child.

ELIGIBILITY OF CHILDREN: A Child must be 3 years old on or before Sept 1st of the present School Year. Priority will be given to income eligible students.

☐ **Proof of Income - that shows total family income** (may include Income taxes, Pay Stubs, Written statement from employer, TANF, Scholarships, Financial Aid, Statement of Eligibility, etc).

☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐ **1st/15th** ☐ **Annual**

☐ **Verification of Age** (Birth Certificate, Baptismal Certificate, Passport)

Application and enrollment are provided regardless of race, sex, creed, color, national origin, or developmental delay/disability.

For more information please contact:

Jolene Nelson

Director

ENIPC Head Start

505.901.3506 cell

jnelson@enipc.org

Website: enipc.org

ENIPC Head Start Program - Application Packet

STUDENT INFORMATION:

Child's Name: _____ DOB: _____ Sex: M F

Race or Ethnicity: ___Anglo ___African American ___Other ___Hispanic ___American Indian – Census/Enrollment #:_____ Tribe: _____

Primary Language spoken in the home: _____

PARENT/GUARDIAN INFORMATION:

Father: _____ Contact #: _____

Address: _____ Employed □yes □no Work #_____

Mother: _____ Contact #: _____

Address: _____ Employed □yes □no Work # _____

Guardian/Foster Parent_____ Contact #:_____

Address: _____ Work #:_____Cell #:_____

HOUSEHOLD INFORMATION: Head of Household: _____Marital Status: _____

List all persons living in your household (list on the back of page if additional space is needed)

Name	Relationship	Age	DOB	Male or Female	Highest Grade completed

Total Number in Family: _____

FAMILY INCOME INFORMATION: **This section to be completed by Staff Only**

Please submit any of the following documents that may pertain to your family:

□ Check Stubs

□ SSI

□ TANF/Public Assistance

□ Tax Form 1040

□ Foster Care

□ Letter (if un-employed)

□ Homeless

□ Other:_____

For Official Use Only

Total Gross Annual Income $ _____ Verified By/Date:_____

Birth Certificate # _____ Verified By/Date: _____

Social Security Card # _____ Verified By/Date: _____

Child's Status: □ Income eligible □ Over income □ Age in-eligible □ Special needs

What document was used for eligibility determination? _____

EMERGENCY CONTACT INFORMATION:

Emergency contacts are required for each child enrolled at the center. Below is a verification form, please list emergency contact names and required information. **Contacts must be eighteen years of age** and have a phone number where they can be reached. The **EMERGENCY Contact Person must not be under the influence of drugs and/or alcohol when picking up your child.** Please contact your child's teacher as soon as any changes occur with your contacts.

I_____ give permission to the individuals below to pick up my child.

Parent Signature: _____Date:_____

1st Contact

Name:_____Relationship to child_____

Home Number:_____Work Number_____

Cell Number:_____

2nd Contact

Name:_____Relationship to child_____

Home Number:_____Work Number_____

Cell Number:_____

3rd Contact

Name:_____Relationship to child:_____

Home Number:_____Work Number_____

Cell Number:_____

Emergency Medical Treatment: □ **I CONSENT** □ **DO NOT CONSENT**

To provide emergency medical treatment in the event, my child is injured while at the Head Start Center. I understand I will be notified immediately. In the event that I am not reachable this form allows the Head Start staff to access medical treatment for my child. If required, I hereby authorize the Emergency Medical Service (EMS), Indian

Health Service or a licensed physician, dentist, or nurse to provide medical aid for my child_____.

This statement allows my child to be transported for medical attention either by private vehicle or ambulance. In the event that my child has an accident on the school grounds or being transported by bus (during school functions), I authorize certified staff to administer Basic First Aid and /or CPR.

_____ _____

Parent/Guardian Signature **Date**

Source of Health and Emergency Care:

□ Indian Health Service □ Private Insurance

□ IHS Dental Service □ Private Dental □ Small Smiles

□ Medicaid □ yes □ no Medicaid # _____

Parent Center Agreement

During my child's enrollment at Head Start Center, I/We agree to participate in the review of parent involvement objectives and School Readiness Goals. I/We will also be involved in Family night activities and volunteer in the classroom.

_____ _____

Parent/Guardian Signature **Date**

Field Trip Permission

I, _____ **consent/do not consent** for my child to participate in field trips within the communities of San Ildefonso or Nambe Pueblos. Additional permission slips for any field trips outside of the exterior boundaries of the two pueblos will be sent home for parental consent.

_____ _____

Parent/Guardian Signature **Date**

Multi- Media Release

I, _____, hereby **grant permission** for my child's _____, image (photographs, video, audio tape, or related formats) for use by ENIPC Head Start. The release for multi-media purpose is valid for school year 20___-20___.

_____ _____

Parent Signature **Date**

Child's Health Record - Please Do Not Leave Any Spaces Blank

Pregnancy/Birth History:

Did mother have any health problems during pregnancy or child birth? ____yes ____no

Are there any Health concerns that we should be made aware of? ____yes ____no

If yes, please list concerns: _____.

Hospitalization & Illness:

Has your child ever had surgery? ____yes ____no

Has your child ever had a serious accident? ____yes ____no

(broken bones, burns, falls, head injuries)

Has your child ever had a serious illness? ____yes ____no

Health Issues:

Does your child have any of the following (frequently). Please check all that apply:

_____Sore throat _____Coughs

_____Diarrhea _____Stomach pain

_____Trouble urinating _____Ear infections

_____Vomiting _____Asthma

_____Other, please explain _____

Does you child have difficulty seeing? ____yes ____no

Does your child wear glasses? ____yes ____no

Does your child have problems with his/her hearing? ____yes ____no

Has your child ever had convulsions? ____yes ____no

Is your child currently on medication? ____yes ____no

Has your child ever had (please list at what age):

_____Mumps _____Hives _____Measles

_____German Measles _____Chicken Pox _____Hepatitis

_____Whooping Cough _____Scarlet Fever _____Polio

_____Other

ALLERGY INFORMATION:

Does your child have allergies? ____yes ____no

To food? ____yes ____no

If yes, please list_____

To medication? ____yes ____no

If yes, please list_____

To animals, fur, insects, dust? ____yes ____no

If yes, please list_____

If any of the above conditions apply, will they interfere with your child's everyday activities? ____yes ____no

Any other conditions that were not included above? ____yes ____no

If so, please explain_____

DIETARY INFORMATION:

Does your child take vitamins and/or mineral supplements? ____yes ____no

Is your child on a special diet? ____yes ____no

If yes, please explain_____

Has there been a change in your child's appetite in the last month? ____yes ____no

If yes, please explain_____

Does your child take a bottle? ____yes ____no

Does your child have trouble chewing and/or swallowing? ____yes ____no

Any other concerns we should be aware of?

_____

_____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT INFORMATION:

Tell us two things that your child is interested in: 1._____
2._____

Does your child take naps? ____yes ____no

Does your child sleep less than 8 hours a night? ____yes ____no

Does your child have trouble sleeping? ____yes ____no

Does your child tell you when he/she needs the restroom? ____yes ____no

Does he/she need help in the restroom? ____yes ____no

Does your child worry a lot? Is he/she afraid of anything? ____yes ____no

If yes, please explain_____.

How does your child act with adults he/she does not know? _____.

How does your child act with children their own age?

Please explain_____.

Does your child have difficulty saying what he/she wants and/or needs? ___yes ___no

Is your child's speech easy to understand? ___yes ___no

Does your child grunt as a form of communication? ___yes ___no

Does your child point as a form of communication? ___yes ___no

Is there an issue that may affect your child's behavior? ___yes ___no

If yes, please explain_____.

Do you have any concerns about your child's behavior at home? ___yes ___no

If yes, please explain_____.

Has there been a significant change in your child's life recently? ___yes ___no

If yes, please explain_____.

_____ _____

Parents Signature **Date**

EARLY INTERVENTION PROGRAMS:

I, _____, hereby grant permission for my child, _____, to participate in the health screenings listed below:

Vision

Dental

Audiology

Speech and Language

Blood Pressure checks

Height / Weight

ASQ (Ages & Stages) Social/Emotional

ASQ (Ages & Stages) Developmental

Classroom Observations

The consent has been explained to me. I understand I will be notified before screenings are administered. I further understand results will be shared with me. This parent consent for Health Screenings is valid for school year 20___-20___.

_____ _____

Parent Signature **Date**

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION:

I, _____, hereby authorize the disclosure of information from my child's medical record.

The information is to be disclosed by:

The Santa Clara Health Center, Santa Clara Pueblo, NM 87532

And/or the Indian Health Service, Santa Fe, NM 87505,

Or

Named Medical Facility/Address: _____And, is to be provided to: **ENIPC Head Start Program, P.O. Box 969, Ohkay Owingeh, NM 87566.** The information to be disclosed from my child's Health record is information related to Child Find 20___, or medical screenings required by the Head Start Program. I understand that I may revoke this authorization in writing at anytime.

_____ _____

Signature of Patient/Signature of Guardian **Date**

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal Agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3).

Patient Name (child):_____ Address: _____

Record #: _____ DOB: _____ City/State: _____

These are supporting documents that are needed with the ENIPC Head Start Application:

- ☐ Birth Certificate
- ☐ Social Security Card
- ☐ Enrollment for Certificate of Indian Blood
- ☐ Proof of Income
- ☐ Immunization Record
- ☐ ASQ/ASQ SE Survey
- ☐ Physical Form – Should include Height/Weight/Body Mass Index (BMI)/Blood Pressure
- ☐ HCT reading
- ☐ Lead Test Results
- ☐ Nutrition Screening Results
- ☐ Speech Screening Results
- ☐ Audiology Screening Results
- ☐ Behavior Health Screening
- ☐ Dental Screening
- ☐ Vision Screening
- ☐ IEP (if identified)

For more information please call or email:

Jolene Nelson

ENIPC

Head Start Director

505.901.3506 cell

jnelson@enipc.org

Website: enipc.org

Head Start Child Find

Name of Child: _____ ***Date***_____

Date of Birth: _____ ***Age of Child:*** _____

Parents Names: _____ ***Phone #***_____

Circle one: *ENIPC San Ildefonso Site* *ENIPC Nambe Site*

Height	Weight	BMI	BP	Screener's Signature/Date

Screening Description	Pass	Retest	Refer	Follow up date (Appointment)	Screener's Signature/Date
Nutrition					
ASQ DEV					
ASQ SE					
Speech					
Audiology					
Immunization Record					
Behavior Health					
Dental					
Vision					
Lead					
Physical					

Staff Use Only

Vital Records Verified? ____Yes ____No _____Staff Signature/Date

Income Records Verified? ____Yes ____No _____Staff Signature/Date

Application Reviewed? ____Yes ____No _____Staff Signature/Date