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 so a complete application may be reviewed
Please provide Proof of Age and Proof of Family Income with Application

Please print, and use a black/blue pen when filling out the application. Selection for Enrollment is based on: Income, Age, Special Needs of a Child, as well as other factors.

ELIGIBILITY OF CHILDREN: A Child must be 3 years old on or before the first day of school in the current School Year. Priority will be given to income eligible students.

☐ Proof of Income - that shows total family income (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 acceptance and enrollment are provided regardless of race, sex, creed, color, national origin, or developmental delay/disability.

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This section to be completed by Staff Only
☐ Check Stubs ☐ Foster Care
☐ SSI ☐ Letter (if un-employed)
☐ TANF/Public Assistance ☐ Homeless
☐ Tax Form 1040 ☐ Other: ______________

For more information please contact:

Jolene Nelson
Director
ENIPC Head Start
505.901.3506 cell
jnelson@enipc.org
Website: enipc.org
STUDENT INFORMATION:
Child’s Name: ____________________________ DOB: ___________ Sex: M or F
Race or Ethnicity: American Indian – Census/Enrollment #: ________ Tribe: ________ Other: ________
Primary Language spoken in the home: __________________________ Other Languages: ____________________

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: ________ Total in Family: ______

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
<th>DOB</th>
<th>Male or Female</th>
<th>Highest Grade completed</th>
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Are you interested in receiving information about other ENIPC programs, please check:
□ Food Distribution □ Environmental □ Peacekeepers □ Seniors □ Higher Education □ WIC □ Circle of Life
Behavioral Health □ Employment & Training □ Adult Vocational Training

EMERGENCY CONTACT INFORMATION:
Emergency contacts are required for each child. Please list emergency contact names and required
information. Contacts must be eighteen years of age. The EMERGENCY Contact Person must not be under
the influence of drugs and/or alcohol when picking up your child. Please let the teacher know when any
changes occur with your contacts.
I __________________________ give permission to the individuals below to pick up my child.
Parent Signature: ___________________________________________ Date: ____________________

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<th>1st Contact</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Relationship to child:</td>
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<tr>
<td>Home #:</td>
<td>Work #:</td>
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<th>2nd Contact</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Relationship to child:</td>
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<tr>
<td>Home #:</td>
<td>Work #:</td>
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<th>3rd Contact</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Relationship to child:</td>
</tr>
<tr>
<td>Home #:</td>
<td>Work #:</td>
</tr>
</tbody>
</table>

**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. If 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 __________________________ (child’s name).

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 during school, I authorize an ENIPC staff member to administer Basic First Aid and /or CPR.

_________________________________________  ______________________________
Parent/Guardian Signature                  Date

**Source of Health and Emergency Care:**
□ Indian Health Service □ Private Insurance or □ Medicaid □ yes □ 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 all school activities, and volunteer in the classroom or kitchen.*

_________________________________________  ______________________________
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. Outside field trips 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 your 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 food allergies/environment allergies? ___ yes ___no
If yes, please list______________________________
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: ____________________
For Official Accounting Use Only
Birth Certificate # ______________ Signature/Date: ____________________________

Social Security Card # __________ Signature/Date: ____________________________

Child’s Status: □ Income eligible □ Over income □ Special needs □ Other: __________
Is Child eligible to participate in the Head Start program? □ Yes □ No
Type of eligibility interview: □ In-person □ Telephone
What document was used for eligibility determination? ____________________________
Signature/Date: ____________________________

For Official Accounting Use Only - Income Verification for Head Start 20 ______

□ Weekly □ Bi-Weekly □ 2x a Month (eg.1st & 15th) □ Monthly □ W-2

Pay period: ____________________________
Last date of Pay Period: _____________________
# Of completed months: _____________________
Calculation: ____________________________

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Last date of Pay Period: _____________________
# Of completed months: _____________________
Calculation: ____________________________

# In head of household: ______

20___ Poverty Guidelines: ____________ Applicant Income_______________

□ Receives Public Assistance (TANF, SSI, General Cash Assistance, etc./HSPPS 1302.12.i.2

Prepared by: __________________________ Date: __________________________

Approved by: __________________________ Date: __________________________