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
- □ SSI
- □ TANF/Public Assistance
- □ Tax Form 1040
- □ Foster Care
- □ Letter (if un-employed)
- □ Homeless
- □ Other: _______________

For more information please contact:

Jolene Nelson
Director
ENIPC Head Start
505.901.3506 cell
jnelson@enipc.org
Website: enipc.org
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ENIPC Head Start Program - Application Packet

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)

Name	Relationship	Age	DOB	Male or Female	Highest Grade completed

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:____________________

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 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 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 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	**Height / Weight**
Dental	**ASQ (Ages & Stages) Social/Emotional**
Audiology	**ASQ (Ages & Stages) Developmental**
Speech and Language	**Classroom Observations**
Blood Pressure checks	

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 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 : _____________________________

Pay period: ______________________________
Last date of Pay Period: _____________________
Of completed months: ____________________
Calculation : _____________________________

In head of household: _______

20___ Poverty Guidelines: ____________ Applicant Income_______________

Prepared by _________________________ Approved by ___________________