Racine Kenosha Community Action Agency
Head Start Program 2014-2015

Application Instructions

- Please print clearly
- Fill in all information
- If you make a mistake, you must initial all corrections.
- **Sign and date each page.**
- Have the physical and dental exam forms completed, or provide a verification card for any upcoming appointments **(these will be required within 30 days after your child is enrolled.)**

At the time you submit the application you must bring the following items:

- ☐ **Birth certificate, baptismal certificate, or hospital record.**
- ☐ **Proof of income for the previous 12 months: prior year's tax forms, employment W-2's, or a recent letter from your employer.**
- ☐ **T.A.N.F. benefits verification - Examples: Child Care Subsidy Program, W-2 Payments, Kinship Care, SSI Caretaker Supplement, etc.**
- ☐ **An immunization record that is up-to-date.**
- ☐ **If your child is receiving services for a documented disability or special need, you must provide a copy of the I.E.P.**

Applications will not be processed for enrollment until all documentation is provided and verified. To qualify for the full-day program additional information is required and additional requirements must be met. Please consult the RKCAA Head Start Enrollment Office for details.

Return the completed application and the necessary documents to:

RKCAA Head Start Program Recruitment/Enrollment Office
1032 Grand Ave., Racine, WI 53403
(262) 633-0082 (se habla español)
Fax# (262) 635-8050
www.rkcaa.org

"PREPARING TOMORROW'S FUTURE TODAY"

Racine Kenosha Community Action Agency

Head Start Program

RKCAA Head Start's Mission Statement

The Racine/Kenosha Community Action Agency Head Start Program is in the business of shaping and preparing today's children to succeed in tomorrow's world. All participating children will enter school ready to learn and continue to be successful learners. We will accomplish this mission one child and one family at a time. Services provided will be of the highest quality and will constantly be modified to meet the needs of the families we serve. The RKCAA Head Start Program will become a part of a comprehensive system of integrated community services for young children in Racine County. We value families and children in all we do.

The Head Start Program is a **FREE**, federally funded, child development program designed to meet the needs of pre-school aged children from low income families.

The RKCAA Head Start Program provides:

- A quality education program designed to meet each child's individual needs.
- Free nutritious meals and snacks.
- Services for children with special needs.
- Comprehensive physical, mental health and nutrition services.
- Family support services to assist families in becoming self-sufficient.
- Opportunities for parents to be directly involved in the program operation and their child's education.

Families are eligible for program participation if their income meets the H.H.S. Poverty Guidelines*. (1305.2(I))Income means gross income including earned income, military income, veteran's benefits, social security benefits, unemployment compensation, and public assistance. If the family receives; Wisconsin Works (W-2) T.A.N.F. benefits (i.e. child care, W-2T, etc.) or the child is a foster child, they are considered eligible regardless of the income. Children with a documented disability are considered a higher need and are given priority.

2014 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090
For families/households with more than eight persons, add $4,060 for each additional person.	

The RKCAA Head Start Program believes that parents are the key to success in Head Start. As the primary educators of their children, parents are encouraged to be involved in and care about their child's education. Parents are invited to volunteer in all phases of the RKCAA Head Start Program.

R/K CAA HEAD START PROGRAM
2014-2015 Program Year

CHILD INFORMATION

Last Name: | **First Name:**

Race: Black Hispanic Native American Asian Pacific- Islander White Bi-racial Other_____

Ethnicity: _____

Gender

Date of Birth

Language: Primary _____ Secondary _____

English Proficiency: (Circle One) **Proficient Moderate None**

Primary Health Coverage: (Circle One) BadgerCare **Please submit current card**// Private/Work Insurance // None

Do you receive TANF Benefits? Yes No **Circle One:** ChildCare W2 Payments Kinship Care **Other:** _____ Foodshare

OPTIONAL: Does your child have a disability or special need? No Suspected _____ Yes (diagnosis, date and source) _____

FAMILY INFORMATION

Parental Status: Single Two Foster* Non-Parent*
*Must provide verification of placement

Number In Family:

Number Of Children In Family:

Number In Household:

Primary Adult:

Name: _____ **Date of Birth:** _____ **Race:**_____ **Relationship:**_____

Living in the Home: Yes No Primary Language:_____ **Pregnant: Yes No Child age of 1yr or younger: Yes NO**

Address: _____ **City:** _____ **Zip Code:** _____

Phone number: Home:_____ **Cell:** _____ **Message:**_____

Employment Status: (Circle One) Full Time Part Time Unemployed Student Disabled Retired

Highest Grade Completed in School: _____ **High School Diploma/GED:** Yes No

Employer/School Name: _____ **Phone number:** _____

Secondary Adult:

Name: _____ **Date of Birth:** _____ **Race:**_____ **Relationship:**_____

Living in the Home: Yes No Primary Language:_____ **Pregnant: Yes No Child age of 1yr or younger: Yes NO**

Address: _____ **City:** _____ **Zip Code:** _____

Phone number: Home:_____ **Cell:** _____ **Message:**_____

Employment Status: (Circle One) Full Time Part Time Unemployed Student Disabled Retired

Highest Grade Completed in School: _____ **High School Diploma/GED:** Yes No

Employer/School Name: _____ **Phone number:** _____

OTHER FAMILY MEMBER INFORMATION (lives in the home)

First and Last Name	Birth date	Relationship to child that is applying	Race	Gender
C02)				M F
C03)				M F
C04)				M F

I certify that this information is true. If any part is found to be false, my participation in this agency's programs may be terminated and I may be subject to legal action. I understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature_____**Date**_____

R/K CAA HEAD START PROGRAM
2014-2015 Program Year

CHILD'S NAME: ______________________________ BIRTH DATE: ______________________________

Transportation will NOT be provided	
PLEASE CHECK YOUR SITE AND SESSION PREFERENCE	
Site:	***Session***
Grand Site ☐	Morning ☐
Green Site ☐	Afternoon ☐
NGN ☐	Full Day ☐
Burlington Site ☐	*Additional Full Day Documentation Required*
Union Grove ☐	

EMERGENCY CONTACT / ESCORT INFORMATION		
Name:____________________ Relation:____________________ **Emergency Contact: Y or N Escort: Y or N**	Address: City, State, Zip:	Phone #s: Home ( )____________ Cell ( )____________ Work ( )____________
Name:____________________ Relation:____________________ **Emergency Contact: Y or N Escort: Y or N**	Address: City, State, Zip:	Phone #s: Home ( )____________ Cell ( )____________ Work ( )____________
Name:____________________ Relation:____________________ **Emergency Contact: Y or N Escort: Y or N**	Address: City, State, Zip:	Phone #s: Home ( )____________ Cell ( )____________ Work ( )____________
Name:____________________ Relation:____________________ **Emergency Contact: Y or N Escort: Y or N**	Address: City, State, Zip:	Phone #s: Home ( )____________ Cell ( )____________ Work ( )____________
Name:____________________ Relation:____________________ **Emergency Contact: Y or N Escort: Y or N**	Address: City, State, Zip:	Phone #s: Home ( )____________ Cell ( )____________ Work ( )____________

MEDICAL INFORMATION Does your child have a doctor? Yes No Does your child have a dentist? Yes No		
Child's Physician:____________________ Date of last visit: ____________________	Clinic Address: City, State, Zip:	Phone #: Fax #:
Child's Dentist: ____________________ Date of last visit: ____________________	Clinic Address: City, State, Zip:	Phone #: Fax #:

R/K CAA HEAD START PROGRAM

Student/Family Residence Questionnaire

Are you or your family living in any of the following situations:

- ☐ Staying in a shelter (family shelter, domestic violence shelter, youth shelter).
- ☐ Waiting for foster care placement.
- ☐ Sharing the housing of others due to financial difficulties.
- ☐ Living in a car, park, campground, abandoned building, or other inadequate accommodation.
- ☐ Temporary living in a motel or hotel due to loss of housing, financial difficulties or similar reason.
- ☐ Living without a parent or legal guardian (unaccompanied youth).

If you checked any box, please complete the following:

Please print information about you or your children ages 3-21.

Last	First	Middle	M/F	Birth Date

☐ **None of the above listed situations apply to me or my family**.

The undersigned certifies the information provided above is accurate.

_____

Print Name Signature Date

_____

Phone Street Address City State Zip Code

For Staff Use Only

Notes:

_____ _____

Staff Verification Date

R/K CAA HEAD START PROGRAM
ATTENDANCE POLICY 2014-2015

In order for a child to fully benefit from the RKCAA Head Start Program, he or she must attend on a regular basis. It is the responsibility of the parent or legal guardian to contact the center each day of the child's absence. If the center is not contacted after four consecutive days, the RKCAA Head Start Education Staff will contact the family to determine the reason for the child's absence. Please call the main office at 262-633-0082.

To be considered an **"EXCUSED"** absence, the center should be informed of an acceptable reason for the absence. **Failure to inform the center is considered an "UNEXCUSED" absence.** Your child may be withdrawn from the RKCAA Head Start Program if you fail to adhere to the attendance policy.

The following is a list of acceptable reasons for an "excused" absence; of course, any given reason will be considered, depending on the circumstances or situation.

- Illness of the child
- Illness of the parent
- Family Emergency requiring the parent and child to travel away from home
- Time spent away from home with a parent or other relative, as required by a court of law, or that is in the interest of the child.
- Transportation
- Vacation
- Inclement Weather
- Exemptions (will be excused for one week)

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I understand the RKCAA Head Start Program's Attendance Policy and I realize the importance of maintaining regular attendance and that my child may be dropped if policy is not adhered to.

_____ _____

Parent/Guardian Signature **Date**

_____

Child's Name (please print)

For staff use only

Notes:

Staff Verification: _____ Date: _____

R/K CAA HEAD START PROGRAM
AUTHORIZATION FOR PARTICIPATION AND SCREENING 2014-2015

Developmental Screening
I give my consent for my child to receive developmental, sensory and behavior screening by RKCAA Head Start Staff, volunteer or other agency contracted by the Head Start Program. Screenings are to determine my child's current level of functioning and for an individual learning program to be developed, based on results (Speech, Language, Growth and Development).

☐ **Yes** ☐ **No**

Health Screenings and Evaluations
I give my consent for my child to receive health related services from the staff and trained health volunteers. My child may be screened for height, weight, blood pressure, hearing and vision. The health staff/volunteers may observe in the classroom and consult with the teacher about my child's general health.

☐ **Yes** ☐ **No**

Mental Health
I understand that services of the Mental Health Consultation may include: review of school records, observation of student, interviews with the student and consultation of school personnel and/or parents. This consent does not include permission for psychological testing. Additional written permission is required before any formal testing can begin.

☐ **Yes** ☐ **No**

Escort Information
I will assure that my child is escorted to and from the RKCAA Head Start classroom by a person who is at least 12 years old and on the approved Release List.

☐ **Yes** ☐ **No**

Field Trips
I give my consent for my child to participate in field trips, which include neighborhood walks, realizing that all trips are adequately supervised and scheduled as an integral part of the classroom curriculum.

☐ **Yes** ☐ **No**

Media Release
If any pictures or videotapes are taken of my child, I give the RKCAA Head Start Program permission to use them to promote the program in television and/or newspaper ads, displays, bulletin boards, flyers, or other educational publications.

☐ **Yes** ☐ **No**

Mandated Reporting
I understand that all RKCAA Head Start employees are mandated reporters of suspected child abuse and neglect. Mandated reporters are required by law to report suspicions of child abuse and neglect to those agencies designated by the state to investigate such reports. ☐ **Yes** ☐ **No**

The RKCAA Head Start Program staff is obligated not to discuss information about my child or family with anyone outside of the RKCAA Head Start Program. I understand that the information I have shared with the RKCAA Head Start staff will be kept strictly confidential and can only be released when I have authorized it in writing.

Parent/Guardian Signature: _____Date:_____

Child's Name: _____ Birth date: _____

R/K CAA HEAD START PROGRAM

ALLERGY AND NUTRITION SCREENING FORM 2014-2015

CHILD'S NAME: _____ DOB: _____

Explain all YES answers

Does your child have any Food Allergies or Restrictions diagnosed by doctor? ☐ **Yes** ☐ **No**
(See form below)
Explain: _____

Is your child on a special diet* (i.e. medical, religious, lactose-free, diabetic)? ☐ **Yes** ☐ **No**
Explain: _____

List any foods your child should avoid eating. ☐ **Yes** ☐ **No**
Explain:_____

Does your child take vitamins and/or mineral supplements? ☐ **Yes** ☐ **No**
Explain:_____

Is your child a WIC participant? If YES, which location? ☐ **Yes** ☐ **No**

Rapids Dr._____ Burlington_____ Other_____

Does your child have trouble chewing or swallowing? ☐ **Yes** ☐ **No**
Explain:_____

Does your child have other nutritional needs? ☐ **Yes** ☐ **No**

Low Iron Anemia_____ High Lead Level_____ Underweight_____ Overweight_____

Do you have any other nutritional concerns for your child? ☐ **Yes** ☐ **No**

Explain: _____

It is the parent/guardian's responsibility to immediately inform the R/K CAA Head Start Nutrition Services staff of any newly diagnosed Food Allergies or Restrictions. The R/K CAA Head Start Program will not honor individual food preferences unless for medical or religious reasons.

Parent/Guardian Signature: _____ Date: _____

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****FOOD ALLERGY/RESTRICTION STATEMENT****

The physical exam form **must** be filled out and signed by a **physician** if your child has any food allergies, restrictions, or special diet requirements. Please note that food substitutions will not be granted unless a physician's statement is received.

Food Allergies/Restrictions:

Restrictions: _____

Reason for Restrictions: _____

I give permission to the R/K CAA Head Start Program Staff to substitute foods to meet my child's nutritional needs upon their discretion. All restrictions will be forwarded to the Nutrition Manager.

Parent/Guardian's Signature_____ Date_____

R/K CAA HEAD START PROGRAM
HEALTH & DEVELOPMENT SCREENING 2014-2015

Child's Name: _____ Birth Date: _____

	Y	N	EXPLAIN ALL ANSWERS
1. Did the mother have any health problems during pregnancy or delivery?			
2. Was your child born premature (3 weeks early) or born late?			
3. Were there any health problems when your child was born?			
4. What was the child's birth weight and length?			_____Lbs. _____oz., _____ Inches
5. Does your child use the toilet?			
6. Does your child have toileting accidents?			
7. Does your child brush his/her teeth?			
8. Has your child had the opportunity to play with other children in a group setting outside of the home?			
9. Does your child have problems sleeping or staying asleep at night?			
10. Has your child ever been hospitalized for a serious injury, accident, or illness?			
11. Is your child currently under a doctor's care for a medical condition?			
12. Is your child currently taking any medication on a regular basis?			
13. Does your child have any medical conditions which would interfere with his/her daily activities?			
14. Does your child wear glasses or have difficulty seeing?			
15. Has your child ever had a convulsion or seizure to your knowledge?			
16. Has your child ever had hives or boils?			
17. Does your child have any allergies? (Please list.)			
18. Did a doctor or health care professional tell you your child had allergies? If YES, when were you told.			

Has your child having problems in any of the following areas?

Health____ Speech____ Hearing____ Gross Motor Skills____ Emotional____ Behavioral____ Developmental____

Explain: _____

Check any of the following that your child has had or currently has (give dates):

Asthma _____	Chicken Pox_____	Ear Infection_____	Eye Infection _____
Bronchitis _____	Tuberculosis_____	Hepatitis ____	Urinary Tract Infection ____
Diabetes _____	Pneumonia _____	Sickle Cell _____	Epilepsy _____
Anemia _____	Scarlet Fever_____	Lead Poisoning_____	Skin Problem_____
Head Injuries_____	Liver Disease_____	Heart Disease_____	Eczema_____

Explain: _____

I agree to immediately notify the RKCAA Head Start Program Health Services staff of any newly diagnosed medical conditions and/or other health issues regarding my child.

Parent/Guardian Signature: _____Date:_____

R/K CAA HEAD START PROGRAM
DENTAL HISTORY FORM 2014-2015

Child's Full Name: __ Date of Birth: _____ Sex: _____

Home Address/ZIP: _____ Phone Number: _____

1. Has your child previously been seen by a dentist? YES_____ NO____ Date of Service: _____

   Name of dentist/clinic: _____

2. Has child complained of any previous dental problems? YES_____ NO_____

   If yes, please explain: _____

3. Has the child ever experienced bleeding, chewing or swallowing problems? YES____ NO_____

   If yes, please explain: _____

4. During the past six months, has your child had a toothache more than once when chewing? YES_____ NO_____

5. Does your child:

   a. brush his/her teeth daily? YES_____ NO_____

   b. floss every day? YES_____ NO_____

   c. take a fluoride supplement? YES_____ NO_____ Select one: ____Tablet ____Liquid ____Other

6. Does your child drink (circle the correct one): bottled, city, or well water?

7. Has your child had any injuries to mouth, teeth, head? YES _____ NO _____

8. Is your child allergic to Latex ____ Penicillin _____ Please list any other allergies: _____

9. Is your child under a physician's care? YES_____ NO_____
   What for? _____ Physician's name: _____

10. Does your child have, or has your child ever had, any of the following?

    a. ____ Rheumatic Disease/Heart Problems
    b. ____ Cancer
    c. ____ Hemophilia or bleeding problems
    ____ Asthma
    ____ Tuberculosis (TB)
    ____ Epilepsy

11. Please describe any checked problems, or list any other health problems: _____

12. Has your child ever had a traumatic experience at the dentist's office? Please describe:
    _____

_____ _____

Parent/Guardian Signature Date

Room: _____ AM/PM

R/K CAA HEAD START PROGRAM
DENTAL EXAM FORM 2014-2015

Head Start Main Office
1032 Grand Avenue
Racine, WI 53403
Phone: (262) 633-0082
Fax: (262) 635-8050

Child's Name: _____ D.O.B.:_____ Head Start Site: _____

TO BE COMPLETED BY DENTAL PROVIDER

Today's exam includes the following:

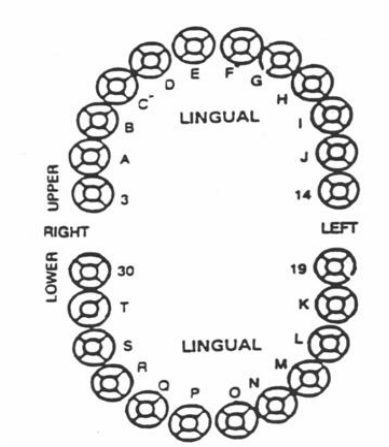
	Completed	Still Needed
Oral Exam	☐	☐
Fluoride Varnish	☐	☐
X-rays	☐	☐
Prophy	☐	☐

ORAL CONDITIONS BEFORE TREATMENT:

MISSING ⊗

DECAYED ●

FILLED ⊗



EXAMINATION AND TREATMENT RECORD		
TOOTH #	**DESCRIPTION OF WORK**	**DATE OF SERVICE**

Child needs follow up appointment for:

Untreated decay ☐ Urgent Care ☐ Fluoride Therapy ☐

CHILD ORAL HEALTH SUMMARY

All planned treatment (____is, _____is not) complete. If not, explain here: _____

_____

Comment/Special Considerations:

_____

_____

_____

Provider signature

Date

Clinic Name

Phone number

Room: _____ AM/PM

RKCAA HEAD START PROGRAM
PHYSICAL EXAM FORM 2014-2015

Head Start Main Office
1032 Grand Avenue
Racine, WI 53403
Phone: (262) 633-0082
Fax: (262) 635-8050

PROVIDER PLEASE NOTE: Federal Head Start Guidelines require information regarding this child's Hemoglobin, Lead Level, Blood Pressure, Height/Weight, Hearing and Vision screenings.

Child's Name:	Date of Birth:	Parent/Guardian Name:

Date of Exam:	BP: ☐ Nrml ☐ Abnl	Height: ☐ Nrml ☐ Abnl	Weight: ☐ Nrml ☐ Abnl	Vision: ☐ Nrml ☐ Abnl R: L: B:	Hearing: ☐ Nrml ☐ Abnl R: L:

If not done within one year, please indicate date and results from most recent test.

Hemoglobin	Most recent date:	Result:	Current Risk? Yes or No
Lead	Most recent date:	Result:	Current Risk? Yes or No

PHYSICAL EXAM	ABNORMALITIES? YES	NO	DESCRIPTION
Head			
EENT			
Heart			
Lungs			
Abdomen			
Hernia			
Musculo-Skeletal			
Genitalia			
Skin			
Neurological			
Gait/Posture			

Important Health Problems	YES	NO	DESCRIPTION
Allergies (please see reverse)			Type & Restrictions
Daily Medications			Type & Dosage
Nutritional Concerns			Describe any dietary accommodations
Developmental Concerns			
Mental Health			
Disabilities			
Asthma			
Seizures			
Diabetes			
Other			

Describe any significant medical, surgical or illness history in past 2 years:

Please attach child's immunization record to this form.

Are Immunizations up to date? Yes No If no, please list next appointment date:

Recommendations for Treatment, Evaluations, Social and/or Educational Service:

Referrals made to:

Can this child have a regular diet at school, including milk? Yes No *****If No, please see back of form

On the basis of my findings, indicated above, and knowledge, of the above named child, I find that: (s)he is free from contagious and communicable disease and is able to fully participate in all Head Start indoor and outdoor activities. Yes No

Comments:

Are you this child's primary medical provider? Yes No

Provider's signature: _____ Date: _____

Provider/Clinic stamp:

****** If child has a diagnosed food allergy you will need the following:**

1. **MD prescription stating very clearly, the allergy, and what needs to be avoided, also must include any substitutions that are allowable.**
   Example: Child has a cow's milk allergy, however can substitute with soy milk. If peanut/nut allergy, please indicate environment and/or ingestion only.
2. **If the child requires an Epipen, MD must complete a written medication consent form in addition to the MD prescription (please request from Head Start).**

Please note we need these required documents in place to accommodate children in the program. If you have any questions regarding food allergies, please call our Health Coordinator at 262-633-0082 Ext: 203.