Racine/Kenosha Community Action Agency

Head Start Program

2011-2012 Program Year

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 R/K CAA Enrollment Office for details.

Return the completed application and the necessary documents to:

R/K CAA Head Start Program Recruitment/Enrollment Office
1032 Grand Ave., Racine, WI 53403
(262) 632-3884 or (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

R/K CAA 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 R/K CAA 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 R/K CAA Head Start Program provides:

- A quality education program designed to meet each child's individual needs.
- Free nutritious meals and snacks.
- Free transportation to and from the half-day sessions.
- 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.

2011 HHS Poverty Guidelines

Family Size	Yearly Income
1	$10,890
2	$14,710
3	$18,530
4	$22,350
5	$26,170
6	$29,990
7	$33,810
8	$37,630
for each additional person add	$3,820

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.

The R/K CAA 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 R/K CAA Head Start Program.

R/K CAA HEAD START PROGRAM
2011/2012 Program Year

CHILD INFORMATION

Last Name: | **First Name:**

Middle Name: | **Social Security #:**

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:** _____

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:** _____ **Relationship:**_____ **Living in the Home:** **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:** _____ **Relationship:**_____ **Living in the Home:** **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

First and Last Name	Birth date	Relationship to child that is applying	Social Security Number	Gender
(do not list child that is applying)				
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
2010/2011 Program Year

CHILD'S NAME: ______________________________ BIRTH DATE: ______________________

TRANSPORTATION

How will your child get to and from the center? Bus Parent will transport Day care Name of Day Care/Child Care Provider________________________

**If you are requesting bus service, you must provide the following information. **

Busing Address

The busing address will determine which site your child will be enrolled in and also whether your child attends an a.m. or p.m. session.

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 ( )__________

MEDICAL INFORMATION

(Does your child have a doctor and/or 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 #:

RACINE KENOSHA COMMUNITY ACTION AGENCY SERVICES

Please mark if you would be interested in receiving information regarding the following RK CAA Programs.

By marking, you will be allowing Head Start to share contact information to the RK CAA Agency.

Energy Assistance	**Wisconsin Home Energy Assistance Program – Assists with energy bill payments**	☐
Weatherization	**Services to help you reduce your home energy cost and conserve energy**	☐
Rental Assistance	**One time financial assistance resources for clients who are homeless or at risk of becoming homeless**	☐
Homeless Prevention	**Services for families who are in imminent risk of becoming homeless and need rent or utility assistance**	☐
Rapid Re-Housing	**For families who are experiencing homelessness and need temporary assistance**	☐
Food Pantry	**Emergency food and nutrition services**	☐

R/K CAA HEAD START PROGRAM

ATTENDANCE POLICY

In order for a child to fully benefit from the R/K CAA 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 R/K CAA Head Start Education Staff will contact the family to determine the reason for the child's absence.

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 R/K CAA 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
- Quarantine
- 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)

= =

I understand the R/K CAA 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) **Staff Verification**

R/K CAA HEAD START PROGRAM

AUTHORIZATION FOR PARTICIPATION AND SCREENING

I give consent for the RKCAA Head Start Program to perform all required screenings, assessments, and observations, which may include, but are not limited to: hearing, vision, blood pressure, height, weight, lead level, behavioral observations and developmental assessments.

☐ **Yes** ☐ **No**

I give permission for my child to participate in neighborhood walks, field trips, and other program activities. All trips are adequately supervised and are scheduled as an integral part of the RKCAA Head Start curriculum.

☐ **Yes** ☐ **No**

I agree to allow center staff to make home visits during the school year at my convenience.

☐ **Yes** ☐ **No**

I will assure that my child is escorted to and from the RKCAA Head Start classroom and/or the assigned bus stop by a responsible person who is at least 12 years old.

☐ **Yes** ☐ **No**

All children must be signed in and signed out by a parent/guardian upon arrival and departure to the RKCAA Head Start Program.

☐ **Yes** ☐ **No**

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**

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**

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

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._____ Health Dept._____ 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:_____

****

FOOD ALLERGY/RESTRICTION STATEMENT

This 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 signature is provided.

Food Allergies/Restrictions:

Restrictions:_____

Reason for Restrictions:_____

Physician's Signature_____ Date_____

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

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.			

Is 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 R/K CAA 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
IMMUNIZATION RECORD

CHILD'S NAME:_____ **DOB:**_____

Wisconsin State Law requires all children in childcare or preschool centers provide written evidence of immunizations against certain disease within 30 days of admission. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the licensed facility (see below).

A complete immunization record consist of:

3 POLIO - 4 DTP/DTaP - 3 HIB - 3 HEP B - 1MMR - 1VARICELLA – 4 PREVNAR

Immunizations this child has received:

VACCINE	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE
DTP/DTaP					
POLIO					
MMR					
HIB					
HEB B					
PREVNAR					
VARICELLA					

*** If the child has had the chicken pox disease you must inform the enrollment staff of the month and year***

----------CERTIFICATION----------

I certify that the above named child has had the immunizations listed above.

Physician's signature:_____Date:_____

Other Health Care Professional:_____Date:_____

WAIVER REQUEST

In accordance with state law {S. 140.06(6)}, a child may be excluded from an immunization or series of immunizations with a signed waiver from a doctor or parent/legal guardian. Please indicate the reason for the waiver request. If it is a medical waiver a physician must sign this form.

I request a waiver for the reasons stated: _____

_____

_____

Parent or legal guardian: _____Date:_____

Physician: _____ Date:_____

R/K CAA HEAD START PROGRAM
PHYSICAL EXAMINATION FORM

Room: _____AM/PM

CHILD'S NAME:_____Sex:_____DOB:_____

All physical forms are valid for one year from the completion date

SHADED ITEMS ARE REQUIRED AS PART OF A COMPLETE PHYSICAL EXAMINATION

REQUIRED	DATE	RESULTS	OPTIONAL	DATE	RESULTS
A. Blood Pressure			H. TB Test (optional)		
B. Hearing			I. Sickle Cell (optional)		
C. Hemoglobin					
D. Height					
E. Lead					
F. Weight					
G. Vision					

PHYSICAL EXAMINATION/ASSESSMENT	NORMAL	ABNORMAL	COMMENTS OR GENERAL FINDINGS
a. General Appearance			
b. Posture, Gait			
c. Speech			
d. Head			
e. Skin			
f. Eyes (1) External Aspect			
(2) Optic Fundoscopic			
(3) Cover Test			
g. Ears (1) External and Canals			
(2) Tympanic Membranes			
h. Nose, Mouth, Pharynx			
i. Teeth			
j. Heart			
k. Lungs			
l. Abdomen (include hernia)			
m. Genitalia			
n. Bones, Joints, Muscles			
o. Neurological/Social			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication Skills			
(4) Cognitive			
(5) Self Help			
(6) Social Skills			
p. Glands (lymphatic/thyroid			
q. Muscular Coordination			

Is a follow-up visit needed for this appointment? ❒ **yes** ❒ **no** **Date of next appointment:_____**

Physician/ Health Professional Signature:_____ **Date of examination:_____**

R/K CAA HEAD START PROGRAM
DENTAL HISTORY / EXAMINATION FORM

Room: ____AM/PM

CHILD'S NAME:_____DOB:_____

All dental forms are valid one year from the completion date

DENTAL HISTORY
To be completed by the parent/legal guardian

1. **ANY PREVIOUS DENTAL PROBLEMS?**
   YES_____ NO_____
   If yes, please explain:_____

2. **HAS THE CHILD EVER EXPERIENCE BLEEDING, CHEWING OR SWALLOWING PROBLEMS?**
   YES_____ NO_____
   If yes, please explain: _____

3. **HAS YOUR CHILD PREVIOUSLY SEEN A DENTIST?**
   DATE OF SERVICE: _____

4. **DOES YOUR CHILD:**
   - **(a) Brush his/her teeth daily? YES_____ NO_____**
   - **(b) Receive Fluoridated Water? YES_____ NO_____**
   - **(c) Fluoridated Supplement? YES_____ NO_____**

   _____TABLET _____LIQUID _____NONE

5. **IS THE CHILD UNDER A PHYSICIAN'S CARE? YES_____ NO_____**
   PHYSICIAN'S NAME: _____

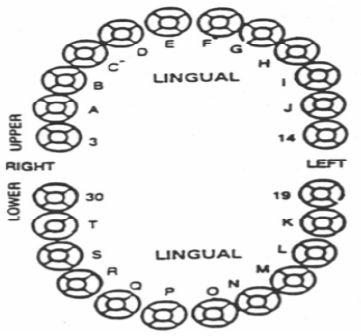
DENTAL EXAMINATION
To be completed by Dentist

ORAL CONDITIONS BEFORE TREATMENT:

MISSING ⊗

DECAYED ⊗

FILLED ⊗



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

DATE OF EXAMINATION:_____ IS ALL PLANNED TREATMENT COMPLETED? _____YES_____NO

DENTIST SIGNATURE:_____NEXT APPOINTMENT DATE?_____