ROCK-WALWORTH HEAD START RETURNING CHILD APPLICATION
PROGRAM YEAR 2020-2021

Dear Families,

Please complete and return the attached application packet for your currently enrolled Head Start child. Completed packets should be given to your child's classroom teacher or your Family Service Coordinator. When the application is received a spot will be reserved for your child for the fall. Spots **CANNOT** be reserved without the application and space and class sizes are limited.

It is **NOT** necessary for returning children to provide proof of income. The income provided for this year will be carried over to the 2020-2021 program year. **If this will be your child's **THIRD YEAR** we **WILL** need proof of your **2019 income**. ** **SIBLINGS** applying for Head Start/Early Head Start **WILL** also need to provide proof of income. **

Children that will be 4 on or before September 1, 2020 may qualify for 4K (4 year old kindergarten) if your community offers it. If your child will be in a Head Start/4K classroom next year you will need to register with your local school district. Further information regarding Head Start/4K will be sent to you as we receive it.

HEAD START RETURNING CHILD CHECKLIST		
	APPLICATION	
	IMMUNIZATION RECORD	
	PHYSICAL	
	DENTAL EXAM (ages 3-5 only)	
	TRANSPORTATION FORM	
	4K PAPERWORK (Beloit & Janesville only)	

☺ Reminder: Please make sure your child's Physical, Immunizations and Dental exams are up-to-date before school starts. If you need these forms please contact your child's classroom teacher or your Family Service Coordinator.

☺ Transportation forms will be given to you prior to the end of classes, in May. We **MUST** have transportation information prior to placement.

☺ If ANY CHANGES occur over the summer please call the Enrollment Office!

Enrollment Department,

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2ND YEAR RETURNING CHILD APPLICATION

THIS APPLICATION SHOULD ONLY BE FILLED OUT & SIGNED BY THE LEGAL PARENT/GUARDIAN(S)

1. Child's Name: _____

DOB: _____ ☐Female ☐Male

Home Address: _____

APT/LOT # CITY ZIP COUNTY

Mailing Address (if different):

2. CHILD LIVES PRIMARILY WITH: (Check all that apply)

	Both parents/Same house		Mother		Father
	Legal Step-Parent		Girlfriend		Boyfriend
	Grandparent(s)		Foster Parent		Legal Guardian

	Other:

Is one parent away on military duty? **NO** **YES**
Is mom pregnant? **NO** **YES** **UNSURE** If yes, when is due date:

3. CURRENT LIVING ARRANGEMENT:

☐Rent ☐Own ☐Living with family/friend ☐Homeless: this means that you're mainly is staying in a car, park, hotel, emergency shelter, staying on the street, transitional housing, or you are **temporarily** living with another family member/friend.

4. PRIMARY PARENT/ LEGAL GUARDIAN #1:

NAME: _____

DOB: _____ **STATUS:** ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

	Birth Mom		Birth Dad
	Legal Step-Parent		Adoptive
	Foster		Guardian

	Other:

Race/Ethnicity: _____

Hispanic? YES NO

Primary Language: _____

Primary Phone: **H C W**	Opt in for text messages: **YES** **NO**
Secondary Phone: **H C W**	E-Mail:
English speaking ability: **NONE** **LITTLE** **MODERATE** **PROFICIENT**	

5. PRIMARY PARENT/ LEGAL GUARDIAN #2:

NAME: _____ DOB: _____

	Birth Mom		Birth Dad
	Legal Step-Parent		Adoptive
	Foster		Guardian
	Other:		

Race/Ethnicity: _____

Primary Language: _____

Custody: **YES** **NO** **SHARED**

Primary Phone: **H C W**	Opt in for text messages: **YES** **NO**
Secondary Phone: **H C W**	E-Mail:
English speaking ability: **NONE** **LITTLE** **MODERATE** **PROFICIENT**	
Address if different than child's:	

6. ADDITIONAL CONTACT PERSON(S) IN CASE WE CANNOT REACH YOU

1. _____
   Name Relationship to child Phone

2. _____
   Name Relationship to child Phone

7. SIBLINGS IN THE HOME

First Last Relationship

1. _____ ☐Male ☐Female DOB: _____
2. _____ ☐Male ☐Female DOB: _____
3. _____ ☐Male ☐Female DOB: _____
4. _____ ☐Male ☐Female DOB: _____
5. _____ ☐Male ☐Female DOB: _____

PLEASE CONTINUE ON BACK IF YOU NEED MORE SPACE

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

For enrollment purposes, I understand that RWCFS Head Start/Early Head Start may need to coordinate programming with my local school district, WI Shot Registry, other home visitation programs, and/or daycare providers for transportation, placement, 4K registration, and scheduling.

By signing, I verify that I am the parent/legal guardian of this child and that the information provided is correct and complete to the best of my knowledge. I further understand that if I knowingly provide false information, that my family may no longer be eligible for further services.

Signature_____ Date_____

Signature_____ Date_____

OFFICE USE ONLY:

	Transportation Form		Health History Form
	Parent/Guardian Permission for Screenings/Testing		Immunizations
	Income (if 3rd year)		Interview (if 3rd year)

POINTS: DATA ENTERED BY: REVIEWED BY:

CC: _____

ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES INC.

HEAD START AND EARLY HEAD START® *Serving Rock & Walworth Counties*

Parent/Guardian Permission to Provide Required or Beneficial Screenings/Testing
Program Term 2020-2021

Child's Name: _____
Last Name First Name MI Date of Birth

Name of parent/guardian authorizing release: _____
Last Name First Name MI Date of Birth

In order to meet required Federal Performance Standards, and as schedules and budgets allow, we provide a health, social/emotional and oral health wellness program throughout the year. RWCFS strives to provide the following services for each participating child. If you would like your child to participate in this program and receive any or all of these services, please sign and date for your permission below.

For the services below, please check YES or NO if you want your child to participate.	**YES**	**NO**
1. **HEARING AND VISION SCREENINGS** provided by local health department nurses or trained RWCFS staff.		
2. **OBTAINING RESULTS OF LEAD AND HEMOGLOBIN TESTING** by the Wisconsin Lead Registry database or the local WIC program (this does not give permission to perform the testing).		
3. **OBSERVATIONS AND/OR SOCIAL/EMOTIONAL OR SENSORY SCREENINGS** completed by a licensed professional (Mental Health Consultant). This professional primarily provides observations of children's' behaviors, concerns expressed by staff and provides recommendations to support staff in working effectively with all children.		
4. **DEVELOPMENTAL SCREENINGS**		
5. **BLOOD PRESSURE SCREENINGS** provided by trained RWCFS staff or health professionals		

This permission will be valid for the program year stated above or for one year following the date of the signature (whichever is later), unless otherwise stated: _____. This information is confidential and will be used to support programming which meets this child's unique needs and goals.

I release the Rock-Walworth Head Start/Early Head Start Program and its staff, outside agencies and staff, from any legal liability for performing services in collaboration with community professionals or professional contracted consultants which I have permitted by signing this form for the period stated above. This permission may be withdrawn, in writing, at any time by the person signing this form, except to the extent that service has already been in reliance upon authorization. Withdrawal of the authorization will be effective following receipt of the written request by RWCFS Head Start/Early Head Start.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

CC: _____

ROCK-WALWORTH COMPREHENSIVE FAMILY SERVICES INC.

HEAD START AND EARLY HEAD START® . *Serving Rock & Walworth Counties*

Health / Nutritional History

Child's Name: _____ Date of Birth: _____

Child's Doctor: _____ Clinic Name/Phone: _____

Child's last Well Child Check: _____ *(We will need a copy if your child is enrolled)*

Child's Dentist: _____ Clinic Name/Phone: _____

Child's last Dental Exam: _____ *(We will need a copy if your child is enrolled)*

Insurance Coverage: □ Private □ Badger Care/Medicaid □ None □ Other_____

Does your child have or did he/she have?	**Yes**		**No**	**Medication**		**Explanation (as needed)**
	Now	**Past**		**Yes**	**No**	
Asthma						
Seizures						
Heart Issues						
Diabetes						
High Lead Level						
Sickle Cell Disease						
Anemia						
Vision Concerns						Glasses? Yes No
Hearing Concerns						Hearing Aids? Yes No Tubes? Yes No
Any Other Health Concerns?						

Will any medication need to be given while here? Yes No
If yes, please list:

Has your child ever had surgery? Yes No **Been in the hospital?** Yes No
If yes, please explain:

Does your child have any allergies to food? Yes No **Other Allergies?** Yes No
If yes, please list:

How does he/she react?

Does your child have any other food restrictions? Yes No
If yes, to what and why:

Was your child born more than 2 weeks early? Yes No	**If yes, how early?**
Were there any concerns with the pregnancy or birth? Yes No	**If yes, explain:**
Do you or your child's doctor have a concern about your child's development? Yes No If yes, please explain:	

Is your child potty trained? Yes No	**Concerns?**
Will he/she need to use diapers/pull ups at school? Yes No	**If yes, what size?**

Has your child seen a dentist? Yes No	**Does your child drink fluoridated water?** Yes No
Has your child ever had a cavity? Yes No	**Does your child complain of mouth pain?** Yes No
How many times a day does your child brush? _____	**Does he/she get help brushing?** Yes No

Does anyone in the household smoke (includes cigarettes, electronic cigarettes, Juul, etc.)?	Yes No
If yes, would you like information on how and why to quit?	Yes No
Would you be interested in a class/support group for people trying to quit?	Yes No

Nutrition Questions			
Foods your child really likes?			
Foods your child doesn't like?			
How does your child feel about meal time?	□ Enjoys	□ Not Interested	□ Needs Encouragement
How is your child's appetite?	□ Good	□ Average	□ Picky □ Poor
Do you have concerns about what your child is eating? □ Yes □ No **If yes, Please explain:**			
Do you have concerns about your child's weight? □ Yes □ No **If yes, Please explain:**			
Any problems with: □ Diarrhea □ Constipation □ Vomiting □ Other **If anything marked, please explain:**			
Do you have any questions or concerns about your child's nutrition that we can help with? □ Yes □ No **If yes, please explain:**			
Do you participate in WIC? □ Yes □ No	**Would you like information on the WIC program?** □ Yes □ No		

Does your child:	**Yes**	**No**	**Comment**
Eat solid food			
Drink from a cup			
Feed self			
Take a bottle			
Eat or chew things that aren't food			
Have trouble swallowing or chewing			
Have more than 1 sugary item a day			
Exercise at least 1 hour every day			
Have more than 2 hours screen time			

For Babies under 12 months:			
	Yes	**No**	**Comment**
Does your baby get breast milk?			
Does your baby get formula?			Type?
How often does your child eat/get fed?	Every _____ hours		
Any food introduced? Please list:			

By signing below, I understand that I am responsible for providing any needed medical, dental, and nutritional records RWCFS requests in order to ensure my child is safe and has his/her unique needs met while in their care. I understand my child may not be able to attend in a classroom until appropriate documentation from a licensed medical provider is given, a plan is completed for care, and/or staff receive needed training. With my signed consent, I understand that RWCFS can support me in getting required records.

_____ _____

Parent/Guardian Signature Date

_____

2nd Year - Parent/Guardian Recertification Date