ROCKINGHAM COUNTY HEAD START 705 Ayersville Rd. Madison, NC 27025 Tel. (336)349-4762

Applicant & Family Member Information

Applicant

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

Other Language Proficiency
☐ Poor
☐ Moderate
☐ Proficient

Primary Health Coverage | Other Health Coverage | Insurance # | Medicaid | Medicaid # | Doctor | Dentist

Medicaid
☐ Not Eligible
☐ On Medicaid
☐ Potentially Eligible

Adult 1

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

Other Language Proficiency
☐ Poor
☐ Moderate
☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col Deg/Train ☐ Grade 12
☐ Col or Adv Train ☐ < Grade 9
☐ GED ☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐ Seasonal ☐ Training or School
☐ Unemployed ☐ Retired or Disabled

Child's Relationship
☐ Natural/Adopted/Step
☐ Grandchild
☐ Niece/Nephew
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

E-mail Address: _____

Adult 2

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

English Proficiency
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

Other Language Proficiency
☐ Poor
☐ Moderate
☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Grade 10
☐ Bachelor's ☐ Grade 11
☐ Col Deg/Train ☐ Grade 12
☐ Col or Adv Train ☐ < Grade 9
☐ GED ☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time ☐ Full Time & Training
☐ Part Time ☐ Part Time & Training
☐ Seasonal ☐ Training or School
☐ Unemployed ☐ Retired or Disabled

Child's Relationship
☐ Natural/Adopted/Step
☐ Grandchild
☐ Niece/Nephew
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

E-mail Address: _____

Additional Child (Non-Applicant) *

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
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☐ No

English Proficiency
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☐ Proficient

Other Language

Other Language Proficiency
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First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

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☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

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☐ Yes
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English Proficiency
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language

Other Language Proficiency
☐ Poor
☐ Moderate
☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
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☐ White	☐ Multi-Racial		☐ None		☐ None
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☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ____________			☐ Proficient		☐ Proficient

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Living Address

Started Living At Date | Living Address | Address Line 2 | ZIP | City | State | County

Family Mailing Address

Same as living? ☐ Yes ☐ No | Started Using Date | Mailing Address | Address Line 2 | ZIP | City | State

Phone Number(s)	Type (*check one*)	Note (extension or best time to call)	Opt In for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Family Income

Income Verified by | Verification Date | TANF Status | SSI

☐ Yes ☐ No ☐ Yes
☐ Formerly on TANF/Not now ☐ No

Family Member	*Amount*	*Per (for example: week, month, year)*	*Annual Amount*	*Description (for example: SSI, Job, Child Support)*	*Verification (for example: W2, check stub)*	*Note*
	$		$			
	$		$			
	$		$			

Income Notes

Emergency Contacts

Contact 1

Name | Relationship | Emergency Contact ☐ Yes ☐ No | Release To ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 2

Name | Relationship | Emergency Contact ☐ Yes ☐ No | Release To ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 3

Name | Relationship | Emergency Contact ☐ Yes ☐ No | Release To ☐ Yes ☐ No

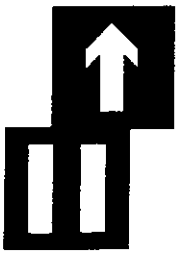
Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also 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 _____

Rockingham County
Governmental Center
Wentworth, NC 27375



Rockingham County
HEAD START
591 NC HWY 65
Reidsville, NC 27320
(336) 349-4762
Fax (336) 342-6634

STANDARD RELEASES

I, _____(Parent or guardian of)_____

AGREE:

That any picture of my child may be used in newspaper, on display, on bulletin boards, or in other types of educational publications.

That I will comply with the rules and regulations of the Head Start program to the best of my ability.

That Head Start staff may arrange to visit me in my home when it is necessary. (I also understand that home visits are a requirement and are a part of the federal regulations.)

That my child may participate in all health activities in which dental, hearing, vision, speech, screenings and physical examinations are given as part of the Head Start program.

That Head Start personnel may provide transportation and professional treatment for my child in the case of an medical emergency. If neither I nor my family physician can be contacted, I authorize Head Start personnel to select a physician to treat my child.

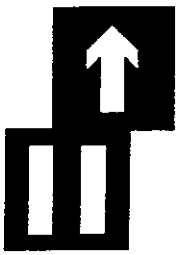
That medical and dental services which medical and dental experts state are necessary for my child's health can be arranged by staff of Rockingham County Head Start and that reports or examinations and services rendered by health specialists can be released for Head Start records. I will try to accompany my child for health service appointments and provide transportation whenever possible.

That my child be evaluated by professionals in the field of mental health, if a need for evaluation is demonstrated, and for recommended services to be arranged by Head Start personnel.

That information in my child's records (i.e. physical, immunization records, reports from health professionals, nutrition or health forms, and handicap information) will be passed on to the schools and/or health delivery systems upon request by such. I understand that all information concerning my child and this application will be kept confidential and will be used only to improve my child's educational potential.

_____
Signature of parent/guardian

Rockingham County
Governmental Center
Wentworth, NC 27375



Rockingham County
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591 NC HWY 65
Reidsville, NC 27320
(336) 349-4762
Fax (336) 342-6634

_____
Child's Name

_____
Center

I, _____ give my permission for

_____ to release information to the Rockingham County Head Start program. This information is to be used only as verification of income for enrollment purposes in the Head Start program.

Applicant's Signature_____

Address _____

Witness _____

Date _____

Caseworker/Contact person _____

Benefit or Salary amount received from _____ to _____

_____

_____

_____

Caseworker/Contact person signature_____

Date _____

I understand that I may revoke this release of information at any time, in writing, except where the agency has already made disclosures in reliance upon my prior authorization.

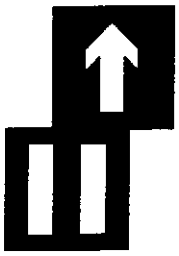
Parent/Guardian Signature: _____ Date: _____

Relationship to Child(ren): _____

Staff Signature: _____ Date: _____

This authorization expires 300 days after it is signed unless revoked earlier

Rockingham County
Governmental Center
Wentworth, NC 27375



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PERMISSION FOR RELEASE OF INFORMATION

I approve the release of any psychological, medical, and/or speech/language information concerning _____ which is on file at _____.

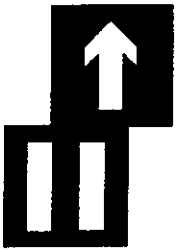
This information will be released to Rockingham County Head Start. It is my understanding that this information will be kept confidential and will be used only in assisting in planning an appropriate program for my child or for release to the Social Security Administration in the event that the guardians wishes to apply for SSI for this child.

Signature_____

Relationship_____

Date_____

Rockingham County
Governmental Center
Wentworth, NC 27375



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AUTHORIZATION TO RELEASE INFORMATION

Parent's Name: _____

Child(ren)'s Name: _____

I understand that the State of North Carolina has created a system that combines limited information about children and families who receive services from publicly-funded programs like the Head Start and Early Head Start programs into a single, statewide system called the NC Early Childhood Integrated Data System (NC ECIDS)

I understand that the purpose of NC ECIDS is to help provide answers to important policy and program questions about publicly-funded programs administered in North Carolina; as well as those questions that my local Head Start or Early Head Start program may have about the services offered in the county(ies) in which it operates.

I understand that NC ECIDS is requesting my permission to receive the following information about my child(ren) and family to be included in NC ECIDS:

Child's Name*	Primary Language
Child's Date of Birth	Category of Enrollment Eligibility
Child's Gender	Health Insurance Status
Child's Race	

**I understand that my child's name will <u>never</u> be released publicly in any report*

I understand that allowing data about my child(ren) and family to be released to NC ECIDS is voluntary and is not a requirement for my child to be enrolled in the Head Start or Early Head Start Program.

_____ I authorize Rockingham County Head Start to release the information about my child(ren)/family noted above to NC ECIDS

_____ I DO NOT authorize Rockingham County Head Start to release the information about my child(ren) family noted above to NC ECIDS

Please sign on the back

I understand that I may revoke this release of information at any time, in writing, except where the agency has already made disclosures in reliance upon my prior authorization.

Parent/Guardian Signature: _____ Date: _____

Relationship to Child(ren): _____

Staff Signature: _____ Date: _____

This authorization expires 300 days after it is signed unless revoked earlier

ROCKINGHAM COUNTY HEAD START
RESIDENCY FORM

The purpose of this form is to determine the extent to which the family is living in a fixed, regular and adequate living situation.

Child's Name: _____

Fixed: Stationary, Permanent, and not Subject to Change

1. Is this a permanent or temporary arrangement? ___ Permanent ___ Temporary
2. How long do you plan on living with friends/family? _____
3. Are you looking for another place to live? ___ Yes ___ No
4. Why are you staying in your current place? _____

_____

Regular: Used on a Regular Basis (Example, Nightly)

5. Do you stay in the same place every night? ___ Yes ___ No
6. Do you have a key to the place where you are living? ___ Yes ___No
7. Do you move around a lot? ___ Yes ___ No
8. How long have you been living in your current place? _____

Adequate: Sufficient for Meeting Both the Physical and Psychological Needs Typically met in Home Environments

9. How many people are living in the home? _____
10. How many bedrooms and bathrooms does it have? _____ Bedrooms _____Bathrooms
11. Does every family member have his or her own bed to sleep in? ___ Yes ___ No
12. Are you and your children sleeping in a bedroom or somewhere public like a living room?
    ___ Bedroom ___ Public Space: _____
13. Does the home have heat, electricity and running water? ___ Yes ___ No

The family's living situation is: ___ Fixed ___ Regular ___ Adequate

Staff Signature: _____ **Date:** _____

Parent / Guardian Name: _____

Income Source	Frequency (How Often)	Received (Yes or No)	Date
1.			
2.			
3.			
4.			

General Notes

_____

_____

_____

_____

Parent / Guardian Name: _____

Income Source	Frequency (How Often)	Received (Yes or No)	Date
1.			
2.			
3.			
4.			

General Notes

_____

_____

_____

_____

Family Information

(living arrangements, domestic violence, custody, health/disability, major circumstances, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Rockingham County Head Start Child Emergency and Medical Information

Name of Child_____ Birthdate _____

Name of Parent or Guardian_____

Address of Parent of Guardian_____

Cell phone_____ Home Phone_____ Work Phone_____

If parent cannot be contacted call:

Name_____ Phone number _____

Name_____ Phone number _____

In Case of Emergency

_____

Hospital Preference Address City State Phone number

_____

Physician Preference Address City State Phone number

Health Care Needs

1. Is child allergic to anything? No___ Yes___ If yes, what?_____

2. Is child currently under a doctor's care? No___ Yes___ If yes, for what reason?_____

_____

3. Is the child on any continuous medication? No___ Yes___ If yes, what? _____

4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what?_____

_____

5. Any history of significant previous diseases or recurrent illness? No___ Yes___

Diabetes No___ Yes___; Convulsions No___ Yes___; Heart trouble No___ Yes___

Asthma No___ Yes___; Seizures No___ Yes___ If others, what/when?_____

_____

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe:

_____

7. Any mental disabilities? No___ Yes___ If yes, please describes:

_____

8. Any particular fears or behavior characteristics the child has? No___ Yes___ If yes, please describes:

_____

9. Other Important Information_____

_____

I, the undersigned parent/guardian, hereby give my consent, in the event of an emergency where neither I nor my family physician can be contacted for the above named child to be taken to the hospital I have named above or to the emergency room at the nearest hospital for treatment by the physician in the emergency room.

I, hereby consent to having this information on this sheet available in the Head Start classroom or on vehicles used to transport my child to/from Head Start Activities.

Parent/Guardian Signature_____ Date_____

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Wentworth, NC 27375

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Pick-Up List

Due to changing standards, a pick-up list is required for every child associated with Rockingham County Head Start. This list will be referenced when someone comes to pick up the child from the classroom. Only those listed on this form will be allowed to pick up the child, and each person will need to show a picture ID to pick up the child.

Name	Telephone Number	Relationship to Child