G. **Child's preadmission record**

DHR-CDC-739

CHILD' S PREADMISSION RECORD

This section is to be completed by the child's parent or guardian. This form must be kept in the child's file in the Child Care Facility (home/center).

Child's Name:	Name child is known by:
Child's birthdate:	Child's home address:
Name(s) of parent(s)/guardian(s):	Home telephone number: ( )
Address of parent(s)/guardian(s):	
Mother's employer:	Father's employer:
Employer's address:	Employer's address:
Employer's telephone number: ( )	Employer's telephone number: ( )
List telephone numbers such as beeper, cellular phone, etc.	Instructions regarding how parent/guardian may be reached in an emergency:

Person(s) to be contacted in an emergency if parent(s)/guardian(s) cannot be reached:

Name	Relationship to child	Address	Telephone number

Name of child's doctor:	Address:	Telephone number: ( )

Emergency Authorization:

I give permission for the child care facility to obtain emergency medical treatment, including emergency transportation, for my child if I cannot be reached immediately. I agree to be responsible for any emergency medical expenses incurred. (*If parent/guardian refuses to sign, instructions must be attached stating what procedure the facility is to follow in an emergency.)*

_____ / _____

Signature **Date**

Form not valid without signature of child's parent/guardian

Page one of two-form not valid without second page

Describe any special needs or instructions below:

Person(s) the child may be released to:

Name	Relationship to child	Address	Telephone number

I understand that the Department of Human Resources does not inspect activities away from the child care facility (home or center). The licensee of the child care facility assumes full responsibility for such activities.

_____/_____

Signature of parent/guardian *Date*

I give permission for my child to participate in:

(Circle yes or no and sign each line)

Activities away from the facility:	**yes**	**no**	**Signature of parent/guardian**	**Date**
Transportation provided by the facility:	**yes**	**no**	**Signature of parent/guardian**	**Date**
Swimming/wading activities provided by the facility:	**yes**	**no**	**Signature of parent/guardian**	**Date**

Form not valid without signature of child's parent/guardian in each space indicated above.

This section is to be completed by the facility's staff.

Child's first day of attendance: _____ **Child's withdrawal date:** _____

Additional information may be attached.

St. Clair County Head Start
21685 U.S. Hwy. 231 N. Old Coal City School
P.O. Box 641
Pell City, Alabama 35125
Phone : (205) 338-9694 Fax: (205) 338-0259

Family Partnership Agreement

The partnership process was explained to me by:

_____ on Date: ___/___/___

I, _____ agree to form a partnership with the St. Clair County Head Start Program towards the achievement of the goals defined in this Partnership Agreement. St. Clair County Head Start will provide resource and referrals as necessary in order to accomplish these goals.

Child's Name: _____ Date of Birth:_____

Signature of Parent/Guardian:_____

Signature of Staff: _____

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Family Assessment

Child's Name: _____
Parent's Name: _____

All information given is completely confidential and will not be shared without your permission. Please answer all questions.

Education:

Highest grade completed_____ Degrees/Certificates_____

Employment:

Are you currently employed? Yes__ No__
If yes, is it Full time____ Part time___
Type of work (clerical, fast food, production, etc.) _____

Health:

Who is your health care provider?_____
If you do NOT have a health care provider, where do you go for medical help?_____
Other than the child enrolled; does your family have adequate health insurance? Yes___ No ___
Describe any need you have for health care:_____
_____
_____

Housing:

Homeless___ Live with friends or relatives ___ Own home ___
Rent home ___ Live in public housing ____ Other _____

Mental Health:

Do you have someone you can talk to when you have a problem or crisis?
Yes ___ No ___
Would you like information about Support Services that are available in the community? Yes___ No___

Social Services:

Are you receiving assistance from any of the following resources?

____DHR
____TANF
____WIC
____Food stamps
____SSI
___Workers Comp
___ Other Services _____

____Section 8
____Mental Health
____Public Housing
____Health Dept.
____Unemployment
____Employee training

Does you family have needs in any of the following areas?

(Check any that apply)

___Drug/Alcohol Abuse
___Employment(WIA Job training)
___Domestic Violence
___Health/Nutrition
___Housing
___Parenting skills
Other Needs:_____

___Education(GED, College etc.)
___English as second language
___Utilities
___Mental Health
___Transportation
___Clothing

Please explain the needs that were checked_____
_____
_____

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

Mission statement: We are dedicated to providing services for children and their families in order to empower them to succeed.

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Attendance Agreement

I _____ do understand that my Child _____ is expected to attend Head Start on a daily basis.

St. Clair County Head Start is a free program to parents. In order for us to maintain funding we must have regular attendance. All absentees will be unexcused unless agency documentation is received. Such as doctors excuse, court appointment notice or funeral documentation etc.

NO PARENT WRITTEN EXCUSES WILL BE ACCEPTED!

You will be contacted by your Family Service Worker when your child is absent 3 or more days. Irregular attendance will also result in home visits. Excessive unexcused absentees will result in the withdrawal of your child from the program.

Parent/Guardian signature _____ Date _____

Staff signature and title _____ Date _____

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Arrival/Departure Policy

Your child should arrive at school at 7:45 am. Your child will be marked absent if he/she arrives after 8:30 am.

Parent pick up time is 1:30 pm. Unless your child rides a bus then you will be notified of bus stop times. Please be on time to get your child.
If your child is left past 2:00pm Department of Human Resources and/or the local police department will be contacted. If your child is left on the bus he/she will be brought back to the school and Department of Human Resources and/or the local police will be contacted.

Only persons that are listed on the pre-admission forms will be allowed to pick up your child. **NO EXCEPTIONS.**
Only those people will be allowed to have access to the child. Anyone not listed will not be allowed to enter the child's classroom.

Any changes to child's pickup/release information must be done in person by the parent/guardian.

No phone calls or faxes will be accepted at anytime.

Is there a custodial dispute or issues? Yes_____ No _____

In order for the program to deny a legal parent or guardian access to a child we must have court documentation in the child's official file. Such documentation would be restraining order, custody papers or Divorce papers.

Parent/Guardian signature _____ Date _____

Staff signature and title _____ Date _____

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Please initial all blanks and sign/date the bottom of form.

_____ I am aware that St. Clair County Head Start has video/audio surveillance installed for the security of my child.

_____ I , hereby, give my consent for any pictures taken of my child to be used in newspapers, displays, bulletin boards, slide presentations, or any other type of educational/ public relations materials or publications.

_____
Signature of Parent/Guardian

_____
Date

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Dear Parents/ Guardians,

St. Clair County Head Start has launched its new website www.stclaircountyheadstart.com. A feature of the website is called Notify Me which allows us to send you text messages and/or email messages concerning school information. You can register yourself on the website or complete the information below if you would like to receive future email or text messages from St. Clair County Head Start via Notify Me.

Parent Name: _____

Student Name: _____

Parent Email: _____

Parent Cellular Phone Number: _____

Cell Phone Service Provider: _____
(AT&T, Verizon, Sprint, etc.)

Best regards,
Latoya Orr
Latoya Orr, Director

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INDIVIDUAL TRANSPORTATION AUTHORIZATION AND PLAN FOR CHILDREN TRANSPORTED TO AND FROM HOME BY CENTER

I,_____, as parent/guardian of _____
(Name of Parent/Guardian) (Name of Child)

request and authorize St. Clair County Head Start to provide transportation for my child to and form the center on the following days each week: Monday-Friday.

I understand that the center vehicle will pick-up and drop-off my child each day at his/her designated location. I agree to have my child ready for pick-up and to receive my child for drop-off no later than **5 minutes** before the vehicle is scheduled to arrive.

In the event no one is there to receive my child at his/her designated location. I understand that I am to go to the last drop-off scheduled and wait. If no one is at the last location to receive my child, I understand the staff will return my child to the St. Clair County Head Start center and that I will be required to speak with the Executive Director on the matter.

I understand that changes in the transportation plan will not be accepted unless they are in writing and signed by me. **PHONE CALLS WILL NOT BE ACCEPTED!!**

Parent/Guardian Signature:_____

Date:_____

Revised
02/2005

THE NATIONAL CENTER ON Health

St.Clair County Head Start
21685 U.S. Highway 231 North
P.O. Box 641
Pell City , Al. 35125
Phone: (205) 338-9694 Fax: (205) 338-3215

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: Yes No

Current Oral Health Status

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? Yes No

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination:	Yes	No
X-rays:	Yes	No
Risk assessment:	Yes	No
Cleaning:	Yes	No
Fluoride varnish:	Yes	No
Dental sealants:	Yes	No

Counseling/Anticipatory Guidance

Yes No

Referral to Specialty Care

Yes No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings:	Yes	No
Crowns:	Yes	No
Extractions:	Yes	No
Emergency care:	Yes	No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: Yes No Next recall date: _____ /_____ (month/year)

More appointments needed for treatment? Yes No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

This document was prepared under grant #90HC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Health.

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Yearly EPSDT Medical Screening

Child's Name: _____ Date of Birth :_____

Height _____ Weight _____ Blood Pressure _____ Hearing _____ Vision _____

Hemaocrit / Hemoglobin_____ Lead_____ Urinalysis _____ Allergies_____

Primary Health Coverage

Private _____ Self Pa y _____ Medicaid _____ All Kids _____

Physical Examination Date:_____

	Normal	***Abnormal***	***Finding, treatments & recommendation***
General Appearance			
Gross dental (teeth/gums)			
Head /Scalp /Skin			
Eyes/Ears/Nose/Throat			
Chest / Lungs /Heart			
Abdomen			
Speech			
Neurological / Social			
This child has a health condition that may Require emergency action at school			

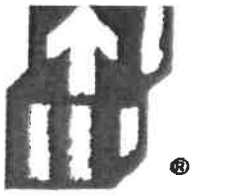
Health care Provider Signature _____ ***Date :*** _____

Address(Please print or stamp):_____ ***PhoneNumber:***_____

I hereby give permission to release this information to SCCHS Program:

Revised 2019

St. Clair County Head Start
Nutrition Records



Child's Name: _____

Date of Birth: _____

Sex: _____**Male** _____ **Female**

PLEASE PRINT

1. **Are there any foods your child cannot eat due to religious, cultural, or medical reasons?** _____**Yes** _____ **No**

   If yes, what foods?

   _____

   _____

2. **Does your child have any allergies to foods?** _____ **Yes** _____ **No**

   If yes, what foods?

   _____

   _____

   What reaction does your child have?

   _____

   _____

   Emergency medications (ex. EpiPen)?

   _____

   _____

   <u>*YOU MUST BRING DOCUMENTATION FROM THE DOCTOR*</u>

3. **Is your child on a special diet?** _____ **Yes** _____ **No**

   Was it prescribed by a doctor? _____ **Yes** _____ **No**

   If yes, what kind of diet?

   _____

   _____

   <u>*IF YES, YOU MUST BRING DOCTOR DOCUMENTATION *</u>