PRIME TIME

HEAD START

APPLICATION

Go ahead and DOWNLOAD/SAVE this document to your DESKTOP or MY DOCUMENTS folder.

4 Locations

MLK Center	3716 Nutland Rd., Monroe, LA 71202
Ransom Center	420 Wheelis St., West Monroe, LA 71292
Robinson Place	5307 Robinson Place, Monroe, LA 71202
Thomas & Wilson	1111 Thomas St., Monroe, LA 71202

Updated: 6.17.20, 3.18.22

PRIME TIME HEAD START

Dear Parent or Guardian:

Thank you for your interest in the PRIME TIME Head Start program. To apply for our program, please provide a copy of the following documents.

Your application is incomplete without all required documents.

Proof of Income for the last 12 months (Bring ALL that apply):

-W-2	-1 month of pay stub(s)	-Child Support
-Social Security	-Utility assistance	-Employment offer letter
-TANF/FITAP award letter	-SSI award letter	-Written statement from employer
-SSD or SSA	-VA assistance	-Student Loan/Aide with class schedule

For families with ZERO income, a ***Zero Income Statement Form*** will be provided.

Documentation of Date of Birth (only one is needed): Birth certificate, passport, or immigration card

- Child must be minimum of 3 years old before September 30th
- Child cannot be kindergarten eligible.

Proof of Residence (only one is needed): Utility bill(s), lease or rental agreement

Parent/Guardian Identification: State ID, State issued driver's license, military ID

----------What's next? ----------

Please note that if your child is selected for our program, you must provide the following **prior to entry into the classroom**:

Insurance Cards: Medical and Dental (if available)

Immunization Record(s)

Physical Exam/Well-Visit form signed by physician
Doctor's report or Universal Child Health Record (attached), showing a physical exam within the last 12 months.

- Blood tests (hemoglobin/hematocrit, lead)
- Vision, and Hearing screenings

Dental Exam documentation completed within the last 12 months

If your ***child has special needs***, the following documentation may be needed:

-Care Plan signed by physician	-Individual Care Plan signed by physician
-Medication Administration Form	-Medical Statement for Food Substitutes provided by physician
-IFEP or IEP	-Disability Evaluations/Results

If you need any assistance getting the required information or completing the application, please contact us at (318) 541-2315.

Sincerely,
PRIME TIME Head Start

Updates: 8/30/2019, 6/17/2020

Office Use only:

OPENetwork Coordinated Application 2022-2023

Placed_____ Not Placed_____

Your Choices Shape Their Chances

STUDENT'S NAME_____
FIRST MIDDLE LAST

○ **MALE** ○ **FEMALE** **AGE:**_____ **DATE OF BIRTH:**_____ **Home Language:**_____

# of Parents/Guardians & Children in Home: _____ **# of children in home:** _____

Have You Applied for CCAP? **Yes** ☐ **No** ☐ _____
Date Application Completed

Are You Approved for CCAP? **Yes** ☐ **No** ☐

Are You on the CCAP Waitlist? **Yes** ☐ **No** ☐

Does the child have a current IEP or IFSP? (Child is receiving services through the school system or Early Steps)

☐ **Yes** ☐ **No**

Concern/Diagnosis:_____

1. PARENT/LEGAL GUARDIAN living in home WITH Child **RELATIONSHIP to CHILD:**_____

NAME:_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP CODE

PHONE:_____**EMAIL:**_____

2.PARENT/LEGAL GUARDIAN living in home WITH child **RELATIONSHIP TO CHILD:**_____

NAME:_____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY STATE ZIP CODE

PHONE:_____**EMAIL:**_____

How did you learn about the participating programs and eligibility? _____

ALTERNATE CONTACT

1. CONTACT NAME:_____ **PHONE#:**_____**RELATIONSHIP:**_____

2. CONTACT NAME:_____ **PHONE#:**_____**RELATIONSHIP:**_____

Ranking	Program (see flyer for all Programs)	Types (Circle One)	Brother or Sister in program
1st Choice		☐Childcare ☐Headstart ☐School	☐ Yes ☐ No
2nd Choice		☐Childcare ☐Headstart ☐School	☐ Yes ☐ No
3rd Choice		☐Childcare ☐Headstart ☐School	☐ Yes ☐ No
* If your 1st choice does not have available seats, this does not guarantee enrollment in your 2nd choice program.			

Parent/Guardian permission for information sharing

I, the undersigned, understand that sharing the information I have provided in this application across early childhood programs in my community will facilitate matching my child to a seat, and I hereby give permission for the information provided here to be shared with the programs/Lead Agency in theOPENetwork._____

Signature (parent or legal guardian) **Date**

Office Use Only

Date Application Received: Received by:

PRIME TIME HEAD START

Program Year Applying for *(check one)*: ☐ **2021-2022** ☐ **2022-2023**

STUDENT'S NAME_____

FIRST MIDDLE LAST DATE OF BIRTH Current Age

Child's Parental/Guardian Marital Status: ☐Single ☐Domestic partnership—*not* child's biological mother/father ☐Domestic partnership—child's biological mother/father ☐Married—spouse present ☐Married—separated

Child's Parental/Guardian Status: ☐One Parent/Guardian household ☐Two Parent/Guardian household

Child's Race: ☐Black/African American ☐White ☐Asian ☐American Indian/Alaskan Native ☐Hawaiian/Pacific Islander ☐Other:_____

Child's Ethnicity: ☐Hispanic ☐Non-Hispanic **Child's Nationality:** ☐American ☐Canadian ☐Other:_____

---

1. PARENT/LEGAL GUARDIAN – Related by *blood, marriage, adoption, foster, or legal assignment.*

NAME_____

FIRST MIDDLE LAST DATE OF BIRTH Current Age

Primary adult caring for child? ☐Yes ☐No **Custody of the child?** ☐Yes ☐No

Phone Number with area code *(Please provide more than 1 number with at least one cell number if possible.)*	**Primary Phone?**	**Phone Type**	**When NOT to call**	**Can receive TEXT messages?**
	☐Yes ☐No	☐Home ☐Cell ☐Work		☐Yes ☐No
	☐Yes ☐No	☐Home ☐Cell ☐Work		☐Yes ☐No
	☐Yes ☐No	☐Home ☐Cell ☐Work		☐Yes ☐No

TEEN parent (19 or younger) at the time of child's birth? ☐Yes ☐No

Parent/Guardian lives with the child most of the time? ☐Yes ☐No

Specific Relationship to child: ☐Natural child ☐Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Niece/Nephew ☐Other: _____

English level: ☐Advanced/Proficient ☐Moderate ☐Poor ☐None

HIGHEST Education Level: ☐High School Diploma ☐GED/HiSet ☐less than grade 9 ☐grade 9 ☐grade 10 ☐grade 11 ☐grade 12 ☐Some College ☐Specialized Certificate ☐Associate's Degree ☐Bachelor's Degree ☐Master's Degree

Employment Status (check all that apply): ☐Currently Unemployed ☐Full Time (35+ hrs.) ☐Part Time ☐Disabled ☐Training or in School ☐Retired ☐Seasonally Employed ☐Multiple Periods of Unemployment over the past 5 years

2. PARENT/LEGAL GUARDIAN – Related by *blood, marriage, adoption, foster, or legal assignment.*

It is NOT necessary for the 2nd parent/guardian to live in the household. Please provide information.
NOTE: Parent/Legal Guardian #1 information should not be repeated in this section.

NAME_____
FIRST MIDDLE LAST DATE OF BIRTH Current Age

Primary adult caring for child? ☐Yes ☐No **Custody of the child?** ☐Yes ☐No

Phone Number with area code *(Please provide more than 1 number with at least one cell number if possible.)*	**Primary Phone?**	**Phone Type**	**When NOT to call**	**Can receive TEXT messages?**
	☐Yes ☐No	☐Home ☐Cell ☐Work		☐Yes ☐No
	☐Yes ☐No	☐Home ☐Cell ☐Work		☐Yes ☐No
	☐Yes ☐No	☐Home ☐Cell ☐Work		☐Yes ☐No

TEEN parent (19 or younger) at the time of child's birth? ☐Yes ☐No

Parent/Guardian lives with the child most of the time? ☐Yes ☐No

Specific Relationship to child: ☐Natural child ☐Adopted ☐Stepchild ☐Foster Child ☐Grandchild ☐Niece/Nephew ☐Other: _____

English level: ☐Advanced/Proficient ☐Moderate ☐Poor ☐None

HIGHEST Education Level: ☐High School Diploma ☐GED/HiSet ☐less than grade 9 ☐grade 9 ☐grade 10 ☐grade 11 ☐grade 12 ☐Some College ☐Specialized Certificate ☐Associate's Degree ☐Bachelor's Degree ☐Master's Degree

Employment Status (check all that apply): ☐Currently Unemployed ☐Full Time (35+ hrs.) ☐Part Time ☐Disabled ☐Training or in School ☐Retired ☐Seasonally Employed ☐Multiple Periods of Unemployment over the past 5 years

ADDITIONAL HOUSEHOLD MEMBERS

ADDITIONAL HOUSEHOLD MEMBERS are those who (1) **live in the home**, (2) are **supported by** a parent/guardian's income, and (3) are **related** to the parent/guardian by ***blood, marriage, or adoption/foster/legal***.

First and Last Name	**Relationship to Child**	**Date of Birth**
Do NOT list the child applicant or the parent(s)/guardian(s)- just those additional household members described above. ****Add more to the back if you run out of space.****		

Total # of people *(including the child, adults listed on page 1, and the additional household members listed above)* **who live in the child's household and are part of his/her family?** _____

Time to hit that SAVE BUTTON!

CHILD'S NEEDS

Does child have a disability (diagnosed by a doctor or specialist)? ☐ Yes ☐ No

If yes, what is the specific disability? _____

Does child receive any special education services? ☐ Yes ☐ No
If yes, what kind of services? _____

Does he/she have an IEP or IFSP? ☐ Yes ☐ No
If yes, please provide detail. _____

Do YOU have any concerns about child in any of the areas listed below? If YES, please check appropriate item(s).

☐ Hearing ☐ Vision ☐ Environmental Allergies ☐ Food Allergies ☐ Asthma ☐ Dental Problems ☐ Overweight
☐ Underweight ☐ Seizures ☐ Anemia ☐ High Lead levels ☐ Diabetes
☐ Other medical/dental/nutrition concern not listed above: _____
☐ Other developmental concern not listed above: _____
☐ Other speech/language development concern not listed above: _____
☐ Other behavior/emotional concern not listed above: _____
☐ **(Only check if NO CONCERNS are listed above.)** I have reviewed the concerns listed above, and child has NO NEEDS listed above at this time.

FAMILY NEEDS

Is your family living with *(check all that apply, if any)* ☐ drug abuse? ☐ alcohol abuse? ☐ incarceration?
☐ child support issues ☐ domestic violence ☐ serious health issue? ☐ mental health issue ☐ None apply to our family.

SERVICES: What services are your family receiving?

Family is receiving OR has received services from DCFS? ☐ Yes ☐ No

☐ Food Stamps (SNAP) ☐ Housing Services (Public Housing, Section 8) ☐ Medicaid/State Health Insurance
☐ WIC ☐ Child Support ☐ Foster Care/Adoption Subsidy ☐ Utility/Energy Assistance ☐ Private Health Insurance
☐ Health Services ☐ Mental Health Services ☐ Emergency/Crisis Intervention

Social Services from another agency? ☐ Yes ☐ No If yes, which one? _____

Do you currently have a caseworker at another agency? ☐ Yes ☐ No If yes, which agency? _____

☐ NONE OF THE ABOVE

Do you currently receive TANF/FITAP? ☐ Yes ☐ No **or SSI?** ☐ Yes ☐ No

Are you HOMELESS? ☐ Yes ☐ No **Have you RELOCATED 2 or more times in the past year?** ☐ Yes ☐ No

Do you currently receive a Child Care Subsidy/Voucher? ☐ Yes ☐ No ☐ Don't know ☐ Not eligible

LEGAL ISSUES

Is your family currently dealing with legal issues such as (check all that apply, if any)

☐ Family Court ☐ Divorce? ☐ Custody? ☐ Probation? ☐ Restraining order(s)? ☐ Incarceration?

☐ Other: _____? ☐ NO, MY FAMILY HAS NO LEGAL ISSUES.

If you checked any legal issues above, please clarify. _____

_____

Have you ever been displaced from home due to a hardship? ☐ Yes ☐ No

Has your child ever been in Foster or Kinship Care? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Has your child previously been enrolled in an Early Head Start? ☐ Yes ☐ No
If yes, which one? _____

Has your child previously been enrolled in a Head Start? ☐ Yes ☐ No
If yes, which one? _____

Has your child previously been enrolled in a Preschool Program? ☐ Yes ☐ No
If yes, which one? _____

Are YOU or a FAMILY MEMBER <u>a staff member of Prime Time Head Start</u>? ☐ Yes ☐ No
If yes, who? _____

Has your child had a sibling previously enrolled in the Prime Time Head Start program? ☐ Yes ☐ No
If yes, is he/she currently enrolled? ☐ Yes ☐ No Specify dates of attendance: _____ to _____

How did you hear about Prime Time Head Start? ☐ Word of mouth (friend/family) ☐ Flyer/Poster ☐ Billboard

☐ Facebook ☐ Bus bench ☐ Radio ☐ Someone who works at Prime Time Head Start

☐ Referred by an agency (WIC, Children's Coalition, child support services, DCFS, child care subsidy, other)?
Specify agency: _____

☐ OTHER resource not listed: _____

PARENT/GUARDIAN SIGNATURE NEEDED

I verify that I completed this application and provided true information.

Print Parent/Guardian Name: _____

Signature of Parent/Guardian: _____ Date: _____

<u>Time to hit that SAVE BUTTON!</u>

PRIME TIME HEAD START

Emergency Contact Information

Child Name:____Date of Birth:______________________________

Address Lives At:____

Parent/Guardian 1:____Relationship to child:__________________

Home Address (if different):____

Work Address: ____

Home Phone:____________________Cell Phone:__________________Work/Other: ____________________

Parent/Guardian 2:____Relationship to child:__________________

Home Address (if different):____

Work Address: ____

Home Phone:____________________Cell Phone:__________________Work/Other: ____________________

Authorized Contacts –*Please provide information for at least 2 people who are permitted to pick up your child from the Shine Early Learning program, and whom we can contact if necessary in an emergency. Please note that we must have a letter on file that documents our agreement to have an authorized contact under 18 years of age pick up your child. Please note that your child* ***will not*** *be released to anyone not on this list.*

Name: ____

Relationship to child: ______________________________

Home Address: ____________________________________

City: ______________________State: _______ Zip: _________

Home Phone: __________ Cell: __________Other: __________

Staff Initials: ____________________ Date: ________________

Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________
Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________
Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________

Name: ____

Relationship to child: ______________________________

Home Address: ____________________________________

City: ______________________State: _______ Zip: _________

Home Phone: __________ Cell: __________Other: __________

Staff Initials: ____________________ Date: ________________

Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________
Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________
Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________

Name: ____

Relationship to child: ______________________________

Home Address: ____________________________________

City: ______________________State: _______ Zip: _________

Home Phone: __________ Cell: __________Other: __________

Staff Initials: ____________________ Date: ________________

Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________
Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________
Removed on: ______	By:____________	Staff: ____________
Added Back: ______	By:____________	Staff: ____________

Is there a court order in place that restricts anyone from picking up your child? (Non-custodial parent or other adult due to restraining order, child' s foster or kinship status, etc) Yes:__________________No:______If yes, please provide Shine Early Learning with documentation, such as a copy of a court order to maintain in file and provide updates as needed

NAME:____RELATIONSHIP TO CHILD: ________________________________

Is there any other person who may try to pick up your child who is not authorized to do so (i.e. but for whom there are no court papers)? If so, please give NAME:_______________________________________RELATIONSHIP TO CHILD:____________________

Parent Signature: ____________________________________ ***Date:*** __________________

Emergency Contact Information

Child Name:____Date of Birth:______________________________

Address Lives At:____

Additional Contacts

Name: ____

Relationship to child: __________________________________

Home Address: _______________________________________

City: ________________State: ______ Zip: ________

Home Phone: __________ Cell: __________Other: ________

Staff Initials: ___________________ Date: ______________

Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________

Name: ____

Relationship to child: __________________________________

Home Address: _______________________________________

City: ________________State: ______ Zip: ________

Home Phone: __________ Cell: __________Other: ________

Staff Initials: ___________________ Date: ______________

Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________

Name: ____

Relationship to child: __________________________________

Home Address: _______________________________________

City: ________________State: ______ Zip: ________

Home Phone: __________ Cell: __________Other: ________

Staff Initials: ___________________ Date: ______________

Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________

Name: ____

Relationship to child: __________________________________

Home Address: _______________________________________

City: ________________State: ______ Zip: ________

Home Phone: __________ Cell: __________Other: ________

Staff Initials: ___________________ Date: ______________

Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________

Name: ____

Relationship to child: __________________________________

Home Address: _______________________________________

City: ________________State: ______ Zip: ________

Home Phone: __________ Cell: __________Other: ________

Staff Initials: ___________________ Date: ______________

Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________
Removed on: _______ By:____________ Staff: ____________
Added Back: _______ By:____________ Staff: ____________

Parent Signature: ________________________________ ***Date:*** ________________

PRIME TIME HEAD START

Permission for Program Activities

STUDENT'S NAME_____

FIRST MIDDLE LAST DATE OF BIRTH

To help us provide your child with the highest-quality services, Prime Time Head Start needs your permission for the activities listed below. **For each item, please check YES or NO.**

1. I give permission for my child to participate in **walking trips** within the Prime Time Head Start center neighborhood, including to local parks or playgrounds. *I understand that children will not enter any other facility unless I am informed in writing in advance; that the route will avoid all safety hazards, and that there will always be an adult-child ratio in keeping with licensing requirements.* ☐ YES ☐ NO

2. I give permission for my child to be **photographed and/or videotaped** while participating in Prime Time Head Start program activities, and for these photos or videos to be used in newsletters, displays, or other formats for educational purposes or program publicity including social media. ☐ YES ☐ NO

3. I give my permission for me to be **photographed or videotaped** during program activities in order to support *Prime Time Head Start*'s staff development activities. I understand that these photographs and videotapes will not be used for any other purposes without my additional consent. ☐ YES ☐ NO

4. I understand that as part of the program, staff and consultants engage in regular observations and assessments of children's progress toward achieving school readiness skills in order to individualize our instruction to best support them, and to improve our program as a whole. In addition to these educational assessments, I give permission for my child to receive the following screenings, that are required of all Head Start programs, and that will help Prime Time Head Start further understand his/her development and provide the best possible learning environment for his/her strengths and needs:

   Health Screenings – hearing, vision, height, weight, blood iron, blood pressure, lead, dental ☐ YES ☐ NO

   Developmental Screening – to identify child's stages of development and possible areas of delay ☐ YES ☐ NO

   Social-Emotional Screening – to identify possible areas of mental health concern ☐ YES ☐ NO

   Speech Screening – to identify any concerns regarding child's language development ☐ YES ☐ NO

5. I give permission for staff to conduct **focused observations** of my child in his/her classroom so that *Prime Time Head Start* can better **understand his/her development, challenges and needs**. I understand that I will be notified of pending observations and will be invited and encouraged to participate in all related conversations and next steps. ☐ YES ☐ NO

6. I give permission for my child to have the above screenings, and other program components as needed, administered in his/her own language by an **interpreter** chosen by Prime Time Head Start. ☐ YES ☐ NO

7. **Prime Time Head Start wants to send you text messages!** These text message could include FUN FACTS and EASY Tips to help support your child's learning, attendance and health follow-up, meeting and event reminders and notifications about school closings and delays. You can choose to stop receiving texts at any time by replying STOP to any message. I give permission for Prime Time Head Start to text me regarding my child's learning and program participation. ☐ YES ☐ NO

Parent/Guardian Name:_____ **Relationship to Child:**_____

Parent/Guardian Signature:_____ **Date:** _____

PRIME TIME HEAD START

Emergency Consent:
Authorization for Medical Care for Minor Child

Child Name:_____ Date of Birth:_____

In the event of an emergency affecting your child, **PRIME TIME® Head Start** will make every attempt to contact you. In unusual circumstances, however, we might need to act immediately to protect your child. **We need your permission to do so.** *Please initial next to each item, then sign below.*

1. I give permission to **PRIME TIME® Head Start to** take emergency measures (e.g. first aid, disaster evacuation) as judged necessary for the care and protection of my child while under the supervision of the center. *Initials:* _____

2. I give permission for my child to receive X-rays, examinations, anesthesia, and/or medical, surgical or dental treatment and care, under the supervision of a licensed physician, dentist or surgeon, when the need for such treatment is immediate and I cannot be reached. *Initials:* _____

3. In case of a medical emergency, I give permission for my child to be transported to an appropriate medical facility for treatment if the local emergency resources (police, rescue squad, ambulance) deem it necessary. I understand that these transportation expenses will be my responsibility as the child's parent/guardian. *Initials:* _____

4. In the event that my child's center needs to be evacuated, I give permission for my child to be transported to another nearby location. I understand that I will be informed by telephone at the earliest possible opportunity. *Initials:* _____

5. I understand that in some medical situations, the staff will need to contact the local emergency resources before the parent, child's physician, and/or other adults acting on the parent's behalf. *Initials:* _____

This form must be signed by the child's parent or legal guardian.

Signature_____ **Date** _____

Print Name_____ **Relationship to Child** _____

To be completed by: **PRIME TIME Head Start**

Physician Name:_____ Phone Number:_____

Dentist Name:_____ Phone Number:_____

Allergies:_____

Medical condition(s) that could be relevant in an emergency: _____

_____

Signature of Staff:_____ Date:_____

The original will be kept in the child's file with a copy of this form in the classroom.

PRIME TIME HEAD START

Permission to Release/Request Information
Consent for Release and Receipt of Child Records

Child's Name:_____Date of Birth: _____

As parent/guardian of the child named above, **I hereby grant Prime Time Head Start permission to:**

- ✓ Release records relevant to my child/family to
- ✓ Request records relevant to my child/family from

the following agency, school or community partner:

Agency/Entity/School/Partner:_____Address: _____

Contact Person (if appl): _____

including **any or all of the following** (as checked below):

- ☐ Family contact information (address, phone number, email)
- ☐ Family eligibility information: employment
- ☐ Family eligibility information: family status, i.e. homeless, zero income, irregular income
- ☐ Child's birth certificate
- ✓ Child health information
- ☐ Child developmental/educational information (assessments, progress reports)
- ☐ Information regarding child's special needs (observations, individual education plan) if applicable
- ☐ Family services information (needs assessment, service plan)
- ☐ Other _____

I also authorize staff of Prime Time Head Start and the above-named organization to **share information verbally**, as needed.

I understand that the confidentiality of any information identifying my child and/or myself will be maintained in accordance with Prime Time Head Start's policy regarding the Privacy of Child Records, and all applicable laws.

By signing below, I also acknowledge that:

- I may review the indicated information at any time.
- This authorization is voluntary, and I may refuse to sign it. My refusal to sign will not affect my eligibility for services or enrollment in the Prime Time Head Start program.
- I may also choose to revoke it at any time by notifying Prime Time Head Start in writing. I understand that if I revoke this consent, my revocation will not affect disclosures or receipts that have already been made.

Authorized by:
Parent/Guardian Name (PRINT):_____Phone:_____

Parent/Guardian Signature: _____Date: _____

Address:_____Email: _____

Time to hit that SAVE BUTTON!

PRIME TIME HEAD START

CENTER:

Child Health and Nutrition History

STUDENT'S NAME_____
FIRST MIDDLE LAST DATE OF BIRTH Current Age

PARENT/GUARDIAN NAME_____
FIRST LAST

STAFF NAME_____ **Initials:** _____ **Date:** _____
FIRST LAST

HEALTH OVERVIEW AND SOURCE OF CARE

Child's last PHYSICAL exam Date: _____ Physician/Clinic:_____

Child's last DENTAL exam Date: _____ Dentist/Clinic:_____

Child's INSURANCE: ☐ Medicaid ☐ State Insurance ☐ No Insurance ☐ Private

Insurance Company: _____ **Child's Policy Number** (if applicable): _____

Family insurance status: ☐ Entire family insured **– Skip to EARLY Child Health Concerns** ☐ Entire family uninsured ☐ Guardian(s) uninsured Please explain: _____

Family insurance eligibility: ☐ Entire family eligible ☐ Entire family ineligible ☐ Guardian(s) ineligible ☐ Other child(ren) ineligible Please explain: _____

If uninsured, do you and/or the child's siblings access medical and dental care through free or low-cost clinics? ☐ Yes ☐ No Comment: _____

EARLY CHILD HEALTH CONCERNS

Concerns	Explain any "YES" answers
Did mother have any **problems during pregnancy**? ☐ Yes ☐ No Child's birth weight:_____lb_____oz	
Has child ever been **hospitalized or operated on**? ☐ Yes ☐ No Had a **serious illness**? ☐ Yes ☐ No Had a **serious accident or broken bone**? ☐ Yes ☐ No	
Does your child need help or have trouble with **toileting**? ☐ Yes ☐ No	
Does your child **sleep** less than 8 hours at night? ☐ Yes ☐ No Does your child nap? ☐ Yes ☐ No	About how many hours per night? Time of day/length of nap?
At what age did your child start **walking/talking**?	Age in months when started to walk? Age in months when started to talk?
Was your child **born pre-mature** (before 37 weeks)? ☐ Yes ☐ No	Born at how many weeks? Reason?

CHILD HEALTH CONDITIONS

Concerns	Explain any "YES" answers
Is a physician or dentist **currently treating** child for **any concerns or special conditions?** ☐ Yes ☐ No	If so, what conditions?
Does child have, or ever had, any of the following? (check ALL that apply) ☐ No, my child does not have any known health conditions. ☐ Asthma ☐ Bleeding Tendencies ☐ Anemia ☐ Diabetes ☐ Heart/Blood Vessel Disease ☐ Sickle Cell Disease ☐ Liver Disease ☐ Under/overweight ☐ High Lead ☐ Convulsion/seizure – if yes: was it related to a high fever? ☐ Yes ☐ No ☐ Other: _____	Explain checked conditions. If checked, date of last convulsion/seizure?
Is child **taking medication**? ☐ Yes ☐ No *If yes, list medication(s):* _____ _____	Reason:
VISION QUESTIONS: Do you have any concerns about child's **ability to see**? ☐ Yes ☐ No Do you have any concerns about the way child **looks at you** (or at **books, or how he/she watches TV**)? ☐ Yes ☐ No Has your child ever been **referred to, or seen by an eye doctor**? ☐ Yes ☐ No	Name of Eye Doctor: Date of last visit: Other Details:
HEARING QUESTIONS: Does child have **trouble with ears/hearing**? (e.g., pain in ear, frequent earaches, infections, drainage, hearing loss) ☐ Yes ☐ No Do you have any concerns about **the way child responds when you talk** to him/her? Or, how he/she is learning to talk? ☐ Yes ☐ No Did child have **newborn hearing screening** done in the hospital? ☐ Yes ☐ No **If yes**, what were the results? ☐ Pass ☐ Fail Has your child ever been **referred to, or seen by an ENT or Audiologist**? ☐ Yes ☐ No	Name of Eye Doctor: Date of last visit: Other Details:

Any significant changes should be shared with appropriate staff and documented in Shine Insight.

CHILD DENTAL CONCERNS

CONCERNS	Explain any "YES" answers
Does child have any **trouble with teeth, gums, chewing/ eating or mouth**? ☐ Yes ☐ No	
Does child currently receive any treatments listed below? (check ALL that apply): ☐ No, my child does receive dental/oral treatments. ☐ Topical fluoride application ☐ Fluoridated water ☐ Fluoride supplement (tablets) ☐ Fluoride supplement (liquid)	**If yes**, how long has child been receiving fluoride?

CHILD ALLERGY AND NUTRITION CONCERNS

CONCERNS	Explain any "YES" answers
1. Does child have any **allergy problems** (e.g., rash, itching, swelling, difficulty breathing)? ☐ Yes ☐ No **If yes**, is allergy related to (check ALL that apply): ☐ Medication ☐ Food ☐ Animals/fur ☐ Insects/dust ☐ N/A or None **Has allergy ever required emergency medical care?** ☐ Yes ☐ No	If yes, describe reaction. Does child have an EpiPen Jr. or other medication? Describe. Describe reason for emergency care?
FOOD/SPECIAL DIET NEEDS: 2. Does your child have a: ☐ Yes ☐ No Food allergy? ☐ Yes ☐ No Food Intolerance? ☐ Yes ☐ No Medical need for a food restriction ☐ Yes ☐ No Religious food restriction	Describe: If food/diet related, list food item(s).
3. Does your child currently have **problems chewing or swallowing foods or liquids**? ☐ Yes ☐ No	Describe concern:
4. Do you have concerns about your **child's size, what he/she eats or feeding behaviors**? ☐ Yes ☐ No **If yes**, would you like to meet with the Nutritionist? ☐ Yes ☐ No	Describe concern:
Child currently takes/uses (Check ALL that apply): ☐ Bottle ☐ Sippy Cup ☐ Drinking Cup ☐ Drinking Straw	If yes, how often?

==========STAFF NOTE==========

If any questions from 1 through 3 answered YES in the *Child Allergy and Nutrition Concerns*, refer to Nutritionist.

Time to hit that SAVE BUTTON!

CHILD ABILITIES AND DEVELOPMENTAL CONCERNS

CONCERNS	Explain any "YES" answers
Does child have a diagnosed disability, with an **IEP or IFSP**? ☐ Yes ☐ No	Describe
Do **YOU** have any **Developmental Concerns** in any of the following areas? ☐ No ☐ Speech or language ☐ Physical Development ☐ Behavior/emotional ☐ Other:	Describe

CHILD TB RISK ASSESSMENT

RISKS	Explain any "YES" answers
Was your **child born in** Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? ☐ Yes ☐ No	**If yes,** in what country was the child born?
Has your **child lived or traveled in** Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month? ☐ Yes ☐ No	**If yes**, what country? For how long?
In the **last 2 years, has your child lived with or spent time with** someone **who has been sick with TB**? ☐ Yes ☐ No	**If yes,** please explain:
Does your child have **any history of immunosuppressive disease or take medications that might cause immunosuppression**? ☐ Yes ☐ No	**If yes,** please explain:

==========STAFF NOTE==========
Any YES answers above in *TB Assessment* section, should be referred to Health team.

FAMILY SMOKING ASSESSMENT

1. Does your **child live with anyone who smokes**? ☐ Yes ☐ No
2. Does **anyone ever smoke in your home or car**? ☐ Yes ☐ No

If yes to either question 1 or 2 above, who smokes? _____

3. Do you currently smoke? ☐ Yes ☐ No, I quit less than a year ago. ☐ No, I have never smoked.

IF you answered NO to #3, skip the following 2 questions in this section.

4. If you smoke, **how interested are you in quitting**? ☐ Very interested ☐ A little interested ☐ Not interested
5. Do you want to learn of free ways to help you quit? ☐ Yes ☐ No ☐ I am not sure.

Any significant changes should be shared with appropriate staff and documented in Shine Insight.

PRIME TIME HEAD START

CACFP ANNUAL ENROLLMENT FORM

October 1, 20___ to September 30, 20___

Directions: To be completed by the parent/guardian as indicated. Complete a separate form every year for each child in the household who does not have a completed F/RP Meal Application (CACFP 106) on file. If enrolled in the Head Start Program, the participant must meet the criteria prescribed under the Head Start Act to automatically qualify for "Free" meal benefits and therefore is exempt from completing a Free/Reduced Price Meal Application. Documentation of enrollment must be updated annually, signed by a parent or legal guardian, and includes information on each child's normal days and hours of care and expected meal participation. [Reference: 7 CFR 226.17(b)(8)]

INSTITUTION NAME/ADDRESS:
Prime Time, Inc.
(PRIME TIME® Head Start)
938 Lafayette Street, Suite 300
New Orleans, LA 70113
(504) 523-4352

CENTER NAME/ADDRESS (circle one):

Ransom Head Start	Robinson Head Start	MLK Head Start	Thomas & Wilson Head Start
420 Wheelis St.	5307 Robinson Place	3716 Nutland Rd,	1111 Thomas & Wilson St.
W. Monroe, LA 71292	Monroe, LA 71202	Monroe, LA 71202	Monroe, LA 71201
(318) 855-1392	(318) 855-1826	(318) 737-2169	(318) 361-3801

Child's Name: _____ DOB: _____(mm/dd/yyyy)

Please indicate the normal days and hours of expected care for participant listed above. Check all that apply and list hours below (Days, hours and meal types may vary based on actual participation.):

Expected days of participation: __X__ Monday __X__ Tuesday __X__ Wednesday __X__ Thursday __X__ Friday

Expected hours of participation: From ___7:40 AM_____ To _____2:20 PM_____

Expected meal participation (check all that apply): __**X**__ Breakfast __**X**__ Lunch __**X**__ Snack

List any allergies to foods or beverages: _____
(Write "NONE" if child has no allergies.)

Parent/Guardian's Name: _____ _____
(PRINT) (SIGN)
Date: _____

Address: _____ Phone Number: _(____)_____
(Street Address, City, State, Zip Code)

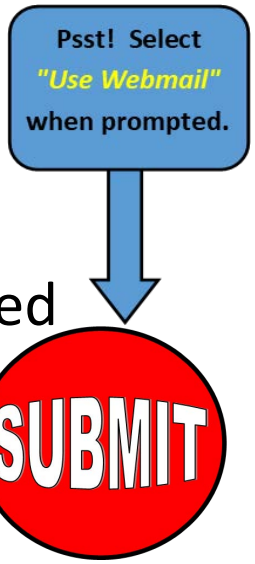
This institution is an equal opportunity provider.

For Official Use Only:
Eligibility Determination: **FREE**
Determining Official's Signature: _____ Date: _____

ALL DONE! You made it!

WHAT'S NEXT?

1. **SAVE** this document ONE MORE TIME to your desktop or in your *My Documents* folder



2. Hit the **SUBMIT BUTTON or ATTACH** the saved document to an **EMAIL** sent to **enroll@primetimefamily.org** if the submit button doesn't work with your system.

3. **EMAIL** required documents for the application:
   -Proof of income if applicable
   -Child's birth certificate
   -Proof of residence (water, gas, electricity, lease, etc.)
   -Identification
   -Medical and dental Insurance Cards
   -Immunization (shot) Record(s)
   -Physical Exam/Well-Visit form signed by physician
   -Dental Exam form signed by physician

4. Call (318) 541-2315 for assistance or to **FOLLOW-UP**.

PRIME TIME