Kickapoo Head Start

Enrollment Application

Child's Name: _____

Child's Date of Birth: _____

Child's School District: _____

Required Documents Needed with Application	Documents Received Date *Office use only: Completed by Staff*
Birth Certificate	
Child's CDIB Card (Certificate of Indian Blood)	
Parent/Guardian CDIB (Certificate of Indian Blood)	
Income Verification (Tax Forms, 3 Consecutive Pay Stubs, SSI, TANF, SNAP)	
Current Proof of Residency (Current Utility Bill)	
Current Immunization Record	
Insurance Card	

This is a recruitment application only. This does not guarantee your child's acceptance. The children are accepted by guidelines established by our Policy Council and federally regulated income guidelines.

Office use only:

Date Application Received		Signature of Staff Member	
Date Application Completed		Signature of ERSEA Manager	
Date Application Accepted		Signature of ERSEA Manager	

Revised 7/2022

Kickapoo Head Start

Applicant & Family Member Information

Date Application Received: _____

(Child) Applicant Information — Please Print

Child's First Name	Middle	Last	Suffix	Nickname	Birthday	Gender ☐ Male ☐ Female

Address of Family | City | State | Zip Code | County

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

☐ Hispanic or Latino origin
☐ Non-Hispanic or Non-Latino origin

Child's Primary Language

Other Languages

English	Other Language
☐ None ☐ Little ☐ Moderate ☐ Proficient	☐ Little ☐ Moderate ☐ Proficient

Public School District in which child resides: _____

Was this child previously in a Head Start Program
☐ No ☐ Yes
If yes, which program? _____

Primary Health Coverage

Medicaid ☐ No ☐ Yes
ID Number: _____

Other Health Coverage

Name of Primary Doctor | Address | Tel No

Name of Dentist | Address | Tel No

Mother's or Guardian's Information- Please Fill Out Completely

First	Middle	Last	Suffix	Birthday	Gender ☐ Male ☐ Female

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

English Language
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language
☐ Poor
☐ Moderate
☐ Proficient

Custody
☐ No
☐ Yes

Check All That Applies:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Highest Grade Completed
☐ Master's
☐ Bachelor's
☐ Associate's
☐ College Degree/Train
☐ Advance Training
☐ < Grade 9
☐ Grade 10
☐ Grade 11
☐ Grade 12
☐ HS Graduate
☐ GED
☐ Currently Enrolled in College

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

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

Head Start Parent?
☐ Current ☐ Former

EMPLOYER:

Father's or Guardian's Information- Please Fill Out Completely

First	Middle	Last	Suffix	Birthday	Gender ☐ Male ☐ Female

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

English Language
☐ None
☐ Little
☐ Moderate
☐ Proficient

Other Language
☐ Poor
☐ Moderate
☐ Proficient

Custody
☐ No
☐ Yes

Check All That Applies:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Highest Grade Completed
☐ Master's
☐ Bachelor's
☐ Associate's
☐ College Degree/Train
☐ Advance Training
☐ < Grade 9
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☐ HS Graduate
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Employment Status
☐ Full Time
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☐ Part Time & Training
☐ Training or School
☐ Retired or Disabled

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

Head Start Parent?
☐ Current ☐ Former

EMPLOYER:

List All Other People Living in Household

Number of People living in household including applicant: _____

FIRST NAME	MIDDLE	LAST NAME	Relationship to applicant	Date of birth	Gender: Male/ Female

Types of Services and/or Financial Services

Does your family receive any of the following services or financial assistance? (check all that apply)

- ☐ TANF (Temporary Assistance for Needy Families)
- ☐ WIC (Women, Infants, and Children Nutrition Program)
- ☐ SNAP (Supplemental Nutrition Assistance Program)
- ☐ SSI (Supplemental Security Income)
- ☐ Foster Care/ Adoption Subsidy
- ☐ Living Assistance Provided by Family or Friends
- ☐ Medical Financial Assistance (SoonerCare/Medicaid/Medicare)
- ☐ Child Support/Alimony
- ☐ Child Care Subsidy/CCDF
- ☐ Financial Aid (FAFSA)

If a family has more than one child applying for Head Start Services, please complete a separate application form for each applicant

_____
Parent Signature

Interviewed By: _____
Staff Signature

Health History Questions- Please Fill Out Completely

Date of Last Physical Exam: _____ **Date of Last Visit to Dentist**: _____

Is your child on an ☐ IEP ☐ IFSP ☐ or have a diagnosed disability? ☐ No ☐ Yes

If yes is the IEP/IFSP for speech/language ☐ No ☐ Yes

Is there an IEP/IFSP for something other than speech/language ☐ No ☐ Yes

Is the Child being treated by Doctor? ☐ No ☐ Yes Dentist? ☐ No ☐ Yes

If yes, please list: _____

Any health problems or concerns for child? ☐ Respiratory (Asthma, RSV, RAD, etc.)

☐ Diabetes ☐ Seizures ☐ Heart Condition ☐ Low Birth Weight ☐ Hearing

☐Ear Aches ☐ Tubes in Ears ☐ Tooth Pain/Decay ☐ Vision ☐ Wears Glasses

☐ My child has/had a potentially life-threatening illness, injury, surgery and/or is being seen by a specialist.

Please explain_____

☐ My child has taken medicine for one or more of the above conditions.

If yes list: _____

Do you have any physical, social, psychological concerns for child?

_____

☐ Abuse/Neglect ☐ Former foster child ☐ Asked to leave child care

☐ Court Order:

If yes list reason for court order:

_____

Do you have developmental concerns for child?

_____

☐ Gross Motor (walking, running, balance, etc).

☐ Fine Motor (drawing, writing, dressing, etc.)

☐ Speech/Talking (delayed talking, hard to understand, difficulty understanding others?

☐ Learning difficulty (remembering, reasoning, problem solving, etc.)

☐ Behavior (relationships, cooperating, responding to others feelings.)

☐ Trouble Sleeping ☐Take Naps ☐Nightmares

Potty Train ☐Yes ☐No ☐Working on

☐Other _____

My child has allergies or severe reactions to the following: **Please Check All That Apply and List.**
(Need Dr's Statement)

☐ Animals _____ ☐ Pollens/Hay Fever ☐ Medications _____

☐ Food _____

☐ Insect _____ ☐ Other _____

Professionally evaluated/diagnosed by: Name of Doctor

_____

Check any of the following nutrition concerns that apply:

☐ Diagnosed health conditions requiring a specific diet ☐ Diagnosed swallowing or feeding concerns

☐ Is there any food your child should not eat for medical, religious, or personal reasons?

_____

☐ Other diagnosed concerns: Please list

_____

Kickapoo Head Start

Transportation/Emergency Parent Authorization

Date: _____ Password: _____

Child's First and Last Name: _____ **DOB:** _____

Address: _____
Street City Zip

Mother's/ Guardian's Name: _____

Cell Phone: _____ Work Phone: _____ Alternate Phone: _____

Father's/Guardian's Name: _____

Cell Phone: _____ Work Phone: _____ Alternate Phone: _____

Directions to Child's Home from Center: _____

_____

_____

In Case of an Emergency at School:

Please place in order who you would like for us to contact in Case of an Emergency if school is unable to reach Parent/Guardian.

The following people are authorized to pick up the child at Kickapoo Head Start or Get child off the bus: Authorized person MUST be 16 years or older.

Name	*Relation to Child*	*Home Number*	*Cell Number*	*Work Number*

If the parent/guardian or Authorized adult is incapacitated for any reason at the drop off point, the child will be taken back to the center.

Kickapoo Head Start

Will your child ride the bus? __Yes __ No. If so, where should we pick him/her up? _____
Where will your child be taken after school? _____

List Any Special Health Conditions: _____
_____
_____

Please list the name, address, and telephone number of your child's usual source of medical and dental care provider.

Medical:
Name: _____
Address: _____
Phone: _____

Dental:
Name: _____
Address: _____
Phone: _____

Health Insurance: Attach a copy of insurance card or complete information below:
Provider: _____ ID Number: _____

I, _____ give my permission for the Kickapoo Head Start Staff to seek emergency medical or dental treatment of my child, _____, in the event either parent/guardian cannot be reached.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Kickapoo Head Start

Residence Status Form

1. Where are you and your family currently staying? Check one box

□ Sharing the housing of another family (i.e., doubling-up) due to loss of housing, economic hardship, or similar reason.
□ Living in a motel, hotel, trailer park, or campground or cannot afford housing.
□ Staying in an emergency or transitional shelter.
□ Living in a vehicle of any kind; in an abandoned building, stay in a tent, or campground or substandard housing without running water/electricity; or in a park, bus, or train station.
□ Section 8 Housing
□ Military Housing
□ None of the above; Living in my own apartment/home that I rent or own.

2. Please Check all that apply.

☐ Child is living with Grandparent.
☐ Child is living with Legal Guardian.
☐ Child is living with an adult that is not a parent or legal guardian.
☐ Child is in foster care placement.
☐ None of the above; Child is my own child.

The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian Name/Adult Caring for Child	Signature		Date
Address (if available)	City	State	Zip Code
(Area Code) Phone Number	(Your own or a family member/friend through which we can reach you)		

Head Start Use Only

Reviewed By:

Print Name	**Title**	**Signature**	**Date**

Revised 7/2022

Kickapoo Head Start

Physical Examination/Assessment Form

Date of Service: _____ Child's Name _____ Sex: ___ Birthday _____

Screening Tests	Date	Results/Comments
Present Age		____Years, ____ Months
Blood Pressure		
Hematocrit or Hemoglobin (Annual Blood Work Required)		
Height		
Weight		
Hearing		Left _____ Right _____
Lead (1 time only)		
Vision (Type of Test) a.Acuity		Left _____ Right _____
b.Strabismus		
Other Tests (Sickle Cell, etc.) _____ Please List		

Physical Examination/ Assessment	Normal For Age	Abnormal	Not Evaluated	Comments
1. General Appearance				
2. Posture, Gait				
3. Speech				
4. Head				
5. Skin				
6.Eyes: a.External Aspects				
b.Optic Fundisopic				
c.Cover Test				
7.Ears: a.External & Canals				
b.Tympanic Membranes				
8. Nose, Mouth, Pharynx				
9. Teeth				
10. Heart				
11. Lungs				
12.Abdomen (include hernia)				
13. Bones, Joints, Muscles				
14. Neurological/Social				
a.Gross Motor				
b.Fine Motor				
c.Communication Skills				
d.Cognitive				
e.Self-Help Skills				
f.Social Skills				
15. Glands (lymphatic/Thyroid)				
16. Other				

Findings, Treatment & Recommendation:

According to the Oklahoma EPDST this child is Up-To-Date: ☐ Yes ☐ No

Physician's Signature **Date**

PO Box 399 ◆ McLoud, Oklahoma 74851 ◆ Phone: (405) 964-3676 ◆ Fax: (405) 964-3417

Early Childhood National Centers
NATIONAL CENTER ON
Early Childhood Health and Wellness

KICKAPOO HEAD START
P.O. BOX 399
McLOUD, OK 74851
PHONE: 405.964.3676
FAX; 405.964.3417

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 _____

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OKLAHOMA Human Services

Compliance File Notification: Child Care Programs and Family Child Care Homes

Program Information

Kickapoo Head Start			K8 30005203'
Program name			License number
105365 S. HWY 102	McLoud	OK	74851
Street address	City	State	ZIP code
P.O. Box 399			
Mailing address			
405-964-3676	Darwin Kaskaske		
Phone	Owner		

Child Information

Please list the name(s) and birth date(s) for any child(ren) you are enrolling in this program:

Name	Date of birth

Agreement and Signature

· I understand and am aware:

☐ this program is required to maintain a copy of the compliance file on-site and the information contained in the file is available for inspection.

☐ of the Compliance File location and its contents.

☐ this form is to be completed:

☐ upon child enrollment; and

☐ every 12 months thereafter.

☐ a copy of the program specific **Notice to Parents** is to be provided to parent(s) or legal guardian(s) upon enrollment.

For program specific information contained in the Notice to Parents, select one:

☐ DHS Publication No. 14-01, Notice to Parents for Child Care Program

☑ Form 07LC084E, Notice to Parents for Family Child Care Home

Parent or legal guardian name	Parent or legal guardian signature	Date

NOTICE TO PARENTS

Please review the following records on a regular basis:

At the Family Child Care Home

Posted: The program is required to post:

- This Notice to Parents (Form 07LC084E, Notice to Parents)
- Child Welfare Investigative Summary, with confirmed findings, for 120 days completion of the investigation

Compliance file: The program is required to make accessible the following:

- Documents issued within the last 120 days:
  - Child care licensing monitoring reports, including most recent report correspondence
  - Form 07LC037E, Notice to Comply
  - Licensing complaints
  - Child Welfare Investigative Summary, with findings of unconfirmed t services not needed or services recommended
- Child Welfare Investigative Summary, with confirmed findings, for one year completion of the investigation

Online

Child care locator and case summary: Access at www.okdhs.org/services/cc/Pages/ChildCareMain.aspx

Child care licensing requirements: Access at www.okdhs.org/services/cc/Pages/ChildCareMain.aspx, or contact your county DHS office.

At the DHS County Office

Public licensing file: Call the DHS county office below to schedule an appointment.

Case summary: Call the DHS county office below for a faxed or mailed copy.

Child care licensing requirements: Call the DHS county office below for a mailed copy.

If you believe licensing requirements are not being met or you have questions, please contact a child care licensing specialist from DHS Child Care Services at:

Child Care Services

DHS Lincoln county office

[address]

[address]

[phone]

www.okdhs.org/services/cc/Pages/ChildCareMain.aspx