

Kickapoo Head Start

Enrollment Application

Child's Name: _____

Child's Date of Birth: _____

Child's School District: _____

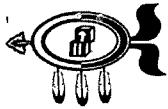
Required Documents Needed with Application	Documents Received Date <i>Office use only: Completed by Staff</i>
Birth Certificate	
Child's CDIB Card (Certificate of Indian Blood)	
Parent/Guardian CDIB (Certificate of Indian Blood)	
Income Verification (Tax Forms, 3 Consecutive Pay Stubs, SSI, TANF, SNAP)	
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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Address of Family		City	State	Zip Code	County	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____ <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;"> <input type="checkbox"/> Hispanic or Latino origin <input type="checkbox"/> Non-Hispanic or Non-Latino origin </div>		Child's Primary Language _____ Other Languages _____ English <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Public School District in which child resides: _____ Was this child previously in a Head Start Program <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, which program? _____		
Primary Health Coverage				Medicaid <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____		English Language <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient		Other Language <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	
Highest Grade Completed <input type="checkbox"/> Master's <input type="checkbox"/> < Grade 9 <input type="checkbox"/> Bachelor's <input type="checkbox"/> Grade 10 <input type="checkbox"/> Associate's <input type="checkbox"/> Grade 11 <input type="checkbox"/> College Degree/Train <input type="checkbox"/> Grade 12 <input type="checkbox"/> Advance Training <input type="checkbox"/> HS Graduate <input type="checkbox"/> GED <input type="checkbox"/> Currently Enrolled in College		Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Seasonal <input type="checkbox"/> Training or School <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired or Disabled		Custody <input type="checkbox"/> No <input type="checkbox"/> Yes	
Check All That Applies: <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent					
Child's Relationship <input type="checkbox"/> Natural <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Adopted <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other <input type="checkbox"/> Grandchild		Head Start Parent? <input type="checkbox"/> Current <input type="checkbox"/> Former			
EMPLOYER: _____					

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

First	Middle	Last	Suffix	Birthday	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____		English Language <input type="checkbox"/> None <input type="checkbox"/> Little <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	Other Language <input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Proficient	Custody <input type="checkbox"/> No <input type="checkbox"/> Yes	Check All That Applies: <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent	
Highest Grade Completed <input type="checkbox"/> Master's <input type="checkbox"/> < Grade 9 <input type="checkbox"/> Bachelor's <input type="checkbox"/> Grade 10 <input type="checkbox"/> Associate's <input type="checkbox"/> Grade 11 <input type="checkbox"/> College Degree/Train <input type="checkbox"/> Grade 12 <input type="checkbox"/> Advance Training <input type="checkbox"/> HS Graduate <input type="checkbox"/> GED <input type="checkbox"/> Currently Enrolled in College			Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Full Time & Training <input type="checkbox"/> Part Time <input type="checkbox"/> Part Time & Training <input type="checkbox"/> Seasonal <input type="checkbox"/> Training or School <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired or Disabled		Child's Relationship <input type="checkbox"/> Natural <input type="checkbox"/> Niece/Nephew <input type="checkbox"/> Adopted <input type="checkbox"/> Foster <input type="checkbox"/> Step <input type="checkbox"/> Other <input type="checkbox"/> Grandchild	
Head Start Parent? <input type="checkbox"/> Current <input type="checkbox"/> 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 _____

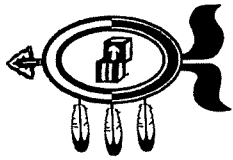
Professionally evaluated/diagnosed by: Name of Doctor

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: _____

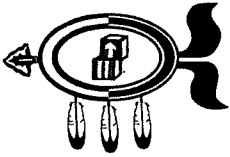
In Case of an Emergency at School:

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.

<i>Name</i>	<i>Relation to Child</i>	<i>Home Number</i>	<i>Cell Number</i>	<i>Work Number</i>

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.

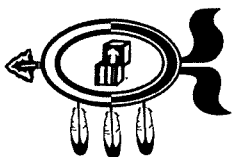
Parent Signature: _____

Date: _____

Staff Signature: _____

Date: _____

Revised 7/2022



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 b.Strabismus		Left _____ Right _____
Other Tests (Sickle Cell, etc.)		

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 _____



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)

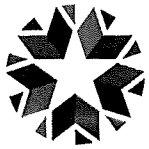
Future Oral Health Care Services

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 _____



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

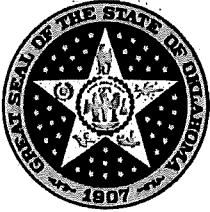
I understand and am aware:

- 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 day 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