

TUSKEGEE-MACON COUNTY HEAD START

103 West Martin Luther King Highway

Tuskegee, Alabama 36083-2225

Fax#: 334-724-2118 Telephone #: 334-724-2116

ENROLLMENT REQUIREMENTS

The child must be 3 years old on or before September 2nd, 4 years old or 5 years old after September 2nd.

To be officially accepted into the program, applicants must submit the following three main requirements and an enrollment application. You must bring all of the following items to begin the application process:

- PROOF OF AGE** (Child's original birth certificate)
- PROOF OF INCOME** (Examples: W-2, Income Tax Form, check stub showing gross amount for year requested, letter from employer, SSI documentation/letter, letter from DHR, child support statement, veterans benefits, TANF, unemployment letter...etc)
- CHILD'S ORIGINAL, UPDATED IMMUNIZATION RECORD** (Blue Slip)

The following documents must also be obtained from the applicant:

- SOCIAL SECURITY CARD** (For child being enrolled only)
- PHYSICAL EXAMINATION** (Form will be provided by Tuskegee-Macon County Head Start, to be completed by your child's doctor)
- DENTAL EXAMINATION** (Form will be provided by Tuskegee-Macon County Head Start, to be completed by your child's dentist)
- HEALTH/MEDICAL INSURANCE** (Medicaid card, Allkids card, or any other private insurance)
- DOCUMENTATION OF CHILD'S SPECIAL NEEDS** (From the child's medical doctor, referral letter and/or IEP)

WEBSITE: www.tuskegeealabama.gov/headstart

BUSINESS HOURS: 8:00 a.m. – 4:30 p.m.

"Touching Children, Reaching Families"
AN EQUAL OPPORTUNITY EMPLOYER



Applicant & Family Member Information

This Section for Agency Use Only:
 Primary Site(s): _____
 ChildPlus Family ID #: _____ Application #: _____

Applicant (child applying for services)

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None	<input type="checkbox"/> Other Language		<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			
Primary Health Coverage		Other Health Coverage		Insurance #		Medicaid #	
						Doctor	
						Dentist	
						<input type="checkbox"/> Not Eligible <input type="checkbox"/> On Medicaid <input type="checkbox"/> Potentially Eligible	

Adult 1

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None	<input type="checkbox"/> Other Language		<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			
Highest Grade Completed		Employment Status at Enrollment		Child's Relationship		Custody	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step		<input type="checkbox"/> Yes	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild		<input type="checkbox"/> No	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew		Check all that apply: <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent If teen parent, subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster			
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other			
<input type="checkbox"/> Some College	<input type="checkbox"/> Master's						
E-mail Address: _____							

Adult 2

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None	<input type="checkbox"/> Other Language		<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			
Highest Grade Completed		Employment Status		Child's Relationship		Custody	
<input type="checkbox"/> Associate's	<input type="checkbox"/> Grade 10	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step		<input type="checkbox"/> Yes	
<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Grade 11	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild		<input type="checkbox"/> No	
<input type="checkbox"/> Col Deg/Train	<input type="checkbox"/> Grade 12	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew		Check all that apply: <input type="checkbox"/> Lives with Family <input type="checkbox"/> Provides Financial Support <input type="checkbox"/> Teen Parent If teen parent, subsidized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Col or Adv Train	<input type="checkbox"/> < Grade 9	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster			
<input type="checkbox"/> GED	<input type="checkbox"/> HS Graduate			<input type="checkbox"/> Other			
<input type="checkbox"/> Some College	<input type="checkbox"/> Master's						
E-mail Address: _____							

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None	<input type="checkbox"/> Other Language		<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN
Race		Hispanic		English Proficiency		Other Language Proficiency	
<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> None	<input type="checkbox"/> Other Language		<input type="checkbox"/> Poor	
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Little			<input type="checkbox"/> Moderate	
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Moderate			<input type="checkbox"/> Proficient	
<input type="checkbox"/> Other: _____				<input type="checkbox"/> Proficient			

Family Information, Income & Contacts

This Section for Agency Use Only:
Applicant Name: _____

Family Information

Living Address	Address Line 2	Zip	City	State	County		
Mailing Address (if different)	Address Line 2	Zip	City	State	County		
Phone Numbers	Type (check one)		Note (for example, an extension or best time to call)				
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____						
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____						
	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____						
Parental Status (check one)	Primary Language at Home	Homeless Family	Military Family	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (if applicable)
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/> Yes <input type="checkbox"/> No					

Family Income

TANF	Supplemental Security Income
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly	<input type="checkbox"/> Yes <input type="checkbox"/> No

Date Verified (agency use only) ____/____/____ Verified by (agency use only) _____

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

Income Notes _____

Emergency Contacts

Contact 1	Name	Relationship	Emergency Contact	Release To
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Zip	City	State
	Phone # 1	Phone # 2	Phone # 3	
	<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W		<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W
Contact 2	Name	Relationship	Emergency Contact	Release To
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Zip	City	State
	Phone # 1	Phone # 2	Phone # 3	
	<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W		<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W
Contact 3	Name	Relationship	Emergency Contact	Release To
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	Zip	City	State
	Phone # 1	Phone # 2	Phone # 3	
	<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W	<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W		<input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> W

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 _____

Medical Home Screenings/Physical Examination/Assessment Record

Child's Name: _____ Address: _____ Sex: M F Birthdate: _____ Phone: _____

Child Development Center: _____

PART A: To be completed by staff or health care provider before physical examination/assessment
RELEVANT INFORMATION (from Health History, Parent/Teacher Observations)

PART B: Stated items (*) are recommended by the EPSDT for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", "A" for NORMAL, SUSPECT, ATYPICAL/ABNORMAL, respectively.

TEST	DATE	RESULTS		TEST	DATE	RESULTS		TEST	DATE	RESULTS	
		Yrs.	Mos.			Normal For Age	Abnormal			Normal For Age	Abnormal
Present Age*				Hearing (type of test)* Screening Results, R/L				Other tests (if indicated) (1) Lead (2) Urinalysis (Age 5) (3) Hematocrit or Hemoglobin			
Height (no shoes, to nearest 1/8 in.)*				Vision (type of test)*							
Weight (light clothing, to nearest 1/4 lb.)*				Acuity, R/L							
Blood Pressure/Pulse				Strabismus							
Temperature, Respiration and Circulation				Nose, Mouth, Pharynx							
General Appearance				Teeth				(3) Communication Skills			
Posture, Gait				Heart				(4) Cognitive			
Speech				Lungs				(5) Self-Help Skills			
Skin				Abdomen (include hernia)				(6) Social Skills			
Head				Nutrition				Glands (lymphatic/thyroid)			
Eyes (1) External Aspects				Genitalia				Muscular Coordination			
(2) Optic Fundoscopic				Bones, Joints, Muscles				Other			
(3) Cover Test				Neurological/Social							
Ears (1) External &				(1) Gross Motor							
(2) Tympanic membranes				(2) Fine Motor							

Medication Administration (Use additional sheet if necessary)

Special Conditions: _____ or No _____. If yes, indicate: _____

Allergies: Yes _____ or No _____. If yes, indicate: _____

PART C: FINDINGS, TREATMENT, AND RECOMMENDATIONS:

Abnormal Findings/Diagnosis	Treatment Plan

General statement on child's physical status:
Signature: _____ Date: _____

Recommended Follow-up or Results

Recommended Follow-up or Results	Date

Circle Appropriate Payment: M - Medicaid H - HeadStart P - Private O - Other C - CHIP

Tuskegee-Macon County Head Start Program Dental Examination/Treatment Record

Child's Name: _____ Sex: M F Date of Birth: _____
 Parent's Name: _____ Phone Number: _____
 Address: _____ Center: _____

Source of Payment:

- Medicaid # _____
 Head Start _____
 Other: _____

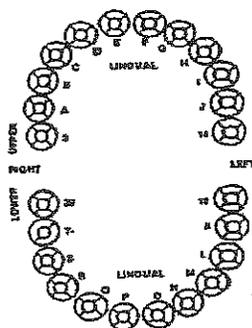
*Medical Alert: _____

Examination (Completed by Dentist)

Name of Dentist: _____ Phone Number: _____

A. Existing Conditions

B. Proposed Treatment (Indicate approximate numbers)



- _____ Fillings
 _____ Crowns
 _____ Extractions
 _____ Other _____
 _____ Number of Appointments

Comments: _____

Dentist Signature: _____ Date: _____

Treatment (Completed by dentist as treatment progresses)

Tooth ID	Surfaces	Treatment/Description of work	Date	Fee

I certify that I have completed the above services and that the child has received all necessary treatment as requested by the Tuskegee-Macon County Head Start Program.

Dentist Signature: _____ Date: _____

I. Authorization for administering medication

DHR-CDC-1949

Authorization for Medication Administration/Medical Procedures

Dear Parent /guardian,

Your written permission is required to administer medication or medical procedures to your child. Any prescription drug or over-the-counter drug sent to the center must be in its original container and must be clearly labeled with your child's name, the name of the drug, and directions for administering the drug. A new authorization form is needed each week. If it is absolutely necessary for your child to be given medication while at the center, please complete the following information.

Child's Name: _____

Prescription Number: NOT APPLICABLE

Name of medication: FLUORIDE TOOTHPASTE

Amount of medication to be given at each dosage: PEA SIZE

Instructions (how to give or apply, such as give by mouth, apply to skin, inhale, drops in eyes, etc) GIVE TO CHILD IN A 3 OZ. CUP TO USE FOR TOOTHBRUSHING.

Time of last dosage given at home: NOT APPLICABLE

Time(s) of dosage(s) to be given at the child care facility AFTER MEALS

Please give my child the above-named medication at the time(s) and in the amount(s) indicated.

Signature of parent/guardian Date

To be completed by licensee/staff/caregiver

Date Medication Given	Time Medication Given	Signature of person giving medication

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In Case of Accident or Illness:

Should _____ (my child) become ill during the time that he/she is in the care of the Tuskegee-Macon County Head Start Program or suffer an accident of any nature the Program shall undertake to contact me immediately.

In the event the Program is unable to reach me immediately, it is authorized to secure such medical attention and care for my child, as deemed necessary.

Parent/Guardian's Authorized Signature

Date

CONSENT FOR EMERGENCY DENTAL TREATMENT

Should _____ (my child) need emergency dental care, due to an accident of any nature, during the time that he/she is in the care of Tuskegee-Macon Head Start Program the Program shall undertake to contact me immediately.

In the event the Program is unable to reach me immediately, it is authorized to secure such dental attention and care for my child, as deemed necessary, without further consent.

Parent/Guardian's Authorized Signature

Date

**TUSKEGEE-MACON COUNTY HEAD START
CHILD'S HEALTH HISTORY**

Child's Name _____
 Date of Birth _____ Sex M F
 Parent's/Guardian's Name _____

Are there any health problems in the immediate family? (mother/father) yes no
 If yes, explain _____

Child's Health History

Asthma	Liver Disorder
Eczema	Obesity
Diabetes	Sickle Cell Disease/Trait
Heart Disease	Anemia
Seizures	High Lead
Bowel Disorder	Cancer
Learning Disorder	Other:

Have your child had Chicken Pox? No Yes
 Does child have regular habit of eating dirt, ice, starch or paper? No Yes

List the name, dosage, amount and frequency of any medication or vitamin your child takes regularly.

Name	Dosage	Amount	Frequency

Why? _____
 List the name of any medication, food or other allergies your child has: _____

What is the reaction and treatment used for the allergy listed above? _____

Physical/Psychological/Social Development

Name two things child does well:
 1. _____ 2. _____
 Does child sleep less than 8 hours per night or have trouble falling or remaining sleep? No Yes
 Does child relate poorly with children? No Yes
 Does child relate poorly with adults? No Yes
 Is child afraid of anything? No Yes
 Is child easily upset, disturbed or angry? No Yes
 Does child have trouble expressing self? No Yes
 Do you have trouble understanding child? No Yes
 Does child have problems with toileting? No Yes
 If yes, explain _____

Pregnancy/Birth History

Did the child's mother see a doctor less than two (2) times during the pregnancy?
 No Yes
 Were there problems during or after the pregnancy?
 No Yes
 Was the child born prematurely?
 No Yes
 Was anything wrong at birth or in the nursery?
 No Yes
 If yes, explain _____

Tuberculosis Risk (TB)
 Do you and your family have yearly TB Skin Tests?
 No Yes
 Has the child been around an adult who has a positive TB skin test or had tuberculosis/TB?
 No Yes
 Is there anyone in the family on medication for TB?
 No Yes

Lead Risk

Does child:
 Live in or regularly visit a house built before 1960 with peeling/chipping paint? No Yes
 Have sibling who has been treated for lead poisoning? No Yes
 Live with an adult whose job or hobby results in lead exposure? No Yes

 Parent/Guardian Signature Date

 Staff Signature Date

Family Health History

**TUSKEGEE-MACON COUNTY HEAD START
DENTAL HEALTH HISTORY**

Child's Name: _____ Parent's/Guardian Name: _____

Has your child previously seen a dentist? No Yes If yes, Date of last visit _____

Dentist's Name (Dental Home)	Phone ()	Address	City, State	Zip Code

List any dental problems your child has experience/is experiencing: _____

Is your child taking any medications? No Yes

If yes, list the following information:

Name of Medication	Amount	Frequency

Does your child have a regular physician, or clinic? No Yes

If yes, Date of last visit _____

Dentist's Name (Medical Home)	Phone ()	Address	City, State	Zip Code

Does child have a diagnosed medical condition?

None Asthma Diabetes Seizure Disorder Heart Condition
 Sickle Cell Disease/Trait Allergies Other: _____

Does your child have health coverage?

Medicaid All Kids Insurance (Private) Other _____

Provider: _____ Number: _____

I prefer the following option for my child's dental care needs: (Check only one)

_____ Option A: My child has a dentist and dental insurance. I will make an appointment with my child's dentist and send verification of the dental visit as soon as possible.

_____ Option B: My child has a dental insurance but does not have a dentist. Head Start will make an appointment with a dentist and notify me. I will take an active role in dental care for my child.

Consent for Dental Examination

I give permission for my child to have a dental examination by a licensed dentist. I understand that x-rays and fluoride treatment may be necessary. I give permission for this information to be released to the dentist if needed.

Parent's/Guardian's Signature _____ Date: _____

TUSKEGEE-MACON COUNTY HEAD START CHILD NUTRITION RECORD (AGES 3 – 5)

Date: _____ Center: _____

Child's Name: _____ Date of Birth: _____ Sex: _____

Relationship to child: _____

1. How is your child's appetite? (Circle one) excellent good fair poor
2. What food(s) does your child like best? _____
3. What food(s) does your child dislike? _____

Please check "yes" or "no" for each question. Some questions ask for additional information. Please respond by providing such information if it applies to your child.

		Yes	No
4.	Does your child eat at least 3 meals a day?		
5.	Does your child drink water each day?		
6.	Does your child participate in the WIC program?		
7.	Does your family receive food stamps?		
8.	Is your child following a special diet? If yes, please describe: Type of diet: _____ Reason for diet: _____		
9.	Has there been a big change in your child's appetite recently? If yes, has it increase or decreased? (Please circle one)		
10.	Does your child take a nutritional supplement? If yes, circle which one(s): Vitamins/minerals/combination w/its & min./iron/high calorie supplement/other		
11.	Is your water supply city water? If not, what is your water source?		
12.	Does your child chew or eat things that are not food? If so, what?		
13.	Does your child have diet related allergies? If so, what?		
14.	Does your child take a baby bottle? If yes, how often?		
15.	Is your child on any prescription medication? If yes, please describe:		
16.	Does your child have problems chewing and/or swallowing? (Please circle)		
17.	Does your child often have diarrhea / constipation / nausea? (Please circle)		
18.	Does your child use special eating utensils? If so, describe:		
19.	Does a blood relative of your child have any of the following conditions? Circle all that apply: Heart disease, blood pressure, diabetes, high cholesterol		
20.	Does your child have any special dietary needs that Head Start Nutrition Services should be aware of in planning his/her meals and snacks? Please explain:		

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

EDUCATION

CHILD'S NAME: _____ DATE OF BIRTH: _____

In order to accurately assess your child and provide the necessary opportunities for him/her, please complete the section below as truthfully as possible. Please sign and date after completion.

DEVELOPMENTAL HISTORY (PARENT'S OBSERVATION)

Below are some common childhood problems. Please indicate your observation(s) of any of these problems by checking YES or NO.

PROBLEM	YES	NO		PROBLEM	YES	NO
Shyness				Selfishness		
Nightmares				Thumb Sucking		
Nervousness				Temper Tantrums		
Showing Off				Fainting		
Fighting				Destructiveness		
Rudeness				Stealing		
Refusal to Obey				Whining		
Jealousy				Running Away		
Untruthfulness				Impatience		

Please list any other problem(s) or fear(s) _____

CHECK CHILD'S GROUP EXPERIENCES:

Nursery School			Day Care	
Sunday School			Other	

Specify Other _____

Parent's/Guardian's Signature: _____ Date: _____

TUSKEGEE-MACON COUNTY HEAD START PROGRAM
AUTHORIZATIONS

CHILD'S NAME: _____ **PARENT/GUARDIAN:** _____

Parent/Guardian, please place your initials on each blank.

TRANSPORTATION

I, hereby, give permission for the Tuskegee-Macon County Head Start Program to transport my child as follows:

___ To and from the center for transition field trips, screenings, emergency treatment, and any other services provided by Tuskegee-Macon County Head Start.

___ I agree to have my child ready at the appointed time in the morning and to be available at the appointed time in the afternoon to receive my child. I understand that my child will not be released to anyone other than those persons listed on my child's Pre-Admission Record and that it is my responsibility to keep this record up to date.

INDIVIDUAL TRANSPORTATION

___ I agree that I, or a person authorized by me, will bring my child to his/her designated center each day by 7:30a.m. and I or the person listed on the release list will pick up my child each day at the close of school. I understand that if arrangements are not made to pick up my child by 2:30p.m.; the police and/or child protection services may be notified and my child will be delivered into their custody.

PICTURES AND PUBLICATIONS

___ I, hereby, give permission for any picture 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.

Parent's/Guardian's Signature: _____

Date: _____

TUSKEGEE-MACON COUNTY HEAD START

HARVEY L. SMITH
TEMPORARY EXECUTIVE DIRECTOR



NANNETTE PHILLIPS
HEAD START DIRECTOR

103 W. MARTIN LUTHER KING HIGHWAY
TUSKEGEE, ALABAMA 36083-2225
TEL: (334)724-2116 FAX: (334) 724-2118

PARENTAL AGREEMENT FOR HEALTH SERVICES

I understand that it is my responsibility to obtain a physical and dental examination for my child, _____. However, in the case that my child's physical is incomplete and does not include all of the following elements, I grant permission for Tuskegee-Macon County Head Start Program to conduct or arrange for the following screenings for my child (Please circle yes or no for each screening return form to center).

Growth Assessment (height/weight)	Yes	No
Hemoglobin/Hematocrit	Yes	No
Blood Pressure	Yes	No
Pulse	Yes	No
Lead	Yes	No
Physical Examination	Yes	No
Dental Examination	Yes	No
Vision Screening	Yes	No

I have received a description of each of the above screenings and understand the importance of each screening.

Parent's Signature

Date

Head Start Staff's Signature

Date

**TUSKEGEE-MACON COUNTY HEAD START PROGRAM
FAMILY PARTNERSHIP INITIAL 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

Please check your educational needs.

<input type="checkbox"/> GED	<input type="checkbox"/> Vocation	<input type="checkbox"/> Technical	<input type="checkbox"/> College	<input type="checkbox"/> Other
------------------------------	-----------------------------------	------------------------------------	----------------------------------	--------------------------------

EMPLOYMENT

Are you currently employed? Yes No If yes, Full Time Part Time Seasonal

What type of work do you do? _____

Are you currently having job training or placement problems? Yes No

If yes, please explain: _____

HEALTH

Who is your Medical Doctor? _____ City _____

If you do not have a health care provider, where do you go for medial help?

_____ City _____

Does your family have Health Insurance? Yes No

Briefly describe any medical care need you have: _____

FAMILY & COMMUNITY

What are the most pressing problems for you and your family? Check all that apply.

<input type="checkbox"/> Safety	<input type="checkbox"/> Family Violence	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Health
<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Poor Housing	<input type="checkbox"/> Paying Bills	<input type="checkbox"/> Other

Specify: _____

Are you involved with any social services agency, including mental health, courts, etc.? Please list.

Agency	Contact Person	Brief Description of Services

PARENTING

Would you like information on the following? Check all that apply.

<input type="checkbox"/> Single Parenting	<input type="checkbox"/> Parenting Skills	<input type="checkbox"/> Stage of Growth
<input type="checkbox"/> Positive Behavior	<input type="checkbox"/> Parent/Child Conflicts	<input type="checkbox"/> Child/Family Health

Other: _____

Parent's/Guardian's Signature: _____ Date: _____

Staff's Signature: _____ Date: _____

(Initial Assessor)

Assigned Family Service Worker Signature: _____ Date: _____

TUSKEGEE-MACON COUNTY HEAD START PROGRAM

**FAMILY PARTNERSHIP AGREEMENT
STATEMENT OF UNDERSTANDING**

Tuskegee-Macon County Head Start is a family focused program. We are here to assist not only your child, but your entire family. The purpose of the **Family Partnership Agreement** is to assist families in taking steps towards personal and economic independence.

The information shared in interviews and home visits will be kept confidential within the Head Start Program with the exception of child and/or elder abuse as mandated by the State Law to report. Any other information will only be release to outside agencies with written authorization by the legal guardian.

Tuskegee-Macon County Head Start can provide assistance in the following ways: Written materials, parent training and referrals to community agencies. We may not be able to assist you in meeting all your needs, but we will try our best to work closely with you, your family and the community.

The home visit shall be made as early as possible, after the child's enrollment. Additional home visits will be conducted as needed.



As a parent of the Tuskegee-Macon County Head Start Program, I have read and understand the statements printed above. I agree to share information with the appropriate Head Start Staff in order for them to assist me and my family.

Parent's/Guardian's Signature: _____ Date: _____

Family Services Advocate's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____