Applicant & Family Member Information

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
Select One	Select One	Select One		Select One

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
Select One			Select One		

Dental Coverage	Dental Coverage #	Dentist/Dental Home

Have transportation?	If no, need the bus?	Transportation Type
Select One	Select One	

Housing Type	Housing Payment
Select One	

DISABILITY INFORMATION

Have disability?

Select One

CSBG Family Info

CDIB

Select One

Citizenship Status

Primary Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID
						Select One		

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
Select One	Select One	Select One		Select One

Highest Grade Completed	Employment Status	Child's Relationship	Custody	Check all that apply:
Select One	Select One	Select One	Select One	Select One

Email Address:

HEALTH INSURANCE

Health Ins./What type

Select One

DISABILITY INFORMATION

Have disability?

Select One

CSBG FAMILY INFO

Military Status

Select One

CDIB

Select One

Citizenship Status

Non-Cash Benefits	If other, list.
Select One	

Marital Status

Disconnected Youth

Select One

Secondary or Other Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID
						Select One		

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
Select One	Select One	Select One		Select One

Highest Grade Completed	Employment Status	Child's Relationship	Custody	Check all that apply:
Select One	Select One	Select One	Select One	Select One

Email Address:

HEALTH INSURANCE

Health Ins./What Type

Select One

DISABILITY INFORMATION

Have disability?

Select One

CSBG FAMILY INFO

Military Status

Select One

CDIB

Select One

Citizenship Status

Non-Cash Benefits **If Other, List.**

Select One

Marital Status

Disconnected Youth

Select One

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN/Alt ID
						Select One	

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
Select One	Select One	Select One		Select One

HEALTH INSURANCE

Health Ins./What Type

Select One

DISABILITY INFORMATION

Have disability?

Select One

CSBG FAMILY INFO

Military Status

Select One

CDIB

Select One

Citizenship Status

Non-Cash Benefits **If other, list.**

Select One

Marital Status

Disconnected Youth

Select One

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Living Address

Started Living At Date	Living Address	Address Line 2	ZIP	City	State	County

Family Mailing Address

Same as living?	Started Using Date	Mailing Address	Address Line 2	ZIP	City	State
☐ Yes ☐ No						

Phone Number(s)	Type (*check one*)	Note (extension or best time to call)	Opt In for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Family Income

Income Verified by	Verification Date	TANF Status	SSI
		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ No

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

Income Notes

Emergency Contacts

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 2

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 3

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

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 _____

1. Child Health History; *Has the child ever had any of these conditions? Please give explanation to any "Yes" answers. (Use space provided below to explain.)*

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Allergies			Anemia (low iron)			Asthma		
Boils			Bleeding conditions			Broken bones		
Cancer			Chicken pox			Diabetes		
Eczema			Hives			Heart conditions		
High Blood Pressure			High Blood Lead			Mumps		
Measles			Immune System Disease			Inherited Disease		
Liver Disease			Seizures			Emotional Disturbance		
Down Syndrome			Overweight			Pneumonia		
Sickle Ceil Disease			Sickle Cell Trait			Tubes In Ears		
Tonsils Removed			Rheumatic Fever			Scarlet Fever		

Please explain "Yes" answers:

_____
_____
_____
_____

2. Is child receiving treatment for any of the following health conditions?

Condition	Yes	No	Condition	Yes	No
Anemia (low iron)			Asthma		
Overweight			Hearing Difficulties		
Vision Problems			High Lead Levels		
Diabetes			Other		

3. a. Is the child currently taking medication? ☐ Yes ☐ No
If "Yes", explain: Name of Medication: _____
Dose:_____
How often? _____

b. Will Head Start staff need to administer this medication? ☐Yes ☐ No
(If "Yes" a special consent form must be completed entirety before the child can receive medication while attending the Head Start program.)

4. Does this child have a diagnosed health problem? ☐Yes ☐ No
If "Yes" Name of Physician _____
Address_____
Phone# _____

5. Has this child ever had surgery? ☐ Yes ☐ No
*If "Yes" please explain:*_____

6. Has this child ever had a seizure? ☐Yes ☐ No
*If "Yes" please explain: Cause if known.*_____
How often: _____
Date of last seizure: _____

7. Has the child ever been diagnosed with asthma? ☐Yes ☐ No
If "Yes" please explain: Cause if known: _____
How often: _____
Date of last asthma attack: _____

8. Has the child ever had an allergic reaction? ☐ Yes ☐ No
*If "Yes", please explain the reaction:*_____
_____
Cause if known: _____
Date of last reaction:_____

9. Has this child ever had problems with the following conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Frequent Ear Infections			Frequent sore throats			Frequent bed wetting		
Frequent chest pains			Frequent coughing			Frequent stomach aches		
Problems with bowels			Problems eating			Problems with urinating		
Hearing problems			Vision problems			Problems with eyes		
Frequent trouble sleeping			Speech problems			Temper Tantrums		
Other _____			Other _____			Other _____		

Explain any "Yes" answers:

10. Has this child ever been involved in a child abuse &/or neglect incident or case? ☐ Yes ☐ No
If "Yes", please explain: _____

11. Does child have a regular doctor? ☐ Yes ☐ No
If "Yes", please explain. When did you obtain doctor for child? _____
Where does child receive medical care? ☐ Doctor office ☐ Clinic
Date of last physical exam: _____

Name of Doctor _____
Address _____
Phone Number _____

12. Does child have a regular dentist? ☐ Yes ☐ No
If "Yes", please explain: When did you obtain dentist for child? _____
Where does child receive dental care? ☐ Dentist office ☐ Clinic
Date of last dental exam: _____

Name of Dentist _____
Address _____
Phone Number _____

13. Are child's immunizations up to date? ☐ Yes ☐ No
If "No", child cannot be accepted into program. Please attach copy of record.

Disability Information: _____
Children with special needs may receive priority for Head Start enrollment. Your disclosure of this information is strictly voluntary.

1. Does this child have any additional condition that could interfere with his/her daily activities? ☐ Yes ☐ No
If "Yes", please explain: _____
_____

2. Is this child's routine screenings (developmental, sensory, and behavioral) completed? ☐ Yes ☐ No

If "Yes", does the child need follow-up assessment or format evaluation to determine if the child had a disability?

3. Does your child have a disability? ☐ Yes ☐ No *(if no, please go to question #8.)*

4. Type of special needs or disability? _____

5. Has the disability been professionally diagnosed? ☐ Yes ☐ No *If so, by whom?* _____

6. Is the child receiving special services for the disability? ☐ Yes ☐ No
If "Yes", type of services? _____

7. Does child currently have an (IEP) Individual Education Plan? ☐ Yes ☐ No
If "Yes", which school district completed the IEP? _____

8. In your opinion, does your child have a special need that has not yet been diagnosed? ☐ Yes ☐ No

NUTRITION ASSESSMENT SURVEY	2018-2019

Name of Child:_____ **Center Name:** _____

Please answer the following questions regarding your child:

1. Is your child taking a vitamin supplement? . . . . . ☐ Yes ☐ No
   If yes, are they prescribed? . . . . . ☐ Yes ☐ No
2. Does your child have any persistent/current issues? . . . . . ☐ Yes ☐ No
   If yes, please select: ☐ Nausea or vomiting? ☐ Diarrhea? ☐ Constipation? ☐ Trouble Swallowing?
3. Has your child experienced a dramatic weight change in the past year? . . . . . ☐ Yes ☐ No
   If yes, please explain: _____
   _____
4. Is your child on a special diet? . . . . . ☐ Yes ☐ No
   If yes, please list type of diet: _____
5. Does your child have an allergy to food? . . . . . ☐ Yes ☐ No
   If yes, please list: _____
6. Is your child enrolled in a Nutrition Program? . . . . . ☐ Yes ☐ No
   If yes, which program? ☐ WIC ☐ Food Stamps ☐ Other _____
7. Does your child use spoon and fork? . . . . . ☐ Yes ☐ No
8. Does your child have a feeding tube? . . . . . ☐ Yes ☐ No
   Other method? ☐ Yes ☐ No If yes, please list _____
9. Do you have any concerns about your child's size? . . . . . ☐ Yes ☐ No
   If yes, please check your concern: ☐ Too Thin? ☐ Too Small? ☐ Too Heavy? ☐ Too Tall?
10. Please check which meals your child eats daily: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snack

11. On a WEEKLY basis, how often does your child eat items from the following food groups? (Please check number)

a.	Dairy (milk, cheese, yogurt)	0*	1*	2*	3	4	5	6	7	7+
b.	Meat, fish, poultry, eggs or dried beans / peas peanut butter?	0*	1*	2*	3	4	5	6	7	7+
c.	Grains (rice, grits, bread, cereal, tortillas)	0*	1*	2*	3	4	5	6	7	7+
d.	Vegetables (greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes)	0*	1*	2*	3	4	5	6	7	7+
e.	Fruit or juices (oranges, grapefruit, tomatoes, grapes)	0*	1*	2*	3	4	5	6	7	7+
f.	Oil, butter, margarine, etc.	0*	1*	2*	3	4	5	6	7	7+
g.	Sweets (cakes, cookies, soda/pop, fruit drinks (Kool-Aid), candy)	0*	1*	2*	3	4	5	6	7	7+

*Starred answers may require follow-up. Explain or provide additional comments here:

12. Criteria for Referral: ☐ Suspect Dietary Problem ☐ Inadequate food intake ☐ Underweight ☐ Overweight