Carbon County Child Development Programs
1801 Edinburgh Rawlins, WY 82301
(307)324-4951 FAX: (307)324-8424 or (307)324-9571 FAX: (307)324-4429

PLEASE READ ALL INFORMATION BEFORE FILLING OUT PACKET

The following documents are required in determining enrollment into our program:

- ***Pre-enrollment packet**
- ***Proof of age which may include a Copy of Birth Certificate, Passport etc…**
- ***Proof of Income for 12 months, from ALL parent or guardians living with the child (pay stubs, w-2, tax return, unemployment, child support etc...) SNAP benefits card, TANF enrollment documentation or S.S.I. paperwork.**
- **Immunization Records (required within 30 days after enrollment)**

A completed application DOES NOT ensure your child's enrollment in our program.

Your family is eligible for Head Start services if your income is determined to be at or below the federal poverty level. Children are also eligible for our program if your family is homeless, enrolling child is in foster care, family is receiving TANF/POWER, SNAP or SSI. CCCDP may enroll up to 10% of slots from families whose income is higher than the federal poverty level.

*If you are new family to our program you can scan the QR code to fill out an online application. However, if you are a returning family to our programs the online application will not work since you are already in our system. Printable copies are available online for you to fill out and return to our office.

Carbon County Child Development Programs, Inc.

Application for Head Start

"Carbon County Child Development Programs, Inc. is an equal opportunity provider."

Completion of this application does not guarantee acceptance into the program

Child Application Information

Child's name: _____ Child date of birth: _____/_____/_____ Male/Female___

Family Information:

Living address: _____

City State Zip

Mailing address: _____

City State Zip

Parent or Legal guardian phone numbers: (please indicate below with name of parent or guardian)

We will contact you via text/email messages with important school information, so please make sure we have current phone numbers and email addresses.

Parent/Guardian (Relationship to child)_____
Home_____
Cell_____
Work_____
Other_____
Email Addresses: _____

Parent/Guardian (Relationship to child)_____
Home_____
Cell_____
Work_____
Other_____
Email Address_____

Have any of the student's siblings been enrolled in our program before? _____

Parent Status please circle: One Parent or Two parent (two parent indicates that both parents live in the home of the child.)

Adults living in the home: Please list below

Name	**Date of birth (Required)**	**Relationship to child** biological, foster, step, grandchild, other relative, other	**Gender** Male or Female	**Employment** full time part time unemployed seasonal, training/school retired/disabled	**Education** highest grade completed in school or list degree earned	**Currently in school or job training program?** yes or no

Parent(s) NOT living in child's home: Please list below

Name	**Date of birth (Required)**	**Relation ship to child**	**Gender** Male or Female	**Custody** yes or no	**Employment** full time part time unemployed seasonal, training/school retired/disabled	**Mailing Address**	**Phone number**

Other children living in the home that are related to applicant:

Name	**Date of birth (Required)**	**Relationship to child**	**Gender: male or female**

Check all that apply

- ☐ WIC #_____
- ☐ SSI
- ☐ TANF/POWER
- ☐ Child Care Subsidy
- ☐ SNAP

Check if current housing includes:

☐ Transitional Housing, Safe House, Homeless Shelter, Motel, Vehicle

☐ Homeless

☐ Temporarily living with friends/family, but seeking permanent housing

☐ None of these apply

Primary language spoken in the home: _____ Other language(s) spoken in the home: _____

How did you hear about our programs?

Agency name: _____ Other:_____

Is one or both parent/guardian an active member of the US military? ☐ Yes ☐No

Child Needs:	**Family Needs:**
☐ Currently on an IFSP/IEP ☐ Services receiving: _____ ☐ Child concerns ☐ Behavior ☐ Ability to learn ☐ Attention span ☐ Diagnosed health concerns ☐ Diagnosed mental health concerns ☐ Other _____	☐ Diagnosed health concerns ☐ Mental health concerns ☐ Current pregnancy (if yes) answer the following: ☐ Due date _____ ☐ Receiving prenatal care

Insurance information please include policy number (Indicate all that apply)**:**

Child/Student
☐ Medicaid / Equality Care Policy #_____ ☐ Kid Care / Chip Policy #_____ ☐ Private Insurance Name & Policy #_____ ☐ Military Insurance Name & Policy #_____ ☐ Other _____ ☐ No Insurance

Certification: I certify that this information is true. If any part is false, my participation in the agency's programs may be terminated, and I may be subject to legal action. I also understand that the information in this form will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian: _____ Date: _____

Carbon County Child Development

McKinney-Vento Act Questionnaire

This questionnaire addresses enrolling students under the McKinney-Vento Act. Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

Student's Name:_____

School Year:_____

Address:_____

***Is this address Temporary or Permanent? (circle one)**

Phone #:_____ Age of student: _____ Student's D.O.B.____/_____/_____

Please choose which of the following situations the student currently resides in (you can choose more than one):

☐ House or apartment with parent or guardian

☐ House or apartment with parent or guardian and lacking utilities such as water or electricity

☐ Motel/Hotel, car, or campsite

☐ Abandoned building, bus or train station, or similar setting

☐ Shelter or other temporary housing

☐ In a private or public place not designed for, or ordinarily used as a regular sleeping accommodation for human beings

☐ With friends or family members (other than, or in addition, to parent/guardian)

***If you are living with friends or family, please check all of the following reasons that apply:**

☐ Loss of housing
☐ Economic situation
☐ Loss of employment
☐ Temporarily waiting for a house or apartment
☐ Providing care for a family member
☐ Living with boyfriend/girlfriend who is not biological to the child enrolling
☐ Parent/guardian is deployed
☐ Other (please explain):_____

Any questions please call 307-324-4951

Parent/Guardian:_____ Date:_____

Emergency Card

FOR OFFICE USE ONLY	
PHOTO	SUNSCREEN
Teacher	
Health Information determined	
Photo of Child	

Student's Last Name **First** **Middle**

Physical address

Mailing address if different from above

Birth Date

Parents Information

Parent/ Legal Guardian #1_____ Relationship to child_____

Home # _____ Cell # _____ Work # _____

Parent/ Legal Guardian #2 _____ Relationship to child_____

Home # _____ Cell # _____ Work # _____

Parent/ Legal Guardian #3_____ Relationship to child_____

Home # _____ Cell # _____ Work # _____

Emergency Contact Information

(child may be released to if legal guardian is unavailable)

Emergency Contact #1_____ Relationship to child_____

Home # _____ Cell # _____ Work # _____

Emergency Contact #2_____ Relationship to child_____

Home # _____ Cell # _____ Work # _____

Child's usual source of medical care

Dr./Clinic _____

Address _____

Phone # _____

Child's usual source of dental care

Dr. _____

Address _____

Phone # _____

Child's health insurance_____

Policy holder's name_____ Policy #: _____

Special conditions, disabilities, allergies, or medical information for emergency situations, if any

Parent/Legal Guardian consent and agreement for emergencies

As the Parent/Legal Guardian, I give my consent to have my child receive first aid by facility staff. If it should be deemed necessary, take my child to the appropriate medical facility at my expense. If I do not have a family physician, I understand there is a physician available 24 hours a day at the hospital. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contacts listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

*** Please note this information will be shared with the medical staff.**

Signature of Parent/Legal Guardian Date

Revised 5/22 LMS

CARBON COUNTY CHILD DEVELOPMENT PROGRAMS

1705 Edinburgh 1114 W. Saratoga Ave 1801 Edinburgh

(307) 324-4951 (307) 326-5056 (307) 324-9571

RELEASE OF INFORMATION REQUEST

I, _____, _____ as
(Parent Name) (Address)

Parent/Guardian of _____, _____,
(Child's Name) (Birthday)

hereby grant permission for Carbon County Child Development Programs to release **and/or** obtain information through written or verbal records: birth certificate, evaluation reports, consultation, examination reports and/or specified information requested.

_____

TO AND FROM AGENCIES LISTED BELOW:

Project Reach and Excel Preschool and Early Intervention Center

Kari Skordas LCSW Uplift Counseling

Carbon County School District #1 and #2

Carbon County Public Health

Doctor: _____

Dentist: _____

Other: _____

I understand that my records cannot be released without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, and that this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this expires)

I understand that as a parent and legal custodian of my child I have the right to refuse the release of information. My signature hereunder is written acknowledgment of my permission.

_____
Parent/Guardian Signature Date

_____
Witness Date

Carbon County Child Development Programs

Authorization, Release & Indemnity Agreement

In Consideration of _____
Child's Name

To the Carbon County Child Development Programs, I do hereby give the Carbon County Child Development Programs and person/s operating on its behalf, my consent and permission to:

1. Yes_____ No_____ I hereby given permission to transport said child on a bus, walking or riding provided by Carbon County Child Development Programs on any field trip or excursion arranged for and carried out as part of the education and training for the said child.
2. Yes_____ No_____ I hereby give permission for my child's photo to be used publically to promote our program which may include but not limited to local newspapers, publications and shared with other community agencies. I understand that the images may be used in print publications, online publications, presentations, websites and social media platforms.
3. Yes_____ No_____ I hereby give permission for my child to be videotaped in the school setting. It is my understanding that such videotaping maybe shared with our education partners and will be for educational and training purposes only. This information will be shared on a secure website and will not use your child's last name.

- I (we) Understand that the above child will be screened using the appropriate health, mental health and academic screening tools.
- I hereby release Carbon County Child Development Programs, its agents, servants, successors, and assignees from any responsibility for accidental injury or illness that may occur to the above-named child while enrolled and participating in the program.
- I hereby give my permission for Carbon County Child Development Programs personnel to give emergency first-aid treatment and obtain, if necessary, medical treatment from a doctor and/or hospital for said child. This release is applicable to any emergency that may occur at any school related activity. I understand and agree that Carbon County Child Development Programs is not responsible for the processing or payment of insurance claims or payment for medical care.

Name of Family Physician_____

- I agree to indemnify and hold harmless the Carbon County Child Development Programs, its agents, servants, successors, and assignees, from any liability to third parties, in any way attributable to the conduct of said child.
- I understand it fully and do, for myself, individually, and as a parent or legal guardian for the said child hereby execute the same of my free will.
- I (we) have read the forgoing, which I understand to be AUTHORIZATION RELEASE AND INDEMNITY AGREEMENT.

*I may revoke this permission at any time by sending a written request to the school.

_____ _____

Signature of Parent or Guardian **Date**

CARBON COUNTY CHILD DEVELOPMENT PROGRAMS

AUTHORIZATION TO LEAVE THE CENTER

For your child's safety, we can allow children to leave the center only with:
1. You, the person listed below who is enrolling the child.
2. Persons you have specified below, with photo ID.
3. In an emergency, a person who is not listed below when:

(a) You have told us in person that said person is picking up your child.
(b) We have a signed and dated note from you authorizing us to send the child home with said person. They must have a photo ID and copies can be kept on file.

_____may leave the Center with the following people:
Child's Name

PLEASE LIST YOURSELF FIRST ON THE LIST BELOW.

Name	Phone	Relationship to child

I have read the Center's policy on authorization to leave the center. I understand that this policy is in the best interest of my child's safety and that I am responsible for having people listed above to pick up my

_____ _____

Parent/Guardian Signature Date

Carbon County Child Development Annual Child Enrollment Form for Child and Adult Care Food Programs CACFP

Child's Name: _____ Class: _____

My child is present for the following meals: (please circle all that apply)

Breakfast Lunch Snack

My child receives WIC _____Yes _____No

ETHNICITY:

_____Hispanic _____Not Hispanic

RACE:

_____Asian
_____Black
_____White
_____Other:_____
_____American Indian/Alaskan Native
_____Hawaiian/Pacific Islander
_____Muli-Racial

Please note that we try and meet cultural needs of each child and include items on our menu from the diverse cultures our children come from.

Please check the primary language of your family at home:

_____English
_____Native Central American, South American & Mexican (Mixteco,Quichean)
_____Middle Eastern & South Asian (Arabic, Hebrew, Hindi, Urdu, Bengali)
_____Native North American/Alaska Native
_____European & Slavic (German, French, Italian, Croatian, Yiddish, Portuguese, Russian)
_____Other (American Sign Language)
_____Unspecified (not known or parents decline to identify
_____Spanish
_____Caribbean (Haitian-Creole, Patois)
_____East Asian (Chinese, Vietnamese, Tagalog)
_____Pacific Island (Palauan, Fijian)
_____African (Swahili, Wolof)
_____ Specify:_____

Parent/Guardian Name:_____ Parent Initials: _____Date: _____

CACFP Staff: _____ Date: _____

This institution is an equal opportunity provider

Head Start Child Health History

Child's Health History	YES	NO	If yes, please explain.
Has the child ever been hospitalized or had a major operation?			
Has the child had a serious accident or illness? If so, explain: _____			(Circle "Yes" or "No"): Was child hospitalized/ER visit? Y/N Was the situation resolved? Y/N
Does child have any allergies:			
•When eating any foods?			What foods?
•When near animals, furs, insects, dust, etc.?			What types?
•When taking any medication?			What medication?
Describe past allergic reactions:			
Does child require medication?			Does medication need to be given at school? YES____ NO
Is child being treated by a physician for any condition (asthma, seizures, anemia, diabetes, heart condition, etc...)?			If yes, for what condition? _____ Does the child require medication? Y/N_____ Will this medication be needed during school hours? Y/N_____
Vision History	**YES**	**NO**	
Does your child experience any of the following:			
•Squinting			
•Crossed eyes			
•Difficulty seeing far away			
•Difficulty seeing up-close			
•Child has prescription glasses			
Does your child:			
•Have problems hearing?			
•Have frequent ear infections (more than 3 in 1 year)?			
•Have tubes in ears?			
Dental History	**YES**	**NO**	**Please explain if needed**
Has your child seen a dentist?			
•Brushes teeth regularly			
•Sucks thumb?			
•Chews inappropriate items or has problems chewing?			
•Complains about dental problems/teeth hurting?			
•Uses a bottle?			
•Has swallowing problems?			
Social Emotional Development/ Behavior	**YES**	**NO**	**Please explain if needed**
•Does your child have a temper or outburst?			
•Does child refuse to comply with adults requests?			
•Does child have difficultly paying attention to tasks?			
•Is child timid or easily frightened?			
•Is child distracted by extra stimuli?			
•Can child be aggressive?			
•Child cries easily?			
Nutrition Assessment	**YES**	**NO**	**Please explain if needed**
What foods does child especially like?			
What foods does child dislike?			
Does child take vitamins regularly?			
Can child feed self?			
Does child have a good appetite?			
Family History	**YES**	**NO**	
Is there a family history of vision problems?			
Is there a family history of hearing problems?			
Is there anything else you would like us to know about your child?			

Parent Signature _____ **Date** _____

Updated 5/22 LMS

CCCDP- HEAD START
OVER THE COUNTER MEDICATION AUTHORIZATION FORM

Child's name:_____

This section to be completed by parent/guardian:

I hereby give permission for the administration of the following over the counter non-ingestible medications (check all that apply):

- ☐ Sunscreen
- ☐ Insect repellant
- ☐ Cortisone/Anti-Itch Creams/Ointments
- ☐ Chapstick
- ☐ OTC Antibiotic Creams/Ointments

* To administer non-ingestible over the counter medication:

The OTC medication must be brought in by the parent
The OTC medication must be in it's original container, with the legible label, and expiration date of medication
The child's name must be on the original container
The Medication Consent Form must be thoroughly completed by parent/guardian

Parent/Guardian Signature (required)_____

Date:___/___/___

FOR OFFICE USE ONLY

TO BE FILLED OUT UPON COMPLETION OF APPLICATION AND RETURNED TO

CARBON COUNTY CHILD DEVELOPMENT PROGRAMS

Intake checklist/interview

Child's name_____

Application packet complete with the following information collected

Proof of age_____ Income_____
(Birth certificate, passport etc…)

Does your family receive: SNAP_____ S.S.I._____ TANF_____
Is the child enrolling a foster child_____ Homeless_____

Total number in family _____ # of Adults _____ # of Children_____

Family means all persons living in the same household who are supported by the child's parent(s)' or guardian(s)' income; and are related to the child's parent(s) or guardian(s) by blood, marriage, or adoption; or are the child's authorized caregiver or legally responsible party.

Income collected for all parents/guardians in home _____

Relevant time period means: (1) The 12 months preceding the month in which the application is submitted; or (2) During the calendar year preceding the calendar year in which the application is submitted, whichever more accurately reflects the needs of the family at the time of application. *Income* means gross cash income and includes earned income, military income (including pay and allowances, except those described in Section 645(a)(3)(B) of the Act), veteran's benefits, Social Security benefits, unemployment compensation, and public assistance benefits.

Do you have any concerns about our child's development?

_____

Has your child had a developmental screening? _____ If yes, is your child receiving services? _____

Was this intake done in person? _____
If not, in person please explain:

_____

_____

Comments/Additional information:

_____

_____

_____ _____
Staff Signature Parent/Guardian Signature

Revised 5/22 LMS

For all other FNS nutrition assistance programs, state or local agencies, and their subrecipients, must post the following

USDA Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.
Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

05/05/2022