Save the Children.

Head Start

Master Card

Child's Name:_____ Gender:_____ D.O.B._____

	Mother	Father
Name		
Address		
Employer		
Home Phone #		
Work Phone #		
Cellular Phone #		

Person with whom the child lives:_____
Child's Doctor:_____Phone #:_____
Child's Dentist:_____Phone #:_____

Individuals to contact in case of an emergency:
Name:_____Phone #:_____
Name:_____Phone #:_____
Name:_____Phone #:_____
Does your child have any food allergies? Yes No
Does your child have any other? Yes No
Does your child have any dietary restrictions? Yes No
Please explain any "yes" answer here:_____

My child has permission to be released to the following individuals, childcare facilities or transportation services in addition to emergency contact persons listed above.
(Please notify these individuals that they may be asked to show proof of identity.)

Name	Relationship to child

In case of an emergency and parent or guardian cannot be contacted immediately I authorize the facility to secure emergency medical treatment for my child.
Parent's Signature:_____Date:_____
Date of Enrollment:_____

Save the Children Head Start

Determining, Verifying and Documenting Eligibility- 1302.12

Child's Name_____ **Date**_____

Person Interviewed:_____

Relationship to the child: □Mother □Father □Grandmother □Grandfather □Aunt □Uncle □Foster parent(s) □Other:_____

In-Person Interview: __Center __Home Visit

During my in-person interview with Head Start staff, I provided the following documents checked below to verify and determine my eligibility category for Head Start service:

□ Birth Certificate
□ 1040 tax forms
□ Pay stubs/envelopes
□ Employee Letter
□ W-2 forms
□ SSI documents
□ TANF documents
□ Proof of: ___ No Income
___Foster Care
___Unemployment
___Homelessness

Other Documents: □Social Security Card □Custody Order □Immunization □IEP/IFSP □Child Placement Agreement □Medical □ Other:_____

Parent Signature:

Reason(s) for telephone interview:

☐ **Lack of parent transportation**

☐ **Work schedule conflict with Head Start school hours**

☐ **Other: Explain** _____

Summary of telephone interview:

Signature of Head Start Staff_____ **Job Title**_____

Save the Children® Head Start

Supplementary Questions

Are you in an emergency/transitional Shelter?

Are you temporarily with another family because we cannot afford or find affordable housing?

Do you live with an adult that is not a parent or legal guardian?

Are you doubled-up with an adult (Parent or other relatives)?

In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing.

Are you in emergency housing (ie FEMA trailer or FEMA rental Assistance)?

Do you live in a hotel or motel?

Do you have Section 8 housing/other housing programs?

I receive food stamps?

I receive support from a family member?

How did you hear about Head Start?

Save the Children.

Head Start

Parent Code of Conduct

Courteous and respectful behavior between and among all program participants is essential for Save the Children Head Start- Rapides to achieve its mission, help assure a positive environment and promote the safety and security of children, families, and staff. Employees, parents, volunteers, participants and everyone else involved with the program must follow the Code of Conduct as outlined below.

Standards of Conduct: All staff, consultants, parents and volunteers will:

- Respect and promote the unique identity of each child and family and refrain from stereotyping on the basis of gender, race, ethnicity, culture, religion or disability;
- Follow program confidentiality policies concerning information about children, families and other staff members;
- Leave no child alone or unsupervised while under their care;
- Ensure that all children are escorted by an adult upon entering and leaving the building to and from the classroom.
- Ensure that all children are signed in and out of the classroom daily.
- Hand to hand from parent to staff must be used at arrival and departure.
- Use positive methods of child guidance and not engage in corporal punishment, emotional or physical abuse, or humiliation; not employ methods of discipline that involve isolation, the use of food as punishment or reward, to the denial of basic needs.
- Conduct themselves personally and professionally in a manner that reflects positively upon the program's reputation and upon the children and families the program serves; and,
- Not solicit or accept personal gratuities, favors or anything of significant monetary value from contractors or potential contractors if they are engaged in the award and administration of contracts or other financial awards.

Save the Children Head Start- Rapides will not tolerate behavior by employees, parents, volunteers, consultants or anyone else involved with the program that violates the Code of Conduct. Examples of violations could include but are not limited to the following:

- Threats to staff, parents or children,
- Physical or verbal punishment of a child,
- Swearing or cursing,
- Smoking,
- Quarreling, verbal fighting, loud shouting and displays of anger,

- Bringing drugs, alcohol or weapons to program sites or events,
- Physical violence,
- Inappropriate or excessive displays of physical affection between adults, and
- Inappropriate dress, including, for example, a low-cut top, bare midriff, pajamas, sagging pants below the buttocks or clothes with words or pictures inappropriate for young children while volunteering on the premises/trips.

If a parent violates the Code of Conduct, Save the Children Head Start-Rapides reserves the right to:

- Restrict access to the program, children, classrooms and activities,
- Restrict the parent's access on premises,
- Remove the child's name from the waiting list,
- Contact the Department of Children and Family Services
- Contact the police, (911)
- Take civil or criminal action.

PROCEDURES:

1. The staff person who witnesses the violation will speak directly with the parent in private when possible, practical and if safety is not an issue.

2. When the safety is threatened, staff will contact the local authorities. This could be but is not limited to when parents continue to quarrel, fight or threaten children, staff, or other parents or adults. Staff will notify the Center Director as soon as practical and as immediately as possible.

3. Staff should report violations to the Center Director promptly. In the Center Director's absence, the most senior management staff person at the central office should be notified.

4. The Center Director will notify the Program Director who will determine the program response to the violation and will notify the person(s) involved.

5. The Personnel Policies of Save the Children Head Start- Rapides governs employee violations of this policy.

I have received a copy of the Parent Code of Conduct:

Parent Signature_____ Date_____

Child's Name_____ Class_____

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Early Head Start & Head Start Programs

Parent Consent for Mental Health Classroom Observations

Save the Children Head Start programs aim to offer the most beneficial learning environments for children. This means classrooms that are respectful of different cultures, classrooms that promote children feeling great about themselves, and classrooms that allow children to feel confident in learning and connecting with others. To make this happen, we work with mental health consultants who observe our classrooms and give us feedback on how to keep supporting each child and learning environment to the best of our ability.

These classroom observations happen twice in the school year: (1) within the first three months of school opening, and (2) within three months of school closing. No personal information is shared with the consultant regarding your child, and focus is placed on the management of the overall classroom. Should the mental health consultant happen to notice anything that stands out about your child's behavior, the Save the Children team will be in communication with you.

Please initial below to indicate below whether you agree to allow your child to be present during the observations.

_____ (initials) I give my permission for my child to be present when the mental health consultant provides routine classroom observations this school year.

_____ (initials) I DO NOT give my permission for my child to be present when the mental health consultant provides routine classroom observations this school year.
I understand I am responsible for working with my child's teacher if necessary to make other arrangements for my child while classroom observations are taking place.

Name of child: _____

Parent/Guardian Signature: _____ Date: _____

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Original Materials, Interviews, Film, Photos, Tape and Video Permissions & Release

Please initial in the boxes below to indicate whether you "DO" or "DO NOT" give permission for each item to support the mission of Save the Children. Any permission given will be without expectation of compensation now or in the future.

I DO (initial)	I DO NOT (initial)	PERMISSIONS
		Give permission to interview; film; photograph; record, and/or; video tape **me**, and retain and reproduce such materials.
		Give permission to interview; film; photograph; record, and/or; video tape **my child**, and retain and reproduce such materials.
		Give permission to use, copy, and publish original materials created by my child (such as essays, poems, photos, and artwork);
		Give permission to use **my name**.
		Give permission to use **my child's name**.
		Give ownership rights and permission to Save the Children to use the information/materials I approved above in the following communications. Use of such information/materials will be to promote Save the Children products and/or fundraising for the Save the Children: • Save the Children's publications, • in newspapers, • magazines and other print media, • on television, radio, • electronic media (including "Internet") • theatrical media • mailings for educational and awareness campaigns by Save the Children

I give any permissions above without expiration. Future use of any approved information above does not require my permission. **I do understand that I have the right to revoke my permissions at any time and must do so in writing.**

_____ _____ _____

Signature of Individual/Parent/ Legal Guardian Print Name Date

Address: _____

Phone: _____ Email: _____

The legal guardian signing above gives/denies permissions above on behalf of the following child:

Child's Name: _____ Date of Birth: _____

The following is required if the consent form has to be read to the responsible individual/parent/legal guardian:

I certify that I have read this consent and release form in full to the responsible individual/parent/legal guardian whose signature appears above.

_____ _____

Date Signature and Title of SCUS Representative

FAMILY CODE WORD
_____
(Optional)

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Release and Emergency Treatment Authorization

Child's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Mother _____ H phone _____ W phone _____ C phone _____
Father _____ H phone _____ W phone _____ C phone _____

I GIVE MY PERMISSION FOR MY CHILD TO HAVE:

Yes	No	
☐	☐	First aid and/or emergency medical care including transportation (If no, parent/legal guardian must remain on school premises.)
☐	☐	Emergency blood transfusion (When condition is life threatening and parent/legal guardian cannot be reached.)
☐	☐	Emergency surgery (When condition is life threatening and parent/legal guardian cannot be reached.)

EMERGENCY INFORMATION

Doctor's name _____ Clinic Name _____ Phone _____
Dentist's name _____ Clinic Name _____ Phone _____
Severe allergies such as bee stings, food, etc. _____
Medical alert _____
If parent or legal guardian cannot be reached, contact or release my child to _____
EMERGENCY TREATMENT AUTHORIZATION
In case of a serious medical emergency any physician at _____ Hospital (or the nearest medical facility may treat my child if there is a life-threatening emergency.)

Name _____ Relationship _____
Cell phone _____ 2nd phone number _____
Work phone _____ Work phone _____

Name _____ Relationship _____
Cell phone _____ 2nd phone number _____
Work phone _____ Work phone _____

RELEASE OF INFORMATION

Head Start/Early Head Start cannot refuse to release a child to his/her parents without a copy of a court order. I understand that my child's file is available to either parent to review at any time. This information is confidential except to the appropriate Head Start/Early Head Start staff and consultants, unless I give permission to release it.

Do **NOT** release my child to _____
☐ Protection Order No. _____ Expiration Date _____
☐ Parenting Plan in file. Date ____/____/____

Remember to notify Head Start/Early Head Start staff of any changes to the above information

Parent/Legal Guardian signature _____ Date _____
Witnessed by _____ Date _____

VALID FOR ONE YEAR FROM DATE OF SIGNING
Parent or Legal Guardian may revoke this authorization in writing at their discretion

White—Emergency Notebook Yellow—File Copy Pink—Parent/Legal Guardian

Save the Children Head Start

CONSENT FOR SERVICES AND PERMISSIONS/RELEASES

Program Year 2019-2020

Performance Standard 1302. 41(b)(1), 1302.45((a)(3), 1302.33(a)(1)

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

Families must place initials in each box below.

I give permission for my child to complete the following screenings:

	Parent Initial	
	Yes	No
Developmental		
Hearing		
Vision		
General Classroom Mental health Observation		
Nutritional/growth chart		
Dental (if needed)		
Other: (specify		

I understand that these screenings are done for the purpose of evaluating and determining the overall Health Profile of my child. All information will be kept strictly confidential and will be used only to help access appropriate care as needed. I can review this information at any time.

Permissions/Releases:

	Parent Initial			Parent Initial	
	Yes	No		Yes	No
Walking trips (1/4 mile or less from the school)			Use of Videotape of Child Photography for Brochures		
Confidential Medical/Dental information			Other:		
Emergency Medical/Dental Treatment			Use of Videotape/Photograph of child		

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

For re-enrollment: I have reviewed this form and my consent as stated, has not changed.

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

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Head Start

Consent to Assess

In order to provide high quality comprehensive services for all enrolled children it is important that we assess each child's progress by completing screenings and assessments at specifics time points throughout the school year.

These assessments allow us to provide individualized services to your child by serving as a guide to assist in planning appropriate activities that will enhance his/her develop. The assessments will cover the following areas: Social/Emotional Development, Physical Development, Cognitive Development and Language Development. Parents are encouraged to be involved in all of these processes. Once an assessment is completed, the results will be shared with you.

Below is a brief overview of the various evaluation tools used by STC Head Start.

- Developmental Screening-Measures the child's Cognitive, Prewriting and Fine and Gross Motor skills.
- Speech Screening-Measures the child's language development. This screening must be completed within 45 days of the child enrolling in the program.
- Beginning Continuum Assessment provides an initial indicator of where the child is developmentally.
- Mid-Year Continuum Assessment provides on-going developmental information.
- Ending Continuum Assessment provides a means of tracking child's developmental growth and progress. This assessment is completed at the end of the enrollment year.

In order to complete the scheduled assessment for your child we must have your consent. Please complete the bottom portion of this form.

_____ will receive the above listed assessments within the program year 2019-2020.
Child's name

_____ _____
Parent/guardian signature Date

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Health, Development and Safety Wellness
Parent/Guardian Consent Form

Child's Name: _____ Date: _____

Please initial the appropriate I DO or I DO NOT blank, then sign and date at the bottom.

I, parent/guardian of _____ hereby give permission to Save the Children Cabarrus Head Start program:

I DO (initial)	I DO NOT (initial)	PERMISSIONS
		To transport my child for any medical/dental care or treatment he/she might need, including immunization, doctor appointments and for any emergency medical and/or dental care he/she might need as a result of an accident
		To transport my child to and from the Head Start center for field trips scheduled by the program
		To obtain information and records from the public school my child is or will be attending to observe his/her progress in public school (it is a requirement of the Head Start Federal Performance Standards that we track our students' progress during their school years).
		Permission for use of fluoride toothpaste. Toothpaste will be provided by Head Start
		Permission for my child to use hand sanitizer.
		Permission for Head Start staff to apply use of insect repellant
		Permission for Head Start staff to apply diaper rash ointment
		Permission for Head Start staff to apply sunscreen, SPF 15 or greater, prior to outside play. Sunscreen will be provided by Head Start
		To participate in several types of screenings regarding their general health and development (you will be notified of the results of the screenings and of any follow-up treatment that may be needed). **These screenings may include any or all of the following:** General information screening Health history Physical examination by a doctor Height and weight measurement Blood pressure check Hearing screening Vision acuity screening/strabismus Dental exam Nutrition screening/assessment Developmental hematocrit/hemoglobin Lead Screening/DIAL, Ages and Stages Questionnaire Social-Emotional (ASQ-SE) Speech/language Screening

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Health, Development and Safety Wellness
Parent/Guardian Consent Form

I understand that this consent/permission is valid for one (1) year from the date of signature. **I do understand that I have the right to revoke my permissions at any time and must do so in writing.**

_____ _____ _____

Signature of Individual/Parent/ Legal Guardian | Print Name | Date

Address: _____

Phone: _____ Email: _____

The legal guardian signing above gives/denies permissions above on behalf of the following child:

Child's Name: _____ Date of Birth: _____

The following is required if the consent form has to be read to the responsible individual/parent/legal guardian:

I certify that I have read this consent and release form in full to the responsible individual/parent/legal guardian whose signature appears above.

_____ _____

Date | Signature and Title of SCUS Representative

Save the Children

Head Start

ENROLLMENT AGREEMENT
PROGRAM YEAR ~~2019~~-2020 – 21

Child's Name:_____ Center_____ Date_____

Parent/Guardian's Name(s):_____Teacher's Name:_____

The Head Start program is federally funded thus there is no charge. Our centers are operated by Save the Children Head Start (STC) and, therefore, are in compliance with STC HS' policies and procedures.

The following is an agreement between _____ and the STC Head Start program regarding placement of the above named child at the following center and session.

Program Days: ~~M-F~~ M-T Program Hours: ~~7:30am-2:30pm~~ 8am-2:30pm Meals: B-L-S

_____STC HS staff has explained to me the critical importance of my child's regular attendance. I understand the impact of attendance on my child's development as well as complying with federal regulation.

_____I understand that I will need to sign my child in before the start of his/her class, not arriving more than 15 minutes prior to that session. I also agree to sign-out my child each day at the scheduled time of dismissal. I will note on the Attendance Daily Sign-In/Sign-Out Sheet the actual arrival & departure times and will sign using my full name.

_____I understand that my child will be released to **only** those people I listed on the Authorized / Emergency Contact Form. **I understand that I can only change this form in person with our family's assigned Family Service Coordinator.** I understand that person(s) picking up my child must be at least 18 years of age (if not a parent) and will be asked to show a picture identification.

_____I understand that if my child is not picked up by someone previously authorized and emergency contacts cannot be located after one hour from the end of the session, with no contact from parent or family member, my child will be placed in the custody of the local Police Department and/or the local Child Protective Service Agency.

_____I understand that I am the primary member of a Family Team, which consists of our family's Family Advocate, Classroom Teacher and other resource persons as needed. I understand that I will be asked to join in a partnership with Head Start to establish trust and open communication.

_____I have received a copy of the Family Handbooks and Community Resource Guide and its contents have been explained to me or I agree to attend a Parent Orientation. I agree to abide by the stated policies & procedures.

_____I give permission for the STC Head Start program to apply sunscreen to my child whenever he/she is outside participating in an outdoor activity.

_____I give permission for my child to go on walking trips within a quarter of a mile of the center under the supervision of program staff.

_____I give my permission for staff to administer insect repellant when appropriate.

_____I give my permission I for my child to be videotaped and photographed at the program.

_____ _____

Parent/Guardian's Signature Date

_____ _____

Family Services Staff's Signature Date

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I have received a copy of the Community Resource Directory.

Child's Name_____

Parent's Signature_____

Date_____

Save the Children Head Start-Rapides Parish
1335 Jackson Street
Alexandria, La. 71303
SavetheChildren.org

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Emergency Contact, Treatment and Transportation Instructions

Performance Standard 1302.47 (b) (5) (iv)

The Emergency Contact, Treatment, & Transportation form is completed by the parent/guardian for every child at enrollment. Parent/Guardians must provide at least **three** different emergency contacts (more are recommended) other than their own with local telephone numbers and make sure these individuals are aware that they are being listed. The form is to be updated any/every time there is a change in an emergency contact person and/or numbers.

1. **Child's Name** – Enter child's legal name as it appears on the Enrollment Application.

2. **Site** – Enter center.

3. **Parent/Guardian's Name** – Enter Parent Guardian.

4. **Emergency Contacts** – List each contact along with relationship to the child, language spoken, physical address and home, work, and cell phone numbers. **When contacts are removed, parents are to mark through the information with a single line, then initial and date.**

5. **Signatures** – Parent/Guardian and Staff must sign and date at initial completion.

When all the lines on the form have been filled, begin a new form and staple it to the old one. These are kept at the sign in sheet and in the EPAP Notebook for quick access by the staff.

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Emergency Contact, Treatment and Transportation

Program Year: _____

Child's Name: _____ Site: _____

Parent or Guardian's Name(s): _____

- For your child's safety, your child will not be released to anyone who is not listed on this form. A picture identification will be required to be shown at the time of release.
- The family services staff in the program can help you make changes on the form at any time during the year. The parent/legal guardian must make all changes to the form in person. **Phone calls and written notes will not be accepted in changing this form.**
- This also serves as an EMERGENCY CONTACT FORM. You must provide at least **three** different emergency contacts with local telephone numbers other than your own. Be sure these individuals are aware that you are listing them. We recommend you have more than three names on this list, if possible.

Name	Relationship To Child	Language Spoken	Physical Address	Phone No.	Date
	PARENT/ GUARDIAN			Home: Work: Cell/Pager:	
	PARENT/ GUARDIAN			Home: Work: Cell/Pager:	
				Home: Work: Cell/Pager:	
				Home: Work: Cell/Pager:	
				Home: Work: Cell/Pager:	
				Home: Work: Cell/Pager:	
				Home: Work: Cell/Pager:	
				Home: Work: Cell/Pager:	
				Home: Work: Cell/Pager:	

I hereby give consent for the contacts listed above to receive daily information at drop-off or pick-up regarding my child's day.

By signing below I agree that in the event I, or one of the emergency contacts listed above cannot be reached, SC-HS staff may administer First Aid and/or CPR to my child and if the situation is life threatening to obtain medical aid for my child from a medical provider, dentist, EMT, paramedic, or nurse. I understand that at no time, **except in the event of an evacuation**, will a SC-HS employee transport my child. I also authorize emergency medical personnel to transport my child in an ambulance as necessary.

Parent or Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____