LARAMIE COUNTY HEAD START
A Program of Community Action of Laramie County, Inc.

2017-18 Application

Laramie County Head Start (LCHS) presents opportunities to receive outstanding individualized early childhood learning experiences for families and children prenatal to age 5. Families enjoy individualized education, nutrition in partnership with the USDA free food program, and limited bus services. LCHS fully supports parent involvement, mental health and disability services.

We are ready to help with any questions
Call (307) 634-5829!

LCHS is a federally funded program provided at no cost to our families.

We must have a **birth certificate** and **qualification information** to process the application.

- ☐ Income Tax Form 1040
- ☐ Child Support
- ☐ Supplemental Security Income SSI documentation
- ☐ All 12 months of pay stubs or pay envelopes
- ☐ Foster care reimbursement
- ☐ Scholarships/Grants
- ☐ TANF/Power documentation
- ☐ W-2s
- ☐ Unemployment
- ☐ Food Stamp Benefit History
- ☐ Other, explain:

"A Healthy Child is a Child Ready to Learn!" and the following documents are **essential**:

- Dental exam (will be needed every 6 months)
- Physical including:
  - Hematocrit or Hemoglobin (H/H)
  - Lead screening
- **Complete immunization record**

*Wyoming Department of Health Rules and Regulations for School Immunization: Chapter 1, Section 3 (b) states: No Childcare facility administrator shall retain any pupil, **thirty (30)** days after entry, without official written documented proof of immunization according to the schedule published by the State Health Officer except when there are exemptions as noted in the statute.*

We appreciate you taking the time to complete this application as it is used to determine your family's eligibility and prioritize the application. Please complete before your intake appointment.

Your intake appointment is scheduled

Date: _____at _____am/pm

With _____at **711 Warren Avenue**, Cheyenne

Prenatal to 5

The completion of the intake appointment does not guarantee placement in Head Start. If you have any questions or need help completing it, please call **(307) 634-5829**.

Applicant

First	Middle	Last	Nickname	Birthday	Gender
					☐ Male ☐ Female

Has Hispanic/Latino/Spanish Origin	Race
☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Bi/Multi-Racial ☐Unspecified

English Proficiency	Other Language	Other Language Proficiency	**Has Dental Coverage?**
☐ None ☐ Moderate ☐ Little ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient	☐ Yes ☐ No

Medicaid ☐ **Yes** ☐ **No** ☐ **Seeking** **Number:**	Primary Health Coverage#	Other Health Coverage #

Doctor		Dentist	
Address		Address	
Phone		Phone	
Last Physical Date ____/____/___ ☐**N/A**		Last Dental Exam Date ____/____/___ ☐**N/A**	

Living Address	Address Line 2	Zip	City	State
Mailing Address (if different)	**Address Line 2**	**Zip**	**City**	**State**

Housing ☐Own ☐Rent ☐Rent with Sliding Fee ☐Uses Cheyenne Housing Assistance ☐Stays with friends/family ☐Owns home & rents lot ☐**N/A**

Our housing is ☐Affordable ☐Safe ☐Other, explain:

I am seeking ☐Other housing ☐Home ownership ☐**N/A**

The past 12 months have you ☐Moved ☐Been homeless ☐Been evicted ☐Lived in temporary housing ☐**N/A**

Explain:

☐ **Needs Head Start bus stop, Where?**

Phone Numbers	Type (*check one*)	Note (*extension or best time to call*)
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	
	☐ Cell ☐ Home ☐ Work ☐ Other	

Legal Parent/Guardian- Primary Adult (1) **Provides Financial Support? ☐ Yes ☐ No**

First	Middle	Last	Nickname	Birthday	Gender
					☐ Male ☐ Female

Has Hispanic/Latino/Spanish Origin	Race
☐ Yes ☐ No	☐ White ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Bi/Multi-Racial ☐Unspecified

English Proficiency	Other Language	Other Language Proficiency	Has Medical Coverage
☐ None ☐ Moderate ☐ Little ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient	☐ Health ☐ Dental ☐ **Seeking** ☐ N/A

Has Custody? ☐ Yes ☐ No Teen Parent? ☐ Yes ☐ No	Relationship ☐Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other	Military Member? ☐ Yes ☐ No

Highest Grade Completed	Employment Status (check all applicable)	Participation in Training
☐ Doctorate ☐ High School ☐ Bachelors ☐ GED ☐ Associates ☐12th no diploma ☐ Some College ☐Other_____	☐ Full-time ☐ Seasonally employed ☐ Part-time ☐ Unemployed ☐ In school ☐ Disabled ☐ Retired ☐ In Job Training	☐ Job ☐ Skills ☐ Business ☐ Vocational ☐JOBS ☐JTPA ☐ Trade ☐ Job Corp ☐ Other_____ **Holds Certificate/License** ☐Yes☐No Type_____☐ Started ☐ Finished
☐ **Seeking additional education**	☐ **Seeking employment**	☐ **Seeking job training**

Lives with applicant? ☐Yes ☐ No, address:

Is married? ☐No ☐ Yes, Spouse name:

Agency use only Applicant:_____Birthdate:_____

Legal Parent/Guardian -Secondary Adult (2)

Provides Financial Support? ☐ Yes ☐ No

First	Middle	Last	Nickname	Birthday	Gender
					☐ Male ☐ Female

Has Hispanic/Latino/Spanish Origin
☐ Yes ☐ No

Race ☐ White ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Bi/Multi-Racial ☐Unspecified

English Proficiency
☐ None ☐ Moderate ☐ Little ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Has Medical Coverage
☐ Health ☐ Dental ☐ **Seeking** ☐ N/A

Has Custody? ☐ Yes ☐ No
Teen Parent? ☐ Yes ☐ No

Relationship ☐Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other

Military Member?
☐ Yes ☐ No

Highest Grade Completed
☐ Doctorate ☐ High School
☐ Bachelors ☐ GED
☐ Associates ☐12th no diploma
☐ Some College ☐Other_____

☐ **Seeking additional education**

Employment Status (check all applicable)
☐ Full-time ☐ Seasonally employed
☐ Part-time ☐ Unemployed
☐ In school ☐ Disabled
☐ Retired ☐ In Job Training

☐ **Seeking employment**

Participation in Training
☐ Job ☐ Skills ☐ Business ☐ Vocational
☐JOBS ☐JTPA ☐ Trade ☐ Job Corp
☐ Other_____
Holds Certificate/License ☐Yes☐No
Type_____☐ Started ☐ Finished

☐ **Seeking job training**

Lives with applicant? ☐Yes ☐ No, address:

Legal Parent/Guardian -Other Adult (3)

Provides Financial Support? ☐ Yes ☐ No

First	Middle	Last	Nickname	Birthday	Gender
					☐ Male ☐ Female

Has Hispanic/Latino/Spanish Origin
☐ Yes ☐ No

Race ☐ White ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Bi/Multi-Racial ☐Unspecified

English Proficiency
☐ None ☐ Moderate ☐ Little ☐ Proficient

Other Language

Other Language Proficiency
☐ Poor ☐ Moderate ☐ Proficient

Has Medical Coverage
☐ Health ☐ Dental ☐ **Seeking** ☐ N/A

Has Custody? ☐ Yes ☐ No
Teen Parent? ☐ Yes ☐ No

Relationship ☐Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other

Military Member?
☐ Yes ☐ No

Highest Grade Completed
☐ Doctorate ☐ High School
☐ Bachelors ☐ GED
☐ Associates ☐12th no diploma
☐ Some College ☐Other_____

☐ **Seeking additional education**

Employment Status (check all applicable)
☐ Full-time ☐ Seasonally employed
☐ Part-time ☐ Unemployed
☐ In school ☐ Disabled
☐ Retired ☐ In Job Training

☐ **Seeking employment**

Participation in Training
☐ Job ☐ Skills ☐ Business ☐ Vocational
☐JOBS ☐JTPA ☐ Trade ☐ Job Corp
☐ Other_____
Holds Certificate/License ☐Yes☐No
Type_____☐ Started ☐ Finished

☐ **Seeking job training**

Lives with applicant? ☐Yes ☐ No, address:

Additional Family/Household Members

Full Name | Provides Financial Support? ☐ Yes ☐ No | ☐ Male ☐ Female | Birthday

Member 1

Adult Custody	Adult Relationship	Ethnicity	Race	English Proficiency
Adult 1 ☐Yes☐No		☐ Hispanic/ Latino/ Spanish ☐ N/A	☐ Asian ☐ Black ☐ White ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Bi/Multi-Racial ☐Unspecified	☐None ☐Moderate ☐ Little ☐ Proficient
Adult 2 ☐Yes☐No				
Adult 3 ☐Yes☐No				
Other Language		Other Language Proficiency		☐ Little ☐ Moderate ☐ Proficient

Full Name | Provides Financial Support? ☐ Yes ☐ No | ☐ Male ☐ Female | Birthday

Member 2

Adult Custody	Adult Relationship	Ethnicity	Race	English Proficiency
Adult 1 ☐Yes☐No		☐ Hispanic/ Latino/ Spanish ☐ N/A	☐ Asian ☐ Black ☐ White ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Bi/Multi-Racial ☐Unspecified	☐None ☐Moderate ☐ Little ☐ Proficient
Adult 2 ☐Yes☐No				
Adult 3 ☐Yes☐No				
Other Language		Other Language Proficiency		☐ Little ☐ Moderate ☐ Proficient

Full Name | Provides Financial Support? ☐ Yes ☐ No | ☐ Male ☐ Female | Birthday

Member 3

Adult Custody	Adult Relationship	Ethnicity	Race	English Proficiency
Adult 1 ☐Yes☐No		☐ Hispanic/ Latino/ Spanish ☐ N/A	☐ Asian ☐ Black ☐ White ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Bi/Multi-Racial ☐Unspecified	☐None ☐Moderate ☐ Little ☐ Proficient
Adult 2 ☐Yes☐No				
Adult 3 ☐Yes☐No				
Other Language		Other Language Proficiency		☐ Little ☐ Moderate ☐ Proficient

Full Name | Provides Financial Support? ☐ Yes ☐ No | ☐ Male ☐ Female | Birthday

Member 4

Adult Custody	Adult Relationship	Ethnicity	Race	English Proficiency
Adult 1 ☐Yes☐No		☐ Hispanic/ Latino/ Spanish ☐ N/A	☐ Asian ☐ Black ☐ White ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander ☐ Bi/Multi-Racial ☐Unspecified	☐None ☐Moderate ☐ Little ☐ Proficient
Adult 2 ☐Yes☐No				
Adult 3 ☐Yes☐No				
Other Language		Other Language Proficiency		☐ Little ☐ Moderate ☐ Proficient

Emergency Contacts-(Do not list Legal Parent/Guardian)

	Name - Release To: ☐ Yes ☐ No		Relationship		Phone# - Circle (C) cell (H) Home (W)Work
Contact 1					C H W
	Address	City	State	Zip	C H W
					C H W
	Name - Release To: ☐ Yes ☐ No		Relationship		Phone# - Circle (C) cell (H) Home (W) Work
Contact 2					C H W
	Address	City	State	Zip	C H W
					C H W
	Name - Release To: ☐ Yes ☐ No		Relationship		Phone# - Circle (C) cell (H) Home (W) Work
Contact 3					C H W
	Address	City	State	Zip	C H W
					C H W

Agency use only Applicant:_____Birthdate:_____

Childcare

☐ Uses childcare during school/work hours ☐ Uses before/after school program

Other than parent or guardian my child is cared for by_____

Phone #_____/Relationship_____ ☐ **Needs childcare** ☐ **N/A**

Person(s) who **MAY NOT** pick up my child and **relationship**

Transportation

Are you planning on using a Head Start bus stop? ☐ Yes ☐ No

☐ Family needs reliable transportation ☐ Family member needs current driver's license

☐ Needs a child car seat/safety information ☐ Lives more than 5 miles from center ☐ **N/A**

***Note * If person is legal parent/guardian additional documentation is required.**

Services

Does the applicant or any member of the family receive any of the following?

☐ Life Net	☐ Counseling	☐ Foster Care Subsidy	☐ LIEAP
☐ ACT! Now	☐ SNAP (food stamps)	☐ Child Care Subsidy	☐ DFS Family Preservation
☐ SSI	☐ WIC	☐ GreenPath	☐ Child Support
☐ TANF/POWER	☐ Unemployment	☐ Maternal Child Health	☐ Dads Making a Difference
☐ Weatherization	☐ NEEDS	☐ Telephone Assistance	☐ CLIMB Wyoming
☐ Workforce Services	☐ WYO Family Literacy Program/ACES		☐ Other: _____ ☐ **N/A**

Explain the above:

Experiences

Has the applicant or family members experienced any of the following within the last year?

☐ Foster care	☐ Death of parent/guardian	☐ Job change	☐ Separation
☐ Holds savings/IDA account	☐ Health problems	☐ Job loss	☐ Marriage
☐ Social disorganization	☐ Legal problems	☐ Increase in wages	☐ Divorce
☐ Mental health concern	☐ Adult dental problems	☐ Benefits w/job	☐ Incarceration
☐ Family needs transportation	**Child Abuse/Neglect-**	☐ Family member needs driver's license	
☐ Substance abuse concern	☐ Documented ☐ Suspected		☐ Other
☐ Suicidal concerns	☐ Loss of friend/family member to suicide		☐ **N/A**

Explain the above:

Permission For Services

☐Yes ☐No *Initial*:	**Sunscreen Use –** For outdoor play, I grant Head Start staff permission to apply minimum SPF 15 sunscreen to my child when necessary. I also understand I may provide my own.
☐Yes ☐No *Initial:*	**Field Trip** - I give my permission for Head Start staff to take my child on field trips within city limits, such as parks, or the library. I understand special permission shall be obtained for atypical field trips, such as out-of-town pumpkin patches or farms, etc.
☐Yes ☐No *Initial*:	**Transportation** - I give my permission for Head Start staff to transport my child to and from the classroom and/or field trips. I agree to follow transportation rules in the Parent Handbook.
☐Yes ☐No *Initial:*	**Transfer of Records** - I give my permission for my child's Head Start records to be forwarded to the school district at the end of the school year.
☐Yes ☐No *Initial:*	**Phone Number Release** - I give my permission to Head Start staff to give my phone number to other Head Start parents for purposes related to the program such as planning.
☐Yes ☐No *Initial:*	**Publicity Release** - I give my permission for participants of Head Start activities to appear, with listed first name in the photographs/videos taken under staff supervision with the purpose of promoting Head Start in the newspaper, on television, or other promotional materials.

Consent For Health Screenings

I,_____, give my consent for _____
Parent/Guardian Name Child's Name

to receive the screening examinations that are initialed below and for transportation to and from the screening services. I understand that these services are considered necessary by the Head Start Program and that I will be informed of the results. If concerns are found during screenings I will take my child for further examination and/or treatment. Then I will provide LCHS with the documentation that I did so.

Height/Weight- Initial:	Vision/Strabismus-Initial:	Hearing-Initial:

STRIDE Release of Information Permission

I hereby authorize STRIDE Learning Center to observe and engage in verbal or written communication for the benefit of my child. All pertinent records and information can be released between agencies as necessary for care coordination. I am aware that this information will be used in my child's best interest in order to provide educational management. I am aware that I may deny consent for disclosure to STRIDE.

Signature of Parent/Guardian:_____Date:_____

Ages and Stages Questionnaire Screening Consent

The purpose of the Ages and Stages Questionnaire is to screen children for potential developmental concerns. This screening measures communication, gross/fine motor, problem solving, and personal/social skills. Results will be shared with you. If a concern arises it may indicate a need for formal evaluation. I understand by signing this consent that this is only a screening, not a formal evaluation of my child. All information will be confidential.

Signature of Parent/Guardian:_____Date:_____

Observation Permission

I grant my permission to the Head Start staff and/or the Mental Health Professional Consultant and/or PEAK Wellness personnel to observe and screen my child's social emotional wellness. I understand that all information will be kept confidential. Parents will only be informed if the results of the screenings indicate a concern. If further evaluation, beyond the screenings is necessary or treatment is required for my child's social emotional concerns, a specific meeting will be held, in which my child's social emotional concerns will be discussed with me (parent/caregiver) prior to my giving permission for such evaluation or intervention to occur. LCHS will be screening your child for social/emotional wellness concerns using the following screening tools:

- Ages and Stages Questionnaire: Social/Emotional (ASQ:S/E)
- WY Early Screening Project (ESP)

Signature of Parent/Guardian:_____Date:_____

Annual Child Enrollment Form for CACFP (Only for Classroom child)

I understand my child who lives at the address listed in the application, will normally be served free of charge either a Breakfast and A.M. Snack or a Lunch and P.M. Snack which will happen Monday – Thursday.

Signature of Parent/Guardian:_____Date:_____

Last four digits of Primary Adult Social Security number:_____

Staff Member Signature_____Date_____
By signing the staff member acknowledges verification and/or explanation of purpose and intent of the information contained on the pages, and that the consents/permissions are valid for one year from the date signed.

Agency use only Applicant:_____Birthdate:_____

If there is a special health concern/need identified you must meet with the **Health/Nutrition Manager and/or Nutritionist <u>before</u> your child can receive Head Start services.**

Nutrition History	Is the applicant on a special diet?	☐ No ☐ Yes, explain:
Are there any foods the applicant is allergic to and should **NOT** eat while at Head Start?		☐ No ☐ Yes, explain:
Are there any foods the applicant should **NOT** eat while at Head Start for medical, religious, or personal reasons?		☐ No ☐ Yes, explain:
Has the applicant experienced a big change in appetite in the last month?		☐ No ☐ Yes, explain:
Does the applicant chew/eat things that aren't food?		☐ No ☐ Yes, explain:
Does the applicant have trouble chewing/swallowing?		☐ No ☐ Yes, explain:
Do you have any concerns about what or how the applicant eats?		☐ No ☐ Yes, explain:
Does the applicant have a nutritional risk? (i.e. failure to thrive)		☐ No ☐ Yes, explain:
Is the applicant being monitored for over/under weight concerns?		☐ No ☐ Yes, explain:
Do you want Head Start follow the applicant's special diet needs?		☐ No ☐ Yes, explain:
Does your child take vitamins/mineral supplements?		☐ No ☐ Yes, type_____
*****If yes, are they prescription? ☐ No ☐ Yes		They contain: ☐ Iron ☐ Fluoride ☐ Neither

Circle how often does the applicant eat from the following food groups weekly?									
Milk, cheese yogurt	0	1	2	3	4	5	6	7	7+
Meat, poultry, fish, eggs/dried beans, peas, peanut butter	0	1	2	3	4	5	6	7	7+
Rice, grits, bread, cereal, tortillas	0	1	2	3	4	5	6	7	7+
Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes	0	1	2	3	4	5	6	7	7+
Oranges, grapefruit, tomatoes	0	1	2	3	4	5	6	7	7+
Other fruits/vegetables	0	1	2	3	4	5	6	7	7+
Juices	0	1	2	3	4	5	6	7	7+
Oil, butter, margarine, lard	0	1	2	3	4	5	6	7	7+
Cakes, cookies, sodas, fruit drinks, candy	0	1	2	3	4	5	6	7	7+

Foods my child especially likes are…	
Foods my child does not like are…	

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter 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; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

Health History: Check if applicant is currently or has in the past had any of the condition(s) listed.

Does the applicant see a doctor regularly for any condition or illness? ☐Yes ☐No

Does the applicant take medications regularly for any condition or illness? ☐Yes ☐No

If Yes for the above, What condition (s)? Please check below:

Breathing disorders:	☐ Asthma	☐ RSV	☐ Whooping cough	
Blood disorders:	☐ Anemia	☐ High lead	☐ Bleeding tendencies	☐ Sickle cell disease
Skin disorders:	☐ Eczema	☐ Rashes	☐ Hives	☐ Scabies
Communicable diseases:		☐ MRSA	☐ Chickenpox	☐ Strep/Scarlet fever
Other conditions/illness:		☐Diabetes	☐ Cerebral palsy	☐ Epilepsy/Seizures

Any condition or illness not listed: _____

Special instructions or needs: _____

***NOTE**: A Care Plan, completed with Head Start Health Staff, may be required.

Allergies ☐Pollens/seasonal ☐Animals/pets ☐Medications ☐ Foods

☐ Bee stings/insect bites ☐Other ☐ N/A

Does the applicant have rash, itching, swelling difficulty breathing or sneezing when: ☐ Eating foods

☐ Taking any medications ☐ When near animals, furs, insects, dust, etc.

☐ Other, explain: ☐ N/A

Note If a child has a food allergy you must provide medical documentation to verify the allergy.

Do any of the conditions addressed affect daily activities? ☐Yes ☐No

Are there any conditions not addressed that affect daily activities? ☐Yes ☐No

How is the condition treated?

Do we need to make accommodations at Head Start? ☐Yes ☐No

Explain, any of the above:

Dental History Has the applicant seen a dentist? ☐ No ☐ Yes, date:_____

The child receives ☐ Fluoridated water ☐ Topical fluoride application

☐ Fluoride supplement diet (____Tablets,_____ Liquid) ☐ N/A

Does the applicant have trouble with teeth, gums, or mouth? ☐No ☐Yes, explain:

Hospitalizations and Illnesses- Has applicant experienced: ☐ Serious fall ☐ Head injury

☐ An operation ☐ Poisoning ☐ Burns ☐ Serious accident ☐ Serious illness ☐ Hospitalization

☐ Broken bones ☐ Other: ☐ N/A

The Applicant Has Frequently Occurring: ☐ Stomach aches ☐ Vomiting ☐ Cough

☐ Constipation ☐Urinary infection ☐ Trouble urinating ☐ Sore throat ☐ Diarrhea

☐ Other, explain: ☐ N/A

Vision concerns ☐ Looks too close at books ☐ Eyes turn in/out ☐ Turns head to use one eye

☐ Squints eyes ☐ Other vision concerns, explain: ☐ N/A

Hearing concerns ☐ Frequent ear aches ☐ Discharge from ear ☐ Favors one ear ☐ Pain in ear

☐ Rubs ears ☐ Other hearing concerns, explain: ☐ N/A

Explain any of the above:

Uses the following ☐Wheelchair ☐ Braces ☐ Hearing aid ☐ Glasses/contact lenses

☐Crutches/walker/cane ☐ Tubes in ears ☐Other ☐ N/A

Explain any of the above:

Complete only for Child Applicant – Check for age 3 and over

☐ Uses a bottle ☐ Thumb sucking ☐ Daytime wetting ☐ Wears diapers/pull-ups

☐ Bed wetting ☐ Other, explain: ☐ N/A

Agency use only Applicant:_____Birthdate:_____

Complete only for child applicant- Social/Emotional and Development

What interests and/or activities does your child have/like?

How does your child tell you he/she has to go to the toilet?

How does your child act with a group of children?

How does your child act with a few children his/her age?

How does your child act with adults he/she doesn't know?

Does your child take a nap? ☐No, ☐Yes, if yes how long? When? ☐Morning ☐Afternoon

Does your child sleep less than 8 hours a day or have trouble sleeping (has nightmares, is fretful, stays up late)? ☐No, ☐Yes, if yes describe arrangements?

Does your child worry or seem scared of anything? ☐No, ☐Yes, if yes explain:

Sometimes children act cranky or cry when tired, hungry, sick, and so forth. Does your child act cranky or cry at other times, when you can't figure out why? ☐No, ☐Yes, if yes explain:

How do you help your child to feel better?

Is your child affected by: ☐Family issues/concerns ☐Big changes in last 6 months ☐Social/emotional concerns and needs additional attention ☐N/A

We ask what each child can do easily or had difficulty with to individualize our program. Mark if your child learned each skill.

Skill	Earlier	When expected	Later		**Skill**	Earlier	When expected	Later
Sit on own	☐ 4 to 5 months	☐ 6 to 7 months	☐ 8+ months		Crawl	☐ 6 to 7 months	☐ 8 months	☐ 9+ months
Walk	☐ 9 to 12 months	☐ 13 to 15 months	☐ 16 + months		Talk	☐ 9 to 11 months	☐ 12 to 18 months	☐ 19 + months
Feed/dress self	☐ 14 to 16 months	☐ 17 to 18 months	☐ 19 + months		Use the toilet	☐ 18 to 23 months	☐ 24 to 30 months	☐ 30 + months
Respond to directions	☐ 22 to 23months	☐ 24 months	☐ 25 + months		Understand what is said	☐ 4 to 8 months	☐9 to 12 months	☐ 13 + months
Use crayons	☐ 10 to 11 months	☐ 12 months	☐ 13 + months		Play with toys	☐ 4 to 5 months	☐ 6 months	☐ 7 + months

Explain any of the above:

Complete only for child applicant-Special Services

The child has a documented disability (bring copy of IEP/IFSP) ☐Yes ☐No

☐ Child works with STRIDE Learning Center ☐ Child has parent/sibling with a disability

☐ Child works with developmental clinic (CRMC, PEAK, DCH, private practice)

My child sees a specialist for_____ at Name:_____

Address:_____Phone:_____

Does the applicant have a suspected delay, is at risk, or do you have concerns in any of the following areas:

☐ Fine Motor ☐ Cognitive ☐ Attention ☐ **N/A**

☐ Gross Motor ☐ Speech ☐ Other, explain

☐ Social emotional ☐ Behavior

Does your child have difficulty saying what he/she wants or do you have trouble understanding your child?

☐No, ☐Yes, if yes explain:

Explain any of the above:

Complete only for Child Applicant – Prenatal/Birth History

Child's Birth Weight: _____Pounds _____Ounces				☐Unknown
Pregnancy term	_____#weeks ☐Full (40wks) ☐Over 40 wks ☐Premature			☐Unknown
Type of delivery	☐ Vaginal ☐ C-Section			☐Unknown
Delivery location	☐Hospital ☐Birthing center ☐At home ☐Other			☐Unknown
Length of hospital stay	☐ Routine 1-2 days ☐ Over a month		☐ Non routine (less than a week) ☐ 1 week to 1 month	☐Unknown
Did mother receive more than 2 prenatal visits?	☐ Yes ☐ No	Time mother first received prenatal care	☐ First 3 months ☐ Middle 3 months	☐ Last 3 months ☐Unknown
Did mother experience	☐ Complications/health problems during pregnancy ☐ Complications/ health problems during delivery			☐ N/A ☐Unknown
Did the baby have	☐ Problems during pregnancy ☐ Problems at birth		☐Observable birth defects ☐Problems in the nursery	☐ N/A ☐Unknown
Prenatal exposure to the following	☐ Caffeine ☐ Non-prescription drugs		☐ Cigarettes/tobacco ☐ Prescription drugs	☐ Alcohol ☐ N/A ☐ Other_____
Is mother pregnant now?	☐ Yes ☐ No ☐ Don't know - If yes, is mother receiving prenatal care?			
Explain:				

Complete only if applying for Early Head Start as Pregnant Applicant

How old were you at your first pregnancy?_____	Is the current pregnancy planned? ☐No, ☐Yes
Due Date___/___/____	Medical Provider: ☐Public, ☐Private, ☐Other medical clinic ☐N/A
Prenatal visits started: ☐No, ☐Yes, when: ☐1st 3 months ☐Middle 3 months ☐Last 3 Months ☐N/A	

Have you received mental health interventions and follow up including substance abuse prevention and treatment?	☐No, ☐Yes, if yes explain:
Have you received prenatal information on fetal development?	☐No, ☐Yes, if yes explain:
Have you received information on the benefits of breastfeeding?	☐No, ☐Yes, if yes explain:
Is this pregnancy considered high risk?	☐No, ☐Yes, if yes explain:
Are there any complications with your current pregnancy?	☐No, ☐Yes, if yes explain:
Did you have complications with previous pregnancies?	☐No, ☐Yes, if yes explain:
Was bed rest or hospitalization is/was needed for your CURRENT pregnancy, what was the cause?	☐No, ☐Yes, if yes explain:
If bed rest or hospitalization is/was needed for your PREVIOUS pregnancy, what was the cause?	☐No, ☐Yes, if yes explain:

Mark if you have had complications with current (C), previous (P) or not applicable (N/A) to pregnancy/ies.

Pregnancy induced diabetes	☐C ☐P ☐N/A	Pregnancy induced hypertension	☐C ☐P ☐N/A		
Pain	☐C ☐P ☐N/A	Bleeding	☐C ☐P ☐N/A	C-Section	☐C ☐P ☐N/A
Headache	☐C ☐P ☐N/A	Neonatal death	☐C ☐P ☐N/A	Fatigue	☐C ☐P ☐N/A
Preterm labor	☐C ☐P ☐N/A	Swelling	☐C ☐P ☐N/A	Sickle Cell	☐C ☐P ☐N/A
Diabetes	☐C ☐P ☐N/A	Hypertension	☐C ☐P ☐N/A	Anemia	☐C ☐P ☐N/A

There has been prenatal exposure to: ☐Caffeine ☐Alcohol ☐Cigarettes/tobacco ☐Other ☐Non-Prescription Drugs ☐Prescription Drugs ☐N/A

LARAMIE COUNTY HEAD START
A Program of Community Action of Laramie County, Inc.

Physical Form

2017-2018

Child's Name: **Date of Birth:**

Date of Exam: _____
Meets EPSDT Well Child Check requirements for _____ (indicate age)
Height _____Weight_____
Head Circumference _____
Blood Pressure _____

Date of Test _____
Hematocrit _____Hemoglobin_____
Hct or Hgb is due at 8-12 months, 18-24 months, and after 36 months. Please indicate:
☐ 8-12month ☐ 18 -24month ☐ 36 month
Date of Lead Screening_____
Results _____
Lead screening is due at 12 & 24 months, or at enrollment, if not done previously. Please indicate:
☐ 12month & ☐ 24month **Or** ☐ At enrollment

Hearing Date of last_____
☐ OAE ☐ Immitance ☐ Pure Tone
Results _____

Vision Date of last_____
☐ Acuity- Results _____
☐ Strabismus- Results _____

General Assessment

	Normal	Abnormal	Not Eval		Normal	Abnormal	Not Eval
General Appearance				Genitalia			
Posture, Gait				Bones, Joints, Muscles			
Speech				Neurological/Social			
Head				Gross Motor			
Skin				Fine Motor			
Eyes				Communication Skills			
Ears				Cognitive			
Nose, Mouth, Pharynx				Self-Help Skills			
Teeth				Social Skills			
Heart				Glands(Lymphatic, thyroid)			
Lungs				Muscular Coordination			
Abdomen				Other:			

Comments

Are there any conditions present that could impact upon the child's participation in the Head Start Program? (Such as: asthma, allergies, chronic illnesses, birth defects, etc. Please attach verifying documentation if possible.)
☐ No ☐ Yes, if yes, please explain:

Health Provider's Contact Information and Signature

Provider Printed Name | Phone Number | Fax Number

Practice Name | Address

Provider Signature | Date

Please return this form to Head Start at mailing address:
211 W. 19th Street, Cheyenne, WY 82001 or fax to (307)638-2432
If you have any questions please call (307)634-5829.

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LARAMIE COUNTY HEAD START

A Program of Community Action of Laramie County, Inc.

Oral Health Care Form

2017-2018

Patient Information

Applicant's Name _____ Date of birth _____

Is this practice the applicant's dental home? ☐ Yes ☐ No

Oral Health Care Services Delivered This Visit → Date___/___/____

Diagnostic/Preventative Services		Counseling/Anticipatory Guidance	Restorative/Emergency Care	
Examination	☐ Yes ☐ No	☐ Yes ☐ No	Fillings	☐ Yes ☐ No
X-rays:	☐ Yes ☐ No		Crowns	☐ Yes ☐ No
Risk assessment	☐ Yes ☐ No	**Referral to Specialty Care**	Extractions	☐ Yes ☐ No
Cleaning	☐ Yes ☐ No	☐ Yes ☐ No	Emergency care	☐ Yes ☐ No
Fluoride varnish	☐ Yes ☐ No		Other	
Dental sealants	☐ Yes ☐ No	Please specify specialist	Please specify	

Current Oral Health Status

Does the Patient have any teeth with untreated decay?	☐ Yes ☐ No
Does the Patient have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?	☐ Yes ☐ No
Does the pregnant woman have gum disease?	☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Future Oral Health Care Services

All treatment completed ☐ Yes ☐ No Next recall date___/___/____

More appointments needed for treatment?

If yes, approximate number of appointment needed_____

Next appointment date___/___/____ Time_____

Additional Information for Parents, Head Start Staff and Medical Providers

_____

_____

Oral Health Provider's Contact Information and Signature

Provider Printed Name _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Date _____

Please return this form to Head Start at mailing address:
211 W. 19th Street, Cheyenne, WY 82001 or fax to (307)638-2432
If you have any questions please call (307)634-5829.