



ENIPC Head Start Program Application

327 Eagle Drive • P. O. Box 969, Ohkay Owingeh, NM 87566
505.747.1593 (voice) 505.747.1599 (fax)

Please fill all areas so a complete application may be reviewed
Please provide **Proof of Age** and **Proof of Family Income** with Application

Please print, and use a black/blue pen when filling out the application. Selection for Enrollment is based on: Income, Age, Special Needs of a Child, as well as other factors.

ELIGIBILITY OF CHILDREN: A Child must be 3 years old on or before the first day of school in the current School Year. Priority will be given to income eligible students.

☐ **Proof of Income - that shows total family income** (Income taxes, Pay Stubs, Written statement from employer, TANF, Scholarships, Financial Aid, Statement of Eligibility, etc).

☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐ **1st/15th** ☐ **Annual**

☐ **Verification of Age** (Birth Certificate, Baptismal Certificate, Passport)

Application acceptance and enrollment are provided regardless of race, sex, creed, color, national origin, or developmental delay/disability.

This section to be completed by Staff Only

- | | |
|---|--|
| <input type="checkbox"/> Check Stubs | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> SSI | <input type="checkbox"/> Letter (if un-employed) |
| <input type="checkbox"/> TANF/Public Assistance | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> Tax Form 1040 | <input type="checkbox"/> Other: _____ |

For more information please contact:

Jolene Nelson
Director
ENIPC Head Start
505.901.3506 cell
jnelson@enipc.org
Website: enipc.org



ENIPC Head Start Program - Application Packet

STUDENT INFORMATION:

Child's Name: _____ DOB: _____ Sex: M or F

Race or Ethnicity: American Indian – Census/Enrollment #: _____ Tribe: _____ Other: _____

Primary Language spoken in the home: _____ Other Languages: _____

PARENT/GUARDIAN INFORMATION:

Father: _____ Contact #: _____

Address: _____ Employed ☐yes ☐no Work # _____

Mother: _____ Contact #: _____

Address: _____ Employed ☐yes ☐no Work # _____

Guardian/Foster Parent _____ Contact #: _____

Address: _____ Work #: _____ Cell #: _____

HOUSEHOLD INFORMATION: Head of Household: _____ Marital Status: _____ Total in Family: _____

List all persons living in your household (list on the back of page if additional space is needed)

Name	Relationship	Age	DOB	Male or Female	Highest Grade completed

Are you interested in receiving information about other ENIPC programs, please check:

☐Food Distribution ☐Environmental ☐Peacekeepers ☐Seniors ☐Higher Education ☐WIC ☐Circle of Life
☐Behavioral Health ☐Employment & Training ☐Adult Vocational Training

EMERGENCY CONTACT INFORMATION:

Emergency contacts are required for each child. Please list emergency contact names and required information. **Contacts must be eighteen years of age.** The **EMERGENCY Contact Person must not be under the influence of drugs and/or alcohol when picking up your child.** Please let the teacher know when any changes occur with your contacts.

I _____ give permission to the individuals below to pick up my child.

Parent Signature: _____ Date: _____

1st Contact

Name: _____ Relationship to child: _____

Home #: _____ Work #: _____ Cell #: _____

2nd Contact

Name: _____ Relationship to child: _____

Home #: _____ Work #: _____ Cell #: _____

3rd Contact

Name: _____ Relationship to child: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Medical Treatment: ☐ I CONSENT ☐ DO NOT CONSENT

To provide emergency medical treatment in the event, my child is injured while at the Head Start Center, I understand I will be notified immediately. If I am not reachable, this form allows the Head Start staff to access medical treatment for my child. If required, I hereby authorize the Emergency Medical Service (EMS), Indian Health Service, or a licensed physician, dentist, or nurse to provide medical aid for my child _____ (child's name).

This statement allows my child to be transported for medical attention either by private vehicle, or ambulance. In the event that my child has an accident during school, I authorize an ENIPC staff member to administer Basic First Aid and /or CPR.

Parent/Guardian Signature

Date

Source of Health and Emergency Care:

☐ Indian Health Service ☐ Private Insurance or ☐ Medicaid ☐ yes ☐ Medicaid # _____

Parent Center Agreement

During my child's enrollment at Head Start Center, I/We agree to participate in the review of parent involvement objectives and School Readiness Goals. I/We will also be involved in all school activities, and volunteer in the classroom or kitchen.

Parent/Guardian Signature

Date

Field Trip Permission

I, _____ consent/do not consent for my child to participate in field trips within the communities of San Ildefonso or Nambe Pueblos. Outside field trips will be sent home for parental consent.

Parent/Guardian Signature

Date

Multi- Media Release

I, _____, hereby **grant permission** for my child's _____, image (photographs, video, audio tape, or related formats) for use by ENIPC Head Start. The release for multi-media purpose is valid for school year 20____-20____.

Parent Signature

Date

Child's Health Record - Please Do Not Leave Any Spaces Blank

Pregnancy/Birth History:

Did mother have any health problems during pregnancy or child birth? ____yes ____no

Are there any Health concerns that we should be made aware of? ____yes ____no

If yes, please list concerns: _____

Hospitalization & Illness:

Has your child ever had surgery? ____yes ____no

Has your child ever had a serious accident? ____yes ____no

(broken bones, burns, falls, head injuries)

Has your child ever had a serious illness? ____yes ____no

Health Issues:

Does your child have any of the following (frequently). Please check all that apply:

_____Sore throat	_____Coughs
_____Diarrhea	_____Stomach pain
_____Trouble urinating	_____Ear infections
_____Vomiting	_____Asthma
_____Other, please explain _____	

Does your child have difficulty seeing? ____yes ____no

Does your child wear glasses? ____yes ____no

Does your child have problems with his/her hearing? ____yes ____no

Has your child ever had convulsions? ____yes ____no

Is your child currently on medication? ____yes ____no

Has your child ever had (please list at what age):

_____Mumps	_____Hives	_____Measles
_____German Measles	_____Chicken Pox	_____Hepatitis
_____Whooping Cough	_____Scarlet Fever	_____Polio
_____Other		

ALLERGY INFORMATION:

Does your child have food allergies/environment allergies? ____yes ____no

If yes, please list _____

Any other conditions that were not included above? ____yes ____no

If so, please explain _____

DIETARY INFORMATION:

Does your child take vitamins and/or mineral supplements? ☐ yes ☐ no

Is your child on a special diet? ☐ yes ☐ no

If yes, please explain _____

Has there been a change in your child's appetite in the last month? ☐ yes ☐ no

If yes, please explain _____

Does your child take a bottle? ☐ yes ☐ no

Does your child have trouble chewing and/or swallowing? ☐ yes ☐ no

Any other concerns we should be aware of?

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT INFORMATION:

Tell us two things that your child is interested in: 1. _____

2. _____

Does your child take naps? ☐ yes ☐ no

Does your child sleep less than 8 hours a night? ☐ yes ☐ no

Does your child have trouble sleeping? ☐ yes ☐ no

Does your child tell you when he/she needs the restroom? ☐ yes ☐ no

Does he/she need help in the restroom? ☐ yes ☐ no

Does your child worry a lot? Is he/she afraid of anything? ☐ yes ☐ no

If yes, please explain _____

How does your child act with adults he/she does not know? _____

How does your child act with children their own age?

Please explain _____

Does your child have difficulty saying what he/she wants and/or needs? ☐ yes ☐ no

Is your child's speech easy to understand? ☐ yes ☐ no

Does your child grunt as a form of communication? ☐ yes ☐ no

Does your child point as a form of communication? ☐ yes ☐ no

Is there an issue that may affect your child's behavior? ☐ yes ☐ no

If yes, please explain _____.

Do you have any concerns about your child's behavior at home? ☐ yes ☐ no

If yes, please explain _____.

Has there been a significant change in your child's life recently? ☐ yes ☐ no

If yes, please explain _____.

Parents Signature

Date

EARLY INTERVENTION PROGRAMS:

I, _____, hereby grant permission for my child, _____, to participate in the health screenings listed below:

**Vision
Dental
Audiology
Speech and Language
Blood Pressure checks**

**Height / Weight
ASQ (Ages & Stages) Social/Emotional
ASQ (Ages & Stages) Developmental
Classroom Observations**

The consent has been explained to me. I understand I will be notified before screenings are administered. I further understand results will be shared with me. This parent consent for Health Screenings is valid for school year 20____-20____.

Parent Signature

Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION:

I, _____, hereby authorize the disclosure of information from my child's medical record.

The information is to be disclosed by:

The Santa Clara Health Center, Santa Clara Pueblo, NM 87532

And/or the Indian Health Service, Santa Fe, NM 87505,

Or

Named Medical Facility/Address: _____

And, is to be provided to: **ENIPC Head Start Program, P.O. Box 969, Ohkay Owingeh, NM 87566.** The information to be disclosed from my child's Health record is information related to Child Find 20____, or medical screenings required by the Head Start Program. I understand that I may revoke this authorization in writing at anytime.

Signature of Patient/Signature of Guardian

Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal Agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3).

Patient Name (child): _____

Address: _____

Record #: _____ DOB: _____

City/State: _____

For Official Use Only

Birth Certificate # _____ Signature/Date: _____

Social Security Card # _____ Signature/Date: _____

Child's Status: ☐ Income eligible ☐ Over income ☐ Special needs ☐ Other: _____

Is Child eligible to participate in the Head Start program? ☐ Yes ☐ No

Type of eligibility interview: ☐ In-person ☐ Telephone

What document was used for eligibility determination? _____

Signature/Date: _____

For Official Accounting Use Only - Income Verification for Head Start 20 _____

☐ Weekly ☐ Bi-Weekly ☐ 2x a Month (eg. 1st & 15th) ☐ Monthly ☐ W-2

Pay period: _____

Last date of Pay Period: _____

Of completed months: _____

Calculation: _____

Pay period: _____

Last date of Pay Period: _____

Of completed months: _____

Calculation: _____

In head of household: _____

20__ Poverty Guidelines: _____ Applicant Income _____

☐ **Receives Public Assistance** (TANF, SSI, General Cash Assistance, etc./HSPPS 1302.12.i.2

Prepared by: _____ Date: _____

Approved by: _____ Date: _____