Applicant & Family Member Information

Child's Name

First | Last | Birthday | Gender: Male / Female

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

Primary Language
☐ English
☐ Spanish
☐ French
☐ Other

Second Language
☐ English
☐ Spanish
☐ French
☐ Other

Primary Health Coverage | Doctor/Medical Home | Dentist/Dental Home | POC/MCI # | Can obtain from center if already enrolled

Primary Adult

First | Last | Birthday | Gender

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

Primary Language
☐ English
☐ Spanish
☐ French
☐ Other

Second Language
☐ English
☐ Spanish
☐ French
☐ Other

Highest Grade Completed
☐ Associate's
☐ Bachelor's
☐ Col Deg/Train
☐ Col or Adv Train
☐ GED
☐ Grade 10
☐ Grade 11
☐ Grade 12
☐ < Grade 9
☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed
☐ Full Time & Training
☐ Part Time & Training
☐ Training or School
☐ Retired or Disabled

Child's Relationship
☐ Natural/Adopted/Step
☐ Grandchild
☐ Niece/Nephew
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Email Address:

Secondary or Other Adult (if living in the same household)

First | Last | Birthday | Gender

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes
☐ No

Primary Language
☐ English
☐ Spanish
☐ French
☐ Other

Second language
☐ English
☐ Spanish
☐ French
☐ Other

Highest Grade Completed
☐ Associate's
☐ Bachelor's
☐ Col Deg/Train
☐ Col or Adv Train
☐ GED
☐ Grade 10
☐ Grade 11
☐ Grade 12
☐ < Grade 9
☐ HS Graduate
☐ Master's

Employment Status
☐ Full Time
☐ Part Time
☐ Seasonal
☐ Unemployed
☐ Full Time & Training
☐ Part Time & Training
☐ Training or School
☐ Retired or Disabled

Child's Relationship
☐ Natural/Adopted/Step
☐ Grandchild
☐ Niece/Nephew
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

Email Address:

Additional Child living in household(Non-Applicant) *

First | Last | Birthday | Gender

Additional Child living in household (Non-Applicant) *

First | Last | Birthday | Gender

Additional Child living in household(Non-Applicant) *

First | Last | Birthday | Gender

Additional Child living in household(Non-Applicant) *

First | Last | Birthday | Gender

Additional Child living in household(Non-Applicant) *

First | Last | Birthday | Gender

This Section for Agency Use Only:

Family Information, Income & Contacts

Applicant Name: _____ Birthday _____

Family Information

Family Living Address

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

Family Mailing Address

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

Phone Number(s) | Type (*check one*) | Note (*for example, an extension or best time to call*)

☐ Cell ☐ Home ☐ Work ☐ Other

☐ Cell ☐ Home ☐ Work ☐ Other

☐ Cell ☐ Home ☐ Work ☐ Other

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	TANF Status
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No ☐ Formerly on TANF/Not now

Receiving SSI __yes__no

Parent or child with life threating illness __yes __no

Parent or child with mental health issue __yes __no

INCOME STAFF WILL COLLECT

TURN IN ALL INCOME...WAGES, CHILD SUPPORT, SSI, TANF ETC. SEE INCOME VERIFICATION CHECKLIST

1040 or W2's are best!!!

Emergency Contacts

Contact 1

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

Address | ZIP | City | State

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

Contact 2

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

Address | ZIP | City | State

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

Contact 3

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

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home | Phone Number 3 ☐ 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 Signature_____ Date_____

First Start Delaware Early Head Start
Nutrition Assessment

- Complete the Nutrition Assessment during enrollment

CHILD'S NAME: _____ **DOB:** _____
Center: _____
Child's Doctor: _____ **Dentist:** _____

I. Nutrition/General Questions

	YES	NO
1. At how many weeks (gestation) was the child born?_____ Birth weight _____lbs. _____oz.		
2. Were there any problems with the child immediately after birth?	☐	☐
If yes, explain _____		
Does your child have any of the following: Asthma, Diabetes, Liver Disease, Bleeding tendencies, Heart/ Blood vessel disease, Sickle Cell, Seizers?	☐	☐
_____		
3. Has your child ever been hospitalized, had surgery or serious illness?_____	☐	☐
_____		
4. Is your child taking any medications every day?	☐	☐
a. If yes, what is the medication, dosage and frequency? Why is the child prescribed (or taking) this medication?		
_____		
_____		
b. Will medication be needed at school?	☐	☐
If yes, when should it be administered? _____		
5. Do you have any concerns about your child's growth, weight, nutrition, or eating?	☐	☐
If yes, explain: _____		
6. Does your child chew or eat things that are not food?	☐	☐
If yes, explain: _____		
7. In the past six months, was your child found to be anemic (low iron)?	☐	☐
Is your child involved in active play daily?	☐	☐
8. Does your child have any problems hearing? Hearing aid/ tubes?	☐	☐
_____		
9. Does your child wear glasses or have any problems seeing?	☐	☐
10. Does your child have dental problems now?	☐	☐
11. Does your child have difficulty chewing or swallowing?	☐	☐
12. Does your child eat solid food?	☐	☐
13. Does your child take a vitamin/mineral supplement?	☐	☐
If yes, what kind? _____		
a. Do they contain? ☐Iron ☐ Fluoride		
14. Does your child use a pacifier?	☐	☐
If yes, when: _____		
15. Do you dip your child's pacifier in anything (ex: honey)?	☐	☐
16. Does your child use: (mark all that apply)		
☐Utensils (fork, spoon, knife) ☐Open cup ☐ Sippy cup ☐Baby Bottle		
☐Hands ☐Other _____		

17. Do you put your child to bed with a bottle? ☐ ☐
18. If your child drinks from a bottle, do you add anything to the bottle? ☐ ☐
    If yes, what do you add to the bottle: _____
19. Please list any other conditions or concerns such as serious illness, sleep concerns etc.

    _____

    _____

II. Food Consumption

YES **NO**

*** Question 18 to 24 for Infants Only**

20. *Eating frequency (times per day): _____
21. *Average time spent feeding _____
22. *Ounces consumed per feeding _____
23. *Type of food consumed: ☐Breast milk ☐Formula: ☐with iron ☐without iron
    ☐Milk, type of milk _____ ☐Other: _____
24. *If you feed your child formula, which type do you use and how is it mixed?
    a. If concentrate, #_____ ounces of water mixed with 13 oz. can.
    b. If powdered, #_____ scoops of mix with # _____ ounces of water
    c. If ready to feed, water added? ☐ ☐
25. *Feeding Method: ☐ Breast fed ☐Bottle fed ☐Other_____
26. *Do you feed your child any cereal or baby foods? ☐ ☐
    If yes, what? _____
    and at what age was the food introduced? _____

27. Using the following codes please indicate which foods your child eats, how often, and at what age the food was introduced. **N** = Never / **2-3** = 2 to 3 times a week / **A** = Almost Daily

Type of Food	Age introduced	Frequency (N/ 2-3/ A)
Red beef (meat, pork, ham, veal,)		
Poultry (chicken, turkey, duck)		
Fish and Shellfish (fish, salmon, tilapia, shrimp, scallops, crab, etc.)		
Bacon, Sausage, Luncheon meats, Hot dogs		
Eggs (scrambles, fried, boiled, poached, etc.)		
Fruits (apples, pears, berries, citrus, melons, mango, etc)		
Starchy Vegetables (peas, corn, white potatoes)		
Non-Starchy Vegetables (Leafy greens, okra, kale, celery, broccoli, green beans, eggplant, radishes, cucumber, beets, mushrooms, etc.)		
Beans & Legumes (black beans, kidney beans, navy beans, pinto beans, lentils, split peas, etc.)		
Whole grains (whole grain cereals, breads, pasta and crackers, brown rice, millet, quinoa, spelt berries, etc.)		
Refined grains (white rice, white pasta, crackers, white bread, refined and sugary cereals, tortillas, etc.)		
Nuts, seeds & nut/seed butters (peanuts, peanut butter, almonds, walnuts, pecans, pistachios, sunflower seeds, etc.)		
Salty treat foods (chips, french fries, snack mixes, cheese crackers, cracker sandwiches, etc.)		
Sweet treat foods (ice cream, cookies, cake, candy, pastries, donuts)		
Sweetened drinks (Hi C, soda, juice drinks, sports drinks, kool aid, flavored milk, etc.)		
Added fats (shortening, salad dressing, butter, margarine, mayonnaise, oils, etc.)		

III. Family Habits

	YES	NO
28. Describe your family mealtime: Do you eat together? If yes, which meals _____	☐	☐
29. Where do you eat? _____		
30. Is the TV on during mealtime?	☐	☐
31. Do children and adults eat the same meals?	☐	☐

32. Approximately at what time does your child eat the following meals?
Breakfast: _____ Lunch: _____ Dinner: _____
Snack(s): _____
33. How often do you eat out or have take-out food? _____

IV. Food Substitution

34. Is your child restricted from foods due to religious, vegetarian, medical or personal beliefs? ☐ ☐

If yes, please check all that apply

☐Pork ☐ Beef ☐Poultry ☐Fish
☐Eggs ☐Milk ☐Other_____

35. Does your child have any food allergies or intolerances? ☐ ☐
If yes, please specify _____

36. If food allergy indicated, what kind of reaction does your child have when he/she eats the food specified above?

☐Life Threatening ☐ Rash
☐ Swelling ☐ Difficulty Breathing
☐ Diarrhea ☐ Other, specify _____

37. **Does your child have an EpiPen?** ☐ ☐

38. Is your child on any special diet prescribed by a doctor? ☐ ☐
If yes, specify: _____

> **NOTE:** - Food substitutions needed for medical reasons will be accommodated with a signed statement from a licensed physician or other medical authority. Parents must provide a copy of the statement to the program. Substitutions for non-medical reasons (i.e. religious, vegetarian, etc.) will be discussed on a case-by-case basis with the Nutrition Consultant and Program Manager

Staff's name/Title: _____ **Signature:** _____

Parent/Guardian name: _____ **Signature:** _____

Date: _____

Reviewed/Updated on:

_____	_____	_____
Parent/Guardian Name	Signature	Date
_____	_____	_____
Staff Name/ Title	Signature	Date

First Start Delaware Early Head Start – Child Care Partnership
CONSENT AND RELEASE FORM

Date completed _____/_____/_____ New_____ Update _____

Child's name _____ D.O.B. _____/_____/_____

Parent/Guardian's name _____

Indicate Yes or No by initialing in the appropriate column Yes No

I consent to:

- ❑ The developmental screening and periodic assessment of my child. (Ages and Stages Developmental and Social Emotional, Nutrition, Dental, Vision, Hearing, and TSGOLD Assessment) ____ ____

- ❑ FSD:EHS-CCP requesting health records, immunization updates, lead and hemoglobin results for my child from Health Care providers, WIC or immunization hot line to determine if my child is up-to –date on appropriate preventive health care.

  ____ ____

  Physician/ Medial Practice: _____

- ❑ The **interagency sharing** of information as listed on the attached sheet. I understand that such information will remain confidential and that information will be used for the

  ____ ____

  benefit of my child_____, and me.

- ❑ FSD:EHS-CCP staff contacting the state social service agencies.

  ____ ____

- ❑ Child Development Watch (CDW)-sharing information, referral, IFSP, Assessment results, and any other information related to the results of the referral,

  ____ ____

  Multidisciplinary Assessment, and services being provided.

- ❑ Allow FSD:EHS-CCP to share observations with, and make referrals to, their Mental Health Consultant, Nutrition Consultant, and Nurse Consultant.

  ____ ____

I understand that I can change this agreement at anytime unless the information has already been released. The permission is good for the duration of my enrollment in FSD:EHS-CCP unless I change this agreement. Any information shared will be discussed with me first.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

As the participating organization's representative, I affirm that I have reviewed the form and its use with the consenting person and that to the best of my knowledge, he/she understands.

FSD:EHS-CCP STAFF: _____ DATE: _____

First Start Delaware Early Head Start – Child Care Partnership

PERMISSION TO RELEASE INFORMATION

Sharing information helps agencies provide better service to your child and family. Only those agencies that are planning or giving services to your child may receive information. Other agencies that want information about your child will get it only if you sign an agreement with that agency.

SHARED INFORMATION MAY INCLUDE:

- Child's/My Full-Name
- Address
- Medicaid Number
- Parents and Siblings name
- Developmental Screening results
- Telephone Number
- Birth date

You may limit the information that is released. You may also limit the parties who will receive it.

Special permission from you is required before sensitive information is shared about your child. Examples of sensitive information are: information about drug and alcohol treatment, pregnancy, and HIV status.
Information to be shared will be discussed with you before it is shared or requested.

INFORMATION THAT MAY BE SHARED

- Child enrollment in FSDEHS
- Developmental Assessment
- Individualized Transition Plan
- Individualized Family Service Plan
- Financial Eligibility (TANF, Food Stamps, General Assistance)
- Medical History/Evaluation
- Speech Therapy Evaluation
- Treatment Progress Report
- Child Care and Other Services your Child Receives

AGENCIES THAT MAY SEND /RECEIVE INFORMATION

- Department of Education
- Division of Mental Retardation
- Division of Public Health
- Division of Social Services
- Division of Management Services (Birth-to-Three Program)
- Division of the Visually Impaired
- Division of Child Mental Health Services
- Division of Family Service
- Your Primary Care Physician: _____

Parent initials _____

Photo/Video Release Form

Date: _____

RE: Photograph/Image of: _____

I give permission to have a photograph/image/video taken and/or used by Delaware First Start Early Head Start Child Care Partnership (FSD:EHS-CCP) for use in print media, websites or as FSD:EHS-CCP chooses. I neither request nor expect any fee or compensation of any kind for FSD:EHS-CCP's use of my photograph/image/video. I understand that this photograph/image/video will be used to help illustrate and explain the programs and mission of FSD:EHS-CCP. I further understand that upon execution of this Photo/Video Release Form the photograph/image/video becomes sole property of FSD:EHS-CCP.

Signature _____

Date _____

Formulario de Publicación de Foto / Video

Fecha: _____

RE: Fotografía / Imagen de_____

Doy permiso para que fotografías / imagenes / video puedan ser tomada y utilizada por Delaware First Start Early Head Start Child Care Partnership (FSD: EHS-CCP) para uso en medios impresos, sitios web o como FSD: EHS-CCP elige. No solicito ni espero ninguna tarifa o compensación de ningún tipo para FSD: el uso de EHS-CCP de mi fotografía / imagen / video. Entiendo que esta fotografía / imagen / video se usará para ayudar a ilustrar y explicar los programas y la misión de FSD: EHS-CCP. Además, entiendo que luego de la ejecución de este Formulario de Autorización de Foto / Video, la fotografía / imagen / video se convierte en propiedad exclusiva de FSD: EHS-CCP.

Firma _____

Fecha _____

First Start Delaware
Early Head Start - Child Care Partnership

Parent/Home Visitor Agreement

Child's Name: _____ Child Care Center: _____

As a parent/guardian/caregiver, I agree to meet the following requirements to the best of my ability (parent/guardian/caregiver initial at intake with FSW):

_____ 1. I will be at home for each visit or let the visitor know the day before that I cannot keep our appointment.

_____ 2. I understand my entire home is part of my child's learning environment and activities may occur inside and/or outside of my home.

_____ 3. I will follow through with home learning activities after home visits, and record them on the Home Based Individual Lesson Plan.

_____ 4. I am fully aware that it is my responsibility to fully participate during home visits.

_____ 5. I know the visits are to last at least 90 minutes, but can last longer.

_____ 6. Parent/guardian/caregiver is responsible to sign in and date at beginning of home visit and sign out and date at the end of the home visit.

_____ 7. I will help my child keep track of all Early Head Start materials and return them to the home visitor.

_____ 8. I will be an active participant in planning activities with the home visitor.

_____ 9. I will provide my own transportation to all activities, as required.

_____ 10. I am fully aware that excessive cancellations may result in my child's termination from the program, and cancellations must be made up to fulfill the required number of home visits.

Initials:_____ Date:_____

As a home visitor:

1. I will call if a visit must be cancelled and reschedule any cancellations.
2. A calendar of home visits and socializations will be developed and you will receive a copy.
3. I will be well prepared for each visit.
4. I will help you develop skills so you can be an effective teacher for your child.
5. I will show and assist you how to use household items in the home as learning materials.
6. I will assist you in locating community resources to help your family.
7. I will provide you with opportunities to get together and network with other families for fun, learning and socialization.
8. I will have formal discussions regarding your child's progress towards school readiness through parent conferences and home visits.

I agree to allow my EHS-CCP Home Visitor to visit my home. I also understand that my EHS-CCP Home Visitor's supervisor will monitor our visits occasionally to better service my family.

Parent/Guardian/Caregiver:_____ Date: _____

Home Visitor:_____ Date: _____

First Start Delaware (FSD) Early Head Start – Child Care Partnership
Family Partnership Agreement (FPA) Initiation

Purpose: The FPA is for families and staff to enter into a partnership-building relationship that will foster mutual trust and respect. During this process, FSD believes in offering families the opportunity to identify and implement goals. The FPA process will provide opportunities for family and staff to collaborate on goals.

Parent/Guardian(s): _____ Staff: _____

Child name(s): _____ Date: _____

As the parent/guardian(s) I/we agree:	**As the FSD staff I agree:**
• To ensure my child attends school every day s/he is able, • To keep childcare staff up-to-date on any changes to telephone numbers or addresses, • To share information with staff regarding my progress throughout the program, • To meet with staff for Home Visits and Family Assessments, • To attend Parent Meetings when possible, and • To cancel scheduled meetings if I am unable to attend.	• To be on time for meeting, appointments, etc., • To cancel scheduled meetings if needed in a timely manner, • To meet with your family at an agreed-upon, convenient time, • To notify your family of upcoming events in a timely manner, • To share community resources that would benefit your family, and • To communicate regularly regarding any changes within the program.

Please Check ONE:

_____ At this time, I know that I would like to work on goals (i.e., buying a house, getting a degree, etc.)

_____ I decline to participate in the goal setting process at this time. I understand that I will be offered this opportunity again during the year at Home Visits.

Notes/comments:

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature(s): _____

Staff Signature(s): _____

First Start Delaware Early Head Start Childcare Partnership

Things needed to apply:

*Proof of Birth (Birth Certificate or insurance card)
* Proof of Income or TANF (W2's, 1040 or last 2 paystubs)
*Proof of address (driver's license, utility bill, etc.)
*POC Documentation
*Guardian/ Foster/ Custody Documentation if applicable
*Child Support if applicable
* Up to date Physical
*Immunization Records