The Christian Academy

Urban League Head Start Program Enrollment Pack

"Train up a child in the way he should go..."
Proverbs 22:6

Dr. Mary Crockett-Smith
Executive Director

The Christian Academy
11621West Florissant Ave.
Florissant, MO 63033
(314) 838-DOER (3637)

The Christian Academy Too
8923 Riverview Drive
St. Louis, MO 63137
(314) 455-4172

URBAN LEAGUE
of Metropolitan Saint Louis, Inc.
EMPOWERING COMMUNITIES. CHANGING LIVES.

URBAN LEAGUE HEAD START DOCUMENT CHECKLIST

(Items needed for enrollment)

Child's Information

- Child's Birth Certificate
- Child's Up to Date Immunization / Shot Records
- Child's Physical Exam
  - Including HGB/HCT
  - Lead Test
  - TB Test

- If available, *but not required to enroll*
  - Vision Exam
  - Hearing Exam
  - Child's Dental Exam

Parent Information

- Parent's Photo ID
- Parent's Proof of Income
  - Previous year W-2 or 1040
  - TANF Letter
  - Child Subsidy letter
  - Unemployment Letter of SSI Award

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD – CHILD CARE COMPLIANCE

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNITY FOOD & NUTRITION ASSISTANCE

CHILD CARE ENROLLMENT FORM

FACILITY/PROVIDER NAME URBAN LEAGUE HEAD START – THE CHRISTIAN ACADEMY	ADMISSION DATE	DISCHARGE DATE
CHILD'S NAME	GENDER	BIRTHDATE
CHILD'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		

IDENTIFYING INFORMATION

PARENT/GUARDIAN NAME	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☑	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

PARENT/GUARDIAN NAME N/A	TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE) OR CHECK IF SAME AS CHILD'S ADDRESS ☐	
EMAIL ADDRESS	
EMPLOYER OR SCHOOL	WORK/SCHOOL SCHEDULE
EMPLOYER/SCHOOL ADDRESS (STREET, CITY, STATE, ZIP CODE)	WORK TELEPHONE NUMBER

If you or a member of your immediate family ever served in the U.S. Armed Forces, click here for more information about military-related services in Missouri or visit www.dese.mo.gov/veterans-services.

EMERGENCY CONTACT AND PERSONS AUTHORIZED TO TAKE CHILD FROM FACILITY OTHER THAN PARENT (AT LEAST ONE EMERGENCY CONTACT IS REQUIRED)

NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER(S)
ADDRESS (STREET, CITY, STATE, ZIP CODE)		

COMMENTS ON CHILD'S DEVELOPMENT (PERSONAL DEVELOPMENT, BEHAVIOR, PATTERNS, HABITS, & INDIVIDUAL NEEDS)

CACFP REQUIREMENT

RELATED CHILD

☐ Yes ☑ No	CHILD'S RELATION TO CHILD CARE PROVIDER

ETHNIC AND RACE INFORMATION (YOU ARE NOT REQUIRED TO ANSWER THIS SECTION)

Are you of Hispanic or Latino origin? ☐ Yes ☑ No

What is your race? (Select one or more.)	☐ American Indian or Alaskan native	☐ Asian	☑ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White

CHILD'S PROJECTED ATTENDANCE SCHEDULE AND ANY VARIATIONS EXPECTED

Will child attend: ☐ Full time ☐ Part time Check what days your child will attend.		When does your child usually arrive each day?	When does your child usually leave each day?	Describe any changes or variations in usual attendance, including shift changes.
Monday	☑	☑ a.m. ☐ p.m.	☐ a.m. ☑ p.m.	
Tuesday	☑	☑ a.m. ☐ p.m.	☐ a.m. ☑ p.m.	
Wednesday	☑	☑ a.m. ☐ p.m.	☐ a.m. ☑ p.m.	
Thursday	☑	☑ a.m. ☐ p.m.	☐ a.m. ☑ p.m.	
Friday	☑	☑ a.m. ☐ p.m.	☐ a.m. ☑ p.m.	
Saturday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	
Sunday	☐	☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.	

MEALS YOUR CHILD IS USUALLY GIVEN AT THIS FACILITY

☐ Breakfast ☐ Morning snack ☐ Lunch ☐ Afternoon snack ☐ Supper ☐ Evening snack ☐ None

HOLIDAYS YOUR CHILD IS IN CARE AT THIS FACILITY

☐ New Year's Day	☐ Easter	☐ Labor Day
☐ Martin Luther King, Jr.'s Birthday	☐ Truman Day	☐ Columbus Day
☐ Lincoln's Birthday	☐ Memorial Day	☐ Veterans Day
☐ Washington's Birthday	☐ Juneteenth	☐ Thanksgiving Day
	☐ Independence Day	☐ Christmas Day

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in the event of an emergency with my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice. If I cannot be reached to make the necessary arrangements, or in a critical emergency requiring medical care, I authorize

URBAN LEAGUE HEAD START – THE CHRISTIAN ACADEMY

(CHILDCARE FACILITY NAME)

to contact the following:

PHYSICIAN OR CLINIC

NAME	TELEPHONE NUMBER

PREFERRED HOSPITAL

NAME	TELEPHONE NUMBER

ACKNOWLEDGMENTS

A	I have received a copy of this facility's policies pertaining to the admission, care, and discharge of children.	PARENT/GUARDIAN INITIALS
B	I have been informed that a copy of the licensing rules for child care home or the licensing rules for group child care homes and centers is available at this facility for review.	PARENT/GUARDIAN INITIALS
C	The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior, and individual needs.	PARENT/GUARDIAN INITIALS
D	When my child is ill, I understand and agree that s/he may not be accepted for care or remain in care.	PARENT/GUARDIAN INITIALS
E	I understand that, before the first day of attendance by my child, I will provide proof of completed age-appropriate immunizations or exemption from immunizations.	PARENT/GUARDIAN INITIALS
F	I ☐ do ☐ do not give permission for field trips/excursions. I understand that I will be notified in advance when they are planned.	PARENT/GUARDIAN INITIALS
G	I ☐ do ☐ do not give permission for the facility to transport my child.	PARENT/GUARDIAN INITIALS
H	I have been informed and have received a copy of the facility's safe sleep policy when enrolling a child less than one (1) year of age.	PARENT/GUARDIAN INITIALS
I	I have been notified that I may request notice at initial enrollment or at any time thereafter whether there are children currently enrolled in or attending the facility for whom an immunization exemption has been filed.	PARENT/GUARDIAN INITIALS

PARENT/GUARDIAN SIGNATURE	DATE

CACFP REQUIREMENT			
	FIRST ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	SECOND ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE
	THIRD ANNUAL UPDATE	PARENT/GUARDIAN SIGNATURE	DATE

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-05080002-508-11-28-17Fax2Mail.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.

Applicant & Family Member Information

Applicant

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

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

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Primary Health Coverage | Other Coverage | Insurance # | Medicaid Eligibility | Medicaid # | Doctor/Medical Home

Medicaid Eligibility
☐ Not Eligible
☐ On Medicaid
☐ Potentially

Dental Coverage | Dental Coverage # | Dentist/Dental Home

Primary Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

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

Hispanic
☐ Yes
☐ No

English Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

Other Language

Other Language Proficiency
☐ Little
☐ Moderate
☐ None
☐ Proficient

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

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

Child's Relationship
☐ Biological/Adopted/Step
☐ Grandchild
☐ Other Relative
☐ Foster
☐ Other

Custody
☐ Yes
☐ No

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

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Secondary or Other Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
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☐ Foster
☐ Other

Custody
☐ Yes
☐ No

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

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Additional Child (Non-Applicant) *

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native
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** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

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Urban League Head Start/Early Head Start

Risk Assessment for Tuberculosis

Participant Name _____ DOB _____

The following list of questions should be asked of the parent/legal guardian that is completing an application for their child

1. Has your child had a negative Tuberculin Skin Test within the past 6 months?

   Yes, date _____/_____/_____ No

2. Can you answer *YES* to any of the next 4 questions:

   - Has your child been in contact with a person with confirmed or suspected infectious tuberculosis? This includes family members or friends that have been in jail or prison during the last 5 years.
   - Has your child immigrated from Asia, the Middle East, Africa, or Latin America?
   - Has your child had significant contact with a person from Asia, the Middle East, Africa, or Latin America?
   - Is your child infected with HIV or living with an HIV-infected person?

   Yes No

3. Has your child been exposed to any of the following:
   - HIV-infected person
   - Homeless person
   - Resident of a Nursing Home
   - A person who uses illegal drugs
   - An adolescent or adult who has been institutionalized (living in a group setting/home)
   - An adolescent or adult who has been incarcerated
   - A migrant farm worker

   Yes No

4. Has your child had a Tuberculin Skin Test that was read and if so, when was it given?

   Yes, date _____/_____/_____ No

_____ _____

Parent Signature Date

_____ _____

Staff Signature Date

April 2022

URBAN LEAGUE HEAD START & EARLY HEAD START

URBAN LEAGUE *HEAD START* PROGRAM

Child Health History

Child's Name:	Date of Birth:	☐ Male ☐ Female	ChildPlus ID:
Staff Completing Form: Marian Brooks		Staff Title: Program Coordinator	
Person Interviewed Parent		Date Form Completed:	

Medical and Dental Home

1. Do you have medical insurance?
   ☐ Medicaid ☐ CHIP ☐ Medicaid/CHIP ☐ Private Insurance ☐ No Insurance ☐ Other
2. Primary Doctor: _____
   Clinic Name: _____ Phone Number: _____
   Address: _____ Date of Last Visit: _____
   ☐No Doctor at this time
3. Primary Dentist: _____
   Clinic/Group Name: _____ Phone Number: _____
   Address: _____ Date of Last Visit: _____
   ☐No Dentist at this time

Health Concerns

1. Does the **CHILD** have a history of any of the following & is the child currently being treated for:

	YES	NO		YES	NO		YES	NO
Asthma			Eczema			Ear tubes		
Diabetes			Anemia			Hearing Aide		
Seizure Disorder/Epilepsy			Heart Disorder			Sickle Cell Disease		
Respiratory Disorder			G-Tube			Sickle Cell Trait		

2. ☐ Yes ☐ No Are there any conditions that get in the way of the child's everyday activities?
   If yes, describe: _____

Allergy Information

1. ☐ Yes ☐ No Is your child allergic to anything? (Medications, Animals, Insects, Dust, Food, etc.)
   If yes, please specify: _____
   For staff: If food allergy, please ensure information is completed under "Special Diet" on Nutrition Assessment
   What is the reaction? (rash, hives, etc.): _____
2. ☐ Yes ☐ No Is an EpiPen and/or antihistamine *(Benadryl, Zyrtec, etc.)* needed?

Pregnancy & Birth

1. How much did this child weigh at birth? _____ *pounds* _____ *ounces*
2. ☐ Yes ☐ No Did mother have any health problems during this pregnancy and/or delivery? Explain: _____
3. ☐ Yes ☐ No Was the child born more than 3 weeks early or late?
4. ☐ Yes ☐ No Were there any problems with this child immediately after birth? Explain: _____
5. ☐ Yes ☐ No Does any of the above affect the child now?

Disability & Mental Wellness:

1. ☐ Yes ☐ No Does your child have a disability/mental wellness concern or do you suspect your child may have a disability or mental wellness issue? If yes, please specify: _____
2. ☐ Yes ☐ No Has a professional assessed/diagnosed your child? If yes, who? _____
3. ☐ Yes ☐ No Has your child ever received Early Childhood Intervention (ECI) Services?
4. ☐ Yes ☐ No Is your child currently receiving services at home, if so what Agency? _____
5. ☐ Yes ☐ No Does your child have an Individualized Family Service Plan (IFSP)?

The following questions will help us better understand your child:

1. ☐ Yes ☐ No Does your child regularly brush their teeth and with fluoride toothpaste? _____
2. ☐ Yes ☐ No Have there been any big changes in your child's life in the last six months? _____
3. ☐ Yes ☐ No Are you or your family having any problems that may affect your child? _____
4. ☐ Yes ☐ No Is there anything else you would like for us to know about your child? _____

Will the child need any **medications** or **special accommodations** for any of these health concerns **at the Center**?

☐ Yes ☐ No ***Medication:*** _____

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

URBAN LEAGUE OF METROPOLITAN ST. LOUIS, INC.
HEAD START & EARLY HEAD START

URBAN LEAGUE HEAD START
CHILD NUTRITION RECORD

Child's Name:_____ **Date Completed:** ____/____/____

Sex: (please circle): Male Female **Age:**_____ **Birth Date:** ____/____/____

Food Sources: WIC Community Food Source Family Shopping
(Circle All that Apply)

Type of food: (circle all that apply) Breast Milk Formula Solid Foods Other_____

Methods of consumption: (circle all that apply) Bottle Fed Drink from cup Feeds Themselves

What age did your child start the following:
Eat solid foods (months): _____ Drink from a cup (months): _____ Feed self (months): _____

Eating Frequency	Favorite foods	Foods child dislikes
(Times per day): _____	1. 2.	1. 2.

How many glasses of fluid does your child drink in a day? _____

Circle those most frequently enjoyed: milk juice fruit drinks soda/pop water other _____

DIETARY HABITS	Yes	No
Does your child take vitamins? **If yes**, what kind are they: _____ a. Were they prescribed? b. Do they contain Iron?		
Does your child have a specific problem such as: Anemia Diabetes Overweight Underweight		
Is your child allergic to any foods? If yes, please list:_____ *Have Physician complete the Medical Substitution Form*		
Is there any food your child should not eat for **religious or cultural reasons?** **Foods to Avoid:** 1._____ 2._____ 3._____		
Has your child's appetite changed in the last month? (Circle One) Small Increase Large Increase Small Decrease Large Decrease		
Does your child have trouble feeding him/herself? If **yes**, describe:		
Does your child have trouble chewing or swallowing? If **yes**, describe		
Does your child eat or chew things other than food? (Ex. dirt, crayon, paper, etc.) **If yes**, describe:		
Does your child often have diarrhea or constipation? **If yes**, please circle one: Diarrhea Constipation How Often? _____		
Do you have any concerns about what your child eats? **If yes**, describe		

Parent Signature: _____ Date: _____/_____/_____

Staff Signature: _____ Date: _____/_____/_____

Revised Feb. 2022

URBAN LEAGUE HEAD START & EARLY HEAD START

Urban League Head Start/Early Head Start
PIR ADDENDUM

Participant's Name: _____ **Center:** *The Christian Academy* **Date:** _____

Referrals for all needs that are identified as emergency/crisis are to be provided to family immediately and documented by the FSW in ChildPlus. The PIR Addendum is active for one calendar year.

WOULD YOU LIKE TO RECEIVE INFORMATION FOR THE FOLLOWING SERVICES?	Yes	DETAILS OF SERVICES NEEDED	NO NEEDS / NO CHANGES (date)		
PIR					
Homeless Family					
Acquired housing during the program year.					
At least one parent/guardian is a member of United States military					
Referred for services by a child welfare agency					
Receiving Supplemental Nutrition Assistance Program (SNAP)					
Foster care during program year					
Program receives a child care subsidy for this child					
Emergency /Crisis Assistance/Family Concerns /Development					
WIC					
Emergency (immediate needs for food, clothing or shelter)					
Crisis Assistance (immediate needs for food, clothing or shelter)					
Food					
Housing (subsidies, utilities, repairs, etc.)					
Clothing					
Transportation					
Mental Health Services					
Literacy or Education					
English as a Second Language (ESL) training					
Adult Education / GED classes/ college selection					
Job Training					
Substance Abuse Prevention					
Substance Abuse Treatment					
Child Abuse and Neglect Services					
Domestic Violence Services					
Child Support Assistance					
Health Education (including Prenatal)					
Assistance to Families of Incarcerated					
Parenting Education / Budget /Money Management					
Marriage Education					

URBAN LEAGUE OF METROPOLITAN ST LOUIS, INC
HEAD START & EARLY HEAD START

Urban League Head Start/Early Head Start
Family Partnership Agreement

Child's Name: _____ Parent/Guardian's Name: _____ Center: *The Christian Academy*

Please circle your answer to question below:

I am / I am not currently in a goal setting process with another organization. If so, which organization? _____

I am / I am not willing to participate in family partnership agreement at this time.

What skills/strengths do you have that may help you meet your goals? (circle all that apply)

Confidence Determination Creativity Flexibility Commitment Communication Skills Open-mindedness Honesty

Organization Time-management Reliability Motivation Awareness Supportive Family/Friends Other: _____

Family Goals	Steps To Be Taken By Parent To Meet Goals	Assistance Needed By FSW To Meet Goals

Follow-Up Date	Contact Type	Goal Follow Up Notes/Referrals

Parent/Guardian: _____ Date: _____

Family Service Worker/Home Visitor: _____ Date: _____

The Effective Date of the Family Partnership Agreement is the Child's Enrollment Date.

4/2022

URBAN LEAGUE OF METROPOLITAN ST. LOUIS, INC.
HEAD START & EARLY HEAD START

Urban League Early Head Start/Head Start

Parent/Guardian Program Agreement

Attendance

Urban League Head Start/Early Head Start must maintain or exceed an 85% average daily attendance rate and the cooperation and support of parents is necessary to obtain this goal. As a Head Start parent/guardian, I understand and agree to the Urban League Head Start/Early Head Start Program Agreement as follows ***(Please check all)***:

☐ My child will maintain or exceed an 85% attendance rate.

☐ If my child is absent for five (5) consecutive days of unexcused absences, s/he may be terminated and placed on a waitlist and their slot may be provided to another child.

☐ If my child is ill or otherwise unable attend Head Start/Early Head Start for any reason, I will notify the center by 8:30 am on that day.

☐ If my child is not in attendance and a notice of that absence is not received at the center, the staff will telephone or make a home visit to determine the reason for the absence.

☐ If my child is absent for an excessive period of time his/her enrollment status may change to terminated/waitlisted.

☐ I must contact the center immediately with any change in my address, phone or emergency contact numbers.

☐ I am aware that my child can **only** be picked up by a person listed on my pick up list that is 18 years old and older.

Full-Day Services

If my child is receiving Full-Day services, I understand that:

☐ I **must** provide verification of full-time employment, school or training at **two separate times** during the Head Start/Early Head Start program year, the first time being at enrollment and the second being later in the program year.

☐ I am aware that my child must be signed in/out electronically as well as on the classroom sign in/out sheet.

☐ If I am not eligible to receive the Missouri Child Care Subsidy, I will be responsible for a co-payment for the extended services provided by Urban League Head Start program.

As parent/guardian, I understand the Program Agreement as explained to me on this date.

Child's Name: _____

Parent's/Legal Guardian Signature: _____ Date: _____

URBAN LEAGUE OF METROPOLITAN ST. LOUIS, INC.
HEAD START & EARLY HEAD START

URBAN LEAGUE HEAD START/EARLY HEAD START

Consent for Social/Emotional Observation/Consultation

To support program-wide social and emotional well-being of children in our program, the Urban League Head Start and Early Head Start Mental Health Coordinator will provide classroom observation, individual children observations, and consultation with teachers and parents/guardians (upon request).

Child's Name: _____ DOB: _____

I, _____
(Print Name)

Give consent for the following services to be provided:

- Classroom observations
- Individual observations
- Consultation with the Head Start/Early Head Start Staff
- Social/Emotional activities
- Referrals for services

_____ _____
Parent/Guardian Signature Date

Valid for the entire school year. Consent is voluntary and may be revoked at any time by the parent/guardian.

URBAN LEAGUE OF METROPOLITAN ST. LOUIS INC
HEAD START & EARLY HEAD START

URBAN LEAGUE HEAD START/EARLY HEAD START PROGRAM
DISABILITY/SPECIAL NEEDS INTAKE

Childs Name: _____ Date of Birth: _____

Please review the following list and check all the areas that your child has a suspected or diagnosed Special Need or Concerns. List the name of the person or place that made the diagnosis and can provide Head Start with additional information to help us provide services to your child & family.

Do you have concerns about your child's growth or development? Yes No

Concerns	Not Applicable	Suspected	Diagnosed	Diagnose by (LEA/Dr./First Steps/Hospital)
	(Please check all that apply)			
Speech/Language Difficulties	☐	☐	☐	_____
Hearing Problems	☐	☐	☐	_____
Visual Problems	☐	☐	☐	_____
Behavior Disorder	☐	☐	☐	_____
Medical Problems	☐	☐	☐	_____
Problems Running or Walking	☐	☐	☐	_____
Head Injury	☐	☐	☐	_____
Others	☐	☐	☐	_____

Is your child receiving services for this disability such as therapy or early childhood special education or hospital? Yes No (Please circle one)

Does your child have a **Case Manager from St. Louis Office of Developmental Disability Resources (formally MRDD)**? Yes No (Please circle one)
If yes, Case Manager's Name _____

Does your child have a current Individual Education Program (IEP)? Yes No (Please circle one)
If yes, Can you provide us with a copy of your child's IFSP or IEP? Yes No (Please circle one)

Please list any other **Community Agency or School District** where your child has received services, _____ and complete a **Release of Confidential Information Form** for each named agency or person.

Parent/Legal Guardian _____ **Date** _____

Staff's Signature _____ **Date** _____

Head Start Center *The Christian Academy*

URBAN LEAGUE
HEAD START
& EARLY HEAD START

Urban League HS/EHS
General Consent

I understand that:

I will receive a copy of the ULHS/EHS Parent Program Agreement.
I will receive a copy of the ULHS/EHS Parent Handbook that contains program guidelines pertaining to admission, care and discharge of children, parent participation opportunities, health and community resource information and a calendar for days of attendance at the beginning of the school year.
I have agreed to at least two home visits per year made by the ULHS/EHS classroom teacher and FSW to discuss my child's development and behavior and any progress made towards achieving the goals I established for my family.
I have agreed to participate in at least two ULHS/EHS parent/teacher conferences per year to discuss and ask questions of my child's teachers about my child's progress in the classroom.
My child will not be able to attend the ULHS/EHS program if any of the following illnesses exist: diarrhea or vomiting, fever of 100 degrees or more, severe coughing, difficult or rapid breathing, pink eye, unusual spots or rashes, sore throat or trouble swallowing, infected skin patches and/or headache and stiff neck. **I am aware that due to COVID-19 if any of these illness should occur, I will need to immediately pick my child up and my child will not be able to return until he/she is symptom free.**
I understand my child will participate in the Head Start/Early Head Start required Developmental Screening within forty-five (45) days of enrollment. The developmental screening covers the areas of speech, hearing, vision, language development, cognition motor skills,and social /emotional screenings.
I understand that my child will have the Head Start Required Health Screenings. These screenings cover the areas of: behavioral health, dental, blood pressure, hearing, vision, growth & development, well-child physical, lead & hemoglobin.
I understand my child will participate in ULHS/EHS classroom activities while program approved visitors observe classrooms in the center.
I understand that I will be notified of any scheduled field trips that my child's class will participate in and that I must give written permission for my child to attend.
I understand that no Urban League staff member may accept a gift from any parent of a student. Donations may be made to ULHS/EHS in the form of an age-appropriate book, puzzle and/or educational toy not to exceed a total value of $25.00.
I understand Head Start staff members are mandated reporters of Child Neglect/Abuse and that parents are invited to attend all trainings on the subject.
I have been informed that a copy of the Head Start Performance Standards and ULHS/EHS Policy and Procedure manual are available in the ULHS/EHS center for review.
I understand that the Mental Health Specialist will make routine observations in ULHS/EHS classrooms.
In the event of a natural *or* deliberate disaster *or* emergency , students may need to be transported to another location for safety.

Child's Name: _____

Parent or Legal Guardian Signature: _____ Date ___/___/___

Head Start Staff Signature: _____ Date ___/___/___

Urban League of
Metropolitan St. Louis, Inc.

Empowering Communities.
Changing Lives.

Story and Photo Release Form

By submission of this form, I,_____, agree to allow the Urban League of Metropolitan St. Louis permission to publish my story and/or picture or video of my child classroom activities for use in promotional, educational, display or other media publications including newspapers, video, magazines, television, brochures, pamphlets, instructional material, books, internet, web pages and/or other educational material.

Child's Name: _____

Signed: _____ Dated: _____

Address: _____

City: _____

State/Zip: _____

Phone:( ) _____

Witness: _____

URBAN LEAGUE HEAD START/EARLY HEAD START PROGRAM

CONSENT FOR RELEASE OF INFORMATION

This form approves the exchange of information among all agencies checked

Requested from:

- ☐ The Urban League Head Start Program
- ☐ St. Louis Public School
- ☐ Other _____

St. Louis Special School District
Jennings School District

Child's Name(Last)_____ **First**_____ **Date of Birth:**_____

School/Head Start Center: *The Christian Academy*

Information Requested:

- ☐ Cumulative permanent school record
- ☐ Psychological Reports
- ☐ Medical/Health Records
- ☐ Screening /Background Information
- ☐ Special Education including IEP and most recent Diagnostic Summary (Evaluation report)
- ☐ Other _____

Reason(s) for Request:

- ☐ Transfer of Student to another school district or program
- ☐ New enrollment/re-enrollment
- ☐ Hospitalization
- ☐ Other _____
- ☐ Contractual Placement
- ☐ Student Records
- ☐ Referral for Assessment

Sent to:

- ☐ Urban League Head Start
- ☐ St. Louis Public Schools
- ☐ Other _____
- ☐ St. Louis Special School District
- ☐ Jennings School District

Attn:_____ **Address:**_____

Ofc:_____ **Fax:** _____

This information will be used and disseminated in accordance with The Family Educational Rights and Privacy Act of 1974.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____ _____
Address City, State, Zip Telephone #

Revised 2022