UAACOG-Fremont County Head Start
1718 Brookside Ave.
Canon City, CO 81212
(719) 275-8636 fax (719) 275-4806

APPLICATION FOR ENROLLMENT

Child's Information

Please fill out **completely**.

Child's ***Legal*** Name: _____ _____ _____
Last First Middle

Home Address: _____ City: _____ Zip: _____

Date of Birth: _____ Sex: □ Male □ Female

Is your child of Hispanic or Latino origin?: □ Yes □ No
Race (Select ONE): □ Bi-racial/Multi-racial □ American Indian or Alaska native □ Native Hawaiian or Pacific Islander
□ Asian □ African American □ Caucasian (White) □ Other □ Unspecified

Primary Language of child: _____ Primary Language in Home: _____

Does your child have a disability? □No □Suspected □Yes; please describe: _____
If yes, does your child have an IEP? □Yes □No

Does your child or your family have a specific need or crisis? (Check all that apply) □ NO
□ Sibling was in Head Start □ Recent divorce/separation □ family member receiving Disability
□ family member in jail/prison □ terminal illness or recent death in immediate family □ Special Needs sibling(s)
□ Other-explain: _____

PLEASE PROVIDE COURT DOCUMENTS (if applicable)
Child Custody arrangements (please describe): _____

_____

Are there any other circumstances (restraining order, grandparent raising child, any other Legal issues) with your child that Head Start should know about-Please describe: _____

_____

How did you find out about Head Start? □ Friend □ Bus □ Referral, from: _____

Has your child been in preschool/childcare before? □ No □ Yes, where: _____

Transportation Information

(Bus service is available to and from school)

PLEASE COMPLETE-This information determines class time AND where neighborhood BUS STOPS will be

ADDRESSES MUST BE IN THE SAME TOWN

Pick-up: _____
Address City

Drop off: _____
Address City

Is the address □ Home OR □ Childcare*-Provider's name & phone #:_____

ANSWER THE FOLLOWING ONLY IF YOUR CHILD IS IN CHILDCARE

Is childcare a: □ childcare home □ childcare center □ relative/other adult's home □ pre-K program
Do you receive financial assistance from the Colorado Child Care Assistance Program (CCCAP) through DHS? □ Yes □ No

Child's HEALTH Information

Please fill out **COMPLETELY**.

Does your child have any Special Health Needs (Asthma/Rescue inhaler, seizure, Epilepsy, hearing, etc.)?
□ No □ yes; please describe: _____

Does your child take any medication? □No □Yes; please list:_____
If yes, will it be required at school? □ No □ Yes; describe: _____

Does your child have any **FOOD** allergies? □No □Yes; please list: _____
SEVERITY:_____
REACTION:_____

Does your child have any **Environmental** allergies? □No □Yes; please list: _____
SEVERITY:_____
REACTION:_____

Does your child wear **GLASSES**? □ No □ Yes

Do you have any concerns about your child's vision? □ No □ Yes

Do you have any concerns about your child's hearing? □ No □ Yes

Were there any problems during pregnancy, delivery or within the first few weeks of life? □ No □ Yes
If YES, please describe: _____

Was child born □ on time, □ late or □ premature? If late/premature, how many weeks:_____

Has your child ever been hospitalized? □ No □ Yes-describe: _____

Has your child ever had any surgery? □ No □ Yes-procedure: _____Date: _____
procedure: _____Date: _____
procedure: _____Date: _____

It is NOT a requirement to be potty trained for enrollment at Head Start, Is your child potty trained? □ Yes □ No
□ Not Completely, please describe: _____

Does your child currently take naps/rest time? □ No □ Yes-for how long: _____ at what time of day: _____

Does your child have health insurance? □ No □ Yes-what kind:
□ Medicaid #_____ OR □ Other:_____

Does your child have dental coverage? □Yes □ No

HEAD START REQUIRES DOCUMENTATION OF A CURRENT ECHO SCREENING

When was your child's last ECHO screening (development, hearing & vision check)? Date: _____
Was your child referred for further evaluation? □ No □ Yes; please list:_____

HEAD START REQUIRES DOCUMENTATION OF A CURRENT WELL CHILD CHECK/PHYSICAL EXAM

When was your child's last well child/physical exam? Date: _____

Where was exam done:
Doctor/Clinic Name: _____ Phone:_____
City: _____ State: _____

Is this your child's current doctor? □ Yes □ No: name of current doctor:_____

HEAD START REQUIRES DOCUMENTATION OF LEAD SCREENING AND RESULTS

Has your child ever been screened for lead? □ No □ Yes; date:_____ Results: _____
Where was screening done: □ Public Health Office □ Doctor's Office
□ Other: _____

HEAD START REQUIRES DOCUMENTATION OF A CURRENT DENTAL EXAM

When was your child's last dental exam? Date: _____

Where was exam done:
Dentist/Clinic Name: _____ Phone:_____
City: _____ State: _____

Is this your child's current dentist? □ Yes □ No: name of current dentist:_____
Do you have concerns about your child's teeth? □ No □ Yes; describe:_____

Family Information

□ Single Parent family-child lives with 1 biological parent only □ Foster/KinshipCare family □ Legal Guardian
□ Single Parent family-child lives with 1 biological parent & significant other, but not married □ Married/Re-married
□ Two Biological Parents, but not Married □ Grandparent(s) □ other relative(s) □ Family friend(s)

□ **Primary Adult**: _____ DOB: _____

Relationship to child: □ Biological Parent □ Step Parent □ Other (please describe):_____

Address: _____
Street City Zip

Phone: Home: _____ Cell: _____

Mailing Address (if different from home): _____

E-Mail Address: _____

How is the best way to contact you? □ Home Phone □ Cell phone □ e-mail □ text to your cell

- Employment Status: □ employed □ retired □ disabled □ unemployed
  - ☐ Receiving Unemployment $_____

Work: _____ Phone: _____ How Long?: _____
Company Name Address

Are you currently enrolled in College/Job training: □ No □ Yes: do you get: □ Grant(s) □ Scholarship(s) □ Loan(s)

Are you Active or Past Military: □ No □ Active □ Reserves □ Past-discharge-date: _____

Education Level: □ Less than high school graduate □ High School graduate/GED
□ Some college/vocational school □ Associate's degree □ Bachelor's or advanced degree

□ **Other Adult in home**: _____ DOB: _____

Relationship to child: □ Biological Parent □ Step Parent □ Other (please describe):_____

Phone: Home: _____ Cell: _____

Mailing Address (if different from home): _____

E-Mail Address: _____

How is the best way to contact you? □ Home Phone □ Cell phone □ e-mail □ text to your cell

- ☐ Employment Status: □ employed □ retired □ disabled □ unemployed
- ☐ Receiving Unemployment $_____

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Education Level: □ Less than high school graduate □ High School graduate/GED
□ Some college/vocational school □ Associate's degree □ Bachelor's or advanced degree

Is any adult figure currently pregnant? □ No □ Yes, Who: _____expected due date: _____

Other Children (in the same home)

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Housing/Transportation Information

Is your family currently living in your own home/apartment? □ Yes □ No-describe: _____

Do you: □ Rent □ Pay mortgage □ Other-please describe:_____

Time at current address: □ less than 6 months □ 6-12 months □ 1-2 years □ more than 2 years

How many times has your family moved in the last 12 months? □ none □ 1 time □ 2 times □ 3 times or more

Do you have transportation? □ No □ Yes; is this a: □your vehicle □ friend/relative's vehicle □other:_____

Family Resources

Are you receiving any of the following?

□ WIC □ Food Stamps/SNAP case number: _____ □ LEAP □ Section 8

□ Other: _____

Income Information

Documentation for All Income must be provided.

Are you receiving: □ TANF □ SSI □ Child Support □ Other: _____

If we are unable to contact you about this application, whom can we contact?

Name: _____ Phone: _____

Name: _____ Phone: _____

I give my permission to Fremont County Head Start to share the above listed information and/or obtain additional information with the following agencies to best meet the needs of my child and my family:

UAACOG programs-(WIC, Housing, etc.)
Early Childhood Network-ECHO & the Family Center-(developmental, vision, & hearing screenings)
School Districts RE-1, RE-2, Pikes Peak BOCES-(For children with disabilities to receive services)
Colorado Preschool Program-(Your child's name & siblings for possible enrollment in CPP)
Early Head Start Program-(your child's name and younger sibling's names for possible enrollment)
DHS/Fremont County Public Health-(SNAP, Health Insurance, TANF, immunizations, screenings, etc.)
Sol Vista Mental Health-(services for children & families)

This permission is considered valid from the date signed until child is eligible for Kindergarten-unless a written revocation is received.

I certify that this information is true and correct to the best of my knowledge. If any part has been falsified, my child's participation in this program could be terminated. I understand that the information in this application will be kept confidential.

_____ Date: _____

Parent/Guardian Signature

_____ Date: _____

Parent/Guardian Signature

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Ave., S.W., Washington, D.C. 20250-9410 or call 800-795-3272 or 202-720-6382 (TDD).

FOR OFFICE USE ONLY

Information Verification:

Birth date Verified by: □ State Birth Certificate □ Hospital Birth Certificate □ Other: _____

School Year: _____ Age: _____ **Score: _____ Enrolled in:** □ HS or □ CPP

Family Size: _____ Total Income: _____

Verifying Staff Member: _____ Date: _____

Verifying Staff Member: _____ Date: _____

School Year: _____ Age: _____ **Score: _____ Enrolled in:** □ HS or □ CPP

Family Size: _____ Total Income: _____

Verifying Staff Member: _____ Date: _____

Verifying Staff Member: _____ Date: _____

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