



**FAMILY INFORMATION**

Living Address: \_\_\_\_\_ City \_\_\_\_\_ State: MI Zip Code: \_\_\_\_\_

**Current Living Situation:**  Own/rent/share by choice  Hotel/motel/car  Sharing due to loss of housing/hardship  
 Shelter  Home in foreclosure/getting evicted  Other: \_\_\_\_\_

**Current Teen Parent** (under 20 yrs of age):  Yes  No **Active Military:**  Yes  No **Military Veteran:**  Yes  No

**How did you hear about our programs? (Check all that apply)**

Child Welfare Agency (DHHS)  Doctor/Social Worker  Early On (EO)  WIC  EHS/Preschool Staff  
 Family/Friend  Another child in Preschool  Community Event  Other \_\_\_\_\_

**Currently enrolled in Early Head Start (EHS)?**  Yes  No

**What is your family's estimated annual income?** \_\_\_\_\_

**Does your family receive public assistance?**

**SNAP**  
(food stamps)  
 Yes  No

**SSI**  
(Supplemental Security Income)  
 Yes  No

**TANF**  
(FIP)  
 Yes  No

**WIC**  
 Yes  No

**RISK FACTOR ASSESSMENT (Check all that apply)**

✓	RISK FACTOR	DEFINITION
	Severe or challenging behavior	Child has been expelled from preschool or child care center.
	Primary home language other than English	English is not spoken in the child's home; English is not the child's first language.
	Parent/s with low educational attainment	Parent has not graduated from high school or is illiterate.
	Abuse/neglect of child or parent.	Domestic, sexual, or physical abuse of child or parent; child neglect issues.
	Environmental risk.	Parental loss due to death, divorce, incarceration, military service, or absence; sibling issues; teen parent (not yet age 20 when first child born); family is homeless or without stable housing; residence in a high-risk neighborhood (area of high poverty, high crime, with limited access to critical community services); or prenatal or postnatal exposure to toxic substances known to cause learning or developmental delays.

**PARENT/GUARDIAN SIGNATURE**

*I certify that the information, including income, provided in this application is accurate and truthful to the best of my knowledge.*

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Second Year Participation**

*I have reviewed and updated (if necessary) this application for my child's second year participation in the program.*

**Initials:** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR PROGRAM USE ONLY (OPTIONAL)**

Additional comments to assist with Eligibility:

Type of eligibility interview conducted:  In-Person  Audio or Video Call

Explain why the interview was not in-person:

Staff Signature:

Date:

# CHILD INFORMATION RECORD

State of Michigan - Department of Lifelong Education, Learning, and Potential - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

<b>For Provider Use Only:</b>		Date of Admission	Date of Discharge		
Name of Child (Last, First, Middle Initial)					Child's Date of Birth
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Primary Phone (    )	Parent/Legal Guardian's Name (Optional)		Primary Phone (    )
Home Address (if not child's address)		2 <sup>nd</sup> Phone (if applicable) (    )	Home Address (if not child's address)		2 <sup>nd</sup> Phone (if applicable) (    )
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address (optional)		
Employer Name		Work Phone (    )	Employer Name		Work Phone (    )
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number (    )		
Hospital Preferred for Emergency Treatment (optional)					
Allergies, Special Needs and/or Special Instructions? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, explain: (Attach additional sheets, if necessary.)					

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used

**See Reverse Side**

**Emergency Contact & Release of Child:** List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	(    )	(    )
2.	(    )	(    )
3.	(    )	(    )

**Release of Child Only:** List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	(    )	2.	(    )
3.	(    )	4.	(    )
5.	(    )	6.	(    )

**Parent/Legal Guardian Initials:**

\_\_\_\_\_ I give permission to \_\_\_\_\_, licensed by the Department of Lifelong Education, Advancement, and Potential, to secure emergency medical treatment for the above named minor child while in care.

**I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.**

Signature of Parent or Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

CCL-3731 (Rev. 6/7/2024) Previous editions 7-18, 4-21, & 3-22 may be used

## Parent / Guardian Authorizations

Head Start, GSRP, and Early Head Start programs offer various services to children and families to help prepare for Kindergarten success. Advance authorization is needed for services and actions related to children's health, development, and educational needs for the following actions and services:

### Health Services

Yes \_\_\_ No \_\_\_ Health Checks: I allow trained individuals to perform health screenings, such as height and weight measurements, blood pressure readings, and screenings for hearing, vision, hemoglobin, temperature, and dental health. These checks do not involve drawing blood.

Yes \_\_\_ No \_\_\_ Lead Test: I allow a nurse to collect a few droplets of blood to perform a lead test. The results and limited personal information will be entered into the Michigan Care Improvement Registry database. (Consent is voluntary but this is a **Head Start** requirement and if the result is not provided to the program I may be required to take my child to the lab and it may affect participation)

Yes \_\_\_ No \_\_\_ Immunization Records: I allow the exchange of my child's immunization record to the Michigan Department of Health and Human Services and/or local health departments to improve immunization services and comply with Michigan law.

### Sharing of Information

Yes \_\_\_ No \_\_\_ Sharing Information: I allow my child's information to be exchanged with public schools, community agencies, mental health, health, and dental care providers, and the U.S. Department of Health and Human Services for income verification/program participation purposes

Yes \_\_\_ No \_\_\_ Transfer Information: I allow the program to exchange my child's information, including assessment and health information, with other schools as the child transitions to a new program or from preschool to kindergarten.

### Transportation

Yes \_\_\_ No \_\_\_ Transportation: I allow my child to be transported for school events, field trips, and health visits. A parent or guardian must go with the child for health visits.

### Media Use

Yes \_\_\_ No \_\_\_ Media Permissions: I allow photographs, videos, and other media of my child for advertising, news stories, staff training, and other media-related purposes, without using the child's name or identifying information unless further permission is granted. It is noted that other parents may take pictures or videos during school events, which is beyond the control of school staff.

**As part of the program participation, I understand developmental, mental health, behavioral, and educational observations, screenings, assessments, and consultations will be conducted by school staff or outside agencies. I authorize these services and information sharing described above.**

\_\_\_\_\_  
Child's Name (**Please print clearly**)

\_\_\_\_\_  
Child's Date of Birth

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date of Signature

# Student Residency Questionnaire

*This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services this student may be eligible to receive.*

District: \_\_\_\_\_ Head Start: \_\_\_\_\_ GSRP: \_\_\_\_\_ EHS: \_\_\_\_\_

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Foster Child: \_\_\_ Yes \_\_\_ No If Yes, how long has this foster child lived with you? \_\_\_\_\_

Please list all of your preschool and school-aged children currently living with you: (continue on back if more space is needed)

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ School: \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ School: \_\_\_\_\_

## Information provided on this form is confidential.

What is your current living situation? *(Based on your situation, your child may be eligible for additional services)*

\_\_\_\_\_ **I own or rent my own home/apartment.** If you checked this box, **STOP HERE**, skip remainder of the form and **sign and date at the bottom.**

---

---

\_\_\_\_\_ **Sharing the housing of other persons due to:** (check one)

Loss of housing due to eviction, foreclosure, or other economic hardship (such as job loss)

Explain: \_\_\_\_\_

Long-term, cooperative living arrangement to save money or a similar reason

\_\_\_\_\_ **At a motel, hotel, campground or similar setting due to:** (check one)

Lack of alternative adequate accommodations

It being a convenient living arrangement, or waiting for apartment or house to be ready

\_\_\_\_\_ **In an emergency or transitional shelters** (domestic violence or homeless shelters or transitional housing)

\_\_\_\_\_ **In a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation for humans**

\_\_\_\_\_ **In cars, parks, public spaces, abandoned buildings, substandard housing, bus/train stations, or similar setting**

How long do you anticipate living at this location? \_\_\_\_\_

Current Address: \_\_\_\_\_

---

---

\_\_\_\_\_  
**Parent/Guardian/Unaccompanied Youth Signature**

\_\_\_\_\_  
**Date**

----- OFFICE USE ONLY -----

\_\_\_\_\_ PowerSchool \_\_\_\_\_ Food Service \_\_\_\_\_ McK-V Coordinator \_\_\_\_\_ Building Placed

Dear Parents/Guardians:

Please answer the following questions about your child enrolling in the Head Start Program.

Child's Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Questionnaire for an assessment of your child's risk for tuberculosis**

(Please answer the following questions by marking an "X" in the appropriate column to the left.)

**YES NO**

- |     |     |  |
|-----|-----|--|
| ___ | ___ | 1. Has a family member or contact (someone you live with) had tuberculosis disease?  |
| ___ | ___ | 2. Has a family member had a positive TB skin test result?   |
| ___ | ___ | 3. Was your child born in a high risk country (countries <b>other than</b> the United States, Canada, Australia, New Zealand, or western or northern Europe).  |
| ___ | ___ | 4. Has your child traveled and had contact with resident populations to a high risk country for more than one week (high risk countries equal countries <b>other than</b> the United States, Canada, Australia, New Zealand, or western or northern Europe). |

**Parent's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For Head Start Preschool Returners and Early Head Start:**

Reviewed and no changes: (If there are changes a new form will be needed)

**Parent's initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Parent's initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Parent's initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FOR STAFF USE- If any of the above questions are marked "YES" refer to the TB Screening Procedures.**

Dear Healthcare Provider:

As part of EPSDT standards, the Head Start Program is required to screen children for Tuberculosis. We utilize the above questionnaire to assess which children are at risk.

Please review the results to help determine if a child needs testing and return the form to us via fax at,

\_\_\_\_\_ indicating one of the following:

- Provider reviewed and no further testing/follow up is required
- Testing has been ordered
- Results are attached

Healthcare Provider Signature: \_\_\_\_\_ **Date:** \_\_\_\_\_



Date Received at Center: \_\_\_\_\_

# Head Start Program Dental Form

## Part 1 (COMPLETED BY PARENT OR STAFF)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

## Part 2 (Licensed dental professional must complete this section)

Is patient up to date with oral health recommendations:  Yes  No **(Please comment below)**

Last Date of Service: \_\_\_\_\_

Services Provided:  Propholaxis/Exam  Treatment (extraction, filling, etc.)

### Recommendations:

6 Month Check Up **Scheduled**  No  Yes **Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Additional work is needed **(Please comment below)**

### Comments:

\_\_\_\_\_  
**Provider Signature** **Office** **Date**

These materials were funded in whole or in part under a grant awarded by the Michigan Department of Lifelong Education, Advancement, and Potential.



