Urban League of Metropolitan St. Louis, Inc. | *Empowering Communities. Changing Lives.*

FOR OFFICE USE ONLY

# ELIGIBILITY PRIORITY CRITERIA WORKSHEET

**Participant's Name:** ______________________ **Birth Date:** ____________

Instructions: Complete each category. When appropriate, write in comments to document reason for selection. Sign form below and place in child's file. The "DESCR" and "PTS" for each should be copied onto the application for use with ChildPlus.

| AREA | DESCR | PTS | SELECT |
|---|---|---|---|
| **Parental Status - - CHECK ONE** | | | |
| Pregnant Mom | PM | 30 | |
| O- One Parent | ONE | 20 | |
| T - Two Parent | TWO | 10 | |
| **Disability Status -- ( check all that apply)** | **DESCR** | **PTS** | **SELECT** |
| *Diagnosed Condition **(LEA Approval must accompany application)** | DIAG | 80 | |
| *Physical Impairment/Chronic Illness **(Documented on Phy. Exam or Health History)** | DIAG | 40 | |
| *X - Suspected or Potential Disability **(Parent/Physician Statement Req.)** | SUSP | 30 | |
| **CAN ONLY SELECT ONE (1) FOR ELIGIBILITY (CATEGORICAL/ PUBLIC ASSISTANCE or INCOME)** | | | |
| **CATEGORICAL ELIGIBILITY -- CHECK ONE (must retain copy of documents)** | **DESCR** | **PTS** | **SELECT** |
| Foster Care Children or Children in Protective Services | FOSTR | 70 | |
| Homeless Child | HOMELESS | 70 | |
| **PUBLIC ASSISTANCE (must retain copy of documents)** | **DESCR** | | |
| SSI Income | PUB | 70 | |
| TANF - CASH (only) | PUB | 70 | |
| **INCOME ELIGIBILITY -- CHECK ONE (see income guidelines)** | **DESCR** | **PTS** | **SELECT** |
| Low Income/75% below poverty | L75% | 70 | |
| Low Income/50% below poverty | L50% | 60 | |
| Low Income/25% below poverty | L25% | 50 | |
| Eligible: Income at 100% of Poverty | ELIGIBLE | 40 | |
| **Over Income 101%-130%** | **OV130** | **15** | |
| **Over Income 131% - 185%** | **OV185** | **5** | |
| **AGE ELIGIBILITY - MUST UTILIZE (July 31st, of the current year to determine age for the entire Head Start Program Year (August - September)** | **DESCR** | **PTS** | **SELECT** |
| **HEAD START** | | | |
| 4 years 0 months and older | 4 YRS | 70 | |
| 3 years 0 months - 3 years 11 months **(July 31st and prior)** | 3 YRS | 30 | |
| 3 years **(August 1st and after)** | 2 1/2 | 20 | |
| **EARLY HEAD START - Age determined at the time of application based on child's DOB** | | | |
| 0 weeks to 18 months | 0 - 18m | 50 | |
| 19 months - 35 months | 19m-35m | 40 | |
| **Social/Special Conditions - - CHECK ALL THAT APPLY (provide specific comments as appropriate) Must retain documentation for (*) items** | **DESCR** | **PTS** | **SELECT** |
| Family that is Unemployed or in Transitional Living (circle one)(explain below) | TRAN | 70 | |
| Teen Parent, 19 and under at time of application | TEEN | 70 | |
| Family Crisis within 12 months (explain below) | CRIS | 65 | |
| Relative Care **(child is being cared for by relative & not biological parent)** | RELATIVE | 50 | |
| * Sibling with a diagnosed physical or mental disability | HRISK | 50 | |
| * Incapacity Parent/Guardian diagnosed (Mental/Physical) | HRISK | 50 | |
| ***Receiving/Denied MO Childcare Subsidy, SNAP, MO Healthnet or WIC** (circle one) | WIC/SNAP/MO-HN | 45 | |
| Transitioning from PM/EHS or EHS-HS **(currently enrolled)** | PM/EHS | 45 | |
| Child/Parent/EHS Pregnant Mom without medical insurance | NMED | 30 | |
| Refugee/Immigrant/Non-English (parent or child does not speak English) | RFE/ESL | 25 | |
| Parent has NO high school diploma or GED | LITR | 25 | |
| Applicant's sibling attending HS/EHS **(sibling must already be attending)** | SIB | 25 | |
| *MO Work Assistance Prog or Section 8 Housing | MO-WAP/SEC-8 | 10 | |

**TOTAL:** ____________

**COMMENTS:**

Signature of staff member completing form ______________________ **Date:** ____________

Revised 04/21

**Urban League of Metropolitan St. Louis, Inc.**

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## 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.

Signed: ______________________________ Dated: ____________

Address: ____________________________________________

City: ______________________________________________

State/Zip: __________________________________________

Phone: _____________________________________________

Witness: ____________________________________________

Child's Name ____________________________________

INformational. For Next Page

**Urban League Head Start**

## Risk Assessment for Tuberculosis

The CDC and AAP no longer view mass screening of children for TB as an effective prevention strategy. Targeted screening is now recommended. A simple questionnaire is used to identify children who are at risk. Those found to be "at risk" are then screened using the Tuberculin Skin Test. Our program's strategy will be to follow these recommendations and require TB testing only for those children where the assessment indicates a need for the test.

1. The assessment will be done interview-style with the staff person taking the lead in asking the questions and completing the Risk Assessment.

2. Complete top portion of form with child's name and date of birth.

3. Ask question number 1. Circle yes or no.

4. If the answer is "YES", ask for documentation to include in the child's file and go no further with the questionnaire.

5. If the answer to question 1 is "NO", ask the parent/guardian to listen to the next list of questions (#2). Tell them that when you are finished reading the questions, you would like for them to tell you if they can answer yes to any of the questions. It is not necessary for you to know the specific question that they are responding to. Circle yes or no.

6. If the answer is "YES" to any question, the child must have a Tuberculin Skin Test completed for entry into the program. Explain that the parent/guardian's positive response indicates that the child may be at risk for Tuberculosis. When the child goes to the physical exam, the parent/guardian should request that the PPD skin test be done. The parent may need a copy of the Risk Assessment in order for the physician to approve the test. There is no need to go further with the questionnaire.

7. If the answer is "NO" to question #2, ask the parent/guardian to listen to the next question (#3). Tell them that when you are finished reading it, you would like for them to tell you if they can answer yes to any part of the question (it is not necessary for you to know specifically). Circle yes or no.

8. If the answer is "YES" ask if the child has been tested (with a reading) within the last 3 years (#4). Circle yes or no. If the parent/guardian has documentation that the test has been done and read, no further testing is required. Obtain a copy of the documentation for the child's file. If no test has been done, one needs to be completed for entry into the program.

9. If the answer to question #3 is "NO", skip question #4.

10. Sign and date the form. Have the parent verify the information by signing and dating beneath your signature. Include document in child's file.

Urban League of
**Metropolitan St. Louis**

## Urban League 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

______________________________________ ______________________
Staff Signature Date

______________________________________ ______________________
Parent Signature Date

April 2017

# Urban League HS/EHS
## General Consent

Child's Name________________________________

| ***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. <u>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.</u>** |
| 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 *<u>or</u>* deliberate disaster *<u>or</u>* emergency , students may need to be transported to another location for safety. |

***This Agreement is valid for one year from the date of parent/guardian signature.***

Parent or Legal Guardian Signature: ______________________________ Date ____/____/____
Head Start Staff Signature: ______________________________ Date ____/____/____

July 2020

Urban League of
**Metropolitan St. Louis**

**Urban League Head Start/Early Head Start**

## Family Partnership Agreement

Child's Name: ______________ Parent/Guardian's Name: ______________ Center: ______________

**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.***

4/2018

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# CHANGE OF STATUS

| **Urban League Head Start Center:** Hilltop | **Date:** |
|---|---|
| **Child's Name:** | **Parent/Guardian's Name:** |

**SECTION TO BE CHANGED** (Circle all that apply):

| **Section I –Medical/Work/Parent Information** | **Section II – Client Contacts** | **Misc Items to be Changed** (please explain below) |
|---|---|---|
| **Medical:** Food Asthma Other<br>**Work:** Employment Phone Number<br>**Parent:** Address Phone Number | **New Update Remove** | |

## SECTION I – MEDICAL/WORK/ PARENT INFORMATION

| **Food/Milk Allergy**(name of food)(complete sub. food form): | **Asthma** (need Asthma Action Plan)<br>Yes No Seasonal | **Other Medical Updates** (Please be detailed): |
|---|---|---|
| **Effective Date:** | **Reason:** | |
| **Parent Name:** | **Previous Employment:** | **New Employment:** |
| **Effective Date:** | **Phone Number** | |
| **Parent Name:** | **New Address:** | |
| **Type of New Number:**<br>Home: ____ Cell: ____ Work: _____ Other: ____ | **New Number:** | |

## SECTION II – CLIENT CONTACTS

**CONTACTS**

| **Circle One:**<br>**New Update Remove** | **Contact Name:** | **Relationship:** | **Type of Contact:**<br>**Emergency Contact? Y / N Release Child To? Y / N** |
|---|---|---|---|
| **Contact Address:** | | **Contact Phone #:** | **Effective Date:** |
| **Circle One:**<br>**New Update Remove** | **Contact Name:** | **Relationship:** | **Type of Contact:**<br>**Emergency Contact? Y / N Release Child To? Y / N** |
| **Contact Address:** | | **Contact Phone #:** | **Effective Date:** |
| **Circle One:**<br>**New Update Remove** | **Contact Name:** | **Relationship:** | **Type of Contact:**<br>**Emergency Contact? Y / N Release Child To? Y/N** |
| **Contact Address:** | | **Contact Phone #:** | **Effective Date:** |
| **Circle One:**<br>**New Update Remove** | **Contact Name:** | **Relationship:** | **Type of Contact:**<br>**Emergency Contact? Y / N Release Child To? Y /N** |
| **Contact Address:** | | **Contact Phone #:** | **Effective Date:** |
| **Circle One:**<br>**New Update Remove** | **Contact Name:** | **Relationship:** | **Type of Contact:**<br>**Emergency Contact? Y / N Release Child To? Y / N** |
| **Contact Address:** | | **Contact Phone #:** | **Effective Date:** |
| **Circle One:**<br>**New Update Remove** | **Contact Name:** | **Relationship:** | **Type of Contact:**<br>**Emergency Contact? Y / N Release Child To? Y / N** |
| **Contact Address:** | | **Contact Phone #:** | **Effective Date:** |

Parent Signature: ______________________________ Date: ______________

FSW Signature: ______________________________ Date: ______________

Teacher Signature: ______________________________ Date: ______________

Center Coordinator/Data Entry Signature______________________________ Date:______________

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# URBAN LEAGUE HS/ EHS
# 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 or iron? **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? Yes or No If yes, please list:**________________ *Have Physician complete the Medical Substitution Form* | | |
| Are there any foods your child should not eat as a **Preference; 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 | | |

Staff Signature______________________________________ Date: ______/_______/_____

Parent Signature______________________________________ Date: ______/_____/______

Revised Feb. 2016 Original – In File Yellow – Nutrition Coordinator Pink – Classroom Portfolio

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# 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____________________________________________________________**

**Information Requested:**

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

**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                                        Zip                                        Telephone #

**Revised 2016**

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informational

**ERSEA**

| Policy Number: | Effective Date: | Page 1 of 1 |
|---|---|---|
| Relevant Regulation: | Approved Date: | Revised By: ERSEA Coord. |
| **1303. 24** | **Change of Status** | |

PURPOSE:
Families change information as it relates to the file:

POLICY:
Change of personal and contact information in file.

OPERATIONAL PROCEDURE:
1. After the initial enrollment, if the parents would like to add or make any changes to the information in ChildPlus, the enrolling parent must complete the Change of Status form with the Family Service Worker. Family Service Worker enters the information into ChildPlus and distributes the form to the Center Coordinator, Teacher, and Receptionist/Data Entry. (The change of status form should contain the parent, Family Service Worker and Teacher signatures.
2. This form is placed in the Child's file and in the classroom file.
3. FSW will case note all changes in ChildPlus.
4. The Center Coordinator will run Report 1520-Contact information monthly or as soon as information is changed. The 1520 report is distributed to the classroom teacher and placed in a binder at the front desk with Data Entry.

The Change of Status form is to be used in the event that a child and/ or the child's family has a change in information or contact info as indicated below:

- Change of information
    - Medical Information
    - Place of Employment
    - Address / phone Number

- Change of Contact
    - New
    - Updated
    - To Be Removed

## 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** |
|---|---|---|---|---|
| | | **(Please check all that apply )** | | **(LEA/Dr./First Steps/Hospital)** |
| 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)? 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**_____________________________

Original: File Yellow: Disability Coordinator

**Revised April 19, 2016**

## Urban League Head Start/ Early Head Start
### Full-Day Employment/Training/School Verification Letter

**Child's Name:** ______________________________ **Today's Date**: _______ / _______ / _______
MM DD YY

Please provide the information requested for ______________________________ as follows:
**Parent's Name**

A. Employment/Training/School start date: _______ / _______ / _______
MM DD YY

B. Current work/training hours/school schedule: from ________ a.m. to ____________ p.m.

C. Days of week worked/in training/in class**: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.**
(circle all that apply)

D. Number of hours worked/trained per week/credit hours taken per semester: ____________

**Certification: I certify that this information is true. I understand that if any part is false, the family's participation in the Urban League Head Start/Early Head Start program may be terminated.**

Signature: ______________________________________________
**(SUPERVISOR/MANAGER/COUNSELOR)**

Title: ______________________________________________

Business/School: ______________________________________________

Address: ______________________________________________

Phone number: ________________________ Fax number: ________________________

***Please attach copy of current check stub, training verification or school schedule.***

4/2021

# URBAN LEAGUE HEAD START PROGRAM

## Child Health History

| Child's Name: | Date of Birth: | ☐ Male ☐ Female | ChildPlus ID: |
|---|---|---|---|
| Staff Completing Form: | | Staff Title: | |
| Person Interviewed | | 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: ____________ Date of Last Visit: ________
   Address: ____________ Phone Number: ________
   ☐No Doctor at this time
3. Primary Dentist/Clinic Name: ____________ Date of Last Visit: ________
   Address: ____________ Phone Number: ________
   ☐No Dentist at this time

### Health Concerns & Allergy Information

1. ☐ Yes ☐ No Did mother or child have any serious health problems during this pregnancy, delivery, or immediately after birth?
   Explain: ____________
2. Is the **CHILD** currently being treated for any of the following:

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Asthma | | | Eczema | | | G-Tube | | | Hearing Aide | | |
| Diabetes | | | Respiratory Disorder | | | Anemia | | | Ear Tubes | | |
| Seizure Disorder/Epilepsy | | | Heart Disorder | | | Vision Problems/Glasses | | | Other:________ | | |

3. ☐ 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.):____________
   ☐ Yes ☐ No Does your child require **an antihistamine** *(Benadryl, Zyrtec, etc.)*?
   ☐ Yes ☐ No Does your child require an **EpiPen**?
   a. Have you been notified that your child tested positive for sickle cell disease or sickle cell trait. Please circle No Yes, Disease Yes, Trait
   b. If your child has sickle cell disease, is he/she receiving treatment currently? Yes No
4. **Will the child need any <u>medications</u> or <u>special accommodations</u> for any of these health concerns <u>at school</u>?**
   ☐ **Yes** ☐ **No**
   ***If yes:*** *What medications/accommodations will your child need?* ____________
   ***An Authorization to Give Medication must be completed to administer any medication at school***

### 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 yes,** what Agency? ____________
5. ☐ Yes ☐ No Do you have medical documentation, Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP)?

### 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 Is your child potty trained? If no, explain____________
3. ☐ Yes ☐ No Can your child tell you if he/she has to go to the toilet? If no, how do you know if your child has to go to the toilet? ____________
4. ☐ Yes ☐ No Have there been any big changes in your child's life in the last six months? If yes, describe: ____________
5. ☐ Yes ☐ No Are you or your family having any problems that may affect your child? If yes, describe: ____________

____________________ Parent/Guardian Signature ____________ Date

____________________ Staff Signature ____________ Date



***FORM IS GOOD FOR ONE YEAR***

Urban League of
**Metropolitan St. Louis, Inc.**

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only complete if you are unemployed

## Urban League Head Start / Early Head Start
## Documentation of No Income Form

This form is to be completed **with** the parent/guardian if they report that they had no income during the previous twelve months to help staff determine eligibility. The form needs to be signed by both the parent/guardian and staff member and placed in the child's file.

**The following questions is in regards to income from _____/_____to______/______**
MONTH YEAR MONTH YEAR

1. Did you receive any financial support from the non-custodial parent? If so, how often and what amount? **(please circle one)**

   **YES** Amount: $_______ Number of months received_________

   **NO**

2. Did you receive any additional financial support? **(circle one)** **YES** (please explain) *or* **NO**

   **From Whom**________________________ **Amount:$**__________ **Number of months received:**________

   **From Whom**________________________ **Amount:$**__________ **Number of months received:**________

   **From Whom**________________________ **Amount:$**__________ **Number of months received:**________

3. Have you applied for public assistance and been denied?

   **YES**, if denied please explain__________________________________________________

   *If* **NO**, are you planning to apply? ***YES*** *or* ***NO***

**Parent/Guardian Certification:**
**I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information on this form will be held in strict confidence within the agency.**

Parent Signature: ________________________________________ Date __________________

Verifying Staff Signature: ________________________________ Date__________________

4/2018

**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: ______________

4/2020

# Urban League Head Start/Early Head Start
## PIR ADDENDUM

**Participant's Name**______________________________ **Center:** ____________________ **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 | Empowering Communities. Changing Lives.

Only complete if you are homeless

## Urban League Head Start/Early Head Start

## Documentation of Homelessness

**"Homeless Children" are categorically eligible for enrollment into the Head Start Program. According to the McKinney-Vento Act, homeless refers to any individual who lacks a fixed, regular, and adequate nighttime residence. If a family is living with a family or friend in a cooperative living arrangement that consist of a fixed, regular or adequate apartment/home – the family should not be considered homeless. Due to the unique circumstances of each family, determination of "homelessness" must occur on a case-by-case basis.**

Child Name: ______________________________________

Child's DOB: ______________________________________

Parent/Guardian Name: ______________________________

Since (date) ___________, our family has not had a permanent residence.

**Check the box that identifies family current situation:**

1. Currently, the child is:
   - Living in an Emergency, Crisis or Transitional Shelter
   - Living in a motel, hotel, camp grounds, abandoned building, bus, train station, car, park or any public or private place without heat, electricity or running water
   - Living with more than one family in a house or apartment
   - Living with friends or family member (other than parent/guardian)
   - Awaiting foster care placement
   - Living with migratory worker with lack of fixed regular and adequate housing

2. The following questions should be utilized to gather relevant information to determine if a child or family meets the definition of homeless:
   - Yes · No Is your living residence permanent or just temporary?
   - Yes · No Do you stay in the same place every night?
   - Yes · No Are you searching for another residence?
   - Yes · No Could your friends/relatives ask you to leave if they wanted to?
   - Yes · No Are you sharing your residence equally or are you considered a guest?
   - Yes · No Is there an absence of a parent or guardian due to abandonment, the parent(s)/guardian(s) incarceration, or other reason?

Why are you living in your current place? ________________________________________

______________________________________________________________________________

Where could you go if you couldn't stay where you are? ____________________________

______________________________________________________________________________

**Documentation of Homelessness**

(Homeless Form Cont'd)

**Missing Enrollment Documentation:**

In accordance with the McKinney-Vento Homeless Assistance Act (P.L. 107-110), Urban League Head Start must immediately enroll homeless children, despite being unable to produce the records normally required for enrollment. ***Upon enrollment of the child into the program, it is the staff's responsibility to obtain normally required documentation in a timely manner.***

The following enrollment documents are missing:

______ Proof of Income
______ Proof of Birth
______ Proof of Guardianship
______ Immunization Record(s)
______ Physical/Health Record(s)
______ Other (describe below): ____________________________________________
______________________________________________________________________

**Parent/Guardian Certification:**

**I certify that this information is true. If any part is false, my participation in this agency's program may be terminated. I also understand that the information on this form will be held in strict confidence within the agency.**

Parent/Guardian Signature ________________________________ Date __________

Verifying Staff Member ________________________________ Date __________