Community Action Agency For McHenry County Head Start

100 North Benton Street, Suite 3, Woodstock, IL 60098 Phone 815-338-8790 Fax 815-390-1149

Dear Prospective Parent:

McHenry County Head Start is a free preschool program designed for children three to five years of age. We provide services to low-income families who live within the County. **Transportation may be available, but not guaranteed**. Our focus is on helping children and their families meet educational, health and social needs. Head Start also works with children who have disabilities.

To begin the process of determining if your child is eligible for our program, and to start enrollment, please fill out the application for the upcoming school year 2023-2024. If your family income is within the federal income guidelines, or a SNAP(Link), TANF benefits recipient your child may qualify for enrollment. For Foster Children, we need a letter from DCFS/Foster Care Agency verifying and authorizing you as a State Guardian/Foster Parent.

Please be sure to send in your completed forms as soon as possible. A family service worker will be in contact with you to receive your completed enrollment packet. If you have any questions, please do not hesitate to contact our office at 815/338-8790 and ask for the enrollment staff. We look forward to working with you in the future.

Once we have received your completed forms along with a copy of child's birth certificate, medical card, check stub, and if eligibility for our program has been determined, we will contact you to set up an appointment to complete the enrollment process.

If your family's income is over the federal income guidelines, you will be placed on a waiting list. **Income eligible children will be selected first. If all slots are not filled by income eligible families**, you will be contacted for enrollment as space becomes available.

Sincerely,

Shari Figueroa

Family Services Manager

Applicant & Family Member Information

Applicant (Child applying for services)

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	Spanish	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
			☐ Not Eligible ☐ On Medicaid ☐ Potentially		

Dental Coverage	Dental Coverage #	Dentist/Dental Home

Primary Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Biological/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Other Relative		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

Secondary or Other Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Biological/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Other Relative		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: _____			☐ Proficient		☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

Applicant & Family Member Information

Other Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						None

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______			☐ Proficient		☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's	☐ Grade 10	☐ Full Time	☐ Full Time & Training	☐ Biological/Adopted/Step	☐ Yes	☐ Lives with Family
☐ Bachelor's	☐ Grade 11	☐ Part Time	☐ Part Time & Training	☐ Grandchild	☐ No	☐ Provides Financial Support
☐ Col Deg/Train	☐ Grade 12	☐ Seasonal	☐ Training or School	☐ Other Relative		☐ Teen Parent
☐ Col or Adv Train	☐ < Grade 9	☐Unemployed	☐ Retired or Disabled	☐ Foster		
☐ GED	☐ HS Graduate			☐ Other		If teen parent, subsidized?
	☐ Master's					☐ Yes ☐ No

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender
						Male

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little	None	☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ______			☐ Proficient		☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

Applicant Name: _____

Mother: _____ **Father:** _____

Family Information, Transportation & Contacts

Family Information Only

Living Address	Address Line 2	City	State	ZIP	County
			IL		

Mailing Address (if different)	Address Line 2	City	State	ZIP	County
			IL		

Phone Number(s)	Type (*check one*)	(Circle one)	Opt In for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other	*Mother* ☐ *Father* ☐ *Guardian* ☐	☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other	*Mother* ☐ *Father* ☐ *Guardian* ☐	☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other	*Mother* ☐ *Father* ☐ *Guardian* ☐	☐ Yes ☐ No

E-mail Address(es)	(Circle/check one)	Opt In for E-mail Messages
	Mother ☐ *Father* ☐ *Guardian* ☐	☐ Yes ☐ No
	Mother ☐ *Father* ☐ *Guardian* ☐	☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

TRANSPORTATION – Please complete only if different from living address

Pick up location address: Babysitter/Daycare/Other

Drop off location address: Babysitter/Daycare/Other

Emergency Contacts – If mother/father does not live at home, please make sure to add her/him below

Contact 1

Name	Relationship to Child	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address City State ZIP

Phone Number #1 ☐ Cell ☐ Home ☐ Work

Phone Number #2 ☐ Cell ☐ Home ☐ Work

Contact 2

Name	Relationship to Child	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address City State ZIP

Phone Number #1 ☐ Cell ☐ Home ☐ Work

Phone Number #2 ☐ Cell ☐ Home ☐ Work

Contact 3

Name	Relationship to Child	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address City State ZIP

Phone Number #1 ☐ Cell ☐ Home ☐ Work

Phone Number #2 ☐ Cell ☐ Home ☐ Work

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature:_____ **Date:**_____

CAA for McHenry County Head Start

ATTENDANCE POLICY

HSPPS (1302.16)

1. Minimum 85% attendance goal in each class, and
2. Mandatory family service or center staff follow-up after any absence without parental contact.

Attendance Policy Procedures: These procedures include family and staff responsibilities for implementing the attendance policy requirements:

- Assigned center staff will record the daily attendance of each child. The Teacher or Family Service Worker will follow-up everyday unknown absences, and 3-day illness absences. The Family ServicesManager will prepare the monthly center attendance report for monitoring and follow-up.

- If the child will not be attending classes, **families are required to contact the main office at 815-338-8790 stating the reasons for the absence and if absence is due to illness, then listing the symptoms.**

- If a child determined homeless under 1302.12 (c)(1)(iii), is unable to attend regularly, (i.e., child has no transportation to and from the center) community resources could be used to provide transportation or virtual learning offered for the child when possible. This service will be determined on a case-by-case basis.

- Parents must have a backup plan in case of emergencies, (i.e., illness, transportation cancellation, center early dismissal), and the child needs to get picked up from the center unexpectedly.

- In the event that a classroom is closed and the child cannot attend due to an emergency, (i.e., pandemic, extreme weather, facility deficiency), virtual learning will be provided to maintain attendance.

- If attendance for any child falls below the 85% requirements **(which is 3 days, consecutively or not)**for any given month, the information will be referred to the Family Service Manager for review and possible follow-up. The child will be dropped from the program if attempts to maintain the attendance have been exhausted, based on factors that include:
  - Parental requests.
  - Relocation of the family out of the program's services area.
  - Chronic absenteeism, **3 or more days a month consecutively or not**, that persists for 2 months despite program efforts.

We understand that children under age 5 are typically absent due to illnesses. We get concerned, however, when a child is chronically absent for reasons that are dismissive by the parent/caregiver. Our program helpsprepare children for their entrance into public schools. Good attendance is required at the public schools andwe need to reflect that in our program as well. Please, review the Health and Nutrition section of the Parent Handbook.

Child's Name: _____

Parent Signature: _____ Date: _____

CAA for McHenry County Head Start

CHILD HEALTH INFORMATION HSPPS 1302.42 Child Health Status & Care

Información sobre la Salud del niño

Date completed/*Fecha*: _____

Child's Name/*Nombre del niño/a*: _____

Birth Date/*Fecha de nacimiento*: _____ **Sex**: M F

Parent or Guardian's Name(s)/*Nombre del Padre(s)*: _____

Please list the name, address & telephone number for your child's regular doctor & dentist. If you do not have one, please check "none" *(Por favor escriba los nombres, direcciones y números de teléfonos de los doctores y dentistas de su niño. Si no tiene un doctor, por favor marque ninguno).*

PHYSICIAN/*Doctores*: _____ **None**/*Ninguno*
Telephone/*Teléfono*: _____

DENTIST/*Dentista*: _____ **None**/*Ninguno*
Telephone/*Teléfono*: _____

Does your child have an allergy of any kind, such as an allergy to a certain food, allergy to bee stings, allergy to certain medications, etc? ☐ **NO** ☐ **YES**

If yes, please explain: _____

¿Tiene su hijo alguna reacción alérgica de cualquier tipo, tales como alergias a algunas comidas, alergias a picaduras de abejas, alergias a algunos medicamentos, etc? ☐ *No* ☐ *Sí*

Si es Sí, explique: _____

Does your child need help using the toilet?/ *¿Necesita ayuda su niño cuando va al baño?* ☐ No ☐ Yes/*Sí*

What does your child say when they have to use the toilet?
(¿Cómo le dice su niño a usted cuando quiere ir al baño?)

_____

Are there any family problems at this time or big changes in your child's life recently? ☐ No ☐ Yes/*Sí*
(¿Hay algunos problemas familiares en este momento o grandes cambios en la vida de su niño recientemente?)
If yes, please explain/*Si es Sí, explique*:

_____

Are there any foods your child <u>should not eat</u> for religious or medical reasons? ◯ NO ◯ YES

If yes, please explain: _____

¿Hay alguna comida que su niño no debe comer por razones médicas o religiosas? ◯ *No* ◯ *Sí*

Si es Sí, explique:

_____

Does your child have a medical condition of any kind that requires medication? ◯ NO ◯ YES

If yes, please explain: _____

¿Tiene su hijo alguna condición médica de cualquier tipo que requiera medicación? ◯ *No* ◯ *Sí*

Si es Sí, explique: _____

DIETARY INFORMATION/*INFORMACIÓN DIETÉTICA*

			If yes, please explain/*Si es SÍ, explique*
Does your child eat or chew things that are not food? *¿Come o mastica cosas que no son comida?*	No ◯	Yes/*Sí* ◯	
Does your child have trouble chewing or swallowing? *¿Tiene su niño dificultades al masticar o tragar?*	No ◯	Yes/*Sí* ◯	
Do you have any concerns about what your child eats? *¿Tiene alguna preocupación sobre lo que su niño come?*	No ◯	Yes/*Sí* ◯	

CHILD'S NAME/*NOMBRE DEL NIÑO/A*:

_____

HEALTH HISTORY/*HISTORIAL MÉDICO*

			If yes, please explain/*Si es Sí, explique.*
Asthma or other breathing problems? *¿Diagnóstico de asma o dificultad para a respirar?*	No	Yes/*Sí*	
Birth defects?/ *¿Defectos de nacimiento?*	No	Yes/*Sí*	
Physical developmental delay?/ *¿Tardanza en el desarrollo fisico?*	No	Yes/*Sí*	
Blood disorder? Hemophilia, Sickle Cell? *¿Desórdenes en la sangre/Hemofilia/Células Irregulares?*	No	Yes/*Sí*	
Diabetes?	No	Yes/*Sí*	
Head injury? Concussion? Passed out? *¿Golpes en la cabeza/conmociones cerebrales/desmayos?*	No	Yes/*Sí*	
Seizures?/ *¿Convulsiones?*	No	Yes/*Sí*	
Heart problems? Shortness of breath? *¿Problemas del corazón? ¿Problemas para respirar?*	No	Yes/*Sí*	
Heart murmur? High blood pressure? *¿Murmullo de corazón? ¿Presión alta?*	No	Yes/*Sí*	
Dizziness or chest pain with exercise? *¿Mareos o dolor en el pecho al hacer ejercicio?*	No	Yes/*Sí*	
Bone/joint problems? Injury? Scoliosis? *¿Problemas con los huesos o con las coyunturas? Golpes?*	No	Yes/*Sí*	
Loss of function of one of paired organ? eye/ear/kidney/testicle) *¿Tiene pérdida de funciones en uno de los órganos? (ojos/oidos/riñones/testículos)*	No	Yes/*Sí*	
Hospitalization? When? What for? *¿Hospitalizaciones? ¿Cúando? ¿Porqué?*	No	Yes/*Sí*	

Surgery? When? What for? *¿Cirugías? ¿Cúando? ¿Porqué?*	No	Yes/*Sí*	
Serious illness or injury? / *¿Heridas o golpes graves?*	No	Yes/*Sí*	
TB skin test positive (past or present)? *¿Examen positivo de tuberculosis (pasado o presente)?*	No	Yes/*Sí*	
TB disease (past or present)? *¿Enfermedad de tuberculosis (pasado o presente)?*	No	Yes/*Sí*	
Dental problems?/ *¿Problemas dentales?*	No	Yes/*Sí*	
Eye/Vision problems?/ *¿Problemas con los ojos/visión?* Glasses? ☐ Contacts? ☐ *¿Lentes?* *¿Lentes de contacto?* **Date of last eye exam? _____** *¿Fecha del último exámen de la vista?*	No	Yes/*Sí*	
Ear/hearing problems?/ *¿Problemas con los oídos o para oír?*	No	Yes/*Sí*	
Other concerns?/ *¿Otras preocupaciones?*	No	Yes/*Sí*	

PREGNANCY AND BIRTH HISTORY/*HISTORIA DEL EMBARAZO/NACIMIENTO*			
			If yes, please explain/*Si es SÍ, explique*
Did mother or baby have any problems during pregnancy or during delivery?/ *¿Tuvo la madre o el niño problemas de salud durante el embarazo o nacimiento?*	No	Yes/*Sí*	
Was there anything wrong with the child at birth? *¿Tuvo algún problema el niño al nacer?*	No	Yes/*Sí*	
Did child or mother stay in hospital longer than usual for medical reasons? / *¿El niño o la madre tuvieron que quedarse en el hospital más de lo normal por causas médicas?*	No	Yes/*Sí*	

COMMUNITY ACTION AGENCY FOR MCHENRY COUNTY HEAD START
CHILD HEALTH EXAMINATION HEALTH HISTORY QUESTIONNAIRE

Name of Child/Nombre del Niño/a: _____ Date/Fecha: _____

Please mark YES or NO to the questions/Favor de marcar SI o NO a las preguntas

ENGLISH	NO	YES/ Sí	ESPAÑOL
Asthma or other breathing problem?	☐	☐	¿Diagnostico de asma o dificultad para respirar?
Birth Defects?	☐	☐	¿Defectos de nacimiento?
Developmental Delay?	☐	☐	¿Tardanza en el desarrollo?
Blood disorder? Hemophilia, Sickle Cell?	☐	☐	¿Desordenes en la sanare/Hemofilia/Células Irregulares?
Diabetes?	☐	☐	¿Diabetes?
Head Injury? Concussion? Passed Out?	☐	☐	¿Golpes en la cabeza/convulsiones/desmayos?
Seizures?	☐	☐	¿Convulsiones?
Heart Problems? Shortness of Breath?	☐	☐	¿Problemas del coraz6n? problemas para respirar?
Heart Murmur? High Blood Pressure?	☐	☐	¿Murmullo de coraz6n? lPresi6n alto?
Dizziness or Chest Pain with exercise?	☐	☐	¿Mareos o dolor en el pecho al hacer ejercicio?
Bone/Joint Problems? Injury? Scoliosis?	☐	☐	¿Problemas con los huesos o con las coyunturas? Golpes?
Ear/Hearing Problem?	☐	☐	¿Problemas con los oídos o Para oír?
Eve/Vision Problem?	☐	☐	¿Problemas con los ojos o la vista?
Glasses/ Contacts?	☐	☐	¿Lentes/Lentes de contacto?
Last eye exam date?			¿fecha del último examen?
Loss of function - One of Paired Organ?(Eye, ear, kidney, testicle)?	☐	☐	¿Perdida de funci6n de uno o un par de órganos?(ojo, oído, riñón, testículo)
Hospitalization? When? What for?	☐	☐	¿Hospitalizaciones? *l* Cuando? porqué?
Surgery? When? What for?	☐	☐	¿Cirugías? ¿Cuando? Porque?
Serious illness or injury?	☐	☐	¿Heridas o golpes graves?
TB Skin Test Positive (past or present)?	☐	☐	¿Examen positivo de tuberculosis (pasado o presente)?
TB Disease (past or present)?	☐	☐	¿Enfermedad de tuberculosis (pasado o presente)?
Tobacco Use (Type, Frequency)?	☐	☐	¿Uso de tabaco (que tipo, con qué frecuencia)?
Alcohol/Drug Use	☐	☐	¿Alcohol/uso de drogas?
Family History of Sudden Death before age50? Cause?	☐	☐	¿Historial familiar de muerte repentina antes de la edad de 50 años? Causa?
Dental Problems? Braces/Bridge/Plate/Other?	☐	☐	¿Problemas dentales? Frenillos/Puentes/Placa/Otros?
Other Concerns?	☐	☐	¿Otras preocupaciones?

PARENT/GUARDIAN SIGNATURE_____
(FIRMA DE LOS PADRES/GUARDIANES)

CAA for McHenry County Head Start

DROP-OFF / PICK-UP POLICY HSPPS 1302.21(d)(1), DCFS 407.260

The following rules have been established to provide safe and prompt services for each child.

1. When children are dropped off or picked up from the school, they must be signed into and out of the classroom.

2. A child will **only** be released to an authorized adult providing a photo ID. Head Start must have the name of at least (3) current emergency contacts in writing on the emergency form and/ or on a Change of Status Form) with parent signature.

3. Emergency contacts **MUST** be at least 16 years old and have a Picture ID.

4. Head Start Center hours are specific. **Children cannot be dropped off before class starts and must be picked up at the end of class. Illinois licensing prohibits unauthorized care of children.**

5. When a child is boarding or leaving the bus, a parent or release person at least **16** years old must put the child on the bus and **must** escort the child off the bus.

6. If there is no one to meet your child at the bus drop-off, he/she will remain on the bus until the route is complete.
    a. You can call the office and arrange to pick up or meet your child along the scheduled route as long as the bus is still running.
    b. In case the designated pick-up person is not available at their appointed time and location, Head Start will exercise every available option in terms of at least three (3) attempts in reaching by telephone all parents and emergency contacts.
    c. We (the center or bus driver) will maintain custody and be held responsible for the child until the parent(s), their designated representative(s), or outside authorities arrive.
    d. **However, if you or an emergency contact cannot be reached by the time the driver finishes the route, your child will be taken to the local Police Department and we will call the DCFS Child Abuse Hotline to report the incident.**
    e. Staff shall not hold the child responsible for this situation and discussion of this issue will be held only with the parent or guardian and never with the child.

7. When serious violations occur, "Bus Incident Reports" are filed. Serious incidents include: failing to meet your child at the bus stop or having a non-authorized person attempt to pick up your child. After the second Bus Incident Report is processed, your bus service will be suspended for a week. A third incident will result in **termination** of bus service for the remainder of the school year.

For the safety of your child, **THERE WILL BE NO EXCEPTIONS TO THESE RULES**. It is strongly recommended to have a back-up plan in case you cannot be on time to pick up your child. It is our policy that these situations will not be discussed with the child, only with the parent(s) or legal guardian(s).

Child's Name: _____

I, _____, agree and will comply with the Drop-Off/Pick-Up Policy.

Signature of Parent/Guardian: _____ Date: _____

CAA for McHenry County Head Start

RELEASE/EXCHANGE OF INFORMATION HIPAA Privacy Policy 1996, HSPPS Subpart C

I authorize Community Action Agency – Head Start to release, obtain, and/or exchange information with the following:

☐ McHenry County Department of Health

☐ _____
(name of physician/clinic)

☐ _____
(name of dentist/clinic)

for my child: _____ _____
(*name of child*) (*date of birth*)

for the purpose of enrolling and/or updating files of the above listed child.

Information may include the following data:

- Dental treatment
- Physical exam including height & weight
- Hemoglobin results
- Lead test results
- TB test results
- Immunizations
- Vision & hearing data
- Information on health issues that may require specialized care

I understand that this consent is valid throughout the time my child is enrolled in the Head Start program.

_____ _____
(*parent/legal guardian signature*) (*date*)

CAA for McHenry County Head Start

HEAD START SERVICES CONSENT FORM

HSPPS 1302.41 (B)(1)/ 1302.50(b)(6), DCFS 407.200(n), 407.250(m)

CHILD'S NAME: _____ **BIRTHDATE:** _____

PARENT/ GUARDIAN NAME: _____

The following is a list of services that your child may receive as a part of involvement in the Head Start program. Please read carefully and check whether you give your consent.

HEALTH AND DEVELOPMENTAL SERVICES	YES	NO
I give the Head Start program staff, consultants and school district personnel my permission to do developmental screenings (which include speech/vision/hearing/development and behavior) and to observe him/her in the classroom.	○	○
I agree that I will arrange for the required screenings if my child is not able to attend those scheduled by Head Start.	○	○
I acknowledge that emergency care will be provided for my child if needed, including, but not limited to, First Aid, CPR, and/or ambulance.	○	○
I give my consent to Head Start personnel to secure emergency medical and dental treatment, if such treatment is required. This consent is valid only in situations requiring emergency care as directed by a qualified physician. Head Start personnel will make every effort to contact me in order to obtain my consent for the specific medical procedure recommended by the physician for my child.	○	○
EDUCATION/CLASSROOM ACTIVITIES		
I agree that Head Start personnel may take my child on walking trips around the center and in the community.	○	○
I authorize my child to ride as a passenger on a bus owned by the Community Action Agency Head Start. I understand that all such trips are under the supervision of the Head Start staff.	○	○
I understand that a Head Start staff member will visit me if my child has excessive absences from school.	○	○
I agree that my child may be photographed/video taped for use by center or agency staff for the purpose of classroom activities, children's portfolios, and/or staff/parent training.	○	○
I grant permission for Community Action Agency for McHenry County Head Start to use the pictures, videos, and projects or artwork for print, broadcast and on-line media, such as, but not limited to pamphlets, flyers, newsletters, reports and websites.	○	○
I give Head Start permission to allow students from local Early Childhood Programs to observe my child's classroom during the program year.	○	○

- **Head start personnel in accordance with the state of Illinois licensing requirements and Head Start Program Performance Standards keep all children information and records in strict confidence.**
- **All staff will uphold the code of conduct.**
- **All personal information in children's files is locked in a safe place.**
- **Family information is only shared among staff that need it.**
- **Databases require passwords.**
- **Employees that leave the agency, immediately lose their access to databases and family information.**
- **Parents have the right to review their child's records and to question the contents.**
- **I have read and understood the statements above.**
- **This consent is effective as long as my child is actively enrolled in head start.**

SIGNATURE: _____ **DATE:** _____

PARENT/LEGAL GUARDIAN

CAA for McHenry County Head Start

INCOME CHECKLIST

HSPPS 1302.12 (c)(i)(ii)(iii)(iv)(2)

CHILD'S NAME: _____ **DOB:** _____

PRIMARY ADULT'S NAME: _____ **SECONDARY ADULT'S NAME:** _____

Children are automatically eligible to participate in Head Start if they are from low-income families, if they are eligible for TANF, SSI, homeless, or foster child.

- ***Please check if any of the following apply to your family***

☐TANF ☐ Domestic Violence
☐SSI ☐ DCFS involvement
☐Homeless ☐ Incarcerated Parent
☐SNAP (LINK) ☐Foster Child

Income means total cash receipts before taxes from all sources. Income includes money, wages or salary **before** deductions.

- ***In addition to your pay stub, W-2, tax return, please check-off any of the following income that you have received within the last twelve months. We will need copies of the items that apply to your family.***

☐Unemployment compensation
☐Strike benefits from union funds
☐Worker's Compensation
☐Veteran benefits (with the exception noted below)
☐Alimony
☐Child Support
☐Military Family Allotments or other support from an absent family member or someone not living in the household.
☐Government Employee Pensions (including military retirement pay)
☐College or University scholarships
☐Grants
☐**None of the above**

Note: Head Start shall not count certain types of pay and allowances for members of the "uniformed services" (as defined in 37USC101) for the purposes of determining eligibility of a dependent of such member. "Uniformed services" shall include Army, Navy, Air Force, Marine Corps., Coast Guard, National Oceanic, Atmospheric Administration, and Public Health Service.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

FOR Office use only

	Type of Employment				**Length of employment**	**Hours worked Per week**	**Overtime**	
Primary Adult	Unemployed	Employed	Self-employed	Seasonal			YES	NO
							How often?	
Secondary Adult	Unemployed	Employed	Self-employed	Seasonal			YES	NO
							How often?	

Comments:_____

_____

Interview conducted: ☐ In-person ☐Telephone: (If by telephone, explain why) _____

Eligible: Yes No	**Documentation Used:**	☐Unemployment
☐Income Eligible	☐Pay Stubs	☐Employer Written Statement
☐Income Eligible from Last Year	☐W-2	☐Third Party Support Letter
☐Over Income	☐Income Tax 1040	☐No Income / Zero Income
-Counted as part of 10%	☐Schedule C (Self Employment)	☐ Categorically Homeless
_____	☐Profit/Loss Statement	
☐ **IEP** ☐**IFSP**	☐SSI/ TANF/ SNAP Documentation	
	☐Foster Care Documentation	

Verifier Signature:_____**Date:**_____

CAA for McHenry County Head Start

PARENT NEEDS AND SERVICES QUESTIONNAIRE HSPPS 1302.52(b)

CHILD'S NAME: _____ **DOB:** _____

PRIMARY ADULT NAME: _____

Do you need Immediate Assistance in any of the following areas? Family Well-Being

☐Food
☐Shelter
☐Clothing
☐Counseling

Do you need any of the following services or support?

Health Services

☐Medical Care
☐Pre-Natal Care
☐Dental Care
☐Family Planning
☐Immunizations
☐HIV/Aids
☐Nutrition
☐Other: _____

Family Wellness

☐Child Support
☐Legal
☐Child Abuse
☐Domestic Violence
☐Alcohol/Drug Abuse
☐Parenting Skills
☐Stress/Anger Management
☐Other: _____

Education / Families as Learners

☐Literacy
☐ESL
☐GED
☐Other: _____
☐ None of the above

Family Service Worker Signature: _____ Date: _____

CAA for McHenry County Head Start

PARENT AND PROGRAM COLLABORATION AGREEMENT

HSPPS 1302.52(a) 1302.33 (3)(ii), DCFS 407.250

Child's Name: _____

We recognize that, as parents, you are the first and most important teachers of your children. We welcome your involvement in Head Start activities, and will work as partners with you to help your child progress.

Family Service Worker will:	**As a parent of a Head Start child I will:**
___1. Support your efforts to be the best parent to your child.	___1. Work with Head Start staff as partners to be my child's first teacher.
___2. Be on time for home visits and scheduled conferences, and contact you if we will be late or need to cancel.	___2. Be present for scheduled family services home visits and I will notify you if I need to cancel.
___3. Provide opportunities to be involved in Head Start activities (ie. Employment, Parent Meetings, special events)	___3. Participate in Head Start activities provided by Head Start.
___4. Assist in goal setting to gain better outcomes for your child and family.	___4. Set goals and measure outcomes for our child and family.
___5. Provide you with information on available resources and assist with referrals if needed.	___5. Follow through with referrals provided for my family.
___6. Provide materials and information on child development, GED, literacy, parenting skills, etc.	___6. Read all information provided on child development, GED. Literacy, parenting skills, etc. to the best of my ability.
___7. Send out surveys and follow up on referrals.	___7. Provide feedback through surveys including referrals.
___8. Answer questions about the Head Start Program.	___8. Reach out to my Family Service Worker if I have any questions about the program.
___9. Collaborate with you during the district referral process, if necessary.	___9. Collaborate with Head Start during the referral process.

_____ _____

Signature on behalf of Head Start/ Date ***Parent/Guardian Signature/ Date***

CAA for McHenry County Head Start

VOLUNTEER OPPORTUNITIES

HSPPS 1302.50(b)(4), DCFS 407.180

PARENT NAME: _____

CHILD'S NAME: _____

PHONE: _____ home ☐ cell ☐ (circle one)

Head Start always needs Volunteers. By DCFS requirements there are two ways that you can help us. The first would be to come into the center on non-scheduled basis. The second would be as an on-going volunteer. ***However, to be an on-going volunteer AT THE CENTER you must complete the Volunteer Packet (if more than 3 consecutive times per school year).***

Classroom Involvement: (Please check any that are of interest)

☐ Read a story to the class?
☐ Teach or lead a song?
☐ Show children how to use a musical instrument (guitar, piano, etc)?
☐ Assist children with special needs?
☐ Show children items from another country or ethnic group?
☐ Share your hobby with the class? If so, what is your hobby? _____

Center Involvement:

☐ Accompany children on field trips? (May have to provide own transportation)
☐ Help repair or restore playground?
☐ Help repair or restore classroom equipment?
☐ Prepare a class scrapbook?
☐ Help with simple sewing?
☐ Help teachers prepare child activities from home?
☐ Help with the Developmental Screenings?
☐ Help in the kitchen?

Office Involvement:

☐ Help answer phones or attends to other office duties?
☐ Participates on the Health Services Advisory Committee
☐ Participates on the Policy Council Committee

CAA for McHenry County Head Start

Transition Collaborative Agreement

HSPPS 1302.71(b)(1), DCFS 407.250(k)(m)

Dear Parent/ Guardian:

This permission to release/exchange information is to assist in making the transition to kindergarten process seamless for you and your child.

From the kindergarten school:

The elementary school has permission to confirm participation in kindergarten registration process.

To the kindergarten school:

At the completion of the program year, Head Start will transfer the following records to assist in the transition process. Head Start will follow the privacy requirements as set forth by Performance Standards in subpart C of part 1303.

Address, Telephone Number	Developmental Screening Reports
Head Start Progress Reports	Transition Teacher to Teacher Survey

By signing below, you are giving us permission to release/exchange this information. This will allow us to help your child transition out of Head Start and into the local elementary school. If you have any questions, please feel free to contact the Transition Support Specialist at the Head Start office at 815-338-8790.

Thank you.

Child's name: _____ Birthdate: _____

◯ Yes, I give Head Start permission to release/exchange the information indicated above to/with my elementary school for the purposes of facilitating transitions and reviewing screening results.

◯ No, I do not give Head Start permission to release/exchange the information indicated above to my elementary school. I understand that this may limit their ability to provide my family with the full range of services available.

Signed: _____ Date: _____

(parent or legal guardian)

CAA for McHenry County Head Start

Education and Development Questionnaire HSPPS 1302.21(a), DCFS 407.200

Child's Name: _____

Education:

Is your child currently receiving any special services?	Yes ☐	No ☐
If yes, what services is your child receiving?		
Does your child currently have one of the following education plans?		
Individual Family Service Plan (IFSP)	Yes ☐	No ☐
Individual Education Plan (IEP)	Yes ☐	No ☐
If your child has an IEP, which school district is responsible?		

Please let us know if you have any concerns in your child's development in the following areas:

Language Skills (Talking & Understanding):
Cognitive Skills (Learning, Thinking, Problem Solving, etc.):
Behavior:
Any additional concerns:

CAA for McHenry County Head Start

Discipline and Discharge Policies HSPPS 1302.17, DCFS 407.270(a)

CLASSROOM DISCIPLINE POLICY	DISCHARGE POLICY
Head Start classrooms are designed to be developmentally appropriate for children between the ages of three to five. This design includes the following methods of behavior management. 1. Establishment of reasonable and consistent rules for behavior. 2. Re-direction of the child to a different area or activity when his or her behavior is not acceptable. 3. Use of encouragement to use appropriate behavior. 4. Teaching problem solving/ conflict resolution skills to the children. 5. Use of logical and natural consequences when his or her behavior is not acceptable. At Head Start, we do not use any form of physical punishment, nor do we expel or unenroll children because of their challenging behaviors. If a child is not responding to the above guidance techniques, a special behavior plan will be developed at a meeting by a team consisting of the Child Services Manager, the Health and Disabilities Manager, the Mental Health Consultant, the teaching team, the Family Service Worker and the parents/guardians. When all documented efforts to help the child regulate his/her classroom behaviors are unsuccessful then the program, in consultation with the parents, the child's teacher, the agency responsible for implementing IDEA (if applicable), and the Mental Health Consultant will determine if the child's continued enrollment presents a continued serious safety threat to the child or other enrolled children. They will determine if the program is not the most appropriate placement for the child. The program must work with such entities to directly facilitate the transition of the child to a more appropriate placement. During the process parents may be requires to observe and assist in the classroom. The program will communicate with the parents every time there is a behavior concern.	Head Start makes every effort to provide a consistent and stable learning environment for both children and families. However; there are circumstances in which children will be discharged from the program, including the following: 1. Living outside McHenry County; exception is given to families who reside outside the county for less than thirty days due to protective situations. 2. Excessive absenteeism- repeated unexcused absences. 3. Threats or acts of abuse or violence from adult parents/guardians toward other parents, staff or children. 4. Falsifying or providing inaccurate/incomplete information necessary to maintain enrollment in accordance with day care licensing standards and Head Start Program Performance Standards, such as release persons, emergency contacts, etc.

I have read the above policies. I understand that if at any time I have any questions, I can reach out to anyone in the Agency.

Child's Name: _____

Signature: _____ Date: _____

CAA for McHenry County Head Start

PARENT TRANINING AND TECHNICAL ASSISTANCE HSPPS 1302.51(a)

Head Start is committed to providing workshops and training opportunities to be interesting, informative, and helpful. Throughout the year, you will receive information through many different resources. Please complete the survey below to assist us in better serving you this year.

Tell us the ways you prefer to receive information: (mark as many as apply)
☐E-Mail
☐Written Materials
☐Parent Workshops

Parent/Guardians Name: _____ Child's Name: _____

Would you like to receive information on any of the following topics: (mark as many as apply)

CHILD DEVELOPMENT
☐Ages 3-5
☐Infants and Toddlers
☐Reading with Children
☐Potty Training
☐Discipline
☐Other: _____

MENTAL HEALTH
☐Building Self-Esteem
☐Stress Management
☐Death, dying and grief
☐How to deal with anger
☐How to deal with fear
☐Dealing with Substance abuse (alcohol/drugs)
☐Domestic Violence
☐Counseling
☐Depression
☐Anxiety
☐Other: _____

NUTRITION
☐Food budget
☐Healthy Eating/ Food labeling
☐Weight control
☐Exercising
☐Other: _____

PERSONAL
☐Expanding your education
☐Resume writing
☐Job searching
☐GED
☐ESL
☐Financial Assistance (FAFSA)
☐Obtain Driver's License
☐Other: _____

PARENTING/FAMILY LIFE
☐Child support
☐Peer pressure
☐Step parenting and blended families
☐Grandparents raising children
☐Teen parenting
☐Divorce
☐Other: _____

HOME MANAGEMENT
☐Budgeting/money management
☐Credit counseling
☐Energy Assistance
☐Housing Assistance
☐Other: _____

HEALTH AND SAFETY
☐Childproofing your home
☐Dealing with allergies
☐First Aid
☐Quitting Smoking
☐Signs of drug/alcohol use
☐Health Coverage
☐Birth control
☐Prenatal Information
☐Brushing teeth
☐Prevent cavities
☐Poison control
☐Other: _____

OTHER

_____
_____
_____
_____
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_____
_____
_____

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE EVALUATED FOR LEAD POISONING (410 ILCS 45/6.2)

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area
- all Medicaid-eligible children should have a blood lead test prior to 12 months of age and 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If responses to all the questions are "No":

- re-evaluate at every well child visit or more often if deemed necessary

Child's name _____ Today's date _____

Age_____ Birthdate_____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes ☐ No ☐ Don't Know ☐
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	Yes ☐ No ☐ Don't Know ☐
3. Does this child live in or regularly visit a home built before 1978?	Yes ☐ No ☐ Don't Know ☐
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes ☐ No ☐ Don't Know ☐
5. Is this child a refugee or an adoptee from any foreign country?	Yes ☐ No ☐ Don't Know ☐
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes ☐ No ☐ Don't Know ☐
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes ☐ No ☐ Don't Know ☐
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes ☐ No ☐ Don't Know ☐
9. Does this child reside in a high-risk ZIP code area? (see reverse side of page for list)	Yes ☐ No ☐ Don't Know ☐

If there is any **"Yes"** or **"Don't Know"** response; **and**

- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), **and**
- there has been no change in the child's living conditions, a blood lead test is not needed at this time.

Test 1: Blood Lead Result _____mcg/dL Date _____ Test 2: Blood Lead Result _____mcg/dL Date _____

_____ _____

Signature of Doctor/Nurse *Date*

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

IOCI 15-678 IDCI Printed by Authority of the State of Illinois

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Yo, Nosotros
Please Print Name(s) Por favor escriba los nombres

parent(s) of _____, hereby certify that I/we have
padre(s) de Name(s) of Child(ren) Nombre(s) del/los niño(s) certifico que yo/nosotros hemos

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.
recibido una copia del resumen de los estandares de licencia impresos por el Departamento de Niños y Familias de Illinois

_____ _____
Signature of Parent Date
Firma del Padre Fecha

_____ _____
Signature of Parent Date
Firma del Padre Fecha

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.