# Tri-County Head Start/Early Head Start

Center Based Child's Family File Checklist

Child's Name: _____ Drop Date: _____

**You MUST sign the Confidentiality of Record Form when viewing a file.**

Enrollment Date

_____ 1st year EHS Entry Date
_____ 2nd year EHS Entry Date
_____ 3rd year EHS Entry Date
_____ 4th year EHS Entry Date

_____ 1st year HS Entry Date
_____ 2nd year HS Entry Date
_____ 3rd year HS Entry Date

| | |
|---|---|
| **Section 1 – DCF Forms** | |
| | Comprehensive Check List |
| | DCF Enrollment Form |
| | Physical |
| | Immunization Record |
| | Notarized Medical Authorization Form |
| | Hemoglobin Results |
| | Consent for height, weight, hearing, vision, blood pressure & hemoglobin |
| | Hearing/Vision Results |
| | Change of Address/Phone Number (if applicable) |
| | Disciplinary Form |
| | Permission for Food-Related Activities |
| | Distracted Adult Brochure – September |
| | Distracted Adult Brochure – April |
| | Influenza Brochure |
| **Section 2 – ERSEA** | |
| | Confidentiality of Record Form |
| | Reapplication (if applicable) |
| | Eligibility Priority Criteria Form |
| | ERSEA Verification Form |
| | Child's Application |
| | Proof of Income |
| | Proof of Categorical Eligibility (Foster Care, Homelessness, Public Assistance) |
| | Applicant Interview Form |
| | Proof of Age |
| | Head Start Eligibility Verification Form |
| | Acceptance Letter |
| | 3rd Party Contact Form (if applicable) |
| | Notarized Signature Authorization Form (if applicable) |
| | Emergency Information/Release Permission/Changes/Identification |
| | Arrival/Departure Policy |
| | Absentee Reports (if applicable) |

# Tri-County Head Start/Early Head Start

Center Based Child's Family File Checklist

| | |
|---|---|
| | Attendance Expectations |
| | Attendance Plan (if applicable) |
| | Family Contact Form (if applicable) |
| | Transportation Agreement (Head Start Only) |
| | Field Trip Transportation Agreement (Head Start Only) |
| | Child Drop Information (if applicable) |
| **Section 3 – Family Partnership** | |
| | Tracking Form |
| | Family Goal Statement |
| | Family Partnership Agreement |
| | Needs Assessment |
| **Section 4 – Medical/Dental/Nutrition** | |
| | Consent to Release Information |
| | Dental Exam Follow Up |
| | Health Record |
| | Nutrition History/Menu Survey |
| | Modified Meal Form (if applicable) |
| | CCFP Medical Statement (if applicable) |
| | Health Care Plan (if applicable) |
| | BMI Results |
| | Doctor's Notes |
| | Reminders of immunization, physical, health or dental needs |
| | Consent to Brush Teeth |
| **Section 5 – Family Development** | |
| | Correspondence with Parents |
| | Getting to Know You Survey |
| | Referrals & Follow Ups (if applicable) |
| | Permission for mental health, photo/video, and internet |
| | Confirmation of Receipt |
| **Section 6 – Mental Health** | |
| | Progress Notes (if applicable) |
| | Referral |
| | Observation or Intervention Notes |
| | Permission of Observe |
| | MDT Meeting Notes |
| | Behavior Support Plan |
| | Behavioral Incident Reports |

# Florida Department of Health
# Child Care Food Program

## CHILD CARE APPLICATION FOR ENROLLMENT

**Student Information:** Date of Birth: _____ Sex: ____ Date of Enrollment _____

Full Name: _____
Last First Middle Nickname

Child's Physical Address: _____

Primary Hours of Care: From _____ To _____

Days of the Week in Care: M T W Th F Sa Su

Meals Typically Served While in Care: Br AM Snack Lunch PM Snack Supper Eve Snack

**********

**Family Information:**

Parent 1 Name: _____ Parent 2 Name: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Work Phone: _____/Cell: _____ Work Phone: _____/Cell: _____

Child Lives With: Parent 1 _____ Parent 2 _____ Both Parents _____ Other _____

**********

**Medical Information:**

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor:_____Address:_____Phone:_____

Doctor:_____Address:_____Phone:_____

Dentist:_____Address:_____Phone:_____

Hospital Preference: _____

Please list allergies, special medical or dietary needs, or other areas of concern:_____

_____

_____

Emergency Care Plan Instructions (if applicable): _____

_____

**********

**Emergency Contacts:**

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent or legal guardian cannot be reached:

| Name | Address | Work# | Home# |
|---|---|---|---|
| Name | Address | Work# | Home# |
| Name | Address | Work# | Home# |
| Name | Address | Work# | Home# |

**Helpful Information About Child:**

_____

_____

_____

_____

_____

- Sections 7.1 and 7.2 of the Child Care Facility Handbook require a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.

- Section 7.3 of the Child Care Facility Handbook requires that parents receive a copy of the Child Care Facility Brochure, "Know Your Child Care Facility" (CF/PI 175-24), **or**

  Section 8.3 of the Family Day Care Home/Large Family Child Care Home Handbook requires that parent(s) receive a copy of the family day care home brochure, "Selecting A Family Day Care Home Provider" (CF/PI 175-28.

- Section 2.8 of the Child Care Facility Handbook requires that parents are notified in writing of the disciplinary and expulsion policies used by the child care facility, **or**

  Section 2.3 of the Family Day Care Home/Large Family Child Care Home Handbook requires that parents are notified in writing of the disciplinary and expulsion policies used by the family day care provider.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

**1st year:**

_____ _____

Signature of Parent/Guardian Date

**Subsequent years:**

_____ _____

Signature of Parent/Guardian Updated Date

_____ _____

Signature of Parent/Guardian Updated Date

_____ _____

Signature of Parent/Guardian Updated Date

_____ _____

Signature of Parent/Guardian Updated Date

**Tri-County Head Start/Early Head Start**

# Authorization for Consent to Medical Treatment of Minor Child

I (we)_____ and _____ of _____, _____ county, Florida hereby states that I am (we are) the natural parent(s), legal guardian(s) having legal custody of _____, a minor, age _____ born _____ _____ who resides with me (us) at_____. I authorize the Director or any employees of **Head Start** in the city of _____ _____, County of _____, state of Florida to consent to any X-Ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general special supervision and on the advice of any physician or surgeon licensed in the state(s) of Florida when the need for such a treatment is immediate and when efforts to contact me (us) are unsuccessful.

Child's Doctor: _____
Child's Allergies: _____
Medication child is taking: _____
Choice of Specialists: _____

**Dated this _____ day of _____, 20_____**

_____ _____
Parent/Guardian Signature Contact Number

_____
Insurance Company

STATE OF FLORIDA COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____ 20____, by _____.

_____
Signature of Notary Public

_____
Print, Type or Stamp Name of Notary

Personally Known: _____
OR Produced Identification: _____
Type of Identification Produced: _____

**Tri-County Head Start/Early Head Start**
Health Screenings Consent Form

## Height and Weight

Head Start Performance Standards Subpart D 1302.42 B.1.i. states:

Staff and families must work together to identify each child's nutritional needs, taking into account staff and family discussions concerning any relevant nutrition-related assessment data (height, weight, etc.).

We are requesting permission to obtain your child's height and weight at the Head Start center one time during the school year within 30 days of enrollment.

## Vision & Hearing Screening, Blood Pressure, Hemoglobin

Head Start Performance Standards Subpart D 1302.42 B.1.i. requires that Head Start obtains linguistically and age appropriate screening results to identify concerns regarding a child's developmental and sensory (visual and auditory) skills.

We are requesting permission to perform vision, hearing, blood pressure and Hemoglobin screening for your child at the Head Start or EHS center.

Child's Name: _____

- ☐ Yes, I give permission for my child to participate in height and weight, vision screening, hearing screening, blood pressure, and hemoglobin.
- ☐ No, I do not want my child to participate in: ___ Height ____ Weight ____ Vision ____ Hearing ____ Blood Pressure ____ Hemoglobin

School Year: _____

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature Date

***Parents: You will be given the results of the above screenings.***

# Tri-County Head Start/Early Head Start

Head Start/Early Head Start Disciplinary Policies

The use of corporal punishment and isolation as disciplinary measures in Head Start/Early Head Start are forbidden. This includes, but is not limited to spanking, slapping, and pulling of hair, etc. Children are not subject to discipline which is severe, humiliating, or frightening. Food, rest time or toileting habits are not to be associated with discipline.

We use positive guidance techniques to redirect unacceptable behavior. Children can gain self-esteem, learn self-respect, and increase self-control when childcare staff give positive guidance techniques. An explanation is given to the child why his/her behavior is unacceptable. To carry out child discipline and to ensure that age appropriate, constructive practices are used, we follow these minimum standards.

| **Behaviors** | **Examples of ways to handle behavior** |
|---|---|
| Using swear words | Ignore if seldom heard. If used often, indicate that we do not use those words here. There are other words that tell us how we feel. |
| Disturbing group time | Improve group time to hold the child's interest. Give a child something to hold or to do. Give the child attention at other times so that is not as needed at group time. |
| Disturbing others | I will not let you knock down Tom's blocks. |
| Hitting others | Hitting hurts. I will not let you hit. You may tell the other child that she made you angry. Redirect to pounding clay. |
| Spitting | Spitting should only be done in the toilet. There are many germs in spit, and I will not let you spit on anyone. |
| Biting | Biting hurts. We must take care of the place where you bit John. I will wash it and put a bandage on it. You may bite a carrot, but you may not bite other children or teachers. The teacher tries to prevent biting by close supervision of "biters". |

Positive guidance approaches will be used appropriately to discipline children. The teaching staff will establish guidelines for children's behavior that encourage self-control and that are simple, reasonable, and consistent. The staff will give children real choices and accept the choices made by the child. The teaching staff will use firm and friendly techniques, such as reminding and persuading, when rules are forgotten or not followed. **If time-out is used**, then the time will last one minute for every year old the child is, and no longer. Time-out can be used as a **last measure** to get the child to conform to the classroom rule. If time out is necessary on the playground, the staff must remain with the child for the duration of the time out and staff must continue interacting and communicating with the child, until the time out is over.

| | |
|---|---|
| Child's Name | Center |
| Parent/Guardian Signature | School Year |
| Staff Signature | Date |

# Permission for Food-Related Activities & Special Occasion Food Consumption

*Pursuant to 65C-22.005 (1) (c) 2., F.A.C., licensed childcare facilities must obtain written permission from parents/guardians regarding a child's participation in food-related activities. These activities include such things as: classroom cooking projects, gardening, school wide celebrations and birthdays.*

I _____ give/ decline permission for my child _____, to participate in food related activities and special occasions wherein food is consumed.

Please Provide the following information:

- ☐ My child **DOES NOT** have a food allergy or dietary restriction. He/she **MAY** participate in activities.

- ☐ My child **DOES NOT** have a food allergy or dietary restriction. He/she **MAY NOT** participate in activities.

- ☐ My child **DOES** have a food allergy or dietary restriction. He/she may participate in activities, but **MAY NOT** eat or handle the following items (please see list below):

  _____

  _____

  _____

- ☐ My child **DOES** have a food allergy or dietary restriction. He/she **MAY NOT** participate in activities.

I understand that it is my responsibility to update this form if my decision for permission changes. I agree that this form will remain in effect during the term of my child's enrollment.

_____ _____

Parent/Guardian Date

**Tri-County Head Start/Early Head Start**

Confidentiality of Records

## Family File

Name of Child: _____

Pursuant to Head Start Performance Standards and 45-CFR, this agency provides procedures to insure the confidentiality of records. Only authorized persons within the agency have access to health and other records. Records are stored in a place not accessible to unauthorized personnel. Information is not released to other agencies without the written consent of the child's parents or guardians.

**Any individual who handles this file, other than the designated record keeper, must sign below providing the requested information, and receive clearance from the designated record keeper.**

| Name/Signature | Title | Date | Purpose |
|---|---|---|---|
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# Tri-County Head Start/Early Head Start

Emergency and Release Permission Form

I,_____, give permission for the following people to take or pick up my child, _____, from school when he/she is dismissed. The names listed may also be contacted if/when a child is sick and parent cannot be reached, or if staff has questions regarding information provided on the application.

**Please list names in the order of which they are called.**

1. Name/Relationship: _____DOB/Age:_____

   Address:_____

   Phone #_____ Cell #_____Work#_____

2. Name/Relationship: _____DOB/Age:_____

   Address:_____

   Phone #_____ Cell #_____Work#_____

3. Name/Relationship: _____DOB/Age:_____

   Address:_____

   Phone #_____ Cell #_____Work#_____

4. Name/Relationship: _____DOB/Age:_____

   Address:_____

   Phone #_____ Cell #_____Work#_____

If no one comes to pick up your child at the end of the day we will contact someone from the emergency list. If this is unsuccessful, at the end of the school day, your child could be reported to the Police Department and – pertinent information given to them. We must follow this procedure to protect your child.

Parent/Guardian Name_____
Address _____
Phone #_____ Cell _____Work_____

**I have read, understood, and agree with the Procedure for Dismissal. I certify that the information provided on this application is accurate and truthful to the best of my knowledge.**

_____ _____
Parent/Guardian Signature Date

_____ _____
Notary Signature/Seal Date

# Tri-County Head Start/Early Head Start

Arrival, Departure and Attendance Policy

**Arrival and Departure**

Your child must arrive at the center no earlier than 7:45am and must leave no later than 2:00pm. If your child rides a bus, you or an authorized adult must be at the drop-off at the time assigned to you by the transportation department. Parents who transport will have a pick-up time based on their work or class schedule. If your transportation needs change, please talk with the Center Coordinator at your child's center.

**After three (3) times of late arrival or failure to receive your child, it will be necessary for you to attend a conference with Head Start/Early Head Start staff to discuss other resources and childcare options.**

**Attendance**

Establishing consistent daily routines gives your child security and helps to build a relationship between the classroom and home. Children who have irregular attendance or who are consistently late miss meals and learning activities provided by Head Start/Early Head Start. If you fail to call in when your child is absent, Head Start/Early Head Start staff will contact you regarding the absence. **In the event of excessive absences or tardiness, a conference will be scheduled to complete an Attendance Action Plan. If you fail to comply with the Attendance Plan your child can return to the waiting list and the vacancy will be filled with another family in need of placement.** If your family needs extended leave, you must submit a request in writing for approval or your child's slot will be considered vacant.

I will inform a center staff member immediately at 850 _____ if the following emergencies occur:

- I or my authorized adult cannot be at the center by the scheduled arrival or departure time.
- I or my authorized adult cannot be at the designated drop-off address at the scheduled time, or
- If my child is going to be absent from class.

**Arrival Time: 8:00 am** **Departure Time: 2:00 pm**

I have read the Arrival, Departure & Attendance Policy and it has been explained to me. I understand that my child's full participation in the HS/EHS program depends on the above policy. Failure to contact your child's center or if staff cannot locate you in 5 days, your child will be withdrawn from the center.

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date

# Tri-County Head Start/Early Head Start

Attendance Expectations

- ☐ I agree to bring my child to the center five days a week. I will bring my child in no later than 8:00 am and not pick him/her up later than 2:00 pm for my child to have a quality learning experience each day.

- ☐ I understand whenever my child is absent; I agree to notify the center by phone no later than 9:00 am.

- ☐ I understand if my child's attendance falls below 85%, my child's attendance will be reviewed, and a recommendation will be made based on a reassessment of the family needs.

- ☐ I understand when my child is absent five consecutive days and I have not notified the center, cannot be reached by staff, or the address is vacant, my child will be moved or withdrawn from the center-based program.

- ☐ I understand that it is my responsibility to bring my child to the center on time.

- ☐ I understand that it is my responsibility to pick up my child on time.

- ☐ I understand that these same attendance/tardy expectations also apply to those children who are transported by bus. You must escort your child to the bus and be present to pick him/her up at designated times.

- ☐ I understand that I am responsible for the safety of my child and communicating with the teacher.

- ☐ I understand I am expected to attend regularly scheduled parent meetings.

- ☐ I understand that I am expected to participate in home visits and other periodic contacts made by the staff.

_____ _____

Parent/Guardian Signature Date

# Tri-County Head Start/Early Head Start

Transportation Agreement

Head Start programs are not required to provide transportation services; however, we are required to assist parents to arrange transportation (send notice to form carpools with other parents etc.).

We do not provide door-to-door service. We stop at designated "safe" areas.

If there are more than three no call/no shows, you will be asked to forfeit your child's seat on the bus for a child who needs transportation.

A child may lose bus privileges if your child does not display appropriate behavior on the bus. (2 write ups = suspension)

If there is no adult present to receive your child from the bus more than once, the child will immediately be suspended which may lead to permanent loss of bus privileges.

Do not call the center to change the drop off location, this must be in writing and the change cannot be made off the designated route.

Please consider the above before requesting transportation services and signing this agreement. If this is not practical, we will work with family on other options.

**PARENTS/GUARDIANS WILL RECEIVE COPY OF THIS AGREEMENT**

This agreement is made between Tri-County Community Council, Inc. Head Start and the parent(s) of _____.

Name of Child

**The parent of the above-named child will:**

- Be waiting at the pick-up point on time to place the child on the bus in the morning and pick the child up in the afternoon at the designated stopping area.
- Accompany the child to the bus and wait until the child is on board safely or has left the bus safely. (PARENTS ARE NOT ALLOWED ON BUS).
- Send only an adult listed on emergency contact card to drop off/pick up child in the event parent is unable to do so. Listed adults must have identification and be at least 16 years old.
- NOT SEND medicine, food, drinks, toys, or any other objects that are not school oriented.
- Notify Tri-County Transportation by 7:00 a.m. if your child will not be riding the bus. Transportation Numbers: WESTVILLE-548-5630 or 547-3688 WALTON 892-2422 or 892-7635
- Work with staff and child if child's behavior becomes disruptive on bus.
- BE RESPONSIBLE for picking up child at Head Start Center or drop off point. If an authorized adult does not pick up the child at designated time, Law Enforcement may be called if there is an extended wait for pick up or we are unable to contact an authorized adult for pick-up of the child.
- Do not chase the bus and expect the bus to stop if a parent misses the bus at a designated stop.

# Tri-County Head Start/Early Head Start

Transportation Agreement

**Tri-County Community Council, Inc. Head Start will:**

- Pay for transportation for this child on Tri-County Transportation for the days Head Start is operational during the _____ program year.
- Coordinate services with the transportation services providing transportation for this child.
- Provide trained staff to meet children in the a.m. and help children get on the bus in the p.m. at the center.
- Provide trained bus drivers and escorts to ensure a child's safety while on the bus.
- Ensure children are supervised and safe while waiting on the bus at the Center.
- Notify parents of any problems that occur during the transportation of the child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date

# Tri-County Head Start/Early Head Start

Field Trip Transportation Agreement

Classes will periodically take field trips with parental permission. This agreement is for any field trips taken in the _____ school year. Field trips are used to expand the curriculum and provide opportunities for new experiences for the children.

- ☐ All children will wear a Head Start/Early Head Start shirt to and from the field trip. Shirts must not be removed before returning to the center.
- ☐ All children and staff going on the field trip must be logged in/off on the bus log.
- ☐ No siblings are allowed to ride the bus for field trips. Parents may ride if seats are available.
- ☐ All children must return to the center from the field trip on the bus.
- ☐ Parents are not allowed to check or sign their child out on the field trip.
- ☐ If parents decide to transport their child to and from the field trip, parents will assume all responsibility for their child, will pay for their child's admission as a private party, supervise their child, and Tri-County Head Start/Early Head Start is not liable for any injuries or accidents that may occur during transport or during the field trip.
- ☐ Parents will not bring or buy drinks, gifts, or snacks for any child while on the field trip.
- ☐ Parents will be expected to conduct themselves as representatives of the Head Start/Early Head Start program. No use of foul language, smoking, arguments, alcohol, or drugs.
- ☐ Parents suspected of being under the influence or being disruptive will be asked to separate from the children's group or leave the area.
- ☐ Children who do not have a signed permission slip will not be allowed on the field trip.
- ☐ If you bring a cell phone it must be on mute and answered only if away from children's group.

- ☐ Yes, I agree to abide by the guidelines listed above.

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date

# Tri-County Head Start/Early Head Start

Activity or Service Tracking Form

Child's Name: _____

| Date | Contact Type | Family Member | Location | Subject/Activity/Service | Staff Initials |
|---|---|---|---|---|---|
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Service Code: FF=Face to Face; PC=Phone Call; N=Note Sent Home
OV= Office Visit; CR=Classroom; HV=Home Visit

# Tri-County Head Start/Early Head Start

Family Partnership Goal Statement

Family Name _____ Client's Name _____

FSA _____ Center _____

**Family 1st Goal:**

Steps and Strategies

1._____

2._____

3._____

4._____

5._____

Resources Needed to Meet Goal:

_____

_____

_____ At this time, I (we) choose not to work on any family goals. I understand that we will review this at our next Home Visit /Conference.

Initial Partnership meeting date _____ 1st Goal Met on _____

**Staff's first meeting with parent to discuss goal.**

Parent/Guardian Signature _____

**Goal Work Follow-Up**

| Mid-Year Follow-Up Date: | Mid-Year Achievement Score: | End of Year Follow-Up Date: | End of Year Achievement Score: |
|---|---|---|---|
| ____, _____, _____<br>(month) (day) (year) | 1 2 3 4 | ____, _____, _____<br>(month) (day) (year) | 1 2 3 4 |

**Scoring**

1. Goal Achieved
2. Goal Partially (1/2) Achieved
3. Minimal Progress
4. No Progress

# Tri-County Head Start/Early Head Start

Family Partnership Agreement

Child's Name_____ Date of Birth_____

Tri County Head Start/Early Head Start is committed to working with you as a partner to help your family access services and resources, and to provide developmentally appropriate education services.

The Tri County Had Start/Early Head Start program agrees to:

1. Assign each family a Family Service Advocate who will:
    - Provide opportunities for you to participate in your child's education and in parent training and meetings.
    - Provide opportunities for you to interact with other Tri County Head Start/Early Head Start parents on a regular basis, including the opportunity for involvement in the program policy making and operations.
    - Work with your family in setting and reaching your goals as written in your Head Start/ Early Head Start Family Goals Plan.
    - Communicate and coordinate with other programs working with you and your family in accordance with Tri County Head Start/Early Head Start Confidentiality Policy (this will include any of the programs or people listed on the Tri County Head Start/Early Head Start consent form).
    - Ensure that your child has the opportunity for health, nutrition, mental health, developmental, and dental screening.
    - Follow up on your child's developmental, behavioral, health, nutritional, or dental concerns and work in partnership with you to assess and address any needs.
    - Assist with problem solving and accessing transportation resources.
2. Provide education services in Head Start/Early Head Start classrooms and educational home visits with on-going support available from Tri County Head Start staff.
3. Provide ongoing assessment of family's satisfaction with Tri County Head Start/Early Head Start services.
4. Provide all services until child transitions out of the Tri County Head Start/Early Head Start program.

(Continued)

# Tri-County Head Start/Early Head Start

## Child's Health Record

Child's Name _____

Is your child on WIC? ☐ Yes ☐ No County_____
Does your child have a regular Doctor? ☐ Yes ☐ No Name _____
Does your child have a regular Dentist? ☐ Yes ☐ No Name _____
Has your child had a Lead Test? ☐ Yes ☐ No Provider_____

Does your child currently have any diagnosed disabilities? ☐ Yes ☐ No If yes, please explain.

_____

Diagnosed when/by whom?_____

Does your child have an Individualized Education Plan/IFSP? ☐ Yes ☐ No
Referral Agency _____

| Health Concerns | Yes | No | Explain |
|---|---|---|---|
| Has your child had a serious and/or long-term illness? | | | |
| Does your child have difficulty seeing and/or wear glasses? | | | |
| Does your child have problems with hearing? | | | |
| Is your child potty trained? If no, what size diaper/pull ups? | | | |
| Is a specific brand used? If so, which one? | | | |
| Has your child ever had a convulsion or seizure? | | | If yes, when did it last happen? |
| Is your child taking medication for seizures? | | | If yes, what medicine? |
| Is your child now being treated by a physician and/or dentist for anything other than routine visits? | | | Physician/Dentist Name |
| Are there any conditions we have not talked that get in the way of your child's everyday activities? | | | |
| Did a doctor tell you the child had this problem? | | | |
| Does your child receive mental health treatment? | | | |
| Does your child have any allergies to food, medication or environment? Please explain. | | | |
| Will emergency medication be needed on site? | | | Name of medication: |

*Please note that if your child needs medication during the school day, **we must** have a current medication authorization form on file, and a doctor's written orders.*

Does your child have an up-to-date shot record? ___ No ___ Yes, Date: _____
Does your child have an up-to-date physical? ___ No ___ Yes, Date:_____

_____ _____
Parent/Guardian Signature Staff Signature

*(For staff use only)* Is follow-up required? ☐ Yes, (health care plan in file) ☐ No

Updated 03/24 sbm

# Tri-County Head Start/Early Head Start

Nutrition and Menu Survey

Child's Name _____ Center _____

Is there anything you would like to share about your child's food likes/dislikes, your family eating patterns, and/or any cultural food preferences you have? _____

_____

_____

| | | | |
|---|---|---|---|
| Does your child take vitamins? | Y | N | If yes, what kind? |
| Is there any food your child should not eat for medical or religious reasons? | Y | N | If yes, what kind? |
| Is your child on a special diet? | Y | N | If yes, what kind? |
| Does your child have trouble chewing or swallowing? | Y | N | If yes, explain. |
| Does your child take a bottle? | Y | N | If yes, what kind? |
| Does your child use formula? | Y | N | If yes, what kind? |
| Do you have any concerns about what your child eats? | Y | N | If yes, explain. |
| Does your child have any food allergies? | Y | N | If yes, what kind? |
| Are you interested in nutritional counseling? | Y | N | |
| Does your child use a pacifier? | Y | N | If yes, when is it needed. |

Comments _____

_____

_____ _____

Parent/Guardian Signature Staff Signature

*(For staff use only)*

Is follow-up required? □ Yes, (health care plan or modified meal form in file) □ No

_____

School Year

# Tri-County Head Start/Early Head Start

Family Partnership Agreement

As a family partner in Tri County Head Start/Early Head Start, I agree to:

1. Be available to meet with my Family Service Advocate (FSA) at home, workplace, childcare center, the classroom and/or agreed upon location.

2. Call to reschedule when I cannot keep my appointments with a Head Start/Early Head Start staff.

3. Try to participate in parent involvement opportunities such as parent meetings, workshops, policy council, volunteering in my child's classroom and community events.

4. Do my best to follow the family goals plan that we will develop together which identifies goals, priorities, and strategies.

5. Give permission for sharing and exchanging information between Head Start/Early Head Start and other agencies serving my child/family.

6. Ensure that my child regularly attends the program offered by Head Start/Early Head Start in accordance.

7. Communicate with my child's teacher and my Family Service Advocate about any concerns, changes in my work or living situation, or needs for support and information.

8. Ensure that my child receives regular well-child check-ups, immunizations, and follow-ups on identified concerns.

9. Participate in developmental, health, mental health, nutrition, and dental screenings for my child.

10. Participate in two parent/teacher conferences and two home visits per year with my child's teacher.

I have read and discussed the Agreement with my FSA and am willing to enter this partnership with Tri County Head Start/Early Head Start.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Legal Guardian Signature | Date | School Year |
| _____ | _____ | |
| Staff Signature | Date | |

# Tri-County Head Start/Early Head Start

## Family Needs Assessment

Participant Name _____School Year_____

Preliminary Date_____ Midyear Date_____ End of Year Date_____

Family Service Advocate_____

| Assessment Item | Preliminary Score | Midyear Score | End of Year Score |
|---|---|---|---|
| **Family Well Being** | | | |
| **Housing** | | | |
| 1. Homeless or on the verge. Very temporary housing (such as with friend for 1 week). At a shelter. Camping, living in a vehicle, etc. No income for housing, Dangerous or bad situation. Utilities shut off.<br>2. Temporary housing. Lives with friends/family. Money for rent/utilities uncertain. Unsafe or crowded. No money for repairs. Landlord not fixing problems. Uses help from agencies to get by (LIHEAP, PRC, etc.). Utilities shut off or on the verge.<br>3. Semi-Permanent. Relatively safe and secure. Some repairs. Some repairs are needed. Mostly can pay housing/utilities/repairs. Minor landlord issues. Subsidized/Metro housing. Some help from agencies to get by (LIHEAP, PRC, etc.).<br>4. Safe and secure dwelling for at least 12 months. Able to pay rent/mortgage. Able to pay utilities. Repairs taken care of.<br>5. Able to own or live in long term affordable housing. Safe housing. Enough room for family size. Suits needs and preferences. Able to pay utilities. | | | |
| **Safety** | | | |
| 1. Family is imminent danger. (Violence in home and in neighborhood).<br>2. Family involved or open case with DCF (child abuse/neglect) and/or domestic abuse.<br>3. Family has a history with DCF (child abuse/neglect) and/or past domestic abuse.<br>4. Family has a safety plan in place.<br>5. 5. Family is in no immediate danger and family members report they are safe in their environment. | | | |
| **Health** | | | |
| 1. No regular doctor or dentist. Needs help finding resources. No insurance. Can't afford doctor/dentist. Can't afford to skip needed medications. Serious illness in the family.<br>2. No/Poor insurance. No regular doctor or dentist. Uses the emergency room or doctor. Needs help finding resources. Only goes to doctor/dentist when an emergency. Unmet medical/dental needs. Behind on immunizations.<br>3. Access to doctor and dentist through clinics. Typically, able to see doctor/dentist when needed. Adequate insurance coverage. Immunizations up to date. Typically, able to obtain medications.<br>4. Family doctor and dentist. Immunizations up to date. Everyone is healthy. Money/insurance for medical.<br>5. Family doctor. Family dentist. Immunizations completed. Iron level test done. Lead level test done. Everyone is healthy. Money/insurance for medical. Yearly physicals. | | | |

# Tri-County Head Start/Early Head Start

Family Needs Assessment

| Assessment Item | Preliminary Score | Midyear Score | End of Year Score |
|---|---|---|---|
| **Mental Health/Substance Abuse** | | | |
| 1. Unmanaged depression, anxiety, eating disorder, or other mental health issue. Struggles to cope. Possible danger to self/others. Substance abuse. Unable to function in society. More bad days than good.<br>2. Able to function most days. More good days than bad. Medications partially help.<br>3. Some mental health issues, but medication/coping skills take care of it.<br>4. No mental health issues. Somewhat confident. Good relationships. Mild stress at times.<br>5. Self-confident. Strong sense of identity. Non-stressed. Strong relationships. No mental health issues. | | | |
| **Transportation** | | | |
| 1. No vehicle - No access to transportation with others. No driver's license.<br>2. Unreliable vehicle - May not be able to pay for needed repairs/gas. No driver's license. Unreliable resources for transportation.<br>3. Has access or utilizes public transportation.<br>4. Semi-reliable vehicle - Able to pay for some repairs, but not currently. Able to get reliable rides. Has a driver's license and insurance.<br>5. Reliable vehicle - Has a driver's license. Has money for car repairs, payment, gas, regular maintenance, and insurance. | | | |
| **Financial Security** | | | |
| 1. Limited or no income. Depends strongly on assistance to survive. No budgeting skills. Facing eviction/ repossession. Go without meals/medical.<br>2. Inadequate income. Unable to pay bills. Uses some assistance to get by. Needs help with budgeting skills.<br>3. Stable income. Struggles to pay bills. Accesses resources as needed for unexpected costs. Some budgeting skills.<br>4. Adequate income. Able to pay most bills on time. Mostly able to follow budget. Some credit.<br>5. Reliable income. Able to pay bills on time. Has savings/retirement. Have credit cards/good credit. Able to follow budget. | | | |
| **Employment** | | | |
| 1. Unemployed. Disabled with no benefits. No/limited prospects or skills. Long term unemployment. Barriers to employment (undocumented, criminal history, health issues).<br>2. Temporary or part-time with no benefits. Receiving unemployment compensation. Limited skills. Inadequate pay/benefits.<br>3. A stable or part-time wage job with some benefits. Needs additional training and employment skills.<br>4. Full-time or adequate job. Meets basic needs. Some benefits.<br>5. Permanent and stable. Full benefits. Above average employment. Upgrading skills. Transferrable skills. | | | |
| **Food and Clothing** | | | |
| 1. No food or preparation facilities. Clothing inadequate. Malnutrition. Eating disorders.<br>2. Limited knowledge of food preparation and food/clothing resources. Dietary requirements are not met.<br>3. Sufficient personal and community resources for food/clothing.<br>4. Have resources for healthy food and clothing. Dietary requirements for special conditions i.e., pregnancy, diabetes, etc.<br>5. Has ability and access to resources to provide healthy food and clothing. | | | |

# Tri-County Head Start/Early Head Start

Family Needs Assessment

| Assessment Item | Preliminary Score | Midyear Score | End of Year Score |
|---|---|---|---|
| **Positive Parent Child Relationships** | | | |
| **Nurturing Relationships** | | | |
| 1. No attachment between caregiver and child; severe behavior issues.<br>2. Behavioral Issues. Negative or non-consistent use of discipline. Overwhelmed. No support. Needs help with resources. Need parenting help/skills. Relationship issues.<br>3. Somewhat stressed. Stable relationships. Stable environment. Mostly good parenting skills. Able to access resources. Parenting and or relationships could be improved.<br>4. Relationships good. Environment good. Involved in community. Mostly positive parenting techniques. Stable support network.<br>5. Stable/nurturing relationships. Positive techniques of guidance. Strong support network. | | | |
| **Child Development/Parenting Skills** | | | |
| 1. Parent/child roles and responsibilities are non-existent.<br>2. Parent does not know how or where to get help on child development/parenting skills.<br>3. Parent/child roles and responsibilities are enforced but not always consistent or effective.<br>4. Parent would like information on age-appropriate activities.<br>5. Parent knows how to seek parenting assistance and understands development milestones. | | | |
| **Family as Lifelong Educators** | | | |
| **Family Education at Home** | | | |
| 1. Family is unable to support their child in any learning activities.<br>2. Family has limited access to learning resources and has several concerns about their child's learning.<br>3. Family feels somewhat confident about their child's learning.<br>4. Family completes home activities and is aware of what the child is learning.<br>5. Family is engaged in daily literacy activities in the home and is aware of what the child is learning. | | | |
| **School Readiness** | | | |
| 1. Family not interested in understanding assessment data and progress.<br>2. Family does not understand child assessment data and progress.<br>3. Family has some understanding of child assessment data and participates in parent conferences or program functions.<br>4. Family understands child assessment data and guides the child and knows how to support their child for school readiness.<br>5. Family seeks out information regarding school readiness goals. | | | |
| **Promoting Primary Language** | | | |
| 1. Family prohibits child from using native language in home.<br>2. Family discourages child from speaking native language in the home.<br>3. Family inconsistently uses native language.<br>4. Family consistently uses native language in the home and assists other parents with transitions.<br>5. Family consistently uses native language in the home. | | | |

# Tri-County Head Start/Early Head Start

Family Needs Assessment

| Assessment Item | Preliminary Score | Midyear Score | End of Year Score |
|---|---|---|---|
| **Families as Learners** | | | |
| **Education, Training, and Life Goals** | | | |
| 1. No GED or High School diploma. English as second language. No skills with computer.<br>2. No GED or High School diploma. Able to access GED training. Able to access job training. Remedial courses needed. Has limited computer/internet skills.<br>3. Have GED or High School diploma. Able to access needed resources to attend college or job training. Need a few remedial courses. Have computer/internet skills.<br>4. Enrolled in college or vocational training. Have adequate computer/internet skills.<br>5. Working in chosen profession. Attained degree. Proficient with computer and internet. | | | |
| **Volunteering** | | | |
| 1. Family does not participate in volunteering opportunities.<br>2. Family volunteers occasionally (i.e., at least 20-40 hours' /school year).<br>3. Family volunteers on a monthly basis.<br>4. Family seeks out ways to volunteer.<br>5. Family volunteers on a weekly basis. | | | |
| **Family Engagement in Transitions** | | | |
| **Transitions** | | | |
| 1. Family is not interested in advocating and/or supporting their child's education.<br>2. Family is unaware of their role in supporting and advocating for their child's education.<br>3. Family is beginning to understand and advocate for their Child's learning and development in the transition process.<br>4. Family attends transition meetings as required and gives input into the transition process.<br>5. Family is aware, advocates and actively engages in transition planning. | | | |
| **Family Connections to Peers and Community** | | | |
| **Families and Communities** | | | |
| 1. Family has no support network or any knowledge of community resources.<br>2. Family has limited knowledge on community resources.<br>3. Family knows resources available in the community and how to access.<br>4. Family has dynamic support networks and is actively engaged in their community.<br>5. Family is self-sufficient and is not dependent upon community resources. | | | |
| **Families as Advocates and Leaders** | | | |
| **Leadership and Advocacy** | | | |
| 1. Family is not involved in any leadership/advocacy roles.<br>2. Family has limited ability or barriers to participation.<br>3. Family is interested in obtaining more information about leadership opportunities.<br>4. Family is beginning to form leadership/advocacy partnerships with other parents and/or community groups.<br>5. Family is actively serving in leadership/advocacy partnerships with other parents and/or community groups. | | | |
| Parent Initials | | | |

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____

# Tri-County Head Start/Early Head Start

Consent to Release Information

As parent/guardian of _____ DOB _____

I hereby give my consent to Tri County Head Start/Early Head Start, to obtain from and to release to the following agencies and/or person(s) pertinent social, medical, educational, and other information concerning my child. I understand that any information obtained or released will be used for his/her benefit.

This consent is valid for the _____ school year.

I understand that Tri County Head Start/Early Head Start may exchange information with the agencies or individuals listed below. I have marked yes by those agencies or individuals with which you may exchange information.

| Yes | No | |
|---|---|---|
| | | Physician: |
| | | Dentist: |
| | | WIC: |
| | | Health Dept: |
| | | Other: |

By signing this authorization, I release Tri County Head Start/Early Head Start, its' agents and staff, and the specified agencies listed above, from any legal liability resulting from the disclosure or acquisition of information released or obtained on the above-named child.

This authorization form was explained in full to me on the above-named child, including the purposes of the release and the disclosure, which might be reasonably anticipated.

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date

# Tri-County Head Start/Early Head Start

Nutrition and Menu Survey

Child's Name _____ Center _____

Is there anything you would like to share about your child's food likes/dislikes, your family eating patterns, and/or any cultural food preferences you have? _____

_____

_____

| | | | |
|---|---|---|---|
| Does your child take vitamins? | Y | N | If yes, what kind? |
| Is there any food your child should not eat for medical or religious reasons? | Y | N | If yes, what kind? |
| Is your child on a special diet? | Y | N | If yes, what kind? |
| Does your child have trouble chewing or swallowing? | Y | N | If yes, explain. |
| Does your child take a bottle? | Y | N | If yes, what kind? |
| Does your child use formula? | Y | N | If yes, what kind? |
| Do you have any concerns about what your child eats? | Y | N | If yes, explain. |
| Does your child have any food allergies? | Y | N | If yes, what kind? |
| Are you interested in nutritional counseling? | Y | N | |
| Does your child use a pacifier? | Y | N | If yes, when is it needed. |

Comments _____

_____

_____ _____

Parent/Guardian Signature Staff Signature

*(For staff use only)*

Is follow-up required? □ Yes, (health care plan or modified meal form in file) □ No

_____

School Year

# Tri-County Head Start/Early Head Start

Consent to Brush Teeth

The Tri-County Head Start/EHS Program, in cooperation with our Health Advisory Committee, has instituted the program of brushing teeth once a day at Head Start/EHS.

Each child will be provided a toothbrush by the center staff. The toothbrushes will be in a covered holder and changed every two months and/or after an illness.

The children will be called to the brushing sink two at a time. A staff member will apply a smear of fluoride toothpaste in a one-ounce cup and supervise or assist each child while brushing.

Infants under age 1 will have mouth swabbed out with gauze. Ages 1 up to age 3 will brush with non-fluoride toothpaste.

We ask parents to please brush with the children before bedtime to encourage a good oral hygiene routine.

---

☐ I want my child to participate in tooth brushing.

☐ I do *not* want my child to participate in tooth brushing.

Comments: _____

_____

_____

---

Child's Name _____

Center _____

_____ _____

Parent Signature Date

_____ _____

Staff Name Date

# Tri-County Head Start/Early Head Start

## Child's Health Record

Child's Name _____

Is your child on WIC? ☐ Yes ☐ No County_____
Does your child have a regular Doctor? ☐ Yes ☐ No Name _____
Does your child have a regular Dentist? ☐ Yes ☐ No Name _____
Has your child had a Lead Test? ☐ Yes ☐ No Provider_____

Does your child currently have any diagnosed disabilities? ☐ Yes ☐ No If yes, please explain.

_____

Diagnosed when/by whom?_____

Does your child have an Individualized Education Plan/IFSP? ☐ Yes ☐ No
Referral Agency _____

| Health Concerns | Yes | No | Explain |
|---|---|---|---|
| Has your child had a serious and/or long-term illness? | | | |
| Does your child have difficulty seeing and/or wear glasses? | | | |
| Does your child have problems with hearing? | | | |
| Is your child potty trained? If no, what size diaper/pull ups? | | | |
| Is a specific brand used? If so, which one? | | | |
| Has your child ever had a convulsion or seizure? | | | If yes, when did it last happen? |
| Is your child taking medication for seizures? | | | If yes, what medicine? |
| Is your child now being treated by a physician and/or dentist for anything other than routine visits? | | | Physician/Dentist Name |
| Are there any conditions we have not talked that get in the way of your child's everyday activities? | | | |
| Did a doctor tell you the child had this problem? | | | |
| Does your child receive mental health treatment? | | | |
| Does your child have any allergies to food, medication or environment? Please explain. | | | |
| Will emergency medication be needed on site? | | | Name of medication: |

*Please note that if your child needs medication during the school day, **we must** have a current medication authorization form on file, and a doctor's written orders.*

Does your child have an up-to-date shot record? ___ No ___ Yes, Date: _____
Does your child have an up-to-date physical? ___ No ___ Yes, Date:_____

_____ _____
Parent/Guardian Signature Staff Signature

*(For staff use only)* Is follow-up required? ☐ Yes, (health care plan in file) ☐ No

Updated 03/24 sbm

# Tri-County Head Start/Early Head Start

Mental Health Observation, Media Consent and Holiday Activity Form

## Mental Health

CONSENT FOR CLASSROOM OBSERVATION BY A SOCIAL-EMOTIONAL DEVELOPMENT PROFESSIONAL:

Performance Standard 1302.45 states: *The program will provide supports for effective classroom management and positive learning environments; secure mental health consultation services on a schedule of sufficient and consistent frequency to ensure consultant is available to partner with staff and families in a timely and effective manner.*

We need your permission for the Social-Emotional professionals to do a classroom observation. No child will be singled out unless we are already aware of a behavior problem and have parent/guardian permission on file.

___**Yes** ___**No** My child may be present during classroom observations that will be done in my child's classroom licensed therapists who follow strict rules of confidentiality.

## Photograph/Video/Social Media

Tri-County Head Start/Early Head Start occasionally invites newspapers to photograph enrolled children during various events/activities. Your permission is needed for photographs to be taken and shared with the local newspaper and internet, and agency publications. Every precaution will be taken to ensure the privacy of any child unable to be photographed.

____**Yes** ____**No** Pictures that are taken of my child may be used in newspapers, displays, bulletin boards, brochures, directories, and other type of educational publications.

___**Yes** ____**No** Pictures that are taken of my child may be used within the school building including the classroom group photo and videos that may be made of the children.

## Holiday Activities

___**Yes** ___**No** My child may participate in holiday activities such as Easter egg hunts, Christmas activities, etc. If no, please specify which holiday you do not want your child to participate in. _____

_____

**Child's Name**

_____ _____ _____

Parent/Guardian's Signature School Year Date

# Tri-County Head Start/Early Head Start

Confirmation of Receipt

I confirm that the articles listed below have been provided to me with a full explanation provided on the material. Any questions have been discussed with the staff member listed below and contact numbers provided if any further questions arise.

Child's Name _____ School Year _____

Center _____

____ Community Resource Book

____ Parent Handbook with the following information in it:

- Mission, Vision, and Philosophy
- Bus Safety and Rules
- Car Sear Information
- Pedestrian Safety Information
- Daily Classroom Schedule and Rules
- Disciplinary Policies
- Arrival, Departure and Attendance Policy
- Parent's Rights and Responsibilities
- Privacy Practices
- Know Your Childcare Booklet
- Parent Committees
- In-Kind

____ Emergency Preparedness Plan

____ School Calendar

All policies are available on the Tri-County Head Start website.

www.tricountyheadstart.com

Monthly menus for breakfast, lunch, and snack (including classroom nutrition activities) are also available on the website. If there is no internet access available, copies may be obtained from the Center Coordinator or Family Service Advocate.

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Signature Date

# Tri-County Head Start/Early Head Start

Getting to Know You

Since you know your child best, please share a little bit about him/her with us. This information will help us develop a plan that supports you as your child's first and best teacher and encourages your child to grow and learn!

Has your child been in an early learning program before? If yes, where, and why are you choosing Head Start?_____

What does your child do well? _____

What are some goals you would like to set for your child? _____

How do you and your child spend time together? _____

Does your child get easily frustrated by difficult tasks or with others? _____

What kind of things upset your child, how do you comfort him or her? _____

What keeps your child interested? _____

Do you notice your child struggling with some activities? _____

How does your child interact with others? _____

# Tri-County Head Start/Early Head Start

Getting to Know You

What words would you use to describe your child? _____

_____

_____

How do you motivate your child? _____

_____

_____

Have you ever been concerned with your child's behavior? If so, please describe them._____

_____

_____

Has your child met developmental milestones as expected? Has their pediatrician ever discussed any concerns with you related to their development? _____

_____

_____

In the home, how are you preparing your child to learn? _____

_____

_____

Is your child currently receiving any behavioral health services? If not, would you be interested in your child being assessed? _____

_____

_____

Could you tell us about your family's culture? _____

_____

_____

What are your expectations for your child's early learning experience? _____

_____

_____

What are your child's favorite toys, games, or books? _____

_____

_____

Is there any other way that our program can support your child and family? _____

_____

_____

Family Service Advocates: Please place a copy of this document in the education file.

**Tri-County Community Council Head Start/Early Head Start**

**Child Education/Disability File Checklist**

**Child's Name:** _____ **Entry Date:** _____

| | |
|---|---|
| **General Information/Permissions/Screening Permission** | |
| | Confidentiality of Record |
| | Child's Education/Disability Checklist |
| | Battelle Developmental Inventory 3rd Edition Permission Form |
| | Teaching Strategies GOLD Permission Form |
| | Permission Consent Form Mental Health/Photo/Video/Social Media |
| | Other: |
| | |
| **Contact/Parent Conference/Home Visits** | |
| | Communication to and from Parents |
| | New Child-Getting to Know You (if applicable) |
| | Second Parent Conference |
| | First Parent Conference |
| | Second Home Visit |
| | First Home Visit/Education Orientation |
| | School Attending/Transition (if Applicable) |
| | |
| **Assessments** | |
| | Teaching Strategies GOLD Spring Checkpoint – (Development & Learning) |
| | Teaching Strategies GOLD Winter Checkpoint – (Development & Learning) |
| | Teaching Strategies GOLD Fall Checkpoint – (Development & Learning) |
| | |
| **Observations/Anecdotal** | |
| | Child Individual Plan (CIP) |
| | Observation |
| | |
| **Disability Section 1** | |
| | Behavior Plan (if Applicable) |
| | Progress Notes (If Applicable) |
| | Eligibility Staffing (If Applicable) |
| | ELKS Occupational Therapy referral with Doctor's Rx |
| | Permission for Services |
| **Disability Section 2** | |
| | IFSP/IEP (If applicable) |
| | Referral Form |
| | Battelle Developmental Inventory (BDI) |
| | Ages & Stages (ASQ) |
| | Other: |

***Please check off items off list as you put them in the file with the latest information on top and in the order of which it is arranged in the list of items. Remember to only file items that have been completed in its entirety and into the designated section and order of placement. The child's entry date is the child's first day of school, Not their enrollment date.**

# Tri-County Head Start/Early Head Start

Education File Confidentiality of Records

Name of Child: _____

Only authorized persons within the agency have access to the education records. Any individual that handles this file, other than the teaching staff, must sign below providing the requested information, and receive clearance from the teaching staff.

| Name/Signature | Title | Date | Purpose |
|---|---|---|---|
| | | | |
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# Tri-County Head Start/Early Head Start

Screening Consent Form

Tri-County Head Start/Early Head Start will use the following assessments to screen each child. These assessments help us learn more about your child's progress in all areas of development: Motor, Adaptive, Cognitive, Social-Emotional and Communication.

**The Ages & Stages Questionnaire is completed by the parent. It focuses on your child's social-emotional behaviors. Your timely completion of this screener is helpful in further assessments.**

_____ I understand and will complete the ASQ within 5 days of enrollment.

_____ I need assistance with completing the questionnaire.

**The Battelle Developmental Inventory screening tool will be used within 45 days of enrollment to screen infants, toddlers, and preschoolers.**

_____ Yes, you have permission to administer the BDI screening assessment.

_____ No, you do not have permission to administer the BDI screening assessment.

**The Devereux Early Childhood Assessment (I/T, P2 and C) will be used to assess behaviors related to social-emotional development. These results guide individualized learning strategies in the classroom.**

_____ Yes, you have my permission to administer the age appropriate DECA.

_____ No, you do not have permission to administer the age appropriate DECA.

**Release of Information**

The purpose of these screenings is to determine the skills in which your child may need additional help or early interventions. We will need permission from you to send screening information, evaluations, or recommendations to the proper agency.

_____ Yes, I grant permission to release assessment results.

_____ No, I do not grant permission to release assessment results.

_____ _____

Child's Name Parent's Signature Date

_____ _____

Staff Signature Date Center School Year

**Tri-County Community Council, Inc.**
**Head Start/ Early Head Start**
**2499 Cypress St. Westville, FL 32464**
**(850) 548-9900 FAX (850) 548-5644**

Teaching Strategies GOLD Assessment Permission

Performances Standard

1302.33(5)(b)(1)(2)(3)
Staff must use a variety of strategies to promote and support children's learning and developmental process based on parent input, observations, and ongoing assessment of each child.

Teaching Strategies GOLD is an ongoing observational system for assessing children from birth through kindergarten. It helps teachers to observe children in the context of everyday experiences, which is an effective way to learn what they know and can do. Teaching Strategies GOLD is based on 38 objectives for development and learning that include predictors of school success and are based on school readiness standards. The objectives are aligned with the State Standards, Florida Early Learning and Developmental Standards, and the Head Start Early Learning Outcomes Framework.

If you have any questions concerning the Teaching Strategies GOLD ongoing assessment, please contact Dorothy McClendon, Education Coordinator, at 850-548-9900.

_____ Yes, you have my permission to administer the Teaching Strategies GOLD Assessment with my child.

_____ No, you do not have my permission to administer the Teaching Strategies GOLD Assessment with my child.

_____ _____
Child's Name Center

_____ _____
Parent's Signature School Year

4/2021dsm