HEAD START &
EARLY HEAD START

Your Guide to the Application Process

Thank you for your interest in giving your child a "head start."

Since 1965, the Community Action Program Committee, Inc. has had the honor and privilege of administering the Head Start program in Escambia County, Florida. For nearly 60 years, we have prepared thousands of children in our community for the first day of kindergarten and beyond. Our Head Start alumni are elected officials, doctors, scientists, police officers, attorneys, firefighters, electricians, bankers, builders, nonprofit leaders, public servants and clergy. **We hope to include your child in our Head Start family. Here's what you need to know:**

- **Early Head Start:** Ages 6 weeks to 3 years old
- **Head Start:** Ages 3 to 5 years old
- **There is no cost to attend but strict income guidelines and eligibility criteria are in place.** Federal income guidelines are updated annually, and we are required to ensure our program serves eligible families.
- We offer a **variety of classrooms with varying hours** at locations across Escambia County. Our Century location provides daily transportation; we also transport children to certain health and medical appointments. Health and developmental screenings are a core part of our program and help keep your child on track.
- A healthy **breakfast and lunch** are provided daily to every enrolled child.
- Our **curriculum** is designed to prepare your child for success in school and in life; our education program is based on the latest Florida Early Learning and national Head Start standards.
- Teachers and Family Advocates work with you to **develop goals and access resources** to help your family thrive.

Please note: Your child is eligible for selection and placed on our waiting list when we receive the following:

1. Proof of income: We need proof of your total household income for the last 12 months *(for both parents if in the same household)*. *(Example:* Paycheck stubs; IRS tax form 1040)
2. Proof of residency: We need proof you live in Escambia County, Florida. *(Example: utility bill)*
3. Birth certificate: An official copy of your child's birth certificate or other government-issued proof of birth.
4. If your child has a disability, we'll need a copy of their IEP or IFSP.
5. If applicable, we will need a copy of legal documentation showing guardianship, adoption, etc.

Ready to submit?

Mailing Address:
Community Action Head Start
2050 West Blount Street
Pensacola, Florida 32501

Drop Off :
Any of our locations

Email:
enrollment@capc-pensacola.org

It takes time to process each application. We will contact you when you are placed on our waiting list, and then again when your child is ready to enroll. You can keep in touch with us, and track your application, by emailing us at ***enrollment@capc-pensacola.org.***

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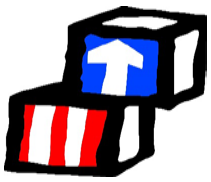
Head Start/Early Head Start Program Application



☐ Head Start (center-based)
☐ Head Start (childcare partner)
☐ Head Start (Title 1 partner site)
☐ Early Head Start
☐ 2021-2022 ☐ 2022-2023

A. APPLICANT (CHILD APPLYING FOR SERVICES)

First Name	Middle Name	Last Name and Suffix	Date of Birth	Gender
				☐ Male ☐ Female

Race
☐ Asian ☐ American Indian or Alaskan native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian ☐ Biracial/Multiracial
☐ Other: _____ ☐ Vietnamese

Primary Language
☐ English ☐ Korean
☐ Spanish ☐ Vietnamese
☐ Arabic ☐ Other
☐ Chinese _____

Ethnicity
☐ Hispanic or Latino Origin
☐ Non-Hispanic or Non-Latino Origin

Living Address	Address Line 2	Zip Code	City	State

Mailing Address (*if different*)	Address Line 2	Zip Code	City	State

Contact Number	Type (cell, work, etc.)	Alternate Number	Type (cell, work, etc.)

B. PRIMARY PARENT or GUARDIAN

First Name	Middle Name	Last Name	Date of Birth	Gender
				☐ Male ☐ Female

Race
☐ Asian ☐ American Indian or Alaskan native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian ☐ Biracial/Multiracial
☐ Other: _____ ☐ Vietnamese

Primary Language
☐ English ☐ Korean
☐ Spanish ☐ Vietnamese
☐ Arabic ☐ Other
☐ Chinese _____

Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino

Employment Status
☐ Full-time (35+ hrs a week)
☐ Part-time (less than 35 hrs a week)
☐ Self-employed
☐ Unemployed
☐ Retired or Disabled

Student Status
☐ Full-time
☐ Part-time
☐ Not a student

School Name

Custody *(if applicable)*
☐ Permanent ☐ Temporary

Paternal rights established?
☐ Yes ☐ No

Income Received (*documentation required for past 12 months*)
☐ Wages ☐ Alimony ☐ Unemployment
☐ SSI/SSDI ☐ Scholarships ☐ Grants ☐ TANF
☐ Child Support ☐ Veteran's ☐ Pension ☐ Other

Highest Grade Completed
☐ Grade 10 or less ☐ Some college, no degree
☐ Grade 11 ☐ Technical certification
☐ GED ☐ Associate's degree
☐ Certificate of completion ☐ Bachelor's degree
☐ High school graduate ☐ Master's degree+

Relationship to child
☐ Natural/adopted/step-child
☐ Foster child
☐ Grandchild
☐ Niece or Nephew
☐ Legal guardian

Lives in house with child
☐ Yes ☐ No

Parent attended Head Start
☐ Yes ☐ No

Siblings in Head Start
☐ Yes ☐ No

Please select all statements below that are TRUE about your household
☐ Child abuse or neglect is present
☐ Applying child *has* an IEP/IFSP
☐ Homeless
☐ Applying child has a *suspected* disability
☐ Active duty military
☐ Receive SNAP (food stamps)
☐ At Risk
☐ In Crisis and type _____
☐ Receive WIC

C. SECONDARY PARENT or GUARDIAN

First Name	Middle Name	Last Name	Date of Birth	Gender
				☐ Male ☐ Female

Race
☐ Asian ☐ American Indian or Alaskan native
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Biracial/Multiracial
☐ Other: _____ ☐ Vietnamese

Primary Language
☐ English ☐ Korean
☐ Spanish ☐ Vietnamese
☐ Arabic ☐ Other
☐ Chinese _____

Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Non-Latino

Employment Status
☐ Full-time (35+ hrs a week)
☐ Part-time (less than 35 hrs a week)
☐ Self employed ☐ Unemployed
☐ Retired or Disabled

Student Status
☐ Full-time
☐ Part-time
☐ Not a student

Income Received (*documentation required for past 12 months*)
☐ Wages ☐ Alimony ☐ Unemployment
☐ SSI/SSDI ☐ Scholarships ☐ Grants ☐ TANF
☐ Child Support ☐ Veteran's ☐ Pension ☐ Other

Highest Grade Completed		Relationship to child	Lives in house with child
☐ Grade 10 or less	☐ Some college, no degree	☐ Natural/adopted/step-child	☐ Yes ☐ No
☐ Grade 11	☐ Technical certification	☐ Foster child	**Parent attended Head Start**
☐ GED	☐ Associate's degree	☐ Grandchild	☐ Yes ☐ No
☐ Certificate of completion	☐ Bachelor's degree	☐ Niece or Nephew	**Siblings in Head Start**
☐ High school graduate	☐ Master's degree+	☐ Legal guardian	☐ Yes ☐ No

D ADDITIONAL HOUSEHOLD MEMBERS YOU SUPPORT (please do not include anyone listed above)

First Name	Last Name	Date of Birth	Relationship to child
First Name	**Last Name**	**Date of Birth**	**Relationship to child**
First Name	**Last Name**	**Date of Birth**	**Relationship to child**
First Name	**Last Name**	**Date of Birth**	**Relationship to child**
First Name	**Last Name**	**Date of Birth**	**Relationship to child**
Referred by			

E. OTHER WAYS WE CAN REACH YOU ***(people we can call and your e-mail address)***

First Name	Last Name	Phone Number
First Name	**Last Name**	**Phone Number**
YOUR EMAIL ADDRESS (1)		**YOUR EMAIL ADDRESS (2)**

I certify that the information in this application is correct and true.
I understand that should the program determine the information given is false or incorrect, my child could be dropped from the program.

Parent Signature ***Date***

For Office Use Only ***(items below to be completed by CAPC Head Start staff)***

The following documents are attached:

	Yes	*No*	*N/A*
1) Child's birth certificate			
2) Proof of family income with signed eligibilty verification			
3) Proof of residency			
4) Guardianship Papers (*if applicable*)			
5) IEP/IFSP (*if applicable)*			

Intake Staff Signature ***Date*** ***Preferred Center Location***

Application has been verified by ERSEA staff member (signature) ***Date***

The 2022 poverty guidelines below are in effect as of January 12, 2022.

Family Size	Poverty guideline	Family Size	Poverty guideline
1	$13,590	**5**	$32,470
2	$18,310	**6**	$37,190
3	$23,030	**7**	$41,910
4	$27,750	**8**	$46,630

For families with more than 8 people, add $4,720 for each additional person

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Self-Identification of Residency Form

Please answer the questions below that best describes your living situation. The purpose of this information is to ensure the rights of your children under the McKinney Vento law and income eligibility under Head Start/State regulations.

1. **Do you own or rent a fixed, regular, adequate night time residence?** ☐ Yes ☐ No

If you checked "Yes" stop here. You must provide a utility bill in your name as proof of residence. Continue if you checked "No".

2. Do you or your family live in any of these situations? (Check all that apply).

- ☐ In a shelter (family shelter, domestic violence, youth, or temporary housing)
- ☐ In a motel, hotel, campground, or weekly rate housing
- ☐ In substandard housing (for example without running water/electricity); abandoned building, trailer, or in a car
- ☐ On the street
- ☐ In temporary foster care
- ☐ Sharing housing with friends or relatives because you cannot find or afford housing

Please explain: _____

_____

Our family has not had a permanent residence since the following **date**:
I have no documentation to support this statement for the following reasons:

When my status changes I will notify Community Action Program Committee, Head Start immediately. Failure to comply may result in termination of my services. I swear under penalty and perjury, to the best of my knowledge, that the above statements are true and correct.

Print Parent/Guardian Name	Parent/Guardian Signature	Date
_____		_____

Applying Child's Name	**Date of Birth**	**Applying Child's Name**	**Date of Birth**

The child(ren) named qualify for the Head Start/Early Head start program and they should be given the rights listed below.

Based on the McKinney Vento Homeless Education Assistance Act, your child(ren) have the right to:

- Be found income eligible for participation in Head Start programs if families/children are defined as homeless. Migrant/ seasonal families will need to also verify that income comes primarily from agricultural work.
- Enroll in program without giving a permanent address and attend programs while the agency arranges for copies of immunization records or other documents required for enrollment.
- Receive the same special programs and services, if needed, as provided to all other children served in Head Start/State programs.

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Zero Income Statement

(please complete this section if you have no income)

Child's Name: _____

This is to verify that my child/children and I do not have any income at this time:

Date: _____

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

Parent's Signature: _____ **Date:** _____

The Head Start staff below has made an attempt to verify income by requesting information in accordance with Head Start Performance Standards.

CAPC Staff Signature: _____ Date: _____

Income Self-Declaration Form

(please complete this section if you have no documentation of income)

Certification: I certify that I have no documentation of income.

☐ I am currently not working.

☐ I have worked for the following in the past year. *Please include self-employment; seasonal employment; irregular employment; paid cash; and family contributions received.*

Please explain below how your family is being supported. Include how housing, clothing and bills are paid.

Parent's Signature: _____ Date: _____

CAPC Staff Signature: _____ Date: _____

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Third Party Verification Form
(*only complete if you have no income*)

I verify that I _____ do not have any other income. I give the CAPC Head Start staff authorization to contact the individual(s) identified below to verify my income status. I further certify that this information is true. I understand that if it is determined that any information is false, my child's participation in this agency's program may be terminated. I also understand that the information on this form will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature: _____

Date: _____

Full Name of Reference	Relationship to Parent	Phone Number	Address
1.			
2.			
3.			

Below to Be Completed By Head Start Enrollment Staff - ONLY

Head Start Staff Verification Notes – Include the information obtained from the Third-Party provider through interview or review of documentation :

_____

_____

Estimated Income – Based on the information gathered through interview and/or review of documentation, provide the estimated income from this source below (attach any available documentation):

- Estimated income from this source: $ _____
- Timeframe this income was received _____ to _____ (Dates)

Eligible ☐ YES ☐ NO Reason Denied – If applicable: _____

I have determined to the best of my ability that the information provided by the family is true and reflects the family's income and verifies their eligibility for acceptance into the Head Start/Early Head Start program.

Verifying Staff Signature: _____ Verification Date: _____

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Emergency Contact Form

☐ **Head Start** ☐ **Early Head Start** ☐ **Contracted Care**

Date: _____

I, _____, understand that in case of an emergency I authorize the following people to pick my child up from school or from the bus stop.

1. _____
   Name Relationship Address
   _____
   City Zip Code Area Code/ Telephone Number (Cell/ Work)
2. _____
   Name Relationship Address
   _____
   City Zip Code Area Code/ Telephone Number (Cell/ Work)
3. _____
   Name Relationship Address
   _____
   City Zip Code Area Code/ Telephone Number (Cell/ Work)
4. _____
   Name Relationship Address
   _____
   City Zip Code Area Code/ Telephone Number (Cell/ Work)
5. _____
   Name Relationship Address
   _____
   City Zip Code Area Code/ Telephone Number (Cell/ Work)

Also, to update our records, please list your correct address and telephone number:
Address: _____ Phone: _____
Child's Name: _____
Parent/ Guardian Signature: _____
Social Service Advocate Signature: _____ Date: _____

White copy – Central file Yellow copy – Classroom folder Pink copy – SSA Photo copy - Transportation

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Permission to Share Information, Receive Emergency Aid and Participate in Activities

Please initial

____ I grant permission to share my child's name, address, and additional identifying information as well as assessment results with partners such as the Escambia County School District, Early Learning Coalition, Ready Kids! and interns. ***All information will be kept strictly confidential***

____ I grant permission for my child to attend all classroom field trips.
____ I grant permission for my child to have his/her picture taken for publicity purposes.

____ I understand I will be notified of all field trips and publicity opportunities.
____ I grant permission to share dental information with oral surgeons.

____ I grant permission for my child to brush their teeth at school.

____ I grant permission for my child to receive simple first aid treatment when necessary. In the event of a more serious injury, I authorize emergency medical treatment.

____ I grant permission for on-site observations of my child by a licensed mental health professional to provide support for effective classroom management and positive learning environments. If my child is recommended for screening, assessment or mental health services, I will be contacted and an appointment for a parent conference will be scheduled.

By initialing and signing, I give my permission to share information on my child with the different entities listed as well as for my child to be transported on classroom field trips and participate in oral health. This permission is valid for the 2022-2023 school year. I understand I may cancel this consent or any portions of it by providing a written request.

Print Name of Child: _____

Print Name of Parent/ Guardian: _____

Signature of Parent: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Original – Central File Copy – Teacher Copy – Health Copy – Parent

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Consent for Screening and Examinations

Please initial

____ I grant permission for my child to receive hearing screening and follow-up screening*
____ I grant permission for my child to receive vision screening and follow-up screening*
____ I grant permission for my child to receive blood pressure and follow-up screening*

____ I grant permission for my child to receive dental screening and examinations (x-rays if necessary) by a dental provider, including the Community Health of Northwest Florida dental van*
____ I grant permission for my child to receive dental cleaning, fluoride treatment, and oral hygiene instruction
____ I grant permission for my child's height & weight measurements to be taken*
____ I grant permission for my child to receive hematocrit/hemoglobin screening and follow-up screening*

____ I grant permission for my child to receive the required developmental, social-emotional, and sensory screenings appropriate for their age

By initialing and signing, I give my consent for my child to receive the listed screening and examinations, including the transport of my child to receive these services. **I understand that the services with an * are required by the Head Start program, and that some services may be repeated during the course of the school year**. I will be informed of the results. The purpose of all screening and examinations has been explained to me.

This consent is valid for the 2022-2023 school year. I understand that I may cancel this consent or any portions of it by providing a written request for denial of services.

Print Name of Child: _____

Print Name of Parent/ Guardian: _____

Signature of Parent: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Original – Central File Copy – Teacher Copy – Health Copy - Parent

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Consent for Blood Lead Test

Dear parent/ healthcare provider:

Federal regulation requires that all children receive a screening blood lead test at 12 and 24 months of age, or between the ages of 36 and 72 months for those children who have not been previously screened for lead poisoning. Head Start mandates that we document one result on each child. We need your assistance in obtaining the results. If you have any questions or concerns, please reach out to your Family Advocate.

Student Name: _____
DOB: _____ Phone Number: _____

_☐_ I give my consent for my child's blood lead screening to be done at Head Start.

_☐_ I **Do Not** give my consent for my child's blood level screening to be done at Head Start. I will be responsible for getting my child's blood lead level tested at my doctor's office and submitting the results to Head Start.

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

Authorization for Release of Medical Information Blood Lead Level

[Authorization is valid for the 2022-2023 school year.]

Physician/ Clinic Name: _____ **Date:** _____

Phone Number: _____

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

Witness: _____ **Date:** _____

Medical Provider – Please record results and return to parent/guardian for submission to Head Start

Lead Level _____

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Mobile Dental Unit Services Permission Form
Elementary Schools

☐ **YES**, I hereby give consent for my child _____, to be examined by the dentist on the Mobile Dental Unit and to receive the preventive treatment that is recommended. I understand that these dental services are being provided by Community Health Northwest Florida (formerly known as Escambia Community Clinics, Inc.) and not by **Escambia County Schools.**

☐ **NO**, I do not consent to having dental services be provided for my child. I do not hold **Escambia County School Board** or Community Health Northwest Florida responsible for any future dental problems resulting from a lack of dental treatment.

LEGAL NAME OF CHILD_____
(LAST) (FIRST) (MIDDLE INITIAL)

Child's Date of Birth (Month/Day/Year) _____ **Sex** ☐ Male ☐ Female

Migrant? ☐ No ☐ Yes

Race _____ **Child Social Security #** _____ **Medicaid #** _____

School_____ **Teacher**_____ **Grade**_____PK_____

****

Parent or Guardian (PRINT NAME) _____ **Relationship to child** _____

Signature of Parent or Guardian_____ **Date**_____

Address_____ **City**_____ **Zip**_____

Parent/Guardian Phone Number(s)_____ **Alternate Phone** _____

IMPORTANT: The health history information and medical release attached must be completed and signed in order for dental treatment to be provided.

1700-F011
10/22/13, Rev 02/09/17; 08/18/18j; 102018 dw

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DENTAL DEPARTMENT MEDICAL HISTORY FORM

Patient Name (print):_____ **Date of Birth:** _____

Reason for today's visit:

_____

Primary care doctor's name and phone number:

Current Medications:

_____

_____

_____

Date of last dental exam and x-rays:

_____

Have you been hospitalized in the past 5 years?
Yes, for _____
No

Dental Information Check ☑ those that apply

Do you have:	Yes	No	Not Sure
Tooth pain?			
Jaw pain?			
Facial swelling?			
Bleeding gums?			
Sensitive teeth?			
Dry mouth?			
Problems with past dental treatment?			

Medical Information Have you **EVER** had any of the following conditions? Check ☑ those that apply:

	☐Diabetes Type I or II	☐High Blood Pressure	☐Sickle Cell Anemia
☐Medication Allergies:_____	☐Dizziness	☐HIV/AIDS	☐Sinus Problems
	☐Drug/Alcohol Addiction	☐Immune disorders	☐Smoker / Tobacco User
☐Anemia	☐Emphysema	☐Kidney Disease	☐Stomach Problems
☐Anxiety	☐Epilepsy	☐Liver Disease or Jaundice	☐Stroke
☐Arthritis	☐Excessive Bleeding	☐Low Blood Pressure	☐Thyroid Problems
☐Artificial Joints or Valves	☐Fainting	☐Mental Disorders	☐Tuberculosis
☐Asthma	☐Glaucoma	☐Osteoporosis	☐Tumors
☐Autism	☐Gastrointestinal Issues	☐Pacemaker	☐Ulcers
☐Blood Disorders	☐Headaches	☐*Currently* Pregnant:	☐Venereal Disease
☐Blood Transfusion	☐Head Injuries	Due Date:_____	☐Other:_____
		Nursing? Yes or No	_____
☐Cancer	☐Heart Attack	☐Radiation Treatment	_____
☐Chest pain/ Angina	☐Heart Disease	☐Recurrent Infections	_____
☐Cholesterol (high)	☐Heart Murmur	☐Respiratory Problems	_____
☐Depression	☐Hepatitis A, B or C	☐Shortness of Breath	

To the best of my knowledge, all of the answers and information that I provided are true and correct. I will not hold my dentist or staff responsible for any action they may take because of errors or omissions made in my responses. If there is a change in my health status or medications, I will inform the doctor and staff immediately.

Signature of patient/legal guardian: _____ **Date:**_____

OFFICE USE ONLY Medical History reviewed by:

Signature of Doctor: _____ Date: _____

Comments: _____

1700-F011
10/22/13, Rev 02/09/17; 08/18/18j; 102018 dw

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RELEASE OF MEDICAL INFORMATION

I acknowledge that records concerning the patient are the property Escambia Community Clinics, Inc. (ECC) dba Community Health Northwest Florida and are maintained for the use and benefit of its medical staff. I authorize ECC to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to the Clinic or to me or to a family member of mine for all or part of the charges including but not limited to the Clinic's medical insurance company, worker's compensation carriers or welfare agencies provided such release of information is in accordance with federal and state laws.

PLEASE PLACE YOUR INITIALS IN EACH BOX IF YOU CONSENT TO RELEASING THIS INFORMATION

I understand that the information in my medical record will include information relating to:

_____sexually transmitted disease
_____acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV)
_____behavioral or mental health services
_____treatment for substance abuse (i.e. alcohol and drug abuse)

ASSIGNMENT OF INSURANCE BENEFITS

I assign payment of all insurance benefits, basic and major medical for this period of medical treatment, to be made directly to ECC.

FINANCIAL AGREEMENT

For and in consideration of services rendered, each of the undersigned agrees to pay ECC for all charges not covered by insurance payment as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services or treatment rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by the clinic including reasonable attorney's fees which shall include, but not be limited to, such fees incurred prior to.

AUTHORIZATON FOR MEDICAL CARE AND TREATMENT

The undersigned hereby make the following Acknowledgments and Agreements regarding the medical treatment to be provided to the patient whose name appears on the reverse side hereof.

- I recognize that a condition exists requiring medical care and do hereby voluntarily consent to such medical care encompassing diagnostic procedures and medical treatment at Escambia Community Clinics, Inc. as is deemed necessary. I understand that this medical care may include tests, examinations and medical treatment.
- I am aware that the practice of medicine and surgery and the administration of medical care are not exact sciences and acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, surgical procedures, medical procedures, treatments, examinations or care undertaken by ECC.
- I understand that such medical care, treatment and procedures will be performed by independent physicians and by employees of ECC between the hours of 7:30 a.m. and 4:00 p.m. (Monday – Friday). I understand that no responsibility will be taken by ECC for long term patient care, or between 8:00 p.m. and 8:00 a.m.
- This consent for medical care and treatment is valid until further revoked by me in writing.

This form has been fully explained to me and I certify that I understand its contents.

_____ _____

Printed Name | Signature of Patient

_____ _____

Print Parent name or Guardian if Minor | Signature of Parent or Guardian if Minor

_____ _____

Patient's Date of Birth | Today's Date

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PRIVACY INFORMATION

It is the policy of Escambia Community Clinics, Inc. dba Community Health Northwest Florida to leave reminder messages on your answering machine or with another person in your home.

It is the policy of Escambia Community Clinics, Inc. to make a follow up telephone call when appropriate and may require leaving a message.

It is the policy of Escambia Community Clinics, Inc. to provide you with a copy of the Notice of Privacy Practices. By signing below I acknowledge that I have received this Notice and understand that it will be placed in my chart and maintained for six years.

_____ I acknowledge these policies.

In accordance with the privacy practices of **Escambia Community Clinics, Inc. dba Community Health Northwest Florida**, I consent to the disclosure of protected health information (PHI) for purposes related to treatment, payment and operations.

I further authorize additional individuals listed below to obtain pertinent PHI for purposes such as picking up lab or x-ray testing or information regarding my billing account, or other purposes.

NAME	**RELATIONSHIP**
_____	_____
_____	_____

This authorization is valid until further revoked by me in writing.

_____ _____ _____

Signature Print Name Date of Birth

_____ _____

Date Witness

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Attendance Policy

Dear families,

Welcome to Head Start! This school year is a great time to start building a habit of good attendance. We have learned that students who miss even a few days of school each month are at a far greater risk of not being ready for kindergarten and, over time, may have a higher risk of struggling academically.

- We have set a goal that every Early Head Start and Head Start student attends school every day. We are required to ensure appropriate attendance is maintained at 85% per classroom.
- It is important to be on time each day, as every minute counts. Please send your child to school on time, every day, unless he or she has a contagious illness or is running a fever. Children arriving after **9:15 a.m**. will be considered tardy. Parents will be asked to complete a late arrival form.
- Parents must contact center staff if their child will be later than **9:30 a.m. and feed them breakfast** prior to arriving at school. This is so the child can be placed on the lunch count for that day.
- **Attendance improvement action plans** will be started if a child has 3 absent days in a month or 2 consecutive days absent without notification or when a student has excessive tardies (defined as 3 tardies in a month). This improvement plan will set goals and completion dates. If a family is unable to complete the goals, then the child may be removed from the program.
- If a child is absent for 5 consecutive days without notification to the center staff, the child will be removed from the program.

The parent/guardian signature below indicates that the information in the policy has been reviewed and agreed upon.

Child's Name: _____ Center: _____

Parent's Signature: _____ Date: _____

Revised Feb. 2022

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Discipline Policy

1. All children are expected to follow classroom rules and limits with regards to acceptable behavior. This includes all areas of age-appropriate social/emotional development as indicated in school readiness goals of regulating emotions and behavior; establishing and sustaining positive relationships; and participating cooperatively and constructively in group situations.

2. No acts of corporal punishment or physical aggression are tolerated on Head Start premises or on the bus. Acts of physical aggression include any form of corporal punishment such as hitting, spanking, biting, kicking, scratching, and throwing objects to hit others. Verbal aggression includes cursing, yelling, demeaning or other humiliating comments.

3. In the classroom, teaching staff and support personnel will follow accepted guidelines when dealing with inappropriate behavior.
   *Model the appropriate behavior.
   *Tell the child what he/she can do.
   *Establish eye contact at the child's level when speaking.
   *Give the child choices whenever possible.
   *Encourage the child to problem solve and try to work out conflicts.
   *Redirect the child to another activity.

4. Children who engage in extreme incidents of physical or verbal aggression will receive intensive interventions from teaching staff and support staff. As the child's first and best teacher, the parents are expected to be involved in this process; which can include weekly parent conferences, working with the child at home using accepted guidelines for dealing with inappropriate behavior and open communication with staff.

5. In the event there is minimum or no improvement in the child's behavior after intensive interventions, placement changes may be made to the child's Head Start day. Placement changes may include: (1) limiting the hours the child spends in daily care; (2) mandatory parent attendance when the child is at school; (3) discontinuing transportation services when safety concerns exist or when there are issues with child pick-up and drop-off; and (4) referral for full evaluation.

The parent/guardian signature below indicates that the information in the policy has been reviewed.

Child's Name: _____ School: _____

Parent's Signature: _____ Date: _____

Calling All Parents - Join our Head Start Policy Council!

Dear Parents/Guardians,
Each year our program must elect parents/guardians of children enrolled in the Head Start/Early Head Start program to serve on the Policy Council. You may be asking, what is the Policy Council?

The Policy Council as a formal leadership and policy-making organization for parents. Today, every Head Start and Early Head Start program must have a Policy Council as part of its leadership structure. Through the Policy Council, parents have a voice in decisions about how the program spends money, what children do in their classrooms, and how the program works with community partners.

The Policy Council is not only made up of parents from each of our centers, but also former parents and members from the community who represent the organizations we partner with. The Policy Council meets once per month, and generally meetings last one hour. ***Parents serving on the Policy Council will receive mileage reimbursement at the prevailing reimbursement rate and childcare payments for children who are not in school or childcare.***

The Policy Council has the responsibility of reviewing, approving, and even participating in many items for our program. Some of these items include:

1. Personnel and staffing
2. Program policies and procedures
3. Eligibility, Recruitment, Selection, Enrollment, Attendance (ERSEA)
4. Grant applications
5. Community assessment and our agency self-assessment

The new Policy Council will begin meeting in October 2022 and continue until September 2023. Attendance is very important throughout the year, especially during the summer months. If this sounds like something you would like to participate in, please complete form below. **Parents will be voted in at the first parent meeting in September.**

Sincerely
Misi Birdsall, Director of Head Start/Early Head Start

☐ No I am not interested (only complete name, child's name and center below)

☐ Yes, I am interested in serving on the Policy Council for the 2022-2023 year. (complete all fields)

Name: _____ Phone number: _____

Child's Name: _____ Center: _____

Address: _____ E-mail_____

City/ZIP: _____

Helping People. Changing Lives.
Community Action
PROGRAM COMMITTEE, INC.

Family Engagement Contract

Child's Name: _____ **Center:** _____

By enrolling your child, you are joining us to achieve our program's mission to bring a relentless focus on positive child and family outcomes to close the achievement gap and build a better future for children, families and communities served CAPC Head Start. To reach our shared mission, and recognizing your hopes and dreams for your child, we need to work together as equal partners. Please officially join us in partnership by signing and following through on this Family Engagement Contract.

One hope or dream I have for my child is .....

Our program will do the following for you and your child:

- Provide an excellent education program—every day—for all of our students
- Guide you through the process of learning and doing high quality parent child activities that support you child's learning at home
- Support you to keep your child healthy and well
- Honor your family's unique strengths, needs and circumstances
- Build an environment that welcome's ALL families as partners in our program
- Welcome your voice and create opportunities for you to provide feedback and to be heard
- Offer many ways for you to participate and volunteer at our program

I, _____, will do the following:
(Parent, Guardian name

- Bring my child to school on time every day
- Participate in my child's learning by completing each week's homework activities every day
- Read with my child every night
- Attend center activities to help build community and to advocate for my child and family.
- Partner with our program to keep my child healthy
- Participate in 2 home visits and 2 parent conferences with your child's teacher
- Participate in 2 home visits with your Family Advocate

Partnership Agreement: We agree that we will work together as equal partners to achieve my child's school readiness goals. We also will help you reach your own family goals.

Parent/Guardian Signature_____ Date: _____

Staff Signature: _____ Date: _____

Original– Central folder Copy - Parent