

SECTION 1: DOECE Applicant & Family Member Information

Center: _____

Please Select: Child Care Head Start Early Head Start

Child Applicant					
First	Middle	Last	Birthday	Gender	SSN
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Choctaw	<input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Yes	<input type="checkbox"/> Little	<input type="checkbox"/> Choctaw	<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Other American Indian/Alaska Native	<input type="checkbox"/> No	<input type="checkbox"/> Moderate	<input type="checkbox"/> Other Native	<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> Proficient	<input type="checkbox"/> Spanish	<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____			<input type="checkbox"/> None		<input type="checkbox"/> None
Primary Health Coverage		Other Health Coverage	Medicaid	Doctor	Dentist
<input type="checkbox"/> Medicaid			<input type="checkbox"/> Not Eligible		
<input type="checkbox"/> CHIP			<input type="checkbox"/> On Medicaid		
<input type="checkbox"/> Other			<input type="checkbox"/> Potentially Eligible		

Adult 1					
First	Middle	Last	Birthday	Gender	SSN
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Choctaw	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little	<input type="checkbox"/> Choctaw	<input type="checkbox"/> Little
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate	<input type="checkbox"/> Other Native	<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Proficient	<input type="checkbox"/> Spanish	<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____			<input type="checkbox"/> None		<input type="checkbox"/> None
Highest Grade Completed		Employment Status		Child's Relationship	Custody
<input type="checkbox"/> <Grade 9	<input type="checkbox"/> Associate's	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Natural/Adopted/Step	<input type="checkbox"/> Yes
<input type="checkbox"/> Grade 10	<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training	<input type="checkbox"/> Grandchild	<input type="checkbox"/> No
<input type="checkbox"/> Grade 11	<input type="checkbox"/> Master's	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Niece/Nephew	
<input type="checkbox"/> Grade 12		<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster	
<input type="checkbox"/> HS Graduate				<input type="checkbox"/> Other	
<input type="checkbox"/> GED					
Check all that apply:					
<input type="checkbox"/> Lives with Family					
<input type="checkbox"/> Provides Financial Support					
<input type="checkbox"/> Teen Parent					
E-mail Address: _____					

Adult 2					
First	Middle	Last	Birthday	Gender	SSN
Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
<input type="checkbox"/> Choctaw	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Yes	<input type="checkbox"/> Little	<input type="checkbox"/> Choctaw	<input type="checkbox"/> Poor
<input type="checkbox"/> Black	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> No	<input type="checkbox"/> Moderate	<input type="checkbox"/> Other Native	<input type="checkbox"/> Moderate
<input type="checkbox"/> White	<input type="checkbox"/> Multi-Racial		<input type="checkbox"/> Proficient	<input type="checkbox"/> Spanish	<input type="checkbox"/> Proficient
<input type="checkbox"/> Other: _____			<input type="checkbox"/> None		
Highest Grade Completed		Employment Status		Child's Relationship	Custody
<input type="checkbox"/> <Grade 9	<input type="checkbox"/> Associate's	<input type="checkbox"/> Full Time	<input type="checkbox"/> Full Time & Training	<input type="checkbox"/> Biological, Adopted, or Step	<input type="checkbox"/> Yes
<input type="checkbox"/> Grade 10	<input type="checkbox"/> Bachelor's	<input type="checkbox"/> Part Time	<input type="checkbox"/> Part Time & Training		<input type="checkbox"/> No
<input type="checkbox"/> Grade 11	<input type="checkbox"/> Master's	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Training or School	<input type="checkbox"/> Grandchild	
<input type="checkbox"/> Grade 12		<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired or Disabled	<input type="checkbox"/> Foster	
<input type="checkbox"/> HS Graduate				<input type="checkbox"/> Other Relative	
<input type="checkbox"/> GED					
Check all that apply:					
<input type="checkbox"/> Lives with Family					
<input type="checkbox"/> Provides Financial Support					
<input type="checkbox"/> Teen Parent					
E-mail Address: _____					

Family Information					
Living Address		Address Line 2	Zip	City	State
Mailing Address (if different)		Address Line 2	Zip	City	State
Phone Numbers		Type (check one)		Note (for example, an extension or best time to call)	
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____		Permission to contact via text <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____		Permission to contact via text <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____		Permission to contact via text <input type="checkbox"/> Yes <input type="checkbox"/> No	

OFFICE USE ONLY: Verifications Received					
<input type="checkbox"/> Birth Certificate <input type="checkbox"/> Social Security Card <input type="checkbox"/> CDIB <input type="checkbox"/> Income Verification					
<input type="checkbox"/> 121 Immunization Form <input type="checkbox"/> Current Physical Exam <input type="checkbox"/> Current Dental Exam <input type="checkbox"/> Current Nutrition Assessment					
Date received at center: _____ Date received at DOECE: _____					

Additional Children in the Household (Not Including Applicant) *

First	Last	Birthday	Gender

Child Applicant Information

Hours of Care Needed _____ hours	Days Needed: (Check all days needed) <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday	Meals Needed: (Check as many as needed) <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> PM Snack (*Please note that outside foods are not allowed in the center)
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Parental Status (check one) <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents <input type="checkbox"/> Foster <input type="checkbox"/> Guardianship	Primary Language at Home _____	Homeless Family <input type="checkbox"/> Yes <input type="checkbox"/> No	Active Duty Military <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent is Military Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred by Child Welfare Agency <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving SNAP <input type="checkbox"/> Yes <input type="checkbox"/> No	Receiving WIC <input type="checkbox"/> Yes <input type="checkbox"/> No
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Family Income

TANF <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly	Supplemental Security Income <input type="checkbox"/> Yes <input type="checkbox"/> No
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Child Applicant Information

Child has an IEP <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child been diagnosed with or tested for the following: <input type="checkbox"/> Visual Impairment/Blindness <input type="checkbox"/> Hearing Impairment/Deafness <input type="checkbox"/> Special Diet <input type="checkbox"/> Learning Disability <input type="checkbox"/> Autism <input type="checkbox"/> Speech/Language Impairment <input type="checkbox"/> Other _____	<input type="checkbox"/> Developmental Delay <input type="checkbox"/> Orthopedic Impairment <input type="checkbox"/> Emotional Disorder <input type="checkbox"/> Health Impairment <input type="checkbox"/> Traumatic Brain Injury
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Child Applicant Information

Consents			Read and initial the appropriate answer to the following items:
My child may be photographed or videotaped at the early childhood center <input type="checkbox"/> Yes <input type="checkbox"/> No	My child is toilet trained <input type="checkbox"/> Yes <input type="checkbox"/> No If no, a consultation between the parent and caregiver is required to be documented prior to toilet training. Date of Consultation: ____/____/____	My child will eat breakfast At the center: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, my child will eat BEFORE Coming into the center.	I have been given a copy and have read the MSDH Regulation Summary for Parents. <input type="checkbox"/> Yes <input type="checkbox"/> No A 121 Immunization compliance Form is on file in the facility before My child attends. <input type="checkbox"/> Yes <input type="checkbox"/> No I have been informed that DOECE Does/does not provide liability Insurance for my child: <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 2: Emergency Contacts

Emergency Contacts				
Contact 1	Name		Relationship	
	Address		Zip	
Phone # 1		Phone # 2		Phone # 3
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name		Relationship		Emergency Contact
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Address		Zip		City
				State
Phone # 1		Phone # 2		Phone # 3
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Contact 2	Name		Relationship	
	Address		Zip	
Phone # 1		Phone # 2		Phone # 3
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name		Relationship		Emergency Contact
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Address		Zip		City
				State
Phone # 1		Phone # 2		Phone # 3
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Contact 3	Name		Relationship	
	Address		Zip	
Phone # 1		Phone # 2		Phone # 3
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name		Relationship		Emergency Contact
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Address		Zip		City
				State
Phone # 1		Phone # 2		Phone # 3
<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work		<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

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

Parent/Guardian Signature _____

Date _____

Center Director Signature _____

Date _____

SECTION 3 : DISPENSING OF GENERIC MEDICATION

The following medical treatment may be given to my child while attending a DOECE program. I understand that I have the right to review all medical records maintained on my family, dispute and correct any information I feel to be incorrect, and to be contacted when the following medications will be administered. I understand that I must provide written authorization to the staff to dispense prescription medications to my child. The Department of Early Childhood Education will not be liable for medications which have been opened prior to being dispensed at the center.

CONDITION	TREATMENT	DEPARTMENT POLICY
Illness requiring a prescription drug.	Medication will be dispensed by staff, according to directions on the label.	Parent signature required.
Minor cuts or Abrasions.	Area will be cleansed and an antibiotic ointment applied.	Accident report will be provided to the parent or guardian.
Insect bite or stings.	Calamine lotion will be applied and basic first aid provided.	Parent will be contacted. Emergency procedures will be initiated for severe allergic reactions.
Diaper rash	Area cleansed and Vitamin A&D ointment applied.	Incident report will be given to the parent or guardian.
Dental Care	Emergency care will be initiated by the staff. Routine dental care will be coordinated between staff and parents.	Parents will be contacted in emergency situations. Appointments for routine care are the responsibility of the parents.

I understand that I have the right to review records maintained on my family and to dispute or correct any information I feel to be incorrect. In understand that any information provided will be strictly confidential.

Signature of Parent/Guardian Date

I do hereby give the Program permission to seek emergency medical attention, including transportation to the nearest hospital, as deemed necessary. In understand that I will be contacted as soon as possible and a written accident form will be given to me.

Signature of Parent/Guardian Date

SECTION 4 : CONSENTS, AUTHORIZATIONS, AND RELEASES

1. I give permission for Choctaw Health Center to release the following health information on my child. I understand the information is used only for admittance to the Department of Early Childhood programs. The information is to determine my child's health status and I understand that I am able to review this information at any time. I also understand that all information is kept confidential. The information listed below is required for admittance to the program but not limited to:
 - a. Physical Exam to include but not limited to height and weight; developmental screening; physical assessment; vital signs; and social history
 - b. Hgb/Hct, urinalysis, lead screening
 - c. Dental Exam
 - d. Hearing screening
 - e. Immunizations
 - f. Nutrition Assessment
 - g. Medicaid or Chips
2. The information may be communicated in the following manner:
 - a. Oral
 - b. Written
3. This authorization shall be in effect for 12 months following the date of signature.
4. I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above.

Child's Name

Parent's/Guardian's Name (Printed)

Parent's/Guardian's Signature

Date

Consents for Initial Screenings		Please initial on the lines if you give DOECE permission for the screenings:	
Vision	_____	Dental	_____
Hearing	_____	Speech	_____
Height and Weight	_____	Developmental Screening	_____

PERMISSION FOR OTHER FAMILY MEMBERS

Only the custodial parent/legal guardian listed on the enrollment form is allowed to sign permission slips and other forms for this child. If the unmarried parents listed wishes for another family member to be allowed to sign permission slips, referrals, and other forms, please fill out the following section.

I, _____, parent/guardian of _____, do hereby give permission to _____ to sign permission slips, referrals, and other forms as necessary.

Signature of Parent/Guardian _____ Date _____

SECTION 5: DEVELOPMENTAL HEALTH HISTORY

BEHAVIOR/MENTAL HEALTH	Mark all that apply
How does your child act with adults he/she doesn't know?	<input type="checkbox"/> shy <input type="checkbox"/> scared <input type="checkbox"/> no reaction <input type="checkbox"/> other _____
Does your child worry a lot, or is he/she very afraid of anything?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____
Have there been any big changes in your child's life in the last six months?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____
Are you or your family having any problems now that might affect your child?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____
Does your child display any excessive behavior problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes explain _____
What method of discipline do you use at home?	<input type="checkbox"/> time out <input type="checkbox"/> spanking <input type="checkbox"/> talking to <input type="checkbox"/> none <input type="checkbox"/> other _____

DEVELOPMENTAL HISTORY

Please indicate by placing a checkmark as to whether your child has met the following developmental tasks based on the age ranges provided: *(please remember that all children are different and accomplish tasks at varying ages)*

	Not Yet	Earlier	When Expected	Later	Age Range
Sit up without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-9 Months
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-9 Months
Play with toys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6-9 Months
Feed Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-12 months
Hold bottle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9-12 months
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12-18 months
Talk (2 word sentences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Respond to directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Use crayons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Understand names of familiar objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18-24 months
Dress self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-2 ½ years
Learn to use the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2-3 years

HEALTH PROBLEMS

How frequently does your child have:

	Never	Seldom	Often		Never	Seldom	Often
Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toothaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Has your child ever had: (Mark if yes)

- | | |
|--|--|
| Asthma <input type="checkbox"/> Yes | Bleeding Tendencies <input type="checkbox"/> Yes |
| Diabetes <input type="checkbox"/> Yes | Epilepsy <input type="checkbox"/> Yes |
| Rheumatic Fever <input type="checkbox"/> Yes | Physical Impairment <input type="checkbox"/> Yes |
| Sickle Cell Disease <input type="checkbox"/> Yes | Hives <input type="checkbox"/> Yes |
| Polio <input type="checkbox"/> Yes | Chickenpox <input type="checkbox"/> Yes |
| German Measles <input type="checkbox"/> Yes | Measles <input type="checkbox"/> Yes |
| Mumps <input type="checkbox"/> Yes | Scarlet Fever <input type="checkbox"/> Yes |
| Whooping Cough <input type="checkbox"/> Yes | |

Name and phone number of your primary care physician:

Phone Number _____

ALLERGY PROBLEMS (Mark if yes)

Does your child have any allergy problems with the following?

- Eating Foods or Drinking Liquids (milk) Yes
- Animals, Furs, Insects Yes
- Latex Yes
- Taking Medication Yes

Explain and identify any reactions if yes to any of the above:

OTHER INFORMATION

Is there anything else concerning your child's health that you would like us to know?

SECTION 6 : CHILD PRENATAL AND BIRTH HISTORY

PRENATAL HISTORY

- Time mother first received prenatal care:**
- First 3 months of pregnancy
 - Middle 3 months of pregnancy
 - Last 3 months of pregnancy
 - No prenatal care received
 - Don't remember/Don't know

- Complications mother experienced during pregnancy (check all that apply)**
- Don't know
 - Stress
 - Diabetes (insulin dependent)
 - Abdominal pain
 - Swelling
 - Pregnancy-induced hypertension
 - Headaches
 - Chronic Fatigue
 - Low Birth Weight
 - Hypertension
 - Pre-term labor
 - Vaginal Bleeding (after 12 wks)
 - Uterine irritability
 - C-Section
 - Anemia (Hgb<10 or Hct <30)
 - Anxiety
 - Sickle Cell Anemia
 - Other _____

- Prenatal Exposure to Drugs:**
- Don't know
 - Prescription Drugs _____
 - Caffeine _____
 - Alcohol _____
 - Cigarettes/Tobacco _____
 - Other _____
 - Non prescription drugs _____

BIRTH HISTORY

- Delivery Location** Hospital/Clinic Birthing Center At Home
 Don't Know Other _____
- Type of delivery** Natural C-Section Don't know
- Length of infant hospital stay** Routine Stay (1 or 2 days) One week to one month
 Non-routine (less than 1 week) Over 1 month Don't know

Reason for non-routine hospital stay: _____

Observable birth defects: _____

Comments if unable to complete Sections 6 (e.g. child is under Social Service program, or guardianship, etc.)

SECTION 7 : PARENT VOLUNTEER INTEREST QUESTIONNAIRE

Please select the activities you would be willing to assist with in our program. Some of these activities require a health card and/or criminal background check. These activities are noted by an *.

I will be willing to donate my time and efforts to the following activities:

- | | | | |
|------------------------------|--------------------------|-----------------------------|---------------------------------|
| Classroom Substitute* ___ | Substitute Cook* ___ | Office Aide ___ | Parent Committee Officer ___ |
| Craft Displays ___ | Disabilities Aide ___ | Janitor Assistant ___ | Policy Council Officer ___ |
| Center Repairs ___ | Training Sessions ___ | Special Art Projects ___ | Field Trips* ___ |
| Storytelling* ___ | | | |

HOLIDAY/CELEBRATION VOLUNTEERS

- | | | |
|-----------------------------|------------------------------|-------------------|
| National Indian Day* ___ | Thanksgiving* ___ | Easter* ___ |
| Christmas* ___ | Green Corn Festival* ___ | Halloween* ___ |
| Valentine's Day* ___ | Year End Celebration* ___ | |

What are some special skills or talents that you would like to share with us?

What are some traditional skills you would like to share with us?

**Note: Anyone who volunteers on a regular basis must have a TB skin test and criminal background check on file at the center. Thank you.*

SECTION 8: BUS RULES (HEAD START ONLY)

1. Head Start children will be returned to the place they were picked up. If there is to be a change in pick-up or deliver, WRITTEN NOTICE must be given to the driver in advance or notification must be given to the center by 1:30 p.m. There are no transportation services after 2:00 p.m.
2. Parents should call or notify the center when their child will not be attending class or riding the bus.
3. Should a child not ride the bus for 2 consecutive days, the parent will need to contact the Center Director in order to make transportation arrangements.
4. Parents should notify Head Start a week in advance when changing residences.
5. Children must be dressed and ready when the bus arrives. The bus will briefly stop.
6. If the child misses the bus, it is the parent's responsibility to take the child to school.
7. When a child is delivered home, the parent or an adult should let the driver know there is someone to receive the child.
8. If no one is home, the child will be returned to the center, and it will be the parent's responsibility to see that his or her child is picked up.
9. If a child has to cross the street to get on or off the bus, he or she must be accompanied by an adult (parent or monitor). The child must cross in front of the bus.
10. Only Head Start children and volunteers will ride the bus to and from the center.
11. There is no food, drink, or smoking allowed on the bus. (exception will be on fieldtrip for food and drink)
12. Toys should not be sent with the child.
13. There will be two adults on the bus at all times.
14. All bus passengers must wear seat belts.
15. The bus monitor may determine if a child is ill at the time he or she boards the bus. A sick child will be returned to the parent(s).
16. Parents who transport their child to Head Start must accompany the child into the building.
17. There is a daily sign in/out sheet that must be signed by those that drop-off/pick up their child at the center.
18. For safety's sake, buses will only be allowed to stop at designated drop-offs.
19. At no time will a child be left on the bus/van unattended by an adult.
20. Federal Regulation Code 1310.20 (b)(3) states that vehicles must not be required to back up or make "U" turns, except when necessary for reasons of safety or because of physical barriers.
21. The Head Start buses begin services at 7:00 a.m. (morning route) and 2:00 p.m. (afternoon route)

WILL YOUR CHILD RIDE THE BUS EVERY DAY? (PLEASE CHECK ONE)

Yes, my child will ride the bus every day.

Where will be your child's primary pickup/drop-off location?

(Address) _____

(Directions to the center) _____

No, my child will only ride the bus for field trips.

Signature parent/guardian

Date