

Ashland Independent Schools Exceptional Early Childhood Center Headstart/Preschool

1820 Hickman Street
Ashland, Kentucky 41101
Phone: (606) 327-2715 Fax: (606) 327-8895
<http://www.ashland.kyschools.us>

Enrollment Procedure 2018-2019

Ashland Head Start is a federally funded program for income eligible **children ages 3 & 4 by August 1**, and with a minimum of 10% enrollment slots for children with identified disabilities.

Kentucky preschool program is a state funded program for income eligible four year olds by August 1, and 3 & 4 year olds with identified disabilities.

Instructions for Application Procedure:

The following documents must be complete and on file before application is considered eligible.

A complete Application for enrollment must have the following:

1. **Completed Application** (all sections must be complete, signed, and dated)
2. **Family's proof of Income** (choose one of the following documents)
Income Tax, Child support document, pay stub within last 30 days,
Printed statement from employers, etc
KTAP Document with case number
SNAP Document with case number
3. **Proof of living address**
Utility bill (must be dated within the last 30 days)
A rental or lease agreement
4. **Birth certificate** or other reliable proof of students identity and age
5. **Kentucky Immunization Certificate** with a valid expiration date
6. **School Physical** with Lead, Hemoglobin, Blood Pressure
7. Dental exam
8. Vision Exam by Optometrist or Ophthalmologist

*All items listed above must be on file and accurate before eligibility can be considered for the Ashland Head Start Program.
NO EXCEPTIONS.*

ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER

**ENROLLMENT APPLICATION 2018-2019
CHILD APPLICANT**

Class Request (Circle One) A.M. or P.M. Requests honored at staff discretion Full Day (Class Age 4 ONLY)

First Name	Middle	Last	Birthdate	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security # (Optional)
Address			Primary Phone _____ Secondary Phone _____	Can you receive text at this number? Yes or no	

Race

Asian American Indian
 Black Pacific Islander
 White Alaska Native
 Native Hawaiian Other _____

Hispanic Yes No

Medical Insurance Type (Check one)

_____ Medicaid # _____
 _____ Private Insurance # _____
 _____ No Insurance

Child Primary Language _____
 Languages spoken in home? _____ Doctor _____ Dentist _____

PRIMARY GUARDIAN

NAME _____ **BIRTHDATE** _____ **GENDER** _____ **RACE** _____ **Hispanic Yes or no (circle)**

RELATIONSHIP TO CHILD

Parent (Biological) Stepparent Is this parent Incarcerated Yes No
 Grandparent Does this parent have custody of this child Yes No
 Relative (not grandparent)) Does this parent provide financial support to child Yes No
 Foster Parents (not related) Was this parent a teen Parent @ child's birth Yes No
 Other, _____ Does this parent and child live in same home Yes No

Education (Mark highest level attained)

Masters Degree Bachelor Degree
 Associate Degree College Degree/Training Cert
 High School Graduate GED
 College or Advance Training
 Grade 9 Grade 10 Grade 11
 Are you currently in school? No Yes

Employment (mark current status)

Unemployed Full Time (35 hrs/week or more)
 Seasonal Part Time (under 35 hrs/week)
 Retired or Disabled Full Time & Training
 Training or School Part Time & Training

Military Active Duty No Yes
 Veteran of U.S. Military No Yes

SECONDARY GUARDIAN

NAME _____ **BIRTHDATE** _____ **GENDER:** _____ **RACE** _____ **Hispanic Yes or No (circle)**

ADDRESS (if different from child) _____ **PHONE** _____

RELATIONSHIP TO CHILD

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 Grandparent Does this parent have custody of this child Yes No
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 Veteran of U.S. Military No Yes

Family Composition

PARENT STATUS: Two parents living in home How many people live in your home total? _____
 One parent living in home.

Number of children per age: 0-3 _____ 4 – 5 _____ 6 and older _____

ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER

(other children living in the Home)

Name _____ Birthdate _____ Gender _____ Race _____

Related To:

- Related to Primary Adult
- Related to Second Adult
- Related to Both Adults

How Related:

- Natural Child
- Foster Child
- Grandchild

- Niece / Nephew
- Other / Specify _____

Name _____ Birthdate _____ Gender _____ Race _____

Related To:

- Related to Primary Adult
- Related to Second Adult
- Related to Both Adults

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- Grandchild

- Niece/ Nephew
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How Related:

- Natural Child
- Foster Child
- Grandchild

- Niece/ Nephew
- Other / Specify _____

(If you have more children to list, please list on the back of this document)

Do you receive: (Please check all that apply)

Must provide documentation for each item checked.

- KTAP / TANF
- Food Stamps
- SSI
- Disability
- Child Support
- Housing Assistance
- WIC
- Income of Wages
- Unemployment

Please check all that may apply for your family living arrangements

- Emergency Runaway
- Special Care Facility
- Motel / Hotel
- Spouse Abuse Shelter
- Unaccompanied Youth
- Public Place
- Uninhabitable
- Temp Friends/ Relatives
- Temp Placement

CERTIFICATION: I certify that this information included on and with this application to be true to the best of my ability. If any part is false, my participation in the agency's program may be terminated and I may be subject to legal action.

Guardian Signature

Date

Office Use Only

Household Size: _____ Total Income: _____

Categorically Eligible

- Returning Student
- McKinney Vento
- SSI
- K-TAP /Case Number _____
- WIC / Case Numer _____
- SNAP /Case Number _____

- Relative Foster Care
- Non Relative Foster Care

- Head Start
- Over Income / Reason _____
- Pre K

- Eligible Date _____
- Waitlist Date _____
- Enroll Date _____
- Terminated Date _____

Class Age: _____
Child Eligible Next Year Yes No

Verifying Staff Signature

Date

**ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER
2018-2019**

PERMISSION AND AGREEMENT

Please **check yes or no** and **initial each item**.

My child may participate in all screening activities which include the following;

YES	NO	INITIAL	
_____	_____	_____	Vision screen
_____	_____	_____	Hearing Screen
_____	_____	_____	Speech/Language Screen
_____	_____	_____	Developmental Screen
_____	_____	_____	Social Emotional Screen
_____	_____	_____	Growth Assessments

WE REPORT CHILD ABUSE

Who Must Report

The law states that it is the duty of everyone who has reasonable cause to believe that a child is abused or neglected to report this information.

Penalty For Failure To Report

KRS 620.990(1) states:

Any person intentionally violating the provisions of this chapter shall be guilty of a Class B misdemeanor. A class B misdemeanor carries a penalty of up to 90 days in jail and/or a fine of up to \$250.

Child's Name _____ Birthdate _____

(Educational records shall be kept confidential according to the requirements of the Family Education Rights & Privacy Act Regulation 34 CFR Part 99).

Guardian Signature _____ Date _____

Staff Signature _____ Date _____

TRANSPORTATION / EMERGENCY INFORMATION

PRIMARY GUARDIAN _____ Phone / Text # _____ - _____ - _____ Email _____	CHILDS NAME _____ ADDRESS _____ BIRTHDATE _____ TEACHER _____ ALLERGIES _____ MEDICINES _____ In case of emergency, your child will be transported to the nearest medical facility.		
SECONDARY GUARDIAN _____ Phone / Text # _____ - _____ - _____ Email _____			
<table style="width:100%; border: none;"> <tr> <td style="width:70%; border: none;"> <input type="checkbox"/> Parent Transport <input type="checkbox"/> Bus Transport <input type="checkbox"/> # Pick up Location _____ <input type="checkbox"/> # Drop off Location: _____ </td> <td style="width:30%; border: none; text-align: center;"> Date & Initial Changes Staff Only _____ _____ _____ </td> </tr> </table>		<input type="checkbox"/> Parent Transport <input type="checkbox"/> Bus Transport <input type="checkbox"/> # Pick up Location _____ <input type="checkbox"/> # Drop off Location: _____	Date & Initial Changes Staff Only _____ _____ _____
<input type="checkbox"/> Parent Transport <input type="checkbox"/> Bus Transport <input type="checkbox"/> # Pick up Location _____ <input type="checkbox"/> # Drop off Location: _____	Date & Initial Changes Staff Only _____ _____ _____		

Emergency Contacts / Authorization to Release Child

only people on the release below will be allowed to get child off the bus or pick up child from school.

Any changes to this form must be made by the Guardian in the office.

NO CHANGES OVER THE PHONE! NO EXCEPTIONS!

Persons listed below must be at least **18 years of age** and present a photo ID. Persons listed will be utilized as alternate contacts for emergencies. We encourage at least three contacts that reside locally.

RELEASE / EMERGENCY CONSENT

In case of an emergency and no one can be reached at the phone numbers listed for my child, I authorize school officials to administer necessary emergency treatment, call the physician listed and / or call 911 for emergency transportation.

NAME	RELATIONSHIP	PHONE #1	PHONE #2	ADDRESS
Primary Guardian				
Secondary Guardian				

Guardian Signature	Date	Verifying Staff	Date

For the safety of your child, information on this page will be shared with the Bus Drivers and Monitors

PAST MEDICAL HISTORY QUESTIONNAIRE

2018-2019

MEDICAL

1. Does the child receive routine medical exams / checkups? NO YES
 2. Is the child presently under medical care for a chronic disease? NO YES If yes explain: _____
 3. Is or has the child been treated for any of the following conditions?
 - ANEMIA ASTHMA HEARING
 - OVERWEIGHT VISION PROBLEMS EAR INFECTIONS
 - HIGH LEAD LEVELS DIABETES SEIZURES OTHER _____
 4. Does your child currently take medication? NO YES If yes, please list: _____
 5. Will your child need medications while at school? NO YES If yes, please list: _____
- (If you answer yes to this question, a special form will need to be completed and signed by the Doctor)**

ALLERGIES

Does your child have a doctor's diagnosed allergy or severe reaction to any of the following?

- Bee stings NO YES
- Animals NO YES
- Pollens (hay fever) NO YES
- Latex NO YES
- Medications NO YES Name of Med: _____
- Food NO YES Name of Food: _____
- Other NO YES Explain: _____
- Is this a life-threatening allergy? NO YES
- Is an Epi-Pen required No YES

DENTAL

Does your child receive routine Dental care or checkups with licensed Dentist? _____ No _____ Yes

DENTIST _____ **DATE OF VISIT** _____

VISION

Has your child seen an optometrist in the last six months? _____ No _____ Yes. If yes,

OPTOMETRIST _____ **DATE OF VISIT** _____

NUTRITION ASSESSMENT

Does your child receive WIC or nutrition services? No Yes

Are you concerned about your child's weight (under/over weight) or eating habits? No Yes

Do you have other dietary/nutritional concerns? No Yes

Explain: _____

Child's Name _____ Birth Date: _____

Guardian Signature

Date

Verifying Staff

Date