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
2019-2020

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 Opthamologist

9. Insurance card

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

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

ENROLLMENT APPLICATION 2019-2020
CHILD APPLICANT

First Name	Middle	Last	Birthdate	☐ Male ☐ Female	Social Security # (Optional)

Address

Primary Phone _____ Can you receive text at this number?
Secondary Phone _____ 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
☐ Grandparent
☐ Relative (not grandparent))
☐ Foster Parents (not related)
☐ Other, _____

Is this parent Incarcerated ☐ Yes ☐No
Does this parent have custody of this child ☐ Yes ☐No
Does this parent provide financial support to child ☐ Yes ☐No
Was this parent a teen Parent @ childs birth ☐ Yes ☐No
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 ☐ Grade10 ☐ 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
☐ Parent (Biological) ☐ Stepparent
☐ Grandparent
☐ Relative (not grandparent))
☐ Foster Parents (not related)
☐ Other, _____

Is this parent Incarcerated ☐ Yes ☐No
Does this parent have custody of this child ☐ Yes ☐No
Does this parent provide financial support to child ☐ Yes ☐No
Was this parent a teen parent @childs birth ☐ Yes ☐No
Does this parent and child live in same home ☐ Yes ☐No

EDUCATION INFORMATION
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Military Active Duty ☐ No ☐ Yes
Veteran of U.S. Military ☐ No ☐ Yes

Family Composition

PARENT STATUS: ☐ Two parents living in home
☐ One parent living in home.

How many people live in your home total?_____

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: **How Related:**
- ☐ Related to Primary Adult
- ☐ Related to Second Adult
- ☐ Related to Both Adults
- ☐ Natural Child
- ☐ Foster Child
- ☐ Grandchild
- ☐ Niece / Nephew
- ☐ Other / Specify_____

Name_____**Birthdate**_____**Gender**_____ **Race**_____
Related To: **How Related:**
- ☐ Related to Primary Adult
- ☐ Related to Second Adult
- ☐ Related to Both Adults
- ☐ Natural Child
- ☐ Foster Child
- ☐ Grandchild
- ☐ Niece/ Nephew
- ☐ Other / Specify _____

Name_____**Birthdate**_____**Gender**_____ **Race**_____
Related To: **How Related:**
- ☐ Related to Primary Adult
- ☐ Related to Second Adult
- ☐ Related to Both Adults
- ☐ 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: _____

Category of Eligibility

_____ Head Start **_____State Preschool** **_____AISD (Over Income/OD)**

___Income Eligible **___Relitive Foster Care** **___Income/Age Eligible**
___HS Over Income **___Non Relative Foster Care** **___Disability**
___SSI **___K-TAP /Case# _____**
___McKenney Vento

Eligible Date _____ **Document used to determine eligibility _____**
Waitlist Date _____ **Class Age: _____**
Enroll Date _____ **Child Eligible Next Year _____Yes ___No**
Terminated Date _____

_____ _____
Verifying Staff Signature Date

ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER
2019-2020

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

PAST MEDICAL HISTORY QUESTIONAIRE

2019-2020

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 childs 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**

2019-2020

TRANSPORTATION / EMERGENCY INFORMATION

PRIMARY GUARDIAN _____

Phone / Text # _____-_____-_____

Email _____

SECONDARY 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.

_____ Parent Transport

_____ Bus Transport

#_____Pick up Location _____

#_____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