## G. Child's preadmission record

**DHR-CDC-739**

# CHILD' S PREADMISSION RECORD

**This section is to be completed by the child's parent or guardian.** This form must be kept in the child's file in the Child Care Facility (home/center).

| | |
|---|---|
| Child's Name: | Name child is known by: |
| Child's birthdate: | Child's home address: |
| Name(s) of parent(s)/guardian(s): | Home telephone number: ( ) |
| Address of parent(s)/guardian(s): | |
| Mother's Employer: | Father's Employer: |
| Mother's Email Address: | Father's Email Address: |
| Employer's address: | Employer's address: |
| Employer's Telephone Number: ( ) | Employer's Telephone Number: ( ) |
| List telephone numbers such as pager, cellular phone, etc. | Instructions regarding how parent/guardian may be reached in an emergency: |

**Person(s) to be contacted in an emergency if parent(s)/guardian(s) cannot be reached:**

| Name | Relationship to child | Address | Telephone number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Name of child's doctor: | Address: | Telephone number: ( ) |
|---|---|---|
| | | |

## Emergency Authorization:

**I give permission for the child care facility to obtain emergency medical treatment, including emergency transportation, for my child if I cannot be reached immediately. I agree to be responsible for any emergency medical expenses incurred.** ***(If parent/guardian refuses to sign, instructions must be attached stating what procedure the facility is to follow in an emergency.)***

_____ / _____

**Signature** **Date**

**Form not valid without signature of child's parent/guardian**

***Page one of two-form not valid without second page***

**Describe any special needs or instructions below:**

| |
|---|
| |
| |
| |

**Person(s) the child may be released to:**

| Name | Relationship to child | Address | Telephone number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***I understand that the Department of Human Resources does not inspect activities away from the child care facility (home or center). The licensee of the child care facility assumes full responsibility for such activities.***

_____ / _____

*Signature of parent/guardian* *Date*

**I give permission for my child to participate in:**

**(Circle yes or no and sign each line)**

| | | | | |
|---|---|---|---|---|
| **Activities away from the facility:** | **yes** | **no** | **Signature of parent/guardian** | **Date** |
| **Transportation provided by the facility:** | **yes** | **no** | **Signature of parent/guardian** | **Date** |
| **Swimming/wading activities provided by the facility:** | **yes** | **no** | **Signature of parent/guardian** | **Date** |

**Form not valid without signature of child's parent/guardian in each space indicated above.**

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**This section is to be completed by the facility's staff.**

**Child's first day of attendance:** _____ **Child's withdrawal date:** _____

☐This child meets the definition of homelessness according to the McKinney-Vento Homeless Assistance Act.

***Additional information may be attached.***

**St. Clair County Head Start**
**21685 U. S. Hwy 231 N. Old Coal City School**
**P. O. Box 641**
**Pell City, Alabama 35125**
**Phone: (205) 338-9694 Fax: (205) 338-3215**

## Family Partnership Agreement

The partnership process was explained to me by: _____

I, _____ agree to form a partnership with the St. Clair County Head Start program towards the achievement of the goals defined in this partnership. St. Clair County Head Start will provide resources and referrals as necessary in order to accomplish these goals.

Child's Name: _____ Child's date of birth: _____

Signature of Parent/Guardian: _____

Signature of Staff: _____

**MISSION STATEMENT**
**WE ARE DEDICATED TO PROVIDING SERVICES FOR CHILDREN AND THEIR FAMILIES IN ORDER TO EMPOWER THEM TO SUCCEED.**

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## Family Assessment

Child's Name: _____

Parent/Guardian Signature: _____

**All information given is completely confidential and will not be shared without your permission.**

Please answer the following questions:

**Education**: Highest grade completed _____ Degrees/Certificates _____

Employment: Are you currently employed? Yes ___ No ___

If yes, is it full time ____ or part time? ____

**Health:**
Who is your health care provider? _____

If you do NOT have a health care provider, where do you go for medical help? _____

_____

Other than the child enrolled; does your family have adequate health insurance? Yes ___ No ___

Describe any need you have for health care: _____

_____

**Housing:**
Homeless ____ Lives with friends or relatives _____ Own home _____
Rent home ____ Lives in public housing _____

**Mental Health:**
Do you have someone you can talk to when you have a problem or crisis? Yes ___ No ___

Would you like information on Support Services available in the community? Yes __ No __

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# Family Assessment (page 2)

**Are you receiving assistance from any of the following resources?**

**(Please circle yes or no)**

| | |
|---|---|
| DHR- YES / NO | Section 8 Housing- YES / NO |
| TANF- YES / NO | Mental Health- YES / NO |
| WIC- YES / NO | Public Housing- YES / NO |
| SNAP- YES / NO | Health Department- YES / NO |
| SSI- YES / NO | Unemployment- YES / NO |
| Workers Compensation- YES / NO | Employee Training- YES / NO |
| Other Services - | |

**Does your family have needs in any of the following areas?**

**(Please circle yes or no)**

| | |
|---|---|
| Employment (WIA Job Training)- Yes / No | English as a second language- Yes / No |
| Drug/Alcohol Abuse- Yes / No | Education- Yes / No |
| Domestic Violence- Yes / No | Utilities- Yes / No |
| Health/Nutrition- Yes / No | Mental Health- Yes / No |
| Housing- Yes / No | Transportation- Yes / No |
| Parenting Skills- Yes / No | Clothing- Yes / No |
| Other Needs- Yes / No | |

**Please explain the needs that was checked yes** _____

_____

**Parent/Guardian Signature** **Date:**

_____

**Staff Signature** **Date:**

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## Attendance Agreement

I, _____, do understand that my child _____ is expected to be at Head Start on a daily basis.

St. Clair County Head Start is a **FREE** program to parents. In order for us to maintain funding, we must have regular attendance. All absentees will be unexcused unless agency documentation is received. Excuses accepted are doctor's excuse, court appointment notice, or funeral documentation, etc.

**NO PARENT WRITTEN EXCUSES WILL BE ACCEPTED!!**

You will be contacted by your Family Service worker when your child is absent three (3) or more days. Irregular attendance will also result in a home visit. Excessive unexcused absentees will result in the withdrawal of your child from the program.

Parent/Guardian Signature: _____

Staff Signature & Title: _____

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## Arrival/Departure Policy

## NO EXCEPTIONS

Your child should arrive at school at 7:45 A.M. Your child will be marked absent if he/she arrives after 8:30 A.M. Parent pick-up time is 1:30 P.M. If your child rides a bus then you will be notified of bus stop times. **Please be on time to pick your child up.** If your child is left pass 2:00 P.M. the Department of Human Resources (DHR) and/or the local police department will be contacted. If no one is at your child's bus stop he/she will be brought back to the school and the Department of Human Resources (DHR) and/or the local police department will be contacted.

**Only people that are listed on the pre-admission forms will be allowed to pick up your child. The person picking up your child must have their picture identification. Any changes to your child's pick-up/release information must be done in person by the parent/guardian. No phone calls or faxes will be accepted at anytime.**

Is there a custodial dispute or issues? Yes ____ No ____

In order for the program to deny a legal parent/guardian access to a child, we must have court documentation in the child's official file. Such documentation would be a restraining order, custody papers, or divorce papers.

Parent/Guardian Signature: _____

Staff Signature & Title: _____

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## Individual Transportation Authorization and Plan

I, _____, as parent/guardian of _____
(Name of Child)

request and authorize St. Clair County Head Start to provide transportation for my child to and from the center Monday – Friday. I understand that the school bus will pick-up and drop-off my child each day at his/her designated bus stop. I agree to have my child ready for pick-up and to receive my child for drop-off no later than **5 minutes** before the bus is to arrive.

In the event no one is at the bus stop to receive my child, I understand to go to the next bus stop scheduled and wait for the bus. If no one is at the last location to receive my child, I understand staff will return my child to St. Clair County Head Start and that I will be required to speak with the Executive Director on this matter.

I understand that changes in the transportation plan will **NOT** be accepted over the phone or by written letters from parents. The primary/secondary adult **MUST** sign a change of status at the bus stop or at the center.

Parent/Guardian Signature: _____

Date: _____

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## ZERO TORLERANCE POLICY

**Effective immediately, St. Clair County Head Start WILL NOT tolerate any threats, cursing, or other disruptions to the smooth operation of this agency from or between participants, clients, staff and/or any other person.**

**Violation of this policy can mean IMMEDIATE termination from participation in any of this agency's services or, for staff members, from employment with St. Clair County Head Start program.**

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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## Picture Consent & Audio/Video Surveillance Form

**Please initial all blanks and sign/date the bottom of the form.**

_____ I am aware that St. Clair County Head Start has audio/video surveillance installed for the security of my child.

_____ I, hereby, give my consent for any pictures taken of my child to be used in newspapers, displays, bulletin boards, slide presentations, or any other types of educational material or publications.

Parent/Guardian Signature: _____

Date: _____

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# Nutrition Records

Child's Name: _____ Child's Date of Birth:_____/____/_____

Sex: ___ Male ___ Female

***(YOU MUST BRING DOCUMENTATION FROM THE DOCTOR)***

**Please Print**

1. Are there any foods your child cannot eat due to religious, cultural, or medical reasons? ___Yes ___No

   If yes, what foods? _____

2. Does your child have any allergies to foods? ___ Yes ___ No

   If yes, what foods? _____

   What reaction does your child have? _____

   Emergency medications (e.g. Epipen)? _____

3. Is your child on a special diet? ___ Yes ___ No

   Did a doctor prescribe the diet? ___ Yes ___ No

   If yes, what kind of diet? _____

4. Does your child drink milk? ___ Yes ___ No
5. Does your child drink water? ___ Yes ___ No
6. Does your child eat a variety of grains, vegetables, fruit, dairy products, and meats or beans? ___ Yes ___ No
7. What nutrition information would you like to receive? _____

Parent Signature _____ Date: _____/_____/_____

Nutrition Manager Signature _____

"This institution is an equal opportunity provider"

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