Baltimore City Head Start
Parent Certification for Children and Families Experiencing Homelessness

This questionnaire is intended to address the McKinney-Vento Homeless Education Assistance Improvement Act 42 U.S.C.11435.

1. Is your current address a temporary living arrangement?

   ☐ Yes ☐ No

2. Is this temporary living arrangement due to loss of housing or economic hardship?

   ☐ Yes ☐ No

If you answered YES to both of the above questions, please complete the remainder of this form.
If you answered NO, you may stop.

Where is the child presently living? *(Check one box.)*

☐ In a motel, hotel, or a weekly rate housing.

☐ In an emergency or transitional shelter (family shelter, domestic violence)

☐ With friends or relatives because you are an unaccompanied youth

☐ Awaiting or temporary foster care placement

☐ With more than one family in a house or apartment (Due to lack of housing-not by choice).

☐ Moving from place to place

☐ In a place not designed for ordinary sleeping accommodations such as a car, park, abandoned building, or campsite or other inadequate accommodations (Substandard housing).

☐ On the street. Abandoned in a Hospital.

Explanation required for Eligibility: Determination Record –Section E

Third Party Verification (Attach Release of Information Form): (please circle) ***Yes*** ***No***

Parent Certification:

"I have carefully reviewed the documents and information I have provided to my Family Services Coordinator and, by signing this form, certify to the best of my knowledge and belief that all information regarding eligibility provided by me is true and accurate."
"I further understand that this is an application for services that are paid for with federal funds and that intentionally providing misleading, inaccurate or untruthful information of a material nature could result in disenrolling my child from Head Start/Early Head Start."

Signature of Parent/Legal Guardian _____ **Date** _____

Child's Name _____

Union Baptist Harvey Johnson Head Start Center

Emergency Incidents/Consent Form

I, _____ Parent/Guardian of _____

grant my consent for the appropriate care to be administered in the event of an emergency. I understand that teachers as well as other staff are certified in Cardiac Pulmonary Resuscitation (CPR) and First Aid.

Parent/Guardian Signature: _____ Date: _____

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UNION BAPTIST - HARVEY JOHNSON HEAD START CENTER

Maryland State Department of Education Accredited and
A Head Start Body Start nationally recognized program for strategic planning and vision and a model for programs across the nation

Parent Authorizations for: Picture/Video Publications & Field Trips/Outings

Picture/Video:

Throughout the year pictures and videos ae taken of children and parents demonstrating the educational activities and family services experienced at Union Baptist Head Start. As a community agency required to report to the public, we have a web presence and publish newsletters, an annual report, a parent handbook, and other materials to inform stakeholders about the program's activities and achievements. Pictures and videos are included in these publications. Additionally, our children and parents have appeared on television and had their pictures taken as a group or individuals to enhance an educational goal in the local community or nationally. To include an image of you or your child engaged in high quality earning and parent experiences or promote the success of Union Baptist Head Start, it is necessary that we have our permission.

_____ YES, I give my permission that pictures or videos taken of me or my child _____, may be used for print publications and other forms of media and for the use of reporting purposes.
_____ NO, I do not give permission for pictures or video to be taken of my child _____, to be used by Union Baptist Head Start or by those reporting on the educational and parent experiences.

Field Trips/Outings:

Learning is a lifelong process to be enjoyed and occurs both within the school walls and through life experiences. To put this philosophy into practice during the school year our children will have the opportunity to take field trips as a part of their educational experiences. These trips provide exposure to new experiences and first-hand knowledge of concepts thought in the classroom. Field trips are taken in and out of the neighborhood. A few examples are:

- Neighborhood Unit- A walk through the neighborhood to observe bare or budding trees
- Farms, Market and Food Unit- an outing to the Farmer's market or grocery store
- Mail and Friendship Unit- a trip to the fire station or post office

Before a child can legally participate in field trips, it is necessary that we have the parent's permission.

_____ YES, my child _____, as my permission to participate in Field Trips/Outings with Union Baptist Head Start.
_____ NO, my child _____, does not have my permission to participate in Field Trips/Outings with Union Baptist Head Start.

Parent/Guardian Signature: _____ Date: _____

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Baltimore City Head Start

Intake Risk List

Child:
First Name: _____ Last Name: _____

D.O.B. ____/____/_____

Concerns About Development: (Parent/Physician)
___Speech/Language
___Motor Skills
- Fine
- Gross

___Hearing
___Vision

Documented Disability:
___IEP
___IFSP
___Previously referred for services
___Previously received Services

Services Rendered:
___Occupational Therapy
___Speech Therapy
___Hearing/Auditory Therapy
___Other: _____

Agencies:
___BITP
___Kennedy Krieger
___Maryland Therapy Network
___Other:_____

Health Concerns:
___Lead
___Hemoglobin
___Dental
___Immunization
___Asthma
___Allergies
___Anemia
___Sickle Cell Trait
___Child Hospitalized
___Childhood Trauma
___Surgeries

Prenatal Care:
___Drug use during pregnancy
___Child born addicted to drugs
___Baby hospitalized
___Toxemia
___Early Birth

Family Risk Factors:
___Physical
___Mental Health
___Health
___Disability
___Significant Life Changes

___**No Concerns Found**

Completed by: ___ (Family Service Coordinator) Date: ___/___/_____

Reviewed by: ___ (Disabilities /Mental Health Coordinator) Date: ___/___/_____

Reviewed by: ___ (Special Education Consultant) Date: ___/___/_____

Reviewed by: ___ (Mental Health Consultant) Date: ___/___/_____

Process:
1. Family Service Coordinator will email Disabilities Coordinator following enrollment with risk list factors
2. Identified Risk List will be reviewed by Disabilities Coordinator
3. Disabilities Coordinator will setup Special Education review and needed screenings
4. Disabilities referral process will begin

Baltimore City Head Start
Permission to Release/Request Information

Child's Name: _____ Date of Birth: _____

As parent/guardian of the child named above, **I hereby grant** _____ **permission to:**

Request information relevant to my child/family from the following agency, school, community partner, or individual person

Agency/School/Individual Name: _____

Address: _____

Phone # _____

Contact Person's Relationship: _____

Please specify type of information:

- ❑ Family eligibility information, including current family status or employment
- ❑ Classroom wide Mental Health consultation
- ❑ Consent to receive text messages # _____/e-mail notifications _____
- ❑ Health Records: share/receive from health care provider
- ❑ Other _____

I also authorize staff of _____ and the above-named organization/individual to **share information verbally**, as needed, related to the documentation being released.

I understand that the confidentiality of any information identifying my child and/or myself will be maintained in accordance with the law in both federal and state regulations. Such information will only be used with my consent for the benefit of my child/children and or me.

By signing below, I also acknowledge that:

- I may review the indicated information at any time.
- This authorization will expire one (1) year from the date below, but I may also choose to revoke it at any time by notifying _____ in writing.

Authorized by:

Parent/Guardian Name: _____ Phone: _____

Address: _____ Email: _____

NON-Consent

- ❑ This authorization is voluntary, and therefore I am not giving consent to contact any person in regards to my child/children and/or myself. My refusal to sign this authorization will not affect my eligibility for services or enrollment in the Head Start program.

Reason for not giving consent to agency (please explain):

_____

Signature: _____ **Date:** _____

BK X SN ___ LU X SN X SU ___

EMERGENCY FORM

INSTRUCTIONS TO PARENTS/GUARDIANS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency:

1. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt# / City / State / Zip Code)

2. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt# / City / State / Zip Code)

3. Name _____ (Last / First) Telephone (H) _____ (W) _____

   Address _____ (Street/Apt# / City / State / Zip Code)

Child's Physician or Source of Health Care _____ Telephone _____

Address _____ (Street/Apt# / City / State / Zip Code)

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian _____ Date _____

Child's Name _____ (Last / First) Birth Date _____

Enrollment Date _____ Hours & Days of Expected Attendance _____

Child's Home Address _____ (Street/Apt# / City / State / Zip Code)

Mother/Guardian's Name _____ (Last / First) Home Telephone _____

Employer/School _____ (Name / Address)

Home Address (*If different from above*) _____ (Street/Apt# / City / State / Zip Code)

Work Telephone _____ Cellular Phone _____ Beeper _____

Father/Guardian's Name _____ (Last / First) Home Telephone _____

Employer/School _____ (Name / Address)

Home Address (*If different from above*) _____ (Street/Apt# / City / State / Zip Code)

Work Telephone _____ Cellular Phone _____ Beeper _____

Name of Person Authorized to Pick-up Child (*daily*) _____ (Last / First / Relationship to Child)

Address _____ (Street/Apt# / City / State / Zip Code)

ANNUAL UPDATES _____ (*Initials/Date*) _____ (*Initials/Date*) _____ (*Initials/Date*) _____ (*Initials/Date*)

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.
(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: _____ Date of Birth: _____

Medical Condition(s): _____

_____

Medications currently being taken by your child: _____

_____

Date of your child's last tetanus shot: _____

Allergies/Reactions: _____

_____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: _____

_____

(2) If signs/symptoms appear, do this: _____

(3) To prevent incidents: _____

_____

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: _____

_____

_____

_____

COMMENTS: _____

_____

_____

_____

_____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

_____ _____
Name of Health Practitioner Date

_____ (_____)_____
Signature of Health Practitioner Telephone Number