Ogden Weber Community Action Partnership
Head Start/Early Head Start Program

Dear Parent/Guardian,

OWCAP Head Start/Early Head Start is a School Readiness Program for all children in need, living in Weber County.

Early Head Start is for children under the age of 3. OWCAP offers a home based program and a center based program with teen parents having first priority.

Head Start is for children ages 3 & 4 by September 1st.

The program is **free** for children and families accepted into these programs.

Please be aware that you will have to provide or plan for transportation services for your child to and from school. Assistance with transportation may be provided when circumstances warrant.

Refer to our website, our Facebook page and call for registration dates and appointments. **Please bring all listed documents to registration.**

When you come to registration. Please have the following items with you, if possible:

BIRTH CERTIFICATE (or other proof of birth date)
INCOME VERIFICATIONS please bring proof of your income for the past 12 months

- **Last year's w-2 forms**
- **Tax form 1040's**
- **Current financial assistance printout from DWS**
- **Social Security Letter (reflecting amount of income)**
- **Employer letter**
- **Check stubs**
- **Proof of Foster Placement or State Custody Letter from DCFS**

PROOF OF PUBLIC ASSISTANCE (SSI, TANF/FEP)
PROOF OF RESIDENCY IN WEBER COUNTY (Examples: utility bill, picture ID, ETC)
OFFICIAL SHOT RECORDS
INSURANCE CARD (private insurance, Medicaid, Chip, etc.)

Other items that are needed if your child is enrolled:
A PHYSICAL (to include Blood Pressure, Hemoglobin, and Lead Test)
DENTAL EXAM (to include cleaning and/or fluoride application

Children with disabilities or special needs are encouraged to apply.

Frequently Asked Questions:

Does my child have to be potty trained to attend Head Start?
No, our teachers are trained to work with children and the parent to help with potty training.

Is there an attendance requirement for my child to attend Head Start/Early Head Start?
It is critical that you arrange, in advance, how your child will get to and from Head Start/Early Head Start. Attendance affects your child's learning and start good habits for the future school experiences. The Office of Head Start has an expectation that children do not miss more than 1 day a month.

What is the Home-Based Program?
The Home-Based Program has a home visitor that comes to the home each week for 90 minutes to work with the parents and the child on school readiness, parenting, health, and other goals. They also have a socialization twice a month to meet other children and families.

For registration information or appointments:
Ogden-Weber Community Action Partnership
3159 Grant Avenue
Ogden, UT 84401
Call (801) 399-9281
www.owcap.org

❑HS
❑EHS

Family Member Information

Primary Adult Name ____ Birthday______________________

Applicant Name (child) ____ Birthday______________________

Primary Adult (nonparticipant) Living in the Household

Last	First	Middle	Preferred
Birthday	Gender	❑ Provides Financial Support	❑ Teen Parent
Highest Grade Completed _________ Graduated High School ❑ Yes ❑ No	Employment Status [1]	Email Address	English Proficiency: ☐ Primary Language ❑ None ❑ Poor ❑ Moderate ❑ Proficient

Secondary Adult (nonparticipant) Living in the Household

Are you related to the child by blood, marriage, adoption, have court-ordered custody, or authorized care giver? ❑Yes ❑No

Last	First	Middle	Preferred
Birthday	Gender	☐ Lives with Child	☐ Provides Financial Support
Highest Grade Completed _________ Graduated High School ❑ Yes ❑ No	Employment Status [1]	Email Address	English Proficiency: ☐ Primary Language ❑ None ❑ Poor ❑ Moderate ❑ Proficient

[1] F- **Full Time,** P - **Part Time,** R - **Retired or Disabled,** T - **Training or School,** S - **Seasonally Employed,** U - **Unemployed**

Child Applying for Head Start

Last	First	Middle	Preferred
Birthday	Gender		

Race (*check all that apply*)	Ethnicity	English Proficiency
☐ Asian ☐ Black ☐ White ☐ Native American ☐ Pacific Islander ☐ Other _________	☐ Hispanic ☐ Non-Hispanic	English Proficiency: ☐ Primary Language ❑ None ❑ Poor ❑ Moderate ❑ Proficient Other Language Spoken ____________________ ☐ Poor ☐ Moderate ☐ Proficient

C-Natural/Adopted/Step **G**-Grandchild **N**-Niece/Nephew **F**-Foster **O**-Other

Choose from list Above

Primary Adult Relationship: ________ Custody: Yes ☐ No ☐	**Secondary Adult Relationship:** _________ Custody: Yes ☐ No ☐

Non-Custodial Parent (Not living in the household)

Last	First	Birthday	Gender
Phone Number		Address	

❑ Medicaid Eligibility: Medicaid Number ______________________
❑ Private Insurance Coverage: Insurance Number__________________
❑ Dental Insurance Dental Insurance No.__________________

Doctor/Dentist (of applying child)

Doctor Name	Address	City	State	Zip	Phone
Dentist Name	Address	City	State	Zip	Phone

Siblings of applying child

Last	First	Birthday	Gender

Family Information

Shaded boxes will be completed by agency staff.

Applicant Name ______________________________ Birthday ____________________

General Information

Living Address	City	State	Zip

Mailing Address (if different)	City	State	Zip

Phone Number	Home, Work, Cell, etc.	Primary	Receive Text Messages	Notes
		☐	☐ Yes	
		☐	☐ Yes	
		☐	☐ Yes	

Do you lack a fixed, regular, and adequate night time residence?	Are you sharing the housing of other persons due to loss of your own housing, your own economic hardship, or a similar reason?	Which of the situations below apply to the child?		
❒ Yes ❒ No	❒ Yes ❒ No	Living in: ❒ a motel ❒ Hotel ❒ trailer park ❒ Campground ❒ Emergency or transitional shelter ❒ Abandoned in hospital ❒ Awaiting foster care placement	❒ Primary Nighttime Residence is a public or private space not designed for sleeping accommodations ❒ Migrant Child	Living in: ❒ Car ❒ Park ❒ Public spaces ❒ Abandoned building ❒ Substandard Housing ❒ Bus or train station

Parental Status ❒ One ❒ Two	Primary Language at Home

At least one parent or guardian is an active duty member of the US Military?	**At least one or parent/guardian is a veteran of the US Military?**
❒ Yes ❒ No	**❒ Yes ❒ No**

At which Elementary School will your child attend kindergarten?		
Primary:	Preferences: 1.____________________ 2.____________________	Choose Preferences from this list: OWCAP Gramercy Your Community Connection OWATC-N Roy Area South Ogden Marshall White James Madison North Ogden Area

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 ____________________

Verifying Staff Member ______________________________ Date ____________________

CHILDPLUS

Emergency Contacts

It is very important that we have *complete* information in case of an emergency!!
Please inform these people that you have added them as a contact for Head Start purposes. These are the only people who will be allowed to pick up your child in addition to the parent/guardians.

Emergency Contacts (Not Primary or Secondary Adults)

Phone Type Codes: **H**-Home **W**-Work **C**-Cell **M**-Message

Contact			Phone Type	Phone Number	Phone Note	
Contact 1	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 2	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 3	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 4	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		
Contact 5	Name		Phone Type	Phone Number	Phone Note	Relationship to Child
	Address			( )		
				( )		Emergency Contact? Yes No
	City			( )		Release To? Yes No
	State	Zip		( )		

Enrollment Information
To be completed by agency staff.

Applicant Name ____ Birthday ________________________________

Releases Signed? ❑ Yes ❑ No			Date Signed:		
Income Amount	**Per**	**Annual Amount**	**Description**	**Verification**	**Note**

Program Details				
Program/Term		Site	Application Number	
Enrollment				
Application Date	Eligibility Notes			
Eligibility				
Eligibility Income		Num in Family	Income Status [2]	Participation Year

Is this child income eligible for Head Start? □Yes □No

Ogden-Weber Community Action Partnership, Inc.
Head Start / Early Head Start Program

Eligibility Consideration Assessment

Child's Name: ______________________________________ **Date:** __________________

Please mark all that apply:

- ☐ Parent is 19 years old or younger: ☐ Father ☐ Mother
- ☐ Non-English speaking child. Please list language _______________________
- ☐ Registering child was enrolled in Head Start/ Early Head Start last school year
- ☐ Child transferring from another Head Start Program
- ☐ Child is transitioning from Early Head Start Program (during current program year)
- ☐ Child in a: ☐ Kinship Placement ☐ State ordered Custody ☐ Foster Care (Documentation must be provided)
- ☐ Only one adult living in household
- ☐ Child living with an adult other than Parent/Guardian Other:____________________________________
- ☐ Family is receiving: ☐ FEP ☐ SSI (documentation must be provided)
- ☐ Both parents currently unemployed
- ☐ Single parent unemployed
- ☐ Currently enrolled in High School or OWATC (not including ESL Classes)
- ☐ Parent has less than a High School diploma or GED: ☐ Father ☐ Mother
- ☐ Parent(s) incarcerated: ☐ Present ☐ Past
- ☐ Parent(s) Deported: ☐ Present ☐ Past
- ☐ Parent(s) Deployed currently or in the past 12 months
- ☐ The gas, water or electricity was turned off in the last 12 months. How many times? _______________
- ☐ Family receiving: ☐ food stamps ☐ WIC
- ☐ Domestic Violence (including emotional, verbal, psychological, and physical): ☐ Present ☐ Past
- ☐ Physical Abuse/Neglect: ☐ Present ☐ Past
- ☐ Current Child Protective Services Involvement
- ☐ Substance abuse/use, includes prescription drug abuse: ☐ Present ☐ Past
- ☐ Child has severe health problems that affect the child's learning listed on application
- ☐ Family referred by another agency/Professional Referred by: ________________________________
- ☐ Registering child has identifying disability with current IEP/IFSP (with documentation provided, initials_____)
- ☐ Registering child has a suspected disability without a current IEP/IFSP
- ☐ In the last 12 months your residence was a car, domestic violence shelter, homeless shelter, campground, park, motel **due to loss of housing or economic hardship**? How long? _______
- ☐ In the last 12 months your residence was with another family **due to loss of housing or economic hardship and not voluntarily to save money**? How long? __________

Child Eligibility: ☐ Eligible ☐ 101-110% ☐111-120% ☐ 121-130% ☐ 131-150%
☐ 151-175% ☐ 176-200% ☐ Over 200%

Ogden-Weber Community Action Partnership Head Start

Head Start / Early Head Start Permission / Consent Form

(Please mark each question with a yes or no)

Child Name: ____ Birth Date: _______________________

The granting of consent is voluntary on the part of the parent and may be revoked at any time. If a parent revokes consent this action is not retroactive and therefore does not apply to an action that occurred before the consent was revoked.

OWCAP will share child's record to include immunization, birth, and IEP/IFSP and health information with the school district or school identified by parent in which the child seeks or intends to enroll. As the parent you have an opportunity to challenge and refuse disclosure of the information in the records.

OWCAP takes and uses photographs and videos of your child for both education and promotional purposes. If you would like to opt out please notify staff. Program may use photographs past the expiration date.

I give my permission/consent for Head Start to:

1. Share and receive child & family records with other agencies or organizations that provides support or services to you and your family: (if you mark yes, please list agency, i.e. WIC, DWS, DCFS, etc.)
   List Agency: ____ ❒Yes ❒No

2. Conduct screenings and assessments:
   A. ❒Yes ❒No Physical
   B. ❒Yes ❒No Blood Pressure
   C. ❒Yes ❒No Hematocrit/hemoglobin
   D. ❒Yes ❒No Growth Assessment
   E. ❒Yes ❒No Lead Screening
   F. ❒Yes ❒No Dental
   G. ❒Yes ❒No Mental Health
   H. ❒Yes ❒No Hearing
   I. ❒Yes ❒No Vision
   J. ❒Yes ❒No Behavioral
   K. ❒Yes ❒No Developmental
   L. ❒Yes ❒No Speech
   M. ❒Yes ❒No Autism (Early Head Start only)
   N. ❒Yes ❒No Nutrition Screening

3. Take my child on field trips and participate in special activities on or off site. ❒Yes ❒No

4. Transport my child when necessary, with prior consent. ❒Yes ❒No

I give my permission/consent for:

5. My child to receive fluoride varnish provided my Head Start. ❒Yes ❒No
   (**IMPORTANT:** fluoride varnishes will be applied every six months)

6. I give permission to any dentist or clinic to release information on my child to the Head Start program. ❒Yes ❒No

7. I give permission to any doctor or clinic to release information on my child to the Head Start program. ❒Yes ❒No

8. I am interested in the:
   A. ❒Yes ❒No OWCAP/WSU in-home Family Literacy Project
   B. ❒Yes ❒No Serving on the OWCAP Head Start Policy Council (similar to school PTA)
   C. ❒Yes ❒No Serving on the Fatherhood Committee (Father/Father Figures only)

9. What is your preferred language? (Which Language would you like Head Start staff to communicate with you?)
   ____

I hereby release the Ogden-Weber Community Action Head Start Program from any and all liability on the information above.

____ _______________________________

Parent/Guardian Signature Date (This form is valid through August 2020)

Nutrition Assessment & Child Health History

Child's Name: ______________________ DOB:__________ Gender: ________Class: _________

Food allergies:
Does your child have any allergies and/or intolerances that have been verified by a physician? ❒ Yes ❒ No
If yes please list: ____
Please bring documentation from your child's physician regarding the allergies you have listed.

Special dietary needs:
Does your child have special dietary requirements (cultural, religious, eating patterns, specialized formula, other personal food preferences, or medical dietary needs)? ______________________________________

Please check all that apply to your child:

- ❒ Anemia
- ❒ Malnutrition
- ❒ Swallowing difficulties
- ❒ Picky/under/over-eating
- ❒ Frequent constipation
- ❒ Other ______________________
- ❒ Tube feeding
- ❒ Vitamin and/or mineral deficiencies
- ❒ Sensorial accommodations
- ❒ Feeding concerns
- ❒ Chewing difficulties
- ❒ Diabetes
- ❒ Overweight
- ❒ Underweight
- ❒ Breastfeeding

Do you have any concerns related to your child's growth? □ Yes □ No
Do you have any other concerns about your child's nutrition status and/or eating habits? □ Yes □ No
If yes, please list your concerns: ______________________________________

Are you interested in speaking to our Registered Dietitian about any of the above nutrition and feeding topics?
❒ Yes ❒ No (*If yes, please complete an in-house referral to the Nutrition Supervisor.)*

Please check all that apply to your child:

- ❒ Diabetes
- ❒ Seizures
- ❒ Birth defects
- ❒ Heart defects
- ❒ Frequent diarrhea/constipation
- ❒ Serious Injuries______________________
- ❒ Other (physical and/or behavioral)______________________
- ❒ Frequent colds/coughs
- ❒ Asthma
- ❒ Ear Infections
- ❒ Hearing Problems/Aids
- ❒ Bone, joint, and muscle deformity
- ❒ Seasonal allergies
- ❒ Allergies to insects/bee stings
- ❒ Eczema/skin irritation
- ❒ Vision problems/glasses

Does your child use an inhaler and/or nebulizer? ❒ Yes ❒ No
Does your child have other medication that is needed in the classroom for a health condition? ❒ Yes ❒ No
Please list the medication and what condition it is treating. ______________________________

Has your child had any serious emergencies or operations?
❒ Yes ❒ No Explain______________________________________

Has your child been exposed to violence or other traumatic experiences?
❒ Yes ❒ No Explain ______________________________________

During pregnancy, did the mother use:
❒ Alcohol; How often? ❒ Monthly ❒ Weekly ❒ Daily
❒ Drugs; How often? ❒ Monthly ❒ Weekly ❒ Daily
❒ Tobacco; How often? ❒ Monthly ❒ Weekly ❒ Daily
❒ Medications prescribed by physician

Parent's Signature/Legal Guardian: ______________________________ Date: ____________