FDL HEAD START- THANK YOU FOR YOUR INTEREST IN OUR PROGRAM

*Following is our process for enrollment:

Fill out application and **provide income verification** (NOW IS THE TIME TO MAKE HEALTH APPOINTMENTS FOR YOUR CHILD)

1. Staff determines eligibility based on your household income
2. You are notified by letter or phone of your child's acceptance into the program
3. You will receive an enrollment packet and have 5 days to complete and return
4. You MUST provide all required documents listed below within 7 days, or contact the Health Safety Nutrition Manager and provide a schedule of the appointment @ 878-8109

*Just completing the application DOES NOT MEAN YOUR CHILD HAS A SPOT IN THE PROGRAM

*Home-based children born after September 1st will not be eligible for a Center-based spot until September 1st of the following year.

*YOU WILL BE REQUIRED TO HAVE AN ENTRANCE INTERVIEW BEFORE YOUR CHILD CAN START

Medical documents and other Information that needs to be provided:

- Birth Certificate would be appreciated
- Current Physical within the last year
- Immunizations need to be CURRENT, or on a catch up schedule approved by the physician. If your child is on a catch-up schedule: Appointment date needs to be turned in to the Health Safety Nutrition Manager for documentation.
- Dental Exam for children ages 1 yr. and older within the last year
- Lead Screening: this should be completed once after age 1.
- Hemoglobin: yearly starting at age 1.

*If filling out a Housing form, references and phone numbers will be required.

**** Once your child is accepted into the program, you will have 7 days to provide all documents. If it is not completed and turned in, we will place your child on the waiting list. Please schedule any appointments necessary if it has been longer than 1 year since your child has had any of the above completed**

Please ask your child's physician to fax immunizations, physical, and dental records to us as soon as possible. Appointment dates will be accepted also. Fax number: 218-878-8115

1/16, 5/17,5/19, 5/20,4/21

Fond du Lac Head Start Programs	1720 Big Lake Road Cloquet, MN 218-878-8100 or Fax-878-8115

2024-2025 Application

Legal Name of Child:		Who does this child live with > 50% ?
Sex: Male ☐ Female ☐	Child's Date of Birth:	Child's Age on 9/1/2024:

Child's Home Address:	E-mail address:

City:	State:	Zip:	County:

Name of Primary Caregiver:	**Name of Secondary Caregiver**: Parent living in home
Relationship to Child:	Relationship to Child:
Phone Number:	Phone Number:
Additional Phone:	Additional Phone:

What Program(s) Are You Interested In For This Child?

Early Head Start (Ages 0-3)

☐	Early Head Start 7:45-3:00
☐	Home Based Program

Head Start (Ages 3-5)

☐	Head Start 7:45-3:00

Child **MUST be 3 by September 1st of 2023 to be eligible for Head Start (ages 3-5)**

What Is Your Child's Ethnicity? (check all that apply)

☐ Asian	☐ Native American/Alaskan Native	☐ Bi-Racial/Multi-Racial
☐ Black/African American	☐ Native Hawaiian	
☐ Other:_____________	☐ White	Is Your Child Hispanic/Latino ☐ Yes ☐ No

My Child Has Tribal Affiliation With: (list tribe)	Name of Person Enrolled:
Person Enrolled: ☐ Child ☐ Parent ☐ Grandparent Birthdate of enrolled family member:	Verified on:_____________ By:_____________ ****OFFICE USE ONLY****

My Child Is Currently Receiving: (check all that apply)

☐	Child Care Assistance	☐	Supplemental Security Income(SSI)	☐	WIC
☐	MFIP- Cash Assistance	☐	TANF	☐	Child Support

Application MUST be returned to the Head Start Office with Income Verification. Please bring one of the following documents when you return the application:

- Pay Stub
- Public Assistance ID Number
- W-2
- Tax Forms

CONTINUED ON BACK

Fond du Lac
Head Start Programs

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Cloquet, MN
218-878-8100 or Fax-878-8115

Is this child currently receiving services for a disability? ☐ Yes ☐ No

☐ Medical ☐ Physical ☐ Emotional ☐ Educational Special Needs

☐ Other:____

Do you have concerns about this child's development? ☐ Yes ☐ No

☐ Speech ☐ Learning ☐ Health ☐ Physical ☐ Emotional

☐ Psychological ☐ Behavioral ☐ Other:_____________________________________

How many people live in your household (including all adults and children)? ________

Works for the reservation ☐

Is this child currently in Foster Care? ☐ Yes ☐ No If yes, what county? _______________________

Name of Social Worker?____

My Household currently has NO INCOME: ☐ Yes **If yes, a No Income Form MUST be filled out**

Please check ALL that apply for your child. This information will only be used to assist us in determining enrollment priority along with income eligibility

		Transitioning Student from Early Head Start to Head Start	
		Single Parent	
		Teen Parent	
		Parent/Guardian(s) in school	
		Parent/Guardian(s) has at least a part time job	
		Parent/Guardian(s) needs/wants high school diploma/GED	
		No prenatal care	
		Child with serious health issue	
		Child has history of neglect	
		Alcohol/drug abuse in child's family	
		Domestic violence history in child's family	
		In need of housing	
		Family caring for elder in home	
		Child has identified disability/special need/mental health issue	
		Family history of diabetes	
		Other family member has identified special need/behavior/mental health issue	
		Child of Incarcerated Parent	
		Head Start Programs Parent on staff	

Caregiver filling out application:________________________________ Date: _______________

Signature

Please print name: ____

Staff Use Only:	
Received by:	Date:

Head Start Authorization for Release of Information

Please fill out all sections of this form.

Patient Name: ____________________________ Social Security #: ____________________

Address: ________________________________ Date of Birth: ____________________

City:______________________State:________ Zip: ________Phone Number#: ___________________

Send Information From: (Request Information From)

____

____

____

Send to:

Fond du Lac Head Start Programs
33 University Rd
Cloquet, MN 55720
Fax 218-878-8139

I would like the records from the following dates:___________through_____________________.

(This can be a specific date or more general: Example June 2018 or September 2017-May2018).

Please check the records you would like:

□ **Medical Exam/Physical**	□ **Vision Exam**	□ **Vision Screening**
□ **Dental Exam**	□ **Blood Lead Screening**	□ **Developmental Screening**
□ **Dental Treatment**	□ **Hearing Screening**	□ **Hemoglobin/Hematocrit**
□ **Blood Pressure**	□ **Other** ________________________________	

Sharing of Special Protected Records: I authorize the sharing of information about:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS)________YES________NO
b. The diagnosis or treatment of drug and /oralcohol abuse, ______YES________NO
c. The treatment and/or consultation for mentalhealth or psychiatric disorders________YES ______NO

Reason records are needed (check all that apply)

____ For Head Start Health Requirements ____Personal Use ____Other: __________________

I understand that I may revoke this authorization in writing at any time. Written statement that I want to revoke my authorization should be delivered to:

Fond du Lac Head Start Programs; 33 University Rd, Cloquet, MN 55720

This authorization expires one year from date signed and will automatically become null and void without my express revocation.

________________ **Date**

________________________________ **Signature of Parent/guardian**

________________________________ **Relationship to Patient**