

Child Information Form

for CAP Early Childhood Programs



A separate copy of this form must be completed for each child applying to CAP Early Childhood Programs.

1 Adult 1 Name

Last Name (Please print) _____

First Name _____ MI _____

2 Adult 1 Date of Birth

Month [] [] Day [] [] Year [] [] [] [] [] []

Program & Site Preference

Please check all that apply.

- I am interested in my child being enrolled in an early childhood education program at a CAP center.
Preferred center: (See staff for site map if needed.) _____
- I am interested in my child receiving early childhood education services at my home. (Child must be younger than 30 months.)
- I am interested in an early childhood education program that combines services at my home and at a CAP center. (Child must be younger than 24 months.)

Child Information

1 Legal Name

Last Name _____ First Name _____ MI _____

2 Preferred Name

3 Date of birth

Month [] [] Day [] [] Year [] [] [] [] [] []

4 Place of birth

City _____ State [] []

Country _____

Child Care Information

- 1 Is this child currently in a full-time childcare or education program?**
- Yes → What type? Childcare Center Friend's/Relative's Home
 No Family Childcare Home Own Home
 Pre-School
- 2 Are you looking for a childcare or education program so that you can attend school or work?** Yes No
- 3 Are you looking for childcare before 8:30am and/or after 2:30pm?**
Please note: All CAP early childhood centers provide services from 8:30am to 2:30pm. Some centers offer extended care from 7:00am to 6:00pm. Extended care is available as a private pay arrangement. Eligible families can use OKDHS childcare assistance to help pay the cost of extended care. Yes No

5 How is this child related to Adult 2? (Check one.)

Biological son or daughter Other relative
 Adopted son or daughter Roomer or boarder
 Stepson or stepdaughter Housemate or roommate
 Brother or sister Foster child
 Grandchild Other nonrelative

Child's Development

- 1 Do you have concerns about your child's overall health and development?**
- Yes → Please describe your concerns: _____
 No
- Who has expressed concerns?**
- Primary Care Physician
 Medical Provider
 CAP Early Childhood Staff
 Sooner Start
 Family Member
 Other → _____

6 Who has custody of this child? (Check one.)

Adult 1 Both Adult 1 and Adult 2
 Shared Custody Agreement → With whom? _____
 Other Person _____

7 What is this child's primary language?

8 How well does this child speak English?

Very well
 Well
 Not Well
 Not at all

2 Does your child have a certified IEP/IFSP? (If yes, provide a copy.)
An IEP/IFSP is an individualized plan written by the public school or SoonerStart that assists your child to achieve goals and objectives listed on the IEP/IFSP.

Yes → Date of IEP/IFSP:
Month [] [] Day [] [] Year [] [] [] [] [] []
 No

3 Does your child have a documented disability or need assistive services? (If yes, you must provide a copy of the medical record with the diagnosis along with the formal evaluation(s) completed by your child's primary care physician or medical provider.) Yes No

4 Do you have concerns about your child's mood or behavior? (For example: excessive crying, aggressive behavior, tantrums, or inappropriate sexual behavior.)

Yes → Please describe your concerns:

No

Nutritional Information

1 Does your child have a food allergy? (If yes, you will need to provide documentation from primary care physician if we are able to enroll your child.)

Yes → What is the allergy to?

No

Please describe any reaction:

2 Is your child on a special diet prescribed by a doctor? (If yes, you will need to provide documentation from primary care physician if we are able to enroll your child.)

Yes → Please explain:

No

3 Please list foods your child cannot or should not eat:

Please indicate reason for not eating these foods:

Medical Religious Personal

4 Do you have concerns about your child's eating behaviors?

Yes → Please describe your concerns:

No

Please complete these questions only if your child is 0-12 months old.

5 What does your child eat?

Breast Milk

Milk

Formula → Specify brand:

Other →

6 Feeding method Breast Fed Bottle Fed

Medical Information

1 Physician

Last Name First Name MI

Name of clinic, if applicable

Area Code + Number -

2 Dentist

Last Name First Name MI

Area Code + Number -

3 Specialist (if applicable)

Last Name First Name MI

Area Code + Number -

4 Health Insurance

a. Type: SoonerCare/Medicaid Private Other None

b. Insurance Provider's Name:

c. Policy Number or ID:

d. Expiration Date: Month Day Year

e. Dental Coverage Included: Yes No

5 Does your child receive care through Indian Health Services?

Yes No

6 Does your child receive regular medical care?

Yes No

7 When was your child's last well-child exam?

8 Does your child receive regular dental care?

Yes No

9 When was your child's last dental screening?

Medical History

1 Has your child ever been hospitalized or had surgery?

- Yes → Please explain: ↴
 No

2 Has your child ever had a serious accident?

- Yes → Please explain: ↴
 No

3 Identify any past or present health conditions your child has had:

- | | |
|---|--|
| <input type="checkbox"/> a. Anemia | <input type="checkbox"/> k. Wears hearing aid |
| <input type="checkbox"/> b. Cancer | <input type="checkbox"/> l. Frequent diarrhea |
| <input type="checkbox"/> c. Eczema | <input type="checkbox"/> m. Traumatic brain injury |
| <input type="checkbox"/> d. Diabetes | <input type="checkbox"/> n. Hearing difficulties |
| <input type="checkbox"/> e. Seizures | <input type="checkbox"/> o. Trouble chewing/swallowing |
| <input type="checkbox"/> f. Allergies | <input type="checkbox"/> p. Asthma |
| <input type="checkbox"/> g. Overweight | <input type="checkbox"/> q. Glasses are prescribed |
| <input type="checkbox"/> h. High lead level | <input type="checkbox"/> r. Heart murmur/condition |
| <input type="checkbox"/> i. Sickle cell disease | <input type="checkbox"/> s. Frequent constipation |
| <input type="checkbox"/> j. Vision problems | <input type="checkbox"/> t. Other ↴ |

4 Does your child take medications at home?

- Yes
 No

5 Will your child need to take medications at school? (If yes, provide a copy of the medication prescriptions.)

- Yes → What are the names of the medications? ↴
 No

Why does your child take these medications? ↴

Birth History

1 Birth weight

Pounds Ounces

2 Length

Inches

3 Gestational age

- Term
 Premature by weeks
 Overdue by more than 2 weeks

4 Type of delivery

- Vaginal Cesarean Unknown

5 Length of infant's hospital stay

- Routine
 Non-routine → Length of stay: _____

6 Delivery location

- Hospital/Clinic Home
 Birthing Center Unknown
 Other

7 Were there any complications associated with this delivery?

(Compression of the placenta/cord, breech or abnormal position of fetus, premature rupture of membranes, uterine bleeding, etc.)

- Yes → Please describe: ↴
 No
 Unknown

8 Did the baby have any problems at birth?

(Pre-term, respiratory distress, low birth weight, birth defect, etc.)

- Yes → Please describe: ↴
 No

Please describe any observable birth defects: ↴

9 Did the mother have any health problems during pregnancy or delivery? (High blood pressure, diabetes of any kind, eclampsia, abruptio placenta or placenta previa, etc.)

- Yes → Please describe: ↴
 No



CAP Early Childhood Programs Authorizations and Releases Form

This entire form must be completed and signed for each child applying to CAP Early Childhood Programs.

Shall Be Referred to as Child and Parent Below:

(Child) Child's Name:

Date of Birth:

(Parent) Parent/Guardian Name:

Date of Birth:

Consent for Health Services

As partial fulfillment of my partnership with Community Action Project of Tulsa County (CAPTC) Early Childhood Education Programs, I hereby agree that **Child**:

1.) Shall receive all of the health services required by the Head Start Performance Standards, within the mandated timeframe from the first day of attendance. These services may be provided by Early Childhood Education Programs staff or by collaborative and/or contracted providers. Providers might include area public school systems, university medical centers, and/or affiliated agencies. I understand that these services may include, but are not limited to:

- Developmental Screening/Observation
- Social/Emotional/Behavioral/Mental Health Observations
- Vision/Hearing Screening
- Height & Weight Assessment
- Dental Screening/Exam
- Well-Child Exam
- Lead Screening

2.) Shall brush his/her teeth daily in the center he/she attends, with an ADA approved fluoride toothpaste and toothbrush provided by CAPTC Early Childhood Education Programs.

As partial fulfillment of my partnership with Community Action Project of Tulsa County (CAPTC) Early Childhood Education Programs, I **(PARENT)** hereby agree and/or understand that:

- 1.) I will receive information regarding **Child's** health status, screenings, observations, and evaluations; information will be shared with collaborative and/or contracted providers which may include area public school systems, university medical centers, and/or affiliated agencies.
- 2.) I will take **Child** for all recommended medical and dental examinations and follow-up services if a concern is found; and I will provide program staff with copies of results from these appointments.
- 3.) I will request assistance from CAPTC program staff to meet requirements.
- 4.) I may be asked to sign specific release of information forms to assist the Early Childhood Education Programs staff in obtaining **Child's** updated health information.
- 5.) In the event I am unable to attend, a CAPTC Early Childhood Program staff member may accompany **Child** to a well-child exam provided by collaborative and/or contracted providers. I understand that in order to complete the exam, my child may be required to remove part or all of his/her clothing.

This consent shall remain in effect for the duration of enrollment unless revoked in writing, by Parent, to CAPTC Early Childhood Education Programs.

Parent Signature:

Date:

Authorization for Emergency Treatment and Transport

I, the undersigned parent or legal guardian of **Child** do hereby authorize any emergency x-ray, examination, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of CAPTC Early Childhood Education Programs, the temporary custodian of the minor. It is understood that this emergency consent is given in advance of any specific diagnosis or treatment being required. This consent shall remain in effect for the duration of enrollment unless revoked, by Parent, in writing to CAPTC Early Childhood Education Programs.

I understand that, if **Child** has a medical emergency while at CAPTC Early Childhood Education Programs, 911 will be called to transport **Child** immediately to the nearest hospital. To the extent possible, transport will be provided to the specified preferred hospital. This consent shall remain in effect for the duration of enrollment unless revoked in writing, by Parent, to CAPTC Early Childhood Education Programs.

Preferred Hospital: _____

Parent Signature:

Date:

Permission to Video, Photograph, or Record with other Medium

I authorize CAPTC to video, photograph, or record with other medium **Child** for research, training, promotional, or marketing purposes for Early Childhood Education Programs. This consent shall remain in effect for the duration of enrollment unless revoked in writing, by Parent, to CAPTC Early Childhood Education Programs.

Parent Signature:

Date:

Notice of Privacy Policy Receipt

This is to acknowledge that I have received a copy of CAPTC's Privacy Policy. The Privacy Policy provides me with information about how CAPTC may use and disclose **Child's** educational, health, and financial information.

Parent Signature:

Date:

CHILD AND ADULT CARE FOOD PROGRAM (CACFP) ENROLLMENT FORM

1. Child's Name: _____ Date of Birth: _____

2. Normal Days In Attendance:

	X	X	X	X	X	
SUN	MON	TUES	WED	THUR	FRI	SAT

3. Head Start Facilities Only: Indicate Session and sign and date form.

A.M. P.M. All Day

4. **Special dietary needs *** Yes No

5. Normal Hours of Attendance: 8:30 to 2:30

6. Normal Meals Eaten:

Breakfast Lunch Supper
 A.M. Snack P.M. Snack Late P.M. Snack

7. Signature of Parent/Guardian: _____ Date: _____

*** Attach signed medical statement.**

Name of Parent/Guardian: _____

Address: _____ City: _____ Zip: _____

Home Telephone: _____

Renewal Updates

If there are no changes to the above information, sign and date. If there are changes, a new enrollment form must be completed, signed and dated.

Parent/ Guardian Signature _____ Date _____
