





**Miami Dade County Community Action Agency  
Head Start / Early Head Start Application  
Family Demographics**



**Family Of: (child's name)** \_\_\_\_\_

**ADULT APPLICANT  Mother/Mother Figure**

**Mother Name:**

\_\_\_\_\_ *First name* *MI* *Last name*

**Date of Birth:** \_\_\_\_\_

**Ethnicity:** (Check One)

Hispanic or Latino Origin

Non-Hispanic or Latino Origin

**Race:** (Check One)

Black or African American

White

Biracial/Multiracial

Unspecified

Other \_\_\_\_\_

**Person's Relationship to the Eligible Child:** \*(Legal-Court documentation is needed to enroll child)

Biological Parent  \*Foster Parent  Step Parent  \*Adoptive Parent  \*Grandparent  \*Aunt/Uncle

\*Godparent  \*Legal Guardian  \*Other Relative  \*No Biological/Legal Relationship

**Highest Level of Education Completed:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

**Applicant is currently pregnant:**  Yes  No

**ADULT APPLICANT  Father/Father Figure**

**Father Name:** \_\_\_\_\_  
*First name* *MI* *Last name*

**Date of Birth:** \_\_\_\_\_

**Person's Relationship to the Eligible Child:** \*(Legal-Court documentation needed to enroll child)

Biological Parent  \*Foster Parent  Step Parent  \*Adoptive Parent  \*Grandparent  \*Aunt/Uncle

\*Godparent  \*Legal Guardian  \*Other Relative  \*No Biological/Legal Relationship

**Highest Level of Education Completed:** \_\_\_\_\_ **Date Completed:** \_\_\_\_\_

**Ethnicity:** (Check One)

Hispanic or Latino Origin

Non-Hispanic or Latino Origin

**Race:** (Check One)

Black or African American

White

Biracial/Multiracial

Unspecified

Other \_\_\_\_\_

**FAMILY MEMBERS**

<b>Name:</b> _____	<b>Date of Birth</b> <u>  </u> / <u>  </u> / <u>  </u>	<b>Relationship to Child</b> _____	<input type="checkbox"/> M	<input type="checkbox"/> F
<b>Name:</b> _____	<b>Date of Birth</b> <u>  </u> / <u>  </u> / <u>  </u>	<b>Relationship to Child</b> _____	<input type="checkbox"/> M	<input type="checkbox"/> F
<b>Name:</b> _____	<b>Date of Birth</b> <u>  </u> / <u>  </u> / <u>  </u>	<b>Relationship to Child</b> _____	<input type="checkbox"/> M	<input type="checkbox"/> F
<b>Name:</b> _____	<b>Date of Birth</b> <u>  </u> / <u>  </u> / <u>  </u>	<b>Relationship to Child</b> _____	<input type="checkbox"/> M	<input type="checkbox"/> F



Miami Dade County Community Action Agency  
Head Start / Early Head Start Application  
Family Demographics



Family Of: (child's name) \_\_\_\_\_

✓Family Type: Check only one

- Two parent family
- Single parent family (mother figure only)
- Single parent family (father figure only)
- Single parent family (father figure only) living with partner
- Foster family
- Other relative(s)
- Single parent family (mother figure only) living with partner
- Other family type: Specify \_\_\_\_\_

Employment/School Status: Check only one

- Single parent family (employed)
- Single parent family (unemployed)
- Single parent family (in job training or school)
- Two parent family (1 in job training or school)
- Two parent family (2 employed parents)
- Two parent family (1 employed parent)
- Two parent family (both in job training or school)
- Two parent family (both unemployed)

✓Types of Services or Financial Assistance Received (Mark all that apply):

- No Services Received
- Medical financial assistance (i.e. Medicaid/Medicare)
- Food Stamps  WIC
- Public Assistance/Welfare (i.e. TANF/AFDC)
- KIDCARE
- Supplemental Security Income (SSI)
- Foster care/Adoption subsidy
- Unemployment Compensation
- Public housing assistance
- Energy program assistance
- Child support/alimony
- Other: Specify \_\_\_\_\_

✓Housing Payment Arrangement:

- Own housing
- Exchange services for housing
- public/ section- 8/subsidized housing
- Rent housing
- Make no payment for housing
- other: Specify \_\_\_\_\_

✓Type of Housing:

- House  Mobile home/trailer  Homeless/no housing  Temporarily living with someone else
- Migrant Housing  Apartment  Community shelter (HAC, Salvation Army, Rescue Mission, etc)
- Hotel/motel room Other: \_\_\_\_\_

✓Homeless in Past 12 Months (Including currently homeless):  Yes  No (Skip to next question)

Length of time homeless:

- Less than 1 month
- 1 - 3 months
- 3 - 6 months
- More than 6 months

✓Family Referred To Program by:

- Department of Children & Families
- Hospital / Physician / Medical Provider
- Court Ordered
- Foster Care Program
- Other: Specify \_\_\_\_\_



**Miami Dade County Community Action Agency  
Head Start / Early Head Start Application  
Child Development**



**Family Of: (child's name)** \_\_\_\_\_

**Assistive Devices Used:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Glasses/Contact Lenses | <input type="checkbox"/> No Assistive Devices Used | <input type="checkbox"/> Crutches/Walker/Cane |
| <input type="checkbox"/> Braces                 | <input type="checkbox"/> Wheelchair                | <input type="checkbox"/> Hearing Aide         |
| <input type="checkbox"/> Other: Specify _____   |  |   |

**Developmental Risk Factors:**

**BIOLOGICAL/MEDICAL RISKS**

- |                                 |                                   |   |
|---------------------------------|-----------------------------------|---|
| <i>Parent Report</i>            | <i>Documented Record</i>          | <input type="checkbox"/> Parent report and records indicate no biological/medical risks |
| <input type="checkbox"/>        | <input type="checkbox"/>          |   |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Spine Bifida   |
|                                 |                                   | <input type="checkbox"/> Diabetes   |
|                                 |                                   | <input type="checkbox"/> Heart Condition  |
|                                 |                                   | <input type="checkbox"/> Sickle Cell  |

**✓ ENVIRONMENTAL RISKS**

- |  |   |  |
|--|---|--|
| <i>Parent Report</i>                             | <i>Documented Record</i>  | <input type="checkbox"/> Parent report and records indicate no environmental risks |
| <input type="checkbox"/>                         | <input type="checkbox"/>  |  |
| <input type="checkbox"/> Parent(s) <17 years old | <input type="checkbox"/> Child abuse and/or neglect                 | <input type="checkbox"/> Parental Disability                                       |
| <input type="checkbox"/> Domestic Violence       | <input type="checkbox"/> Parent(s) education <8 <sup>th</sup> grade | <input type="checkbox"/> Substance Abuse   |

**✓ DISABILITIES**

Parent report and records indicate no disabilities

	<b>Suspected</b>	<b>Identified</b>	<b>Date</b>	<b>Evaluated by</b>
Emotional/Behavioral Disorder	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Health Impairment/Orthopedic Impairment	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Hearing Impairment including Deafness	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Learning Disability/Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Speech/Language Impairment	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Traumatic Brain Injury/Autism	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Visual Impairment including Blindness	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____
Other Impairment: _____	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	_____

Child has been determined eligible by the LEA or Part C Agency to receive special education and related services or Part C services under an Individualized Education Program (IEP) or Individualized Family Plan (IFSP)

- Yes (If yes, please attach documentation)       No

**Comments**



**Miami Dade County Community Action Agency  
Head Start / Early Head Start Application  
HSFIS Household Size and Income/Verification**



**Child's Name:** \_\_\_\_\_ **Parent/Legal Guardian Name:** \_\_\_\_\_

**Number of Adults in Family:** \_\_\_\_\_ **Number of Children in Family:** \_\_\_\_\_

**Number of Adults contributing to the Income:** \_\_\_\_\_

**Effective Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Time period income based on:**     **Previous 12 Month**             **Last Calendar Year**

<i><b>INCOME SOURCE</b></i>	<i><b>AMOUNT</b></i>	<i><b>FREQUENCY</b></i>
(Please Attach Proof of Income)		
<i><b>Non-Agricultural Earned Income (i.e. wages, tips)</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Agricultural Earned Income (i.e. wages, tips)</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Public Assistance, Welfare (i.e. TANF, AFDC)</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Social Security/Pension</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Supplemental Security Insurance (SSI)</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Foster Care/Adoption Subsidy</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Unemployment Compensation/Insurance</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Child Support/Alimony</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month
<i><b>Other Unearned Income</b></i>		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Annually <input type="checkbox"/> Twice a month

**Parent Verification:**

I certify that the information provided in this application package, and the proof of income provided for enrollment eligibility, is accurate and truthful to the best of my knowledge.

**Parent or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Print name:** \_\_\_\_\_

**Miami Dade CAA Head Start / Early Head Start  
Application - Family Demographics Form  
Staff and Parents Interview Section - 2**

**Child's Name:** \_\_\_\_\_  
*First Name*
*MI*
*Last Name*

**ADULT APPLICANT**  **Mother/Mother Figure**

**Applicant Name:** \_\_\_\_\_  
*First Name*
*MI*
*Last Name*

**Person is a Supporting Adult in the Child (ren)'s Life:**  Yes  No  
**Person is the Head of Household for family:**  Yes  No  
**Person resides in same household with Head of Household:**  Yes, all of the time  Yes, some of the time  No, never

**Language(s) Spoken:** Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

**English Speaking Ability:**  Very well  Well  Not Well  Not at all

**Primary Occupational Status** (Mark only one for each parent):

**Paying job**

**Start Date:** \_\_\_\_\_  
 Full-time (more than 34 hours weekly)  
 Part-time  
 Seasonal-Non Agricultural  
 Seasonal-Agricultural  
 Employed and in school

**In job training program**

Training program with salary  
 Training program without salary

**Unemployed**

With past employment experience  
 With no previous employment experience

**In school**

**Start Date:** \_\_\_\_\_  
 Towards high school diploma/GED  
 Towards trade/business qualification  
 Towards college degree  
 Towards postgraduate degree

**Other**

Homemaker  
 Retired  
 Unable to work due to disability

**Attended Vocational Training, Trade or Business School:**  Yes  No (Skip to next question)  
 Received Certificate or license:  Yes  No

**Participated in Government Training Program:**  Yes  No (Skip to next question)

Training program(s) attended (Mark all that applies):  JOBS  JTPA  JOB Corps  Other:  
 Specify \_\_\_\_\_

Person is willing to Pursue Additional Education/Job Training:  Yes  No  Not Applicable

Person Previously Enrolled in Head Start or Other Child Development Program:  Yes  No

If yes, specify which program(s) \_\_\_\_\_ Date from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**For EHS Use Only:**

Applicant is a Teen Mother  Yes  No  
 Applicant Currently in School  Yes  No Current level:  Elementary  Junior High  High School  
 Teen Parent Program in School attended:  Yes  No  
 Applicant enrolled in teen parent program:  Yes  No

# Miami Dade CAA Head Start / Early Head Start Application - Family Demographics Form

## FAMILY COMPOSITION AND RESOURCES

Complete one copy of this section for each family applying for Head Start / EHS services

Child's Name: \_\_\_\_\_  
First Name MI Last Name

### ADULT APPLICANT Father/Father Figure

Applicant Name: \_\_\_\_\_  
First Name MI Last Name

Person is a Supporting Adult in the Child (ren)'s Life:  Yes  No  
Person is the Head of Household for family:  Yes  No  
Person resides in same household with Head of Household:  Yes, all of the time  Yes, some of the time  No, never

Language(s) Spoken: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

English Speaking Ability:  Very well  Well  Not Well  Not at all

### Primary Occupational Status (Mark only one for each parent):

#### Paying job

- Start Date: \_\_\_\_\_  
 Full-time (more than 34 hours weekly)  
 Part-time  
 Seasonal-Non Agricultural  
 Seasonal-Agricultural  
 Employed and in school

#### In job training program

- Training program with salary  
 Training program without salary

#### Unemployed

- With past employment experience  
 With no previous employment experience

#### In school

Start Date: \_\_\_\_\_

- Towards high school diploma/GED  
 Towards trade/business qualification  
 Towards college degree  
 Towards postgraduate degree

#### Other

- Homemaker  
 Retired  
 Unable to work due to disability

Attended Vocational Training, Trade or Business School:  Yes  No (Skip to next question)  
Received Certificate or license:  Yes  No

Participated in Government Training Program:  Yes  No (Skip to next question)

Training program(s) attended (Mark all that applies):  JOBS  JTPA  JOB Corps  Other:

Specify \_\_\_\_\_

Person is willing to Pursue Additional Education/Job Training:  Yes  No  Not Applicable

Person Previously Enrolled in Head Start or Other Child Development Program:  Yes  No

If yes, specify which program(s) \_\_\_\_\_ Date from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**Miami Dade CAA Head Start / Early Head Start  
Application - Family Demographics Form**

***FAMILY COMPOSITION AND RESOURCES***

*Complete one copy of this section for each family applying for Head Start / EHS services*

**If family is receiving Public Assistance, answer the following:**

**Began receiving services:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Scheduled termination:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Family Applied to Receive Supplemental Security Income (SSI):**  Yes     No

**Length of Time at Current Address:**

- |   |  |
|---|--|
| <input type="checkbox"/> Less than 6 months | <input type="checkbox"/> 1 - 2 years       |
| <input type="checkbox"/> 6 - 12 months      | <input type="checkbox"/> More than 2 years |

**Number of Times Family Moved in the Past 12 Months:**

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Family has not moved | <input type="checkbox"/> Twice       | <input type="checkbox"/> Four or more times |
| <input type="checkbox"/> Once                 | <input type="checkbox"/> Three times |   |

**Family Currently Has Means of Transportation:**

- Yes       No

**Primary mode(s) of transportation used (*Mark all that apply*):**

- |  |  |
|--|--|
| <input type="checkbox"/> Private vehicle (car, truck, van) | <input type="checkbox"/> Public transportation (bus, subway, taxi) |
| <input type="checkbox"/> Friend's or relative's vehicle    | <input type="checkbox"/> Other:                                    |

**Family has alternate means of transportation:**

- Yes       No

**Alternative means of transportation (*Mark all that apply*):**

- |  |  |
|--|--|
| <input type="checkbox"/> Private vehicle (car, truck, van) | <input type="checkbox"/> Public transportation (bus, subway, taxi) |
| <input type="checkbox"/> Friend's or relative's vehicle    | <input type="checkbox"/> Other                                     |

**How did you learn about the Head Start/Early Head Start Program?**

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**Parent Signature:** \_\_\_\_\_  
*(Parent or Guardian Being Interviewed)*

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Staff Signature:** \_\_\_\_\_  
*(Staff Person Conducting Interview)*

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## Miami Dade CAA Head Start/Early Head Start HSFIS Household Size and Income Verification

**STAFF INCOME VERIFICATION:**

**Child's Name:** \_\_\_\_\_ **Parent's Name:** \_\_\_\_\_

**Effective Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Family Annual Income Total:**

*Agricultural Earned Income* \$ \_\_\_\_\_

*Non-Agricultural Earned Income* \$ \_\_\_\_\_

*Unearned* \$ \_\_\_\_\_

**Time period income based on:**     **Previous 12 Month**         **Last Calendar Year**

**Income Verification (check all that applies):**

- |   |   |
|---|---|
| <input type="checkbox"/> 1040 Tax Statement | <input type="checkbox"/> W2 Statement                       |
| <input type="checkbox"/> Pay Stubs          | <input type="checkbox"/> I C Supplement                     |
| <input type="checkbox"/> Income Declaration | <input type="checkbox"/> Public Assistance Form (TANF, SSI) |
| <input type="checkbox"/> Unemployment       | <input type="checkbox"/> Other: Specify _____               |

Food Stamps/FDPIR \_\_\_\_\_  
*Case Number*

TANF \_\_\_\_\_  
*Case Number*

**Staff Income Verification Signatures (required):**

**I have examined the income documents checked above and certify that the child is eligible to participate in the program.**

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Center Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Family Meets Income Eligibility		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Over-income Approval	Date:
Enrollment by Eligibility Type		<input type="checkbox"/> Foster Family	<input type="checkbox"/> Public Assistance (TANF/SSI)	<input type="checkbox"/> Over Income	<input type="checkbox"/> Meet Poverty Guidelines



# Enrollment – HSFIS Child Nutritional Assessment Form

**Date Completed:** \_\_\_/\_\_\_/\_\_\_      **Child's Name:** \_\_\_\_\_      **Date of Birth:** \_\_\_\_\_

**Completed By:**  Staff Signature (required) \_\_\_\_\_      Parent Signature (required): \_\_\_\_\_

**A. Infants:**

**Eating frequency (times per day):** \_\_\_|\_\_\_      **Amount consumed in 24 hours:** \_\_\_|\_\_\_|\_\_\_ ounces

**Type of food consumed:** \* Formula Type \_\_\_\_\_  Breast Milk  Milk  Other: Specify \_\_\_\_\_

**\*Miami-Dade Head Start participates in the Child Care Food Program and will provide the above listed formula.**

**Feeding Method:**       Breast Fed       Bottle Fed       Other: Specify \_\_\_\_\_

**B. Toddlers:**

**Eating Frequency (times per day):** \_\_\_|\_\_\_

**At what age did the child start doing each of the following?**

Eat solid food: \_\_\_|\_\_\_ months

Drink from a cup: \_\_\_|\_\_\_ months

Feed self: \_\_\_|\_\_\_ months

**Dietary Habits:**

**Favorite Foods:** \_\_\_\_\_

**Least Favorite Foods:** \_\_\_\_\_

**Check all that applies. An item with an asterisk\* that is checked (yes) requires a referral to Nutrition Services:**

- |   |                          |
|---|--------------------------|
| Child takes vitamin/ mineral supplements?                     | <input type="checkbox"/> |
| Supplements contain iron?                                     | <input type="checkbox"/> |
| Supplements contain fluoride?                                 | <input type="checkbox"/> |
| Supplements were prescribed?                                  | <input type="checkbox"/> |
| **Foods not eaten for medical, religious or personal reasons? | <input type="checkbox"/> |
| *Child on a special diet?                                     | <input type="checkbox"/> |
| *Change in child's appetite in the past month?                | <input type="checkbox"/> |
| *Child takes a bottle?  | <input type="checkbox"/> |
| *Child eats or chews things that aren't food?                 | <input type="checkbox"/> |
| *Child has trouble chewing or swallowing?                     | <input type="checkbox"/> |
| *Child often has:   |                          |
| Diarrhea  | <input type="checkbox"/> |
| Constipation  | <input type="checkbox"/> |
| *Concerns about what the child eats?                          | <input type="checkbox"/> |

**Yes**

\*\*Specify Diet or Formula Need.

Medical reason require note from doctor.

**Usual Food Group Eating Frequency:**

**Approximate Number of Times Each Week**

	0	1	2	3	4	5	6	7	7+
A. Milk, cheese, yogurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Meat, poultry, fish, eggs; or dried beans/peas, peanut butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Rice, grits, bread, cereal, tortillas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Oranges, grapefruit, tomatoes (fruit/juice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Other fruits and vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Oil, butter, margarine, lard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Cakes, cookies, sodas, fruit drinks, candies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Miami Dade CAA Head Start / Early Head Start  
Enrollment – HSFIS Consents and Permissions Form**

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Form Type:    New            Modify Record

Child Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_  
                            *First*                      *MI*                      *Last*

**Consents for Screenings:**

**Initials**

- |   |       |
|---|-------|
| <input type="checkbox"/> Vision                       | _____ |
| <input type="checkbox"/> Blood Pressure               | _____ |
| <input type="checkbox"/> Hearing                      | _____ |
| <input type="checkbox"/> Heights and Weights          | _____ |
| <input type="checkbox"/> Lead Screenings              | _____ |
| <input type="checkbox"/> Dental                       | _____ |
| <input type="checkbox"/> Speech                       | _____ |
| <input type="checkbox"/> Developmental and Behavioral | _____ |
| <input type="checkbox"/> Classroom Observations       | _____ |
| <input type="checkbox"/> Other: Specify _____         | _____ |

**Other Permissions/Releases:**

- |   |       |
|---|-------|
| <input type="checkbox"/> Share health records with the school system and other contracted providers'                      | _____ |
| <input type="checkbox"/> Accompany class on field trips   | _____ |
| <input type="checkbox"/> Use of the child's photograph  | _____ |
| <input type="checkbox"/> Medical / Dental / Emergency Consent   | _____ |
| <input type="checkbox"/> Vaccines Consent   | _____ |
| <input type="checkbox"/> Volunteer classroom assistance from CAA Foster Grandparent Program or Other approved volunteers' | _____ |

**Enrollment Consents and Permissions Signatures**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Parent/Guardian Name: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Staff Name: \_\_\_\_\_

# AGENCY USE ONLY

Child's Name: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

## New Child

**Items received:**

Items	Date Received/Comments
*Birth Certificate (copy in file)	
*Proof of Income (copy in file)	
Parent's Picture Identification (copy in file)	
Social Security Cards for child and family members (copy in file)	
Immunization results(original in file)	
Physical Examination (original in file)	
TB or PPD Test /TB Risk Assessment (original in file)	
Hemoglobin and Hematocrit results (originals in file)	
Lead Screening results (original in file)	
Sickle Cell results (original in file)	
Vision Screening (original in file)	
Hearing Screening (original in file)	
Dental/Oral Health Examination (original in file)	
Diagnosed Disability Documentation (e.g. IEP/IFSP/Evaluation Report)	

## Application Tracking

	Staff Signature	Staff Print Name	Date
Folder Audit			
Medical Review			
Input into HSFIS			
Interview with Social Worker			

## Application Status

Accepted /Date\_\_\_\_\_

Enrolled/Date\_\_\_\_\_

Waiting list/Date\_\_\_\_\_

## Returning Child

	Staff Signature	Staff Print Name	Date
Folder Audit			
Interview with Social Worker			
Medical Review: (End of the year Health Status Report)			