File Cover Sheet

Child Name: __________________________DOB: _______________ Age at acceptance: _________Classroom______

Please Check All Completed:

- ☐ Eligibility Verification
- ☐ Birth Certificate
- ☐ Applicant Eligibility & Enrollment Information
- ☐ Income Documentation
- ☐ Permission for Services PEEC
- ☐ Emergency Card- Digital (From CP)
- ☐ Health and Nutrition Questionare
- ☐ Health Insurance (Maine Care/Private)
- ☐ Release of Information - Medical
- ☐ Release of Information - Dental
- ☐ Release of Information - Specialist
- ☐ Release of Information CDS (CDS Form)
- ☐ Immunization Records
- ☐ Other: ____________________________________

Parent Language(s) Spoken:

Language Facilitator needed?

Child Language(s) Spoken:

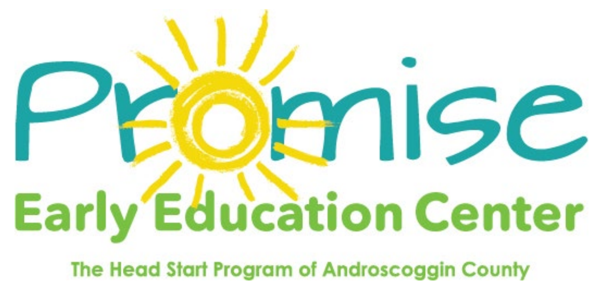
Food Allergies / Dietary Restrictions:
Health / Medical Needs:
Developmental Concerns:
Other:

For Extended Day Only:

** Hours Child Needs Care: _____________________ Hours confirmed with Operations Manager? Initials ______

☐	**Private Pay** – No Subsidy		
☐	**FEDCAP** Verification in File? Y N	Workers Name: ___________________________	Release signed: Y N
☐	**CCSP** Verification in File? Y N	Workers name: ___________________________	
☐	**Transitional Services** Verification in File? Y N	Workers name: _________________________	Release Signed: Y N
☐	**DHHS** Confirmation of payment in file? Y or N	Workers name: ___________________________	

*FA Staff will send the parent signed Client Information Sheet & income to Fiscal within 1 week of child's enrollment.



Child Information

Name: ___________________________ DOB.__________ Male/Female: __________

Mailing Address: ___________________________ City/Zip:____________________

Physical Address: ___________________________ City/Zip:____________________

Ethnicity/Race:______________ Primary Language spoken in the home: ____________________

Does your child have any health/behavioral or developmental needs? [ ] Yes [ ] No

If yes, please explain below:

Health/behavioral/developmental needs are: ____________________________________

____

____

Health Providers: ____

____

List Agencies who provide services for your child: ______________________________

____

Does your child currently have an IFSP or IEP with Child Development Services? [ ] Yes [ ] No

Parent/Guardian Information

Parent /Guardian 1 First Name: __________ M.I.___ Last Name: ______________ DOB__________

Address: ____

Home Phone: ( ) ______________Cell Phone: ( ) ____________________

Occupation/Employer: ______________ Work Phone: ( ) ____________________

Email: ____________________ Number/ages of children in the home: ______________

Parent /Guardian 2 First Name: __________ M.I.___ Last Name: ______________ DOB__________

Address: ____

Home Phone: ( ) ______________Cell Phone: ( ) ____________________

Occupation/Employer: ______________ Work Phone: ( ) ____________________

Email: ____________________ Number/ages of children in the home: ______________

One person we may call to help reach you?

Name: ____________________ Relationship: __________ Phone: ______________

Do you have a funding source for child care? [ ] Yes [ ] No

Do you have or can you arrange transportation for your child to and from the center? [ ] Yes [ ] No

Please list any other additional agencies working with your family: ______________________________

____

____

Is there anything else you would like us to know? ______________________________

____

Which of the following meets your child's needs?

- Head Start – Part day, September - June, ages 3- 5 years, 4 mornings per week, no fee
  - ( ) Lewiston
  - ( ) Auburn
- Head Start Combination Option – 2 mornings a week, ages 3 -5 years, one in-home visit a month, no fee
- Home Based – Weekly in-home visits, 6 weeks-5 years, no fee
  - ( ) Androscoggin County
- Public Pre-K – Age 4 by October 15, 4 mornings a week
  - ( ) Longley
  - ( ) Montello
  - ( ) Livermore
- Child Care – Full day, year-round, 6:30 AM – 5:30 PM, 5 days a week, 6 weeks – 5 years
  - ( ) Lewiston
  - ( ) Auburn

Signature ______________________________ Date: ______________

Received by staff member/date received: ______________________________

Promise
Early Education Center
The Head Start Program of Androscoggin County

Medical Emergency Card

Child's Name: ______________________________ DOB: __________ E-Mail: ______________________

Address: ____ Phone # ____________________

Mother's Name: ______________________ Address ______________________ ______________________ Employer & Hours: ______________________ Work address: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No	Father's Name: ______________________ Address ______________________ ______________________ Employer & Hours: ______________________ Work address: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No

Local Friend or Relative to notify in case of emergency (must list two and authorize to transport)

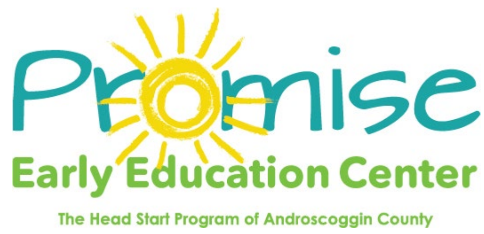
Name: ______________________ Address______________________ ______________________ Relationship to child: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No	Name: ______________________ Address______________________ ______________________ Relationship to child: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No

In addition to those listed above, others who may pick-up and transport child other than parent (must be 14 yrs or older).

Name: ______________________ Address______________________ ______________________ Relationship to child: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No	Name: ______________________ Address______________________ ______________________ Relationship to child: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No
Name: ______________________ Address______________________ ______________________ Relationship to child: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No	Name: ______________________ Address______________________ ______________________ Relationship to child: ______________________ Work # ______________________ Home # ______________________ Cell# ______________________ Home Language: ______________________ Interpreter Needed: ☐ Yes ☐No

Custody / Court Orders ☐ **Legal documentation on file**

269 Bates Street, Lewiston, ME 04240 P: (207) 795-4040 F: (207) 795-4044 www.promiseearlyeducation.org



Medical Emergency Card

Child's Name: ______________________________ DOB: ___________ Classroom: _______________________

Child's PCP: ______________________ Address: ________________________ Phone: ________________________	Hospital Preference: ____ Last DPT Immunization Date: ____________________________________ Current Medications: ____ Allergies: ____ History of Seizures? Yes / No MaineCare or Insurance #: _______________________________________
Child's Dentist: ____________________ Address: ________________________ Phone: ________________________	

Staff: ____ Date: ____________________

Updated: ____ Date: ____________________

Updated: ____ Date: ______________________

Updated: ____ Date: ______________________

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Promise Early Education Center (PEEC) Permission for Services

Parent / Guardian Name:		
Child's Name: **Date of Birth:** **Center:**		
First Aid- I understand that PEEC Staff will provide any basic first aid deemed necessary for my child.	☐ Yes ☐ No	Parent / Guardian Initial:
Emergency Card- I understand that in the event of a medical / dental emergency, for which I cannot be contacted, PEEC staff will obtain necessary treatment. This authorization includes my consent for my child to receive treatment by a physician / dentist in any hospital or emergency department.	☐ Yes ☐ No	Parent / Guardian Initial:
	Hospital Preference:	
Health Record Transfer- In an emergency, I hereby authorize the transfer of my child's health care record to the local hospital.	☐ Yes ☐ No	Parent / Guardian Initial:
Sunscreen Use- I grant PEEC permission to apply sunscreen, SPF 15 or greater, prior to outside play. Sunscreen will be provided by Head Start.	☐ Yes ☐ No	Parent / Guardian Initial:
Field Trip Permission Form – I give my permission for PEEC staff to take my child on walking field trips within city limits, such as parks or the library. I understand that special permission will be obtained for out of town field trips.	☐ Yes ☐ No	Parent / Guardian Initial:
Transfer of Records (Kindergarten) - I give my permission for my child's medical / educational records to be forwarded to my child's receiving school district at the end of the school year.	☐ Yes ☐ No	Parent / Guardian Initial:
Release of Information - I understand that information in my child's record will be provided to the Maine Department of Health & Human Services and Maine Department of Education for use in the administration, audit, and evaluation of this program.	☐ I have read and understand Parent / Guardian Initial:	
Media Release- I give my permission for my child and / or family members to be photographed and / or videotaped during Head Start activities :		
• For classroom and center use	☐ Yes ☐ No	Parent / Guardian Initial:
• For promotional purposes. (Materials used for promotional purposes may include your child's first name and age)	☐ Yes ☐ No	Parent / Guardian Initial:

Consent For Health Screenings

I give my permission for my child to receive the following screening evaluations:

Hearing & Vision Screen   Height & Weight Measurements   Blood Pressure

I understand that these services are considered necessary by the Head Start Program and that I will be informed of the results.

Parent / Guardian Initial:

Permission for Developmental Screenings:

I understand that Head Start will screen my child for potential developmental concerns. Screenings assess children's physical, cognitive, language and social-emotional skills. I understand that by signing this consent that this is only a screening; not a formal evaluation of my child. All information will be kept confidential; results will be shared with you.

Signature of Parent / Guardian: Date:

Permission for Mental Health consultation and observation:

I understand that Head Start will work with mental health consultants to conduct individual child and classroom observations to support children's social and emotional well-being. Results will be shared with you following an individual child observation. All information will be kept confidential.

Signature of Parent / Guardian: Date:

Keep Informed

PEEC will send occasional updates such as school closures and meeting reminders via text and email. Please provide the following contact information below :

Name:	**Text #:**	**Email:**
Name:	**Text #:**	**Email:**

Staff Verification

By signing, the staff member acknowledges verification and / or explanation of purpose and intent of the information contained in these pages, and that these consents are valid for 1 year from the date signed.

Staff Member Signature : Date:

The Head Start Program of Androscoggin County
P: (207) 795-4040 F: (207) 795-4044

Authorization to Release Protected Information

Name: ____ **Date of Birth:** ____________

Send Information From: (Request Information From)

Send to: (Head Start Program Address)

Promise Early Education Center
269 Bates Street, Lewiston, ME 04258
Fax# **888-502-1522**
Attn: Norma Larocque

Please check the records you would prefer:

☐ **Most Current Records**	☐ **Dental Records**
☐ **Physicals/WCC** ☐ **Immunizations** ☐ **Lead/HGB/HCT/Labs**	☐ **Office visits** ☐ **Medication/Prescriptions/Appliances**
☐ **Surgical Services (discharge summary, consults, radiology, Care Plans)**	☐ **Home Health (Plan of care, orders, visit notes)**
☐ **Emergency Department (discharge summary, care plan)**	☐ **Other (Consent to Speak)**

Please Circle

authorized disclosure of any information relating to the diagnosis and/or treatment of **Mental Health** __ **Do** __ **Do Not**

authorized disclosure of information which refers to **HIV, Infection Status and/or Treatment** __ **Do** __ **Do Not**

authorize disclosure of any information relating to Alcohol and/or Drug Abuse __ Do __ **Do Not**

Reason records are needed (check all that apply)

_____For Head Start Health Requirements _____Personal Use _____Other: ____________________

I understand that: I do not have to sign this authorization for Promise Early Education Center. I can refuse to disclose some or all information in my record. I can revoke all or part of this authorization at any time. I understand I am entitled to a copy of this authorization at any time.

Written statement that I want to revoke my authorization should be delivered to:

Promise Early Education Center, 269 Bates St., Lewiston, ME 04254 ATTN:

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

__________________ ____

Date **Signature of Parent/guardian**

The Head Start Program of Androscoggin County
P: (207) 795-4040 F: (207) 795-4044

Authorization to Release Protected Information

Name: ____ **Date of Birth:** ____________

Send Information From: (Request Information From) **Send to: (Head Start Program Address)**

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Please check the records you would prefer:

☐ **Most Current Records**	☐ **Dental Records**
☐ **Physicals/WCC** ☐ **Immunizations** ☐ **Lead/HGB/HCT/Labs**	☐ **Office visits** ☐ **Medication/Prescriptions/Appliances**
☐ **Surgical Services (discharge summary, consults, radiology, Care Plans)**	☐ **Home Health (Plan of care, orders, visit notes)**
☐ **Emergency Department (discharge summary, care plan)**	☐ **Other (Consent to Speak)**

Please Circle

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