EARLY LEARNING
SERVICES
HEAD START STATE PRESCHOOL

SANTA CLARA COUNTY OFFICE OF EDUCATION
Early Learning Services Department
1290 Ridder Park Drive, MC 225
San Jose, CA 95131-2304

www.myheadstart.org

1 (408) 453-6900 or 1 (800) 820-8182

Dear Parent/Guardian,

Thank you for your interest in the Head Start and State Preschool Programs. We provide full-day and part-day preschool services, free of charge or low cost, to eligible families who live in Santa Clara and San Benito Counties. We also offer home-based and center-based services for newborn children to 36 months. Please fill out the application completely and if you need help, you can call us at (408) 453-6900 or (800) 820-8182, Monday through Friday from 8:00 am to 5:00 pm.

Please note that as part of the enrollment process, you will have an interview with a staff member.

DOCUMENTS YOU WILL NEED (Copies only; these will not be returned)

- ☐ **Income Verification** – The documents need to show your income **for the past 12 months**. All parent or guardian income needs to be submitted. This includes:
  - **Pay Stubs for the past 12 Months,** or pay stubs in combination with:
    - **Latest Income Tax Return (1040) or W-2**
  - **Notice of Action** (if receiving CalWORKs)
  - **Proof of SSI - Supplemental Security Income** (if applicable)
  - **Unemployment Income**
  - **Worker's Compensation**
  - **Child Support**
  - **Disability Income**
  - **Completed "Employer Income Verification"** (This is a form showing hours worked and pay rate - only if you do not have pay stubs)
- ☐ **Birth Certificate(s)** (for the child and all siblings under 18)
- ☐ **Proof of Address** (Like a phone bill, water bill, etc.)
- ☐ **Immunization Records**
- ☐ **TB Assessment or TB Test Results**
- ☐ **Current Physical Exam** (submit current physical exam, if possible)
- ☐ **Proof of Legal Custody** (if the child is in foster care)
- ☐ **Homeless Verification** (if applicable and if available)
- ☐ **Current IEP (Individualized Education Program) or IFSP (Individualized Family Service Plan)** (if applicable)
- ☐ **Full Time Employment or School/Training Verification** (if you would like full day services)

SCHEDULE YOUR INTERVIEW

When you have gathered your documents and completed the application, **call (408) 453-6900**. A Head Start Staff will call you back to schedule a date and time for an interview at a location near you. Please be sure to bring all the documents listed above and the completed application.

Please call 1 (408) 453-6900 or 1 (800) 820-8182 to schedule your appointment.

EARLY LEARNING SERVICES
HEAD START STATE PRESCHOOL

CPID #_____

ELS PRESCHOOL SERVICES APPLICATION

I would like to apply for ☐ AM Session (3 ½ hrs.) ☐ PM Session (3 ½ hrs.) ☐ Full Day* (9 hrs.) ☐ Single Session (6 hrs.) ☐ Home-Based ☐ No Preference

*Note: Full day requires that both parents/guardians must be working full time more than 30 hours per week or in school full time taking 12+ units

Child (Applicant)

First Name	Last Name	Middle	Gender ☐ Male ☐ Female	Birth Date / /
Living Address		City/ Zip		Birth Country
Mailing Address (if different)		City/ Zip		

Is the child in foster care? ☐ Yes ☐ No

Ethnicity
☐ Hispanic/Latino
☐ Non-Hispanic /Non-Latino

Race
☐ Asian
☐ White (European, Middle Eastern, North African)
☐ Black/African American
☐ Pacific Islander/Hawaiian
☐ American Indian/Alaskan
☐ More than one race (Bi-racial/Multi-racial)
☐ Other _____

Does the child have a current IEP or IFSP? ☐ Yes ☐ No If yes, please complete the Disabilities section of this application

Family Information

Primary language spoken at home ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

What language does your child use the most? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

Does the child (applicant) have a sibling with a current IEP or IFSP? ☐ Yes ☐ No

Name of Person(s) Having Legal Custody of the Child	Parents/Guardians in the Home ☐ One Parent ☐ Two Parents	Primary Email Address

Primary Parent/Guardian's Name	Birth Date / /	Relationship to Child

Lives with the Child ☐ Yes ☐ No

Marital Status
☐ Married ☐ Single
☐ Divorced ☐ Separated
☐ Widowed

Primary Phone Number
☐ Cell ☐ Home ☐ Work ☐ Other
( )

Employment Status
☐ Employed ☐ Seasonally Employed ☐ Retired
☐ Unemployed ☐ Seeking Employment ☐ Student
☐ Disabled ☐ Incapacitated From _____ to _____

Primary Parent/Guardian's Email Address

Alternate Phone Number
☐ Cell ☐ Home ☐ Work ☐ Other
( )

Education
☐ Less than High School ☐ Some College or AA/AS
☐ High School Grad or GED ☐ Bachelor's or Advanced Degree

Secondary Parent/Guardian's Name	Birth Date / /	Relationship to Child

Lives with the Child ☐ Yes ☐ No

Marital Status
☐ Married ☐ Single
☐ Divorced ☐ Separated
☐ Widowed

Primary Phone Number
☐ Cell ☐ Home ☐ Work ☐ Other
( )

Employment Status
☐ Employed ☐ Seasonally Employed ☐ Retired
☐ Unemployed ☐ Seeking Employment ☐ Student
☐ Disabled ☐ Incapacitated From _____ to _____

Secondary Parent/Guardian's Email Address

Alternate Phone Number
☐ Cell ☐ Home ☐ Work ☐ Other
( )

Education
☐ Less than High School ☐ Some College or AA/AS
☐ High School Grad or GED ☐ Bachelor's or Advanced Degree

List all other family members living in the household for whom you are responsible for the care and welfare - NOT LISTED ABOVE:

First Name	Last Name	Date of Birth	Is this person related to the child's parent(s)?	Is this person supported by the parent'(s) income?
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		/ /	☐ Yes ☐ No	☐ Yes ☐ No

Total number of people living in the household (including you) for whom you provide financial support

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____ **Birth Date** _____

Emergency Contact Information

Name	Phone	Relationship
	( )	
	( )	

Family Residency

Temporarily in one of the following due to inadequate housing, financial hardship, or loss of housing

Family Living Situation (Check all that apply)

☐ Shelter Name _____
☐ Motel/Hotel Name _____
☐ Transitional Housing Name _____
☐ Single Room Occupancy (SRO)
☐ Car, Trailer, or Campsite
☐ Rented Garage
☐ Rented Trailer, Motor Home on Private Property
☐ With another adult (Not the parent/legal guardian)
☐ Another Family's House/Apartment
☐ None of the options apply
☐ Other (Not designed for human beings)
Explain: _____
_____

Eligibility

Primary Parent/Guardian

Primary Parent/Guardian's Name | Has Income ☐ Y ☐ N

Check all that apply

Do you receive: Monthly Amount

☐ TANF/CalWORKs (no food stamps) $ _____
☐ SSI $ _____
☐ Child Support $ _____
☐ Other sources of income $ _____
_____

Employment Information

Employer Name	Employer Phone
	( )
	( )

Pay Periods ☐ Weekly ☐ Every 2 Weeks ☐ Twice Per Month ☐ Monthly

Gross Income $ _____ Per _____

School/Training Information

Are you in School or Training? ☐ Yes ☐ No

School Name	School Phone
	( )

School Units _____

Secondary Parent/Guardian

Secondary Parent/Guardian's Name | Has Income ☐ Y ☐ N

Check all that apply

Do you receive: Monthly Amount

☐ TANF/CalWORKs (no food stamps) $ _____
☐ SSI $ _____
☐ Child Support $ _____
☐ Other sources of income $ _____
_____

Employment Information

Employer Name	Employer Phone
	( )
	( )

Pay Periods ☐ Weekly ☐ Every 2 Weeks ☐ Twice Per Month ☐ Monthly

Gross Income $ _____ Per _____

School/Training Information

Are you in School or Training? ☐ Yes ☐ No

School Name	School Phone
	( )

School Units _____

Parent/Guardian's Signature _____ Date _____

Early Learning Services Staff's Signature _____ Date _____

*At intake, please have parent sign below **(Required for Annual Review)***

Parent/Guardian's Signature _____ Date _____

REVIEW ANNUALLY WITH PARENTS/GUARDIANS

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____ **Birth Date** _____

Health History Information

Medications

Does your child take prescribed medications? ☐ Yes ☐ No	Will your child need to have medication at school? ☐ Yes ☐ No

List all medicines, prescriptive and non-prescriptive that your child takes regularly and what kind, if any, side effects the child experiences

Your child will not be given medication at school without a physician's note and a Classroom Health Plan written with the parent and program staff.

Special Devices

Does your child use any special device(s): ☐ Yes ☐ No	Does your child use any special device(s) at home: ☐ Yes ☐ No
If yes, what kind:	If yes, what kind:

Special Health Needs / Chronic and Past Illnesses

Check illness that the child has had or currently has, and specify approximate dates of illnesses:

	Dates		Dates		Dates
☐ Asthma		☐ Hay Fever		☐ Ten-day Measles (Rubeola)	
☐ Anemia		☐ Mumps		☐ Three-day Measles (Rubella)	
☐ Chicken Pox		☐ Poliomyelitis		☐ Whooping cough	
☐ Diabetes		☐ Rheumatic Fever		☐ Pediatric First Aid Needs	
☐ Epilepsy		☐ Seizures		☐ Other:	

Does your child have frequent colds? ☐ Yes ☐ No	How many in the last year?

Insurance Information

Do you currently have health insurance? ☐ Yes ☐ No	Type of Insurance	☐ California Children's Services CCS	☐ CHDP
		☐ Medi-Cal Santa Clara Family Health Plan	☐ SCC Healthy Kids HMO
		☐ Medi-Cal Anthem Blue Cross	☐ Healthy Families
		☐ Private Medical Insurance:	☐ Uninsured → Referred To:

Usual Source of Health Care

Is child presently under a doctor's care? ☐ Yes ☐ No		
Provider Physician/Clinic:	Name	( ) Phone
	Street Address	City/Zip Code
Dentist:	Name	( ) Phone
	Street Address	City/Zip Code
Other:	Name	( ) Phone
	Street Address	City/Zip Code

Do you have any concerns about your child's health?

What is the plan for care when the child is ill?

REQUIRED HEALTH ASSESSMENT (PHYSICAL EXAM)

A health assessment (physical examination) by a physician is required. If you do not have a copy of a current physical exam for your child, you will be asked to take your child to the doctor within **30 days** of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Child Health Assessment form).

Is a copy of a current Physical Exam included with the application? ☐ Yes ☐ No	Date of Child's Last Physical:

REQUIRED DENTAL EXAM (CHILDREN AGES 1-5 YEARS OLD)

A dental exam by a dentist is required starting at 12 months. If you do not have a copy of a current dental exam for your child, you will be asked to take your child to the dentist within **90 days** of the first day of school to obtain one. It is best to do this before your child is placed on a class list (see attached Dental Examination form).

Is a copy of a current Dental Exam included with the application? ☐ Yes ☐ No	Date of Child's Last Dental Visit:
Do you need assistance in finding a health or dental provider? ☐ Yes ☐ No	If yes, please indicate: ☐ Dental ☐ Medical

AN INCOMPLETE APPLICATION WILL DELAY ENROLLMENT

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____ **Birth Date** _____

Health History Information cont'd

Developmental History

Child walked at: _____ months	Child began talking at: _____ months

Social-Emotional Development

Describe your child's personality:

Does the child have			**Does the child have**		
Problems getting along with other children the same age?	☐ Yes	☐ No	Aggressive behavior?	☐ Yes	☐ No
Problems getting along with other family members?	☐ Yes	☐ No	Extreme shyness?	☐ Yes	☐ No
Problems sleeping?	☐ Yes	☐ No	Problems separating from parent/guardian?	☐ Yes	☐ No
Temper tantrums?	☐ Yes	☐ No	Other concerns you may have about your child's behavior	☐ Yes	☐ No
Severe fears?	☐ Yes	☐ No	Currently receiving mental health services?	☐ Yes	☐ No
Has the child had group play experiences?	☐ Yes	☐ No	**If yes,** agency name		

Disabilities

Does your child have an Individualized Education Plan (IEP) with your local school district of residence or County Office of Education program? If yes, please attach copy of the most recent IEP.	☐ Yes	☐ No
Does your child have an Individual Family Service Plan (IFSP) with an early intervention program, regional center, County Office of Education, or school district? If yes, please attach a copy of the most recent IFSP.	☐ Yes	☐ No

Additional information about your child's disability or other developmental concerns. Please explain if checked "yes" above.

Ears and Eyes

Do you have any concerns about your child's hearing?	☐ Yes	☐ No	Do you have any concerns about your child's vision?	☐ Yes	☐ No

Allergies

List all allergies (food or other)

Has your child been prescribed medication for an allergic reaction? ☐ Yes ☐ No

Daily Routines

Sleeping Routine

What time does your child get up?	Does your child take naps? ☐ Yes ☐ No	
What time does your child go to bed?	If yes, when?	How long?

Diet Pattern

What does your child usually eat for these meals?	Breakfast	What are the usual eating hours?	Breakfast
	Lunch		Lunch
	Dinner		Dinner
Any food dislikes?		Any eating problems?	

List special diets to accommodate for cultural preference or for religious or medical reasons (indicate what specific foods are included)

A Classroom Nutrition Plan will be written with the parent and program staff to address all allergies and special diets.

Toileting

Toilet training started at: _____ months	Is your child Toilet Trained? ☐ Yes ☐ No If Yes, at what stage:	Are bowel movements regular? ☐ Yes ☐ No What is his/her usual time?
Word used for "Bowel Movement":	Word used for "Urination":	

REVIEW ANNUALLY WITH PARENTS/GUARDIAN

ELS PRESCHOOL SERVICES APPLICATION

Child's Name _____ **Birth Date** _____

Parent Authorization for Program Services

I understand that the Early Learning Services Preschool programs are comprehensive programs that will provide many services to support my child and family. Classroom observations and screenings are part of the program, which enable staff and SCCOE's DataZone (Internal Department) to share data in order to plan for my child's individual development and for ongoing program improvement. I understand that the Early Learning Services Program will keep me informed as each service is completed and will provide me the results of all procedures and services my child receives. As part of my child's enrollment in Early Learning Services Preschool programs, my child will be assigned a Statewide Student Identifier (SSID).

While children with special needs are already assigned a Statewide Student Identifier (SSID) in most early learner programs, this is the first time that we are entering a large number of preschool children into California Longitudinal Pupil Achievement Data System (CALPADS) before their entry to kindergarten. This ground-breaking effort will provide participating school districts and lead agencies the ability to share data to better improve services to your child.

I give permission for Early Learning Services staff to complete the following with my child: ☐ **Yes** ☐ **No**

- Dental Screening
- Nutrition Assessment
- Vision & Hearing Screenings
- Blood Pressure
- Height & Weight
- Social Emotional Screening / Behavioral Health Consultation
- Developmental Screenings / Other Services

_____ _____ _____ _____

Parent/Guardian's Signature | Date | Staff's Signature | Date

Agreement to Release Information

All release of information about my child will follow the procedural safeguards outlined in the provisions of Federal and State Administrative Codes: Health Insurance Portability and Private Act, (HIPAA), 2003; Family Educational Rights and Privacy Act, (FERPA), 2009; Individuals with Disabilities Education Improvement Act, (IDEA), 2004; and Head Start Performance Standards 1302.41(b)(1), 1302.45(a)(3), 1303.21 (a)(b), 1305.2.

I understand this information is strictly confidential and will be used to better provide support services and to permit data sharing, understanding to improve program quality. This authorization shall be valid for one year from the date it is signed.

I certify that the information in this application is true and complete to the best of my knowledge. I understand that failure to report correct information may be grounds for rejection of this application or termination of childcare services. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing childcare services.

Parent/Guardian's Signature | Date

Parent/Guardian's Signature **(Required for Annual Review)** | Date **(Required for Annual Review)**

AN INCOMPLETE APPLICATION WILL DELAY ENROLLMENT