FORT BELKNAP HEAD START/EARLY HEADSTART PROGRAM

2024-2025 SCHOOL YEAR

NEW & RETURNING STUDENT APPLICATION

Teaching Children Supporting Families

Gilbert Horn Sr. Early Childhood Center Agency Service Area: (406) 353-2827

Ramona King Center Hays Service Area: (406) 673-3387

Three Strikes Center Lodgepole Service Area: (406) 673-3307

Fort Belknap Head Start & Early Head Start Program
Student Application 0 to 3 and 3 to 5 years old

"It is not required that your child be potty trained to attend Head Start Program"

Application Check list: "All applications will be accepted but will NOT be processed until all highlighted areas and required documentation is turned in and signed!"

1.	**Complete Application** Application must be completed and turned with all required and dated signatures by the parent/guardian.	**6.**	**Medical Insurance HS & EHS** HMK, Medicaid, Chips, Blue Cross Etc.
2.	**Proof of Income:** Pay stubs, last year's tax returns, W-2 Forms, TANF letter/benefits, Unemployment, Veteran's benefits, etc.	**7.**	**Tribal Enrollment or Proof of Descendency** A copy will be taken
3.	**Immunization Record** Must be up to date, A copy will be taken (To be handed in with application)	**8.**	**Any Court Orders** Custody papers, restraining orders, divorce papers, or any other legal document that involves your child. **(An actual court document/order signed by a judge. A petition is not considered a legal court document)**
4.	**Child's Physical (HS) or Well Child Checkup (EHS)** Must be up to date with **Hematocrit/Hemoglobin** results posted. A copy will be taken (To be handed in no later than 30 days of handing in application) Form attached	**9.**	**Dental Exam HS** Forms attached
5.	**Birth Certificate** A copy will be taken	**10.**	**Letter of disability (if applicable)** For applying child

HEAD START & EARLY HEADSTART OPTIONS 0-3 OR 3-5 YEARS

Please check the box on the right for the program and center you want your child to attend

Head Start Program: Children 3 years old by September 10th, 2024 or no more than 5 years old by September 10th, 2024.		**Early Head Start Program:** Birth to age 3 years by September 10th, 2024 Pregnant women can also be eligible	
Center Based Option: Classroom setting		**Home Base Option:** Instruction is based out of the child's home/place of residence, once a week for 1 1/2 hours	
New Student Application		**Returning Student Application**	

Gilbert Horn Sr. Early Childhood Center (GHSECC): 231 Chippewa Ave. Fort Belknap Agency Service Area	
Ramona King Center (RKC): 180 John Capture Rd, Hays Service Area	
Three Strikes Center (TSC): 138 Medicine Bear Rd, Lodgepole Service Area	

Certification: I have carefully reviewed the documents and information I have provided with my Fort Belknap Head Start/Early Head Start application and by signing this form, certify to the best of my knowledge and belief that all information regarding eligibility provided be me is true and correct. I also understand information provided will be kept strictly confidential and is available to me within 24 hours of advance notice.

Name of Child:	**DOB:**
Signature of Parent/Guardian:	**Date:**
Signature of Staff Member:	**Date:**

Family & Child Information:

Applicant Child's Legal Name:			
Gender:	___Male ___Female		
Is your child a NEW student to Head Start/Early Head Start Program	Yes or No	Head Start Program Please circle	Early Head Start Program Please circle
Has child been previously enrolled at another Head Start/Early Head Start or Pre-K program?	Yes or No	If Yes what Program, Dates, & Location?	
Is your child transitioning from Early Head Start to Head Start?			Yes or No
Parent/Guardian Name(s):			

Current Mailing Address:			
Current Physical Address:		Primary Phone #:	
Pick Up and Drop off Address: **(If riding the bus)**			
Email Address:		Emergency Phone #:	
Best way to contact you: **(Please circle)**	Email, Primary Phone, Cell Phone, Text Message, Other		

Race Ethnicity: (Please Circle)

Native American/Alaska Native	Hispanic or Latin	Black or African American
1st Nation/Canadian Native	Asian	Native Hawaiian or Pacific Islander
European German/Decent	White/Caucasion	Other
Is child an enrolled member?	Yes or No	If Yes What Tribe?:

Language(s): (Please check & circle all that apply)

	English: Primary Language? Yes or No		Assiniboine (Nakota): Primary Language? Yes or No
	Gros-Ventre (AAH-AH-NI): Primary Language? Yes or No		Any Other Tribal language Spoken: Please List:_____Primary Language? Yes or No
	French: Primary Language? Yes or No		German: Primary Language Yes or No
	Spanish: Primary Language? Yes or No		Any other language spoken? Please list:_____Primary Language? Yes or No

Military Background:

Are you currently or have ever served in the Military?	**Yes or No**
If answered yes Please list branch and years served?	

Education Grade Level (Please check the best answer)

	Dropped out of high school		High school Diploma
	GED		Some College
	Vocational School/Training		Job Corps
	Associates Degree (Field of Study:_____)		Bachelor's Degree (Field of Study:_____)
	Master's Degree		PHD/Doctorate

Employment Status: (Please check all that apply)

	Full Time		Part Time
	Seasonal/Temporary		Disabled (Receive Benefits? Yes:____No:____)
	Unemployed (Receive Benefits? Yes:____No:____)		Self Employed (Occupation:_____)
	Retired (Receive Benefits? Yes:____No:____)		Homemaker

Family type (Check all that apply)

	Two Parent Family		Grandfather raising child(ren)
	Single Parent Family (mother figure only)		Grandmother raising child(ren)
	Single Parent Family (father figure only)		(Both) Grandparents raising child(ren)
	Foster Family (must provide legal documentation)		Other:_____

	Blended Family (step family)		Parent(s) serving in military

Additional Family Information: Does your family have any special circumstances, concerns or needs?

	Abusive home situation, alcohol, drugs, spouse abuse		Applicant is a foster child
	Applicant currently is under the protection of child welfare services (Social Services)		Child's parent(s) are currently incarcerated
	Current address is temporary living arrangement due to loss of housing or economic hardship ***Fill out Homeless Verification Form***		First time parent
	Parent has a disability/special need Please Describe:_____		Parent has no work experience and or secondary education (college courses)
	Recent death in the family within last 12 months		Child's parents are recently divorced/seperated
	Child is currently living with Grandparents		Family would like school be 5 days a week.
	Family is in need of childcare/wrap around.		Parent/guardian(s) suffer from PTSD

Current Assistance or Benefits Received: (Please check all that apply)

	TANF/477 (Family:____Child Only:____)		Food Stamps (Family:____Child Only:____)
	General Assistance (G/A)		LIEAPP
	Commodities (Family:____Child Only:____)		Social Security
	Local Food Bank (Family:____Child Only:____)		Disability Benefits
	WIC:		Alimony/Spousal Support
	Child Support		Wrap Around Program
	Child Care Program		Do not receive services

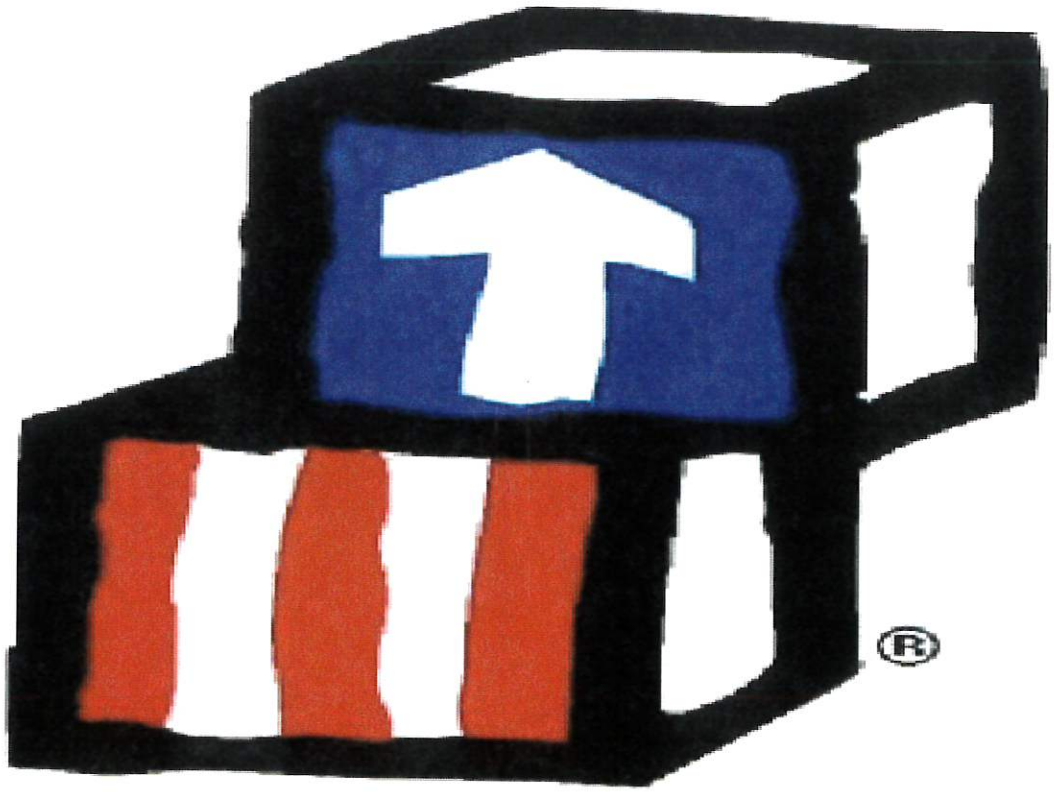
Current Housing Information: (Please check all that apply)

	House (Private Ownership)		**Homeless/No housing** (You do not have your own permanent night time place of residence) ***Need Homeless Verification Form***
	Apartment Complex		Living with relatives/Friends
	Renting (Low Rent, Mutual Help, Landlord etc)		Other

Child Health History Questionnaire (Please circle Y or N)

Does your child have or suffer from frequent colds?	**Yes or No**
Does your child have or suffer from allergies and or seasonal allergies?	**Yes or No**
Does your child have or suffer from frequent ear infections?	**Yes or No**
Does your child have any difficulty seeing?	**Yes or No**
Does your child currently wear glasses?	**Yes or No**
Does your child have difficulty with speech/communication skills?	**Yes or No**
Does your child have any behavioral issues?	**Yes or No**
If yes please list:	
Does your child have or suffer from colic? (EHS only)	**Yes or No**
Does your child suffer from diaper rash? (EHS only)	**Yes or No**
Does your child have a skin condition or suffer from skin rash? If yes please list:_____	**Yes or No**
Does your child take daily naps? If answered yes how long? _____	**Yes or No**
Does your child have breathing problems or asthma?	**Yes or No**
If answered yes does your child have to use a nebulizer or inhaler?	**Yes or No**
If answered yes does your child have to use the breathing medication on a daily basis?	**Yes or No**
Has your child ever had a convulsion or seizures?	**Yes or No**
If yes does your child take medication for seizures?	**Yes or No**
Does your child currently take medication for any possible medical condition?	**Yes or No**
If Yes Please List:	
Has your child ever had surgery or been hospitalized?	**Yes or No**
If Yes Please List Reason:	
Has your child been diagnosed with a possible disability? a.) Type of Disability:_____	**Yes or No**

b.) IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? If yes please attach a copy for our records.	
Do you have any concerns about your child's: a.) Speech? If yes describe:_____ b.) Hearing? If yes describe:_____ c.) Vision? If yes describe:_____ d.) Dental? If yes describe:_____ f.) Developmental delay? If yes describe:_____ g.) Behavioral Issues? If yes describe:_____ h.) Weight Issues? If yes describe: _____	**Yes or No**
Any other health or development concerns? If yes please describe:_____	**Yes or No**
Are you or your partner currently pregnant?	**Yes or No**
Was your child born premature? If yes how many weeks?_____	**Yes or No**
Was anything wrong with your child at birth?	**Yes or No**
If yes please describe:	
Was anything wrong with the child in the nursery?	**Yes or No**
If yes please describe:	
Did mother and child stay in the hospital longer than usual?	**Yes or No**
If yes please state reason:	



EMERGENCY CONTACT AND PARENTAL PICK UP & DROP OFF CONSENT

THIS FORM MUST BY TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED

Child's Name:		Date of Birth:	
Physical Address:			
Mailing Address:			

Mother/Legal Guardian's Name:		Home Number:	
Physical Address:		Cell Number:	
Mailing Address:		Emergency Number:	
Work Address:		Work Number:	
Father/Legal Guardian's Name:		Home Number:	
Physical Address:		Cell Number:	
Mailing Address:		Emergency Number:	
Work Address:		Work Number:	
Emergency Contact Person #1:		Primary Contact Number:	
Physical Address:		Cell Number:	
Emergency Contact Person #2:		Primary Contact Number:	
Physical Address:		Cell Number:	
Emergency Contact Person #3:		Primary Contact Number:	
Physical Address:		Cell Number:	
Physician/Medical Care		Contact Number:	
Health Insurance Carrier & Policy Number:			

Person's authorized to pick up child:

Name & Relationship to child:		Contact Number:	
Name & Relationship to child:		Contact Number:	
Name & Relationship to child:		Contact Number:	
Name & Relationship to child:		Contact Number:	
Name & Relationship to child:		Contact Number:	

PARENT'S RIGHTS AND RESPONSIBLITIES AGREEMENT

RIGHTS:

1. Take part in major policy decisions affecting planning and operations of the program.
2. Have access to programs/resources based around family strengthening, parent involvement, improved health, and wellness.
3. Be treated with respect, dignity, and always feel welcome by teachers and staff members.
4. Be informed regularly about my child's progress and or incidents while at Head Start.
5. Expect guidance for my child from the teachers and staff that will help his/her individual development.
6. Have the chance to learn all aspects of the program including budget, education and job requirements that can lead to possible employment opportunities.
7. Volunteer work is an essential component of Head Start. It is your right as a parent/guardian to be a volunteer.
8. Expect complete confidentiality among teachers and staff in matters relating to my child at all times.

RESPONSIBILITY:

1. Learn all facets of the program in order to help make possible policy changes, resolutions, and the necessary steps needed to carry them out.
2. Accept Head Start as an opportunity through which I can improve my life and the lives of my children.
3. Participate in the program as an observer, volunteer, paid employee, and or establish a partnership where services provided will vastly improve curriculum components.
4. Provide leadership by taking part in elections, parent committee meetings, and encourage parent involvement.
5. Welcome teachers and staff into home in order to discuss ways I can help my child's development in relation to school readiness transition.
6. Work with teachers, staff, and other parents in a cooperative manner.
7. Provide guidance to my children in a loving and protective manner.
8. Offer constructive criticism, participate in program evaluations, and defend against unfair condemnation.
9. Participate in all program activities/socializations that can improve health, education, family strengthening/involvement, and overall individual wellness.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS.

_____ _____

Parent/Guardian Signature: **Date:**

_____ _____

Staff Signature: **Date:**

Release of Liability Statement

IT IS THE MISSION OF THE FORT BELKAP HEAD START PROGRAM TO HAVE ESTABLISHED POLICIES AND PROCEDURES THAT ARE ALWAYS TOTALLY COMMITTED TO THE HEALTH, SAFETY, AND WELFARE OF EACH AND EVERY CHILD ENROLLED ALONG WITH THEIR PARENTS/ FAMILIES.

HOWEVER, I AM ALSO AWARE THAT ANY AND ALL ACTIVITIES CAN POSSIBLY BE HAZARDOUS AND POSSIBLE INJURIES/DEATH CAN OCCUR. I AM VOLUNTARILY PARTICIPATING IN ANY AND ALL ACTIVITIES WITH KNOWLEDGE OF THE POSSIBLE DANGERS INVOLVED AND AGREE TO ASSUME ANY AND ALL RISKS OF BODILY INJURY, DEATH, OR PROPERTY DAMAGE, WHETHER THOSE RISKS ARE KNOWN OR UNKNOWN.

I release the Fort Belknap Head Start Program and the Fort Belknap Indian Community Council from any and all actions, claims, or demands that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives now have, or may have in the future, for injury, death, or property damage related to (i) my participation these activities, (ii) the negligence or other acts, whether directly connected to these activities or not, and however caused, by any releasee, or (iii) the condition of the premises where there activities occur, whether or not I am then participating in the activities.
I also agree that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives will not make a claim against, sue, or attach the property of any releasee in connection with any of the matters covered by the foregoing release.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT IS A RELEASE OF LIABILITY AND AN AGREEMENT BETWEEN THE FORT BELKNAP HEAD START PROGRAM, THE FORT BELKNAP INDIAN COMMUNITY COUNCIL, AND I THE PARENT/GUARDIAN. I HEREBY SIGN IT OF MY OWN FREE WILL.

_____ _____

Parent/Guardian Signature: **Date:**

_____ _____

Staff Signature: **Date:**

Head Start application form updated by Ronald F. Doney Jr. FSM March 2019