WEST CENTRAL MINNESOTA
Communities Action

WCMCA Head Start Enrollment & Emergency Agreement
School Year 2024-2025

Name:________________________________ **DOB:**________________ **FES:** ____________________

	Name	Complete Address including City	Child's Address (Mark X)	Best phone # I can be reached at during Head Start hours (include area code)
Parent/Guardian 1				
Parent/Guardian 2				
Child Care Name & Number (if applicable):				

Emergency Contacts and Authorized Persons my child may be released to. List a minimum of two: <u>If you do not list two, local law enforcement will be called to ensure your family's safety.</u>

Name	Relationship to Participant	Complete Address including City	Phone Number (include area code)

Family Medical and Dental Home:

	Name of Clinic	Complete Address including City	Phone Number (include area code)
Medical Clinic:			
Dental Clinic:			

Current Health and Dental Insurance:

	Medical Assistance/ Minnesota Care	Private	Military	Name of Insurance Company and ID#	None*
Health Insurance:	☐	☐	☐		☐
Dental Insurance:	☐	☐	☐		☐

*Please specify reason if coverage is not provided: ____

5/24

WEST CENTRAL MINNESOTA
Communities Action

WCMCA Head Start Enrollment & Emergency Agreement
School Year 2024-2025

Name: ____

Grant Permission (Circle your response)		
Y	N	In case of an emergency, if I or my emergency contacts cannot be reached, I give permission for Head Start staff to provide first aid or obtain emergency treatment from providers listed or to call 911.
Y	N	I give permission for Head Start to exchange info with_________________________County Public Health and WIC Program.
Y	N	I give permission for Head Start to exchange info with _________________________School District.
Y	N	I give permission and opt-in to receive text messages/emails on phone numbers provided to the program through the ChildPlus school messaging system. I understand I can opt-out at any time in writing to my FES.
Y	N	I give permission for Head Start to collect Child and Family data and share with the Minnesota Head Start Association School Readiness Goals Project for the purpose of program improvement.
Y	N	I give permission for Head Start to use photos/videos of my child and family for public relations, recruitment, and/or marketing purposes.
Y	N	Head Start staff and cooperating partners have permission to diaper my child, including the use of wipes and over-the-counter creams as needed.
Y	N	I give permission for sunscreen lotions, hand cream, or insect repellant to be administered according to the manufacturer's instruction or instruction from the family's licensed physician or dentist.
Agree and Participate (Circle your response)		
Y	N	I agree to follow the MN Child & Teen Check-up schedule of Age-Related Screening and Immunization Standards for my child.
Y	N	I agree to submit a physical exam for my child (including hearing, vision, developmental, social/emotional screening, a lead and hemoglobin test) within 30 days of enrollment and to complete any recommended treatment.
Y	N	I agree to complete a dental exam for my child within 90 days of enrollment and to complete any recommended treatment.
Y	N	I understand that the Mental Health Consultants may observe periodically in my child's classroom. I also understand that if my child is to be observed specifically my FES will notify me in advance.
Y	N	I understand that the Head Start management staff meets periodically with my FES to plan, coordinate, and adapt services to meet the needs of my child and family. Supervising staff may join my FES on occasional home visits for staff observation purposes.
Y	N	I will plan and participate in the required number of home visits/parent conferences and socializations/ family events. My child will attend center days on a regular basis. If I or my child are unable to attend, I will notify staff prior to the scheduled start time.
Y	N	I have received and participated in Parent Orientation Training. This included reviewing the Head Start Parent Policy Handbook, the Parent Code of Conduct and the Head Start Community Resource Guide.
Pregnant Mom Enrollee Only (Circle your response)		
Y	N	Upon enrollment, I intend to accept and follow comprehensive prenatal and postpartum care. This includes nutritional assessments and medical/dental exams as early in pregnancy as possible. I will continue with appointments as recommended by my physician and dentist.
Y	N	I understand that within the first two weeks after baby is born, I will meet with Public Health, Hospital Nurse or another health provider for a post visit.

I have read and understand each of the above statements. I understand that their purpose is to ensure a safe and successful Head Start/Early Head Start experience for my child and family.

Signature of Parent/Legal Guardian:___________________________________Date: ________________

5/24