Clover Park School District

Creating Promising Futures.

Thank you for applying to our Clover Park Early Learning Program. Our program serves families with the greatest needs and is at no cost.

In order to be eligible for the 2017 – 2018 school year families must qualify as low income and your child's birthdate must be on or before August 31st, 2013. Qualifying children that are four years old by August 31st will be enrolled as a priority. If space is available, we will enroll children that are three years old by August 31st.

Please return the completed application along with the following documents to:

Clover Park Early Learning Program
10202 Earley AVE SW
Lakewood WA 98499
253-583-5360

- ✓ Proof of Income (2016 tax return or W2; Public Assistance (TANF or SSI award letter); Foster care authorization letter; etc.)
- ✓ Immunization Record
- ✓ Proof of guardian (birth certificate)
- ✓ Well Child Exam and Dental Exam (completed by a health care provider)
- ✓ Health Insurance (provider one card)

Early Childhood Education & Assistance Program
Washington State Department of Early Learning

Head Start

RETURN TO: Fax# 253-583-5369

Dental Examination

Report

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Name:_____ Birth Date:_____

Date of exam:_____ Routine exam ☐ Follow-up treatment ☐

Preventative care received today:
- ❑ Cleaning
- ❑ Fluoride Application
- ❑ Sealants

Comments:

Oral Health Status:
- ❑ No oral health disease
- ❑ Active oral health disease
  - ❑ Cavities (#_____)

Comments:

Treatment Received Today:
- ❑ Restoration (#_____)
- ❑ Extraction (#_____)
- ❑ All restorative treatment completed

Comments:

Treatment Needed at Next Visit:
- ❑ No treatment needed, recall in 6 months
- ❑ Preventative Care (ex: sealants)
- ❑ Restoration
- ❑ Extraction

Approximate number of visits needed: _____

Date of next appointment:

Referrals:
- ❑ Needs referral to pediatric dentist
- ❑ Needs treatment under general anesthesia
- ❑ Needs referral to other dental specialist

Referred to:

Name

Phone Number

Appointment Date

Please list oral health education completed with child's family.

Signature of Provider: _____ Date: _____

Printed Name: _____ Phone: _____

Address: _____

2017-2018 Early Learning Application

Total Points

Section A: Child's Information

Child's Information

Child's First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female Telephone: _____

Address: _____ Age (STAFF ONLY)

Apartment Name/Number: _____ City: _____ Zip: _____

What's your child's home language? _____

How do you identify your child's race(s)/ethnicity(s)? _____

During last year, did your child attend? ❑ Early Head Start ❑ Head Start and/or ECEAP

If yes, name of program: _____

Section B: Eligibility Information

Family Information

Does your family currently receive TANF cash assistance? ❑ No ❑ Yes Child-only TANF? ❑ No ❑ Yes

Is your family currently receiving Childcare Subsidy? ❑ No ❑ Yes

Are you or a member of your family currently receiving SSI? ❑ No ❑ Yes

If yes, who: _____ Relationship to applicant: _____

Is this application for a child in Foster care? ❑ No ❑ Yes Kinship care? ❑ No ❑ Yes (FS/FA see App. Proc. for add'l explanation)

Are you currently experiencing homelessness? ❑ No ❑ Yes

Is the child's family currently receiving Child Protective Services (CPS) or similar Indian Child Welfare (ICW) services? ❑ No ❑ Yes

Is the child's family currently receiving services from Family Assessment Response (FAR)? ❑ No ❑ Yes

Household income for the last calendar year or the last 12 months: _____

Number of people in your household: _____ List ages of children: _____

Section C: Health and Development Information

Child's Information

Has your child been **DIAGNOSED** by a Health Care Provider with any of the conditions listed below? ❑ No ❑ Yes

If yes, check all that apply:

❑ Respiratory (Asthma, RSV, RAD, other) ❑ Diabetes ❑ Seizures ❑ Heart Condition

❑ Food Allergies (list): _____ ❑ Swallowing

❑ Non-Food Allergies (list): _____ ❑ Other (list): _____

Do you have any other concerns about your child's health? ❑ No ❑ Yes

If yes, check all that apply:

❑ Feeding and/or special diet ❑ Low birth weight (5.5lbs or less) ❑ Hearing ❑ Tooth Pain/Decay/Bleeding Gums

❑ Vision ❑ Mental Health ❑ Drug/Alcohol Affected

❑ Food Intolerance (list): _____ ❑ Other health concerns(list): _____

Does your child have medical insurance? ❑ No ❑ Yes

If yes, what type: ❑ Apple Health/ProviderOne ❑ Private ❑ Indian Health ❑ Other: _____

Does your child have dental insurance? ❑ No ❑ Yes

If yes, what type: ❑ Apple Health/ProviderOne ❑ Private ❑ Indian Health ❑ Other: _____

Has your child experienced (Check all that apply):

❑ Abuse/Neglect ❑ Former Foster Care ❑ Asked to leave a childcare center because of behavior

Does your child have a special need? (Check all that apply): ❑ Individualized Family Service Plan (IFSP)

❑ Individualized Education Plan (IEP) Start Date: _____ End Date: _____ ❑ A diagnosed disability

❑ Enrollment in an Early Intervention Birth to 3 program in the last 6 months

Do you have concerns about your child's development? ❑ No ❑ Yes

If yes, check all that apply:

❑ Speech/Talking (making sounds, delayed talking, hard to understand and/or difficulties understanding others)

❑ Fine Motor (grasping, drawing, writing and/or dressing)

❑ Behavior (hitting, biting, having tantrums and/or not cooperating)

❑ Gross Motor (walking, climbing, throwing, spinning, lack of eye contact, loss of skills)

❑ Other concerns: _____

RETURN TO: Fax# 253-583-5369

WELL CHILD EXAM - EARLY CHILDHOOD: 4 YEARS

(Meets EPSDT Guidelines)

DATE

EARLY CHILDHOOD: 4 YEARS

PARENT TO COMPLETE ABOUT THE CHILD

CHILD'S NAME	BROUGHT IN BY	DATE OF BIRTH

ALLERGIES	CURRENT MEDICATIONS

ILLNESSES/ACCIDENTS/PROBLEMS/CONCERNS SINCE LAST VISIT	TODAY I HAVE A QUESTION ABOUT:

YES	NO		YES	NO	
☐	☐	My child eats a variety of foods.	☐	☐	My child can hop on one foot.
☐	☐	My child gets along with other children.	☐	☐	My child can sing a song.
☐	☐	My child can dress self.			

WEIGHT KG./OZ. PERCENTILE	HEIGHT CM/IN. PERCENTILE	BLOOD PRESSURE

☐ Review of systems ☐ Review of family history

Screening:

	MHZ	R	L
Hearing Screen	4000		
	2000		
	1000		
	500		
Vision Screen		20/	20/

Development: Circle area of concern

Adaptive/Cognitive Language/Communication

Gross Motor Social/Emotional Fine Motor

	N	A	
Behavior	☐	☐	
Mental Health	☐	☐	

Physical:

	N	A		N	A
General appearance	☐	☐	Chest	☐	☐
Skin	☐	☐	Lungs	☐	☐
Head	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Neck	☐	☐	Neurologic	☐	☐
Nodes	☐	☐	Gait	☐	☐

Describe abnormal findings and comments:

Diet _____

Elimination _____

Sleep _____

☐ Review Immunization Record ☐ Lead Exposure

☐ Fluoride Supplements ☐ Fluoride Varnish

☐ Hct/Hgb _____ ☐ TB ☐ Dental Referral

Health Education: (Check all discussed/handouts given)

☐ Nutrition ☐ Child Care ☐ Development

☐ Regular Physical Activities ☐ Car Safety/ Booster Seat

☐ Safety ☐ Discipline/Limits/Rules ☐ Books/Reading

☐ Passive Smoking ☐ Limit TV/Computer Time ☐ Helmets

☐ Other: _____

Assessment/Plan: _____

IMMUNIZATIONS GIVEN

REFERRALS

NEXT VISIT: 5 YEARS OF AGE

HEALTH PROVIDER NAME

HEALTH PROVIDER SIGNATURE

HEALTH PROVIDER ADDRESS

DSHS 13-684C (REV. 08/2004) - TRANSLATED

☐ SEE DICTATION

DISTRIBUTION: White - Physician Yellow - Parent/Guardian

EARLY CHILDHOOD: 4 YEARS

Section D: Family Information

Parent/Guardian Information

Child lives with: ❑ One parent/guardian ❑ Two parents/guardians

Parent(s)/Guardian(s) Relationship to the applicant: ❑ Foster Parent(s) ❑ Grandparent(s) ❑ Aunt/Uncle ❑ Biological/Adoptive Parent(s) ❑ Step Parent(s) ❑ Other:

Parent/Guardian ❑ Mother ❑ Father ❑ Other	**Parent/Guardian** ❑ Mother ❑ Father ❑ Other
Name: _____	Name: _____
Address – if different than child: _____ _____	Address – if different than child: _____ _____
Are you a teen parent? ❑ Yes ❑ No	Are you a teen parent? ❑ Yes ❑ No
Primary Phone: _____ ❑ Home ❑ Cell ❑ Work ❑ Message Secondary Phone: _____ ❑ Home ❑ Cell ❑ Work ❑ Message	Primary Phone: _____ ❑ Home ❑ Cell ❑ Work ❑ Message Secondary Phone: _____ ❑ Home ❑ Cell ❑ Work ❑ Message
Email Address:	Email Address:
Date of birth: ____/____/____ Month Day Year	Date of birth: ____/____/____ Month Day Year
Is parent/guardian in active U.S. military duty? ❑ No ❑ Yes Is parent guardian a U.S. military veteran? ❑ No ❑ Yes Is parent/guardian in job training or school? ❑ No ❑ Yes Is parent/guardian employed? ❑ No ❑ Yes ❑ Full Time ❑ Part Time ❑ Seasonal ❑ Retired ❑ Disabled If employed, how many hours a week? _____	Is parent/guardian in active U.S. military duty? ❑ No ❑ Yes Is parent guardian a U.S. military veteran? ❑ No ❑ Yes Is parent/guardian in job training or school? ❑ No ❑ Yes Is parent/guardian employed? ❑ No ❑ Yes ❑ Full Time ❑ Part Time ❑ Seasonal ❑ Retired ❑ Disabled If employed, how many hours a week? _____
Do you need an interpreter? ❑ No ❑ Yes What language(s) do you speak? _____	Do you need an interpreter? ❑ No ❑ Yes What language(s) do you speak? _____
Education Level (check highest completed) ❑ Grade 6 or less ❑ High School Graduate ❑ Grade 7 ❑ College/Adv. Training ❑ Grade 8 ❑ College Degree/Training Certificate ❑ Grade 9 ❑ Associate Degree ❑ Grade 10 ❑ Bachelor Degree ❑ Grade 11 ❑ Master's Degree ❑ Grade 12 *(No diploma)* ❑ GED	Education Level (check highest completed) ❑ Grade 6 or less ❑ High School Graduate ❑ Grade 7 ❑ College/Adv. Training ❑ Grade 8 ❑ College Degree/Training Certificate ❑ Grade 9 ❑ Associate Degree ❑ Grade 10 ❑ Bachelor Degree ❑ Grade 11 ❑ Master's Degree ❑ Grade 12 *(No diploma)* ❑ GED

To best support your family, please check all areas of concern you have for yourself and/or your family?

❑ Disability/Unable to work ❑ Job/Employment ❑ Little or no support from family or friends
❑ Drug/Alcohol issues ❑ Learning difficulties ❑ Immigrant/Refugee (*past 3 years*) ❑ Health Concern
❑ Medical coverage ❑ Loss/Grief ❑ Incarcerated Parent(s) ❑ Family Violence
❑ Housing ❑ Legal issues ❑ Military deployment (current or in last year)
❑ Immigration ❑ Mental Health, Post-Partum Depression, Anxiety, Depression, PTSD
❑ Past CPS Involvement ❑ Homeless in the past 12 months (not currently)

How did you hear about our program?
❑ Agency referral from: _____ ❑ Other: _____

I have answered the questions to the best of my knowledge. The information provided will be used to determine my child's eligibility for the Early Learning Programs. The information on your application is confidential and used ONLY to determine eligibility. We do not release information to immigration or other government authorities.

Parent/Guardian Signature: _____ **Date:** _____

STAFF ONLY **STAFF ONLY** **STAFF ONLY** **STAFF ONLY**

Date received: _____
Date sent to PSESD: _____
Site ID/Name: _____

Child's Name: _____
❑ This child is currently enrolled in a community slot at this center
❑ This child's sibling is currently enrolled in a community slot at this center
Date FSS contacted family to review Application: _____