

# Ashland Independent Schools Exceptional Early Childhood Center Headstart/Preschool

1820 Hickman Street  
Ashland, Kentucky 41101  
Phone: (606) 327-2715 Fax: (606) 327-8895  
<http://www.ashland.kyschools.us>  
<https://www.facebook.com/AshlandPreschool/>

## Enrollment Procedure 2022-2023

Ashland Head Start is a federally funded program for income eligible **children ages 3 & 4 by August 1**, and with a minimum of 10% enrollment slots for children with identified disabilities. Kentucky preschool program is a state funded program for income eligible four year olds by August 1, and 3 & 4 year olds with identified disabilities.

### Instructions for Application Procedure:

The following documents must be complete and on file before application is considered eligible.

**A complete Application for enrollment must have the following:**

1. **Completed Application** (all sections must be complete, signed, and dated)
2. **Family's proof of Income** (choose one of the following documents)  
Income Tax, Child support document, pay stub within last 30 days,  
Printed statement from employers, etc.  
KTAP Document with case number  
SNAP Document with case number
3. **Proof of living address**  
Utility bill (must be dated within the last 30 days)  
A rental or lease agreement
4. **Birth certificate** or other reliable proof of students identity and age
5. **Kentucky Immunization Certificate** with a valid expiration date
6. **School Physical** with Lead, Hemoglobin, Blood Pressure
7. Dental exam
8. Vision Exam by Optometrist or Ophthalmologist
9. Insurance card

All items listed above must be on file and accurate before eligibility can be considered for the Program.

NO EXCEPTIONS.

**ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER  
ENROLLMENT APPLICATION 2022-2023**

**Class Request (Circle One)**

A.M. or P.M.

Requests honored at staff discretion

**Full Day (Class Age 4 ONLY)**

**Applicant & Family Member Information**

First Name	Middle	Last	Birthday	Gender	SSN (Optional)
Living Address		Zip	City	State	County

**Race**  
 Asian       Multi-Racial  
 Black       Hawaiian/Pacific Islander  
 White       American Indian/Alaska Native  
 Other \_\_\_\_\_

**Hispanic**  
 Yes       No

**Medical Insurance Type (Check one)**  
 \_\_\_\_\_ Medicaid # \_\_\_\_\_  
 \_\_\_\_\_ Private Insurance # \_\_\_\_\_  
 \_\_\_\_\_ No Insurance

Child Primary Language \_\_\_\_\_  
 Languages spoken in home? \_\_\_\_\_      Doctor \_\_\_\_\_      Dentist \_\_\_\_\_

**PRIMARY GUARDIAN**

First	Middle	Last	Birthday	Gender	Race: _____ Hispanic Yes or No (circle)
Phone Number(s):		Opt in for Text Messages Yes or No (circle)	Email Address:		

**RELATIONSHIP TO CHILD**

Parent (Biological)       Stepparent  
 Grandparent  
 Relative (not grandparent)  
 Foster Parents (not related)  
 Other, \_\_\_\_\_

Is this parent incarcerated       Yes       No  
 Does this parent have custody of this child       Yes       No  
 Does this parent provide financial support to child       Yes       No  
 Was this parent a teen parent @child's birth       Yes       No  
 Does this parent and child live in same home       Yes       No

**Education (Mark highest level attained)**  
 Master's Degree       College or Advance Training  
 Bachelor Degree       College Degree/Training Cert  
 Associates Degree  
 HS Graduate       GED  
 Grade11       Grade 10       <Grade 9  
 Are you currently in school?       No       Yes

**Employment (mark current status)**  
 Full Time       Full Time & Training  
 Part Time       Part Time & Training  
 Seasonal       Training or School  
 Unemployed       Retired or Disabled

Are You Military Active Duty       No       Yes / Veteran of U.S. Military       No       Yes

**SECONDARY or Other Adult**

First	Middle	Last	Birthday	Gender	Race: _____ Hispanic Yes or No (circle)
Address (if different than child):		Phone Number(s)	Opt in for Text Messages Yes or No (circle)	Email:	

**RELATIONSHIP TO CHILD**

Parent (Biological)       Stepparent  
 Grandparent  
 Relative (not grandparent)  
 Foster Parents (not related)  
 Other, \_\_\_\_\_

Is this parent incarcerated       Yes       No  
 Does this parent have custody of this child       Yes       No  
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 Was this parent a teen parent @child's birth       Yes       No  
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**Employment (mark current status)**  
 Full Time       Full Time & Training  
 Part Time       Part Time & Training  
 Seasonal       Training or School  
 Unemployed       Retired or Disabled

Are You Military Active Duty       No       Yes / Veteran of U.S. Military       No       Yes

**ALL FIELDS MUST BE ANSWERED TO BE CONSIDERED COMPLETE**

**ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER**

**Additional child living in the home**

First	Middle	Last	Birthday	Gender	Race
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**Related To:**

- Related to Primary Adult
- Related to Second Adult
- Related to Both Adults

**How Related:**

- Natural Child
- Foster Child
- Grandchild
- Niece / Nephew
- Other / Specify \_\_\_\_\_

**Additional child living in the home**

First	Middle	Last	Birthday	Gender	Race
-------	--------	------	----------	--------	------

**Related To:**

- Related to Primary Adult
- Related to Second Adult
- Related to Both Adults

- Natural Child
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- Natural Child
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- Grandchild
- Niece/ Nephew
- Other / Specify \_\_\_\_\_

***(If you have more children to list, please list on the back of this document)***

**Do you receive: (Please check all that apply)**

Must provide documentation for each item checked.

- \_\_\_ KTAP / TANF
- \_\_\_ Food Stamps
- \_\_\_ SSI
- \_\_\_ Disability
- \_\_\_ Child Support
- \_\_\_ Housing Assistance
- \_\_\_ WIC
- \_\_\_ Income of Wages
- \_\_\_ Unemployment

Please check all that may apply for your family living arrangements

- \_\_\_ Emergency Runaway
- \_\_\_ Special Care Facility
- \_\_\_ Motel / Hotel
- \_\_\_ Spouse Abuse Shelter
- \_\_\_ Unaccompanied Youth
- \_\_\_ Public Place
- \_\_\_ Uninhabitable
- \_\_\_ Temp Friends/ Relatives
- \_\_\_ Temp Placement

**CERTIFICATION: I certify that this information included on and with this application to be true to the best of my ability. If any part is false, my participation in the agency's program may be terminated and I may be subject to legal action.**

*Guardian Signature*

*Date*

***This Section for Agency Use Only***

Household Size: \_\_\_\_\_ Eligibility Income: \_\_\_\_\_ Eligibility Date \_\_\_\_\_ Class Age \_\_\_\_\_  
 Initial Status  New  Accepted  Waitlisted Status Date \_\_\_\_\_

**Category of Eligibility**

- \_\_\_ Head Start
- \_\_\_ State Preschool
- \_\_\_ AISD (Over Income/OD)
- Income Status**
- Over Income
- Public Assistance
- Eligible (Below 100%)
- Foster child
- Homeless
- Status**
- Income/Age Eligible
- Disability

**Child eligible to participate in program**

- Yes
- No

**Type of eligibility interview**

- In- Person
- Telephone

**Documentation used to determine eligibility**

- Income Tax Form
- W-2
- TANF Documentation
- Pay stub or pay envelopes
- Written statements from employers
- SSI Documentation
- Foster Care reimbursement
- Unemployment
- Other \_\_\_\_\_

Verifying Staff Signature

Date

**ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER  
2022-2023**

**PERMISSION AND AGREEMENT**

Please **check yes or no** and **initial each item**.

**My child may participate in all screening activities which include the following;**

<b>YES</b>	<b>NO</b>	<b>INITIAL</b>	
_____	_____	_____	Vision screen
_____	_____	_____	Hearing Screen
_____	_____	_____	Speech/Language Screen
_____	_____	_____	Developmental Screen
_____	_____	_____	Social Emotional Screen
_____	_____	_____	Growth Assessments

**WE REPORT CHILD ABUSE**

**Who Must Report**

The law states that it is the duty of everyone who has reasonable cause to believe that a child is abused or neglected to report this information.

**Penalty For Failure To Report**

KRS 620.990(1) states:  
Any person intentionally violating the provisions of this chapter shall be guilty of a Class B Misdemeanor. A class B misdemeanor carries a penalty of up to 90 days in jail and/or a fine of up to \$250.

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

(Educational records shall be kept confidential according to the requirements of the Family Education Rights & Privacy Act Regulation 34 CFR Part 99).

\_\_\_\_\_  
Guardian Signature \_\_\_\_\_ Date

\_\_\_\_\_  
Staff Signature \_\_\_\_\_ Date

**PAST MEDICAL HISTORY QUESTIONNAIRE****2022-2023****MEDICAL**

1. Does the child receive routine medical exams / checkups?  NO  YES
2. Is the child presently under medical care for a chronic disease?  NO  YES If yes explain: \_\_\_\_\_
3. Is or has the child been treated for any of the following conditions?
- ANEMIA  ASTHMA  HEARING
- OVERWEIGHT  VISION PROBLEMS  EAR INFECTIONS
- HIGH LEAD LEVELS  DIABETES  SEIZURES OTHER \_\_\_\_\_
4. Does your child currently take medication?  NO  YES If yes, please list: \_\_\_\_\_
5. Will your child need medications while at school?  NO  YES If yes, please list: \_\_\_\_\_
- (If you answer yes to this question, a special form will need to be completed and signed by the Doctor)*

**Primary Care Physician** \_\_\_\_\_**ALLERGIES**

Does your child have a doctor's diagnosed allergy or severe reaction to any of the following?

- Bee stings  NO  YES
- Animals  NO  YES
- Pollens (hay fever)  NO  YES
- Latex  NO  YES
- Medications  NO  YES Name of Med: \_\_\_\_\_
- Food  NO  YES Name of Food: \_\_\_\_\_
- Other  NO  YES Explain: \_\_\_\_\_
- Is this a life-threatening allergy?  NO  YES
- Is an Epi-Pen required  No  YES

**DENTAL**

Does your child receive routine Dental care or checkups with licensed Dentist? \_\_\_\_\_ No \_\_\_\_\_ Yes

**DENTIST** \_\_\_\_\_ **DATE OF LAST VISIT** \_\_\_\_\_**VISION**

Has your child seen an optometrist in the last year? \_\_\_\_\_ No \_\_\_\_\_ Yes.

**OPTOMETRIST** \_\_\_\_\_ **DATE OF LAST VISIT** \_\_\_\_\_**NUTRITION ASSESSMENT**Does your child receive WIC or nutrition services?  No  YesAre you concerned about your child's weight (under/overweight) or eating habits?  No  YesDo you have other dietary/nutritional concerns?  No  Yes

Explain: \_\_\_\_\_

Guardian Signature

Date

Verifying Staff

Date

**TRANSPORTATION / EMERGENCY INFORMATION**

Classroom \_\_\_\_\_

<b>PRIMARY GUARDIAN</b> _____ Phone / Text # _____ - _____ - _____	<b>CHILDS NAME</b> _____ <b>ADDRESS</b> _____ <b>BIRTHDATE</b> _____ <b>ALLERGIES</b> _____ <b>MEDICINES</b> _____ In case of emergency, your child will be transported to the nearest medical facility.
<b>SECONDARY GUARDIAN</b> _____ Phone / Text # _____ - _____ - _____	

___ Parent Transport    and/or    ___ Bus Transport	Date & Initial Changes
# ___ Pick up Location _____	_____
# ___ Drop off Location: _____ Staff Only	_____
<b>Transportation (24 hr notice required for bus transportation changes)</b>	

**Emergency Contacts / Authorization to Release Child**

*only people on the release below will be allowed to get child off the bus or pick up child from school.*

Any changes to this form must be made by the Guardian in the office.

**NO CHANGES OVER THE PHONE! NO EXCEPTIONS!**

Persons listed below must be at least **18 years of age** and present a photo ID. Persons listed will be utilized as alternate contacts for emergencies. We encourage at least three contacts that reside locally.

**RELEASE / EMERGENCY CONSENT**

In case of an emergency and no one can be reached at the phone numbers listed for my child, I authorize school officials to administer necessary emergency treatment, call the physician listed and / or call 911 for emergency transportation.

NAME	RELATIONSHIP	PHONE #1	PHONE #2	ADDRESS
Primary Guardian				
Secondary Guardian				

Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_      Verifying Staff \_\_\_\_\_ Date \_\_\_\_\_

*For the safety of your child, information on this page will be shared with the Bus Drivers and Monitors*