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
2021-2022

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 2021-2022

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

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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
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)
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☐ Bachelor Degree ☐ College Degree/Training Cert
☐ Associates Degree
☐ HS Graduate ☐ GED
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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

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ALL FIELDS MUST BE ANSWERED TO BE CONSIDERED COMPLETE

Applicant Name: ______________ Birthday____________

ASHLAND EXCEPTIONAL EARLY CHILDHOOD CENTER

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

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
- ☐ 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

How Related:
- ☐ Natural Child
- ☐ Foster Child
- ☐ 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

Income Status
- ☐ Over Income
- ☐ Public Assistance
- ☐ Eligible (Below 100%)
- ☐ Foster child
- ☐ Homeless

_______State Preschool

Status
- ☐ Income/Age Eligible
- ☐ Disability

______AISD (Over Income/OD)

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
2021-2022

PERMISSION AND AGREEMENT

Please check yes or no and initial each item.

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

YES	NO	INITIAL	
_____	_____	______	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

Applicant Name: ____________________ Birthday____________

PAST MEDICAL HISTORY QUESTIONAIRE

2021-2022

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)

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? ____No ____ Yes.

OPTOMETRIST ____________________________________ **DATE OF LAST VISIT**______________________________________

NUTRITION ASSESSMENT

Does your child receive WIC or nutrition services? ☐ No ☐ Yes

Are you concerned about your child's weight (under/overweight) or eating habits? ☐No ☐ Yes

Do you have other dietary/nutritional concerns? ☐No ☐Yes

Explain:____

____________________________ ______________ ___________________________ __________

Guardian Signature **Date** **Verifying Staff** **Date**

2021-2022

TRANSPORTATION / EMERGENCY INFORMATION **Classroom** ________________________

PRIMARY GUARDIAN ________________________________
Phone / Text # ______________-______________-__________

SECONDARY GUARDIAN______________________________
Phone / Text # ___________-____________-________________

CHILDS NAME ____________________________________
ADDRESS ____
BIRTHDATE ______________________________________
ALLERGIES _____________________________________
MEDICINES ______________________________________
In case of emergency, your child will be transported to the nearest medical facility.

____ Parent Transport

____ Bus Transport

#_____Pick up Location ____

#_____Drop off Location: ____

Date & Initial Changes
Staff Only

____________ ____________
___________ ____________
___________ _____________

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,

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

I authorize school officials to administer necessary emergency treatment, call the physician listed and / or call 911 for emergency transportation.

______________________________ ________________ ________________________ ___________
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