

**EOP BIRTH TO 5 SCHOOL READINESS PROGRAM**  
**HEAD START/EARLY HEAD START**  
**APPLICATION**

- **Items needed for Completion of Application:**
- Complete all sections of this application
- Proof of Current Address
- Copy of Child's Date of Birth-Birth Certificate or Medical Records
- Signed Medical Release Form **Provided In The Application**
- Current Physical and Immunization records on NYS Child in Care "daycare form" (**last page of this application - for Dr to complete**)
- Custody Papers (if applicable)
- **Verification of Eligibility:**
  - **Current SNAP, SSI, or TANF eligibility documentation**
    - **NOTE:** If one of the above are submitted, no other other forms of income are necessary to confirm eligibility.
  - **IF you do not have any of the above, please provide any of the following that apply:**
    - Last year's Tax Returns, W2's or 12 months of Pay Stubs
    - Any other type of income

You may Drop off, Mail or Fax your completed application to:

**Manager of Enrollment Services**  
**650 Baldwin Street**  
**Elmira, NY 14901**  
**Fax: (607) 737-7210**

Please call with any questions:  
Ask for an Enrollment Specialist  
**(607) 734-6208**

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**Additional Family Members:** Please provide information for anyone living in the household. Use the Additional Family Member form if necessary.

Mother    Father    Other Adult    Child

Relationship to Child: \_\_\_\_\_

**Name:** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employment: \_\_\_\_\_

Education: \_\_\_\_\_

Race: \_\_\_\_\_

Full Time (Where?) \_\_\_\_\_

< Than Grade 9\*

White/Caucasian

Part Time (Where?) \_\_\_\_\_

Grade 10

Black/African American

School/Job Training (Where?) \_\_\_\_\_

Grade 11

Asian

Looking for Employment

Grade 12

Native Hawaiian/Pacific Islander

Unemployed/Laid Off

GED

American Indian/ Alaska Native

Seasonal

High School Diploma

Hispanic (Origin) \_\_\_\_\_

Associates Degree

Bi-Racial (Origin) \_\_\_\_\_

Bachelors/Master's Degree

Other \_\_\_\_\_

\*Highest Grade Completed: \_\_\_\_\_

Mother    Father    Other Adult    Child

Relationship to Child: \_\_\_\_\_

**Name:** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employment: \_\_\_\_\_

Education: \_\_\_\_\_

Race: \_\_\_\_\_

Full Time (Where?) \_\_\_\_\_

< Than Grade 9\*

White/Caucasian

Part Time (Where?) \_\_\_\_\_

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Black/African American

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Mother    Father    Other Adult    Child

Relationship to Child: \_\_\_\_\_

**Name:** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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Education: \_\_\_\_\_

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Other \_\_\_\_\_

\*Highest Grade Completed: \_\_\_\_\_

**Family Size:**

**Services my family receives:**

Number in the family _____	TANF/ Cash Assistance	SNAP
Number of children _____	Unemployment Benefits	SSI
Number of children 0 - 3 _____	WIC	SSD
Number of children 4- 5 _____	Day Care Subsidies	Other _____
Number of Adults & children living in the household _____	Foster Care Subsidies	

**Family Type:**

**How did you hear about the Birth to Five School Readiness Program?**

Two Parent      Facebook    Flyer    Friend    Other \_\_\_\_\_

**Single Parent/Female    Have you applied to the B25 School Readiness program or another EOP program before?**

Single Parent/Male      Yes    No

Guardian/Foster      If Yes, name of program: \_\_\_\_\_

Duel Custody Family

**Would you like to be contacted with information about any other Programs? (check all that apply)**

Medicaid	WIC	EDCC	TANF	Child health/Family Plus
COE/New Day	Literacy Zone	Career Center	SSI/SSD	
OPWDD	Literacy Volunteers	Weatherization	SNAP	

***I give permission for the Enrollment Facilitator to make referrals and share information for the programs that I have requested.***

\_\_\_\_\_ (Please sign)

**Insurance:** (Please make sure all information is filled out)

Does your child have Health Insurance?    Yes    No    Dental Insurance?    Yes    No

Physician's name: \_\_\_\_\_      Dentist Name: \_\_\_\_\_

Medicaid #: \_\_\_\_\_      Sequence #: \_\_\_\_\_ (number that starts and ends with a letter)

Private Insurance Carrier: \_\_\_\_\_      Dental Insurance Carrier: \_\_\_\_\_

**Housing Information:**

Our home type is:    Rent    Subsidized rent    Own

My family receives:    Section 8    Live in public housing

My family is temporarily living with a friend or family member because we cannot find affordable housing:    Yes    No

If Yes, who do you live with? \_\_\_\_\_

My family is living in emergency/transitional housing:    Yes    No

My family is living in a motel/hotel, street, camp ground or vehicle:    Yes    No

Do you have any concerns regarding your child's development? Yes \_\_\_\_\_ No

Does your child receive speech, SEIT, PT or OT services? Yes \_\_\_\_\_ No

Does your child have any medical or health concerns? Yes \_\_\_\_\_ No

My child will need special accommodations: \_\_\_\_\_

Does your child have any food allergies? Yes \_\_\_\_\_ No

Will you need an EPI pen? Yes No (We will need a medical statement from your doctor)

Is your child fully potty trained? Yes No

Has your child been in preschool or daycare before? Yes No

Currently where is your child staying during the daytime? \_\_\_\_\_

Is your family working with any other agencies? Yes \_\_\_\_\_ No

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Does your family have reliable transportation? Yes No

**Head Start only:** If available, do you need busing? (EDFC and Able 2 only) Yes No

Are you interested in becoming a Policy Council Member or Classroom Volunteer? Yes No

Policy Council Classroom Volunteer

***I have read and reviewed all the information contained within this application and the answers are complete to the best of my knowledge and belief. I understand that if any information contained within this application changes I am obliged to notify EOP Head Start immediately. I understand that this information will be kept confidential within EOP.***

I give permission for Head Start to share information after completing or leaving the program for up to one year with my child's home school district for the purpose of transitional planning following enrollment in a Pre-K or Kindergarten setting.

Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

My child will be attending the: \_\_\_\_\_ School District

**Thank you for applying to the Head Start program. Your application will not be complete without all the necessary documentation, including the medical statement and the shot records. We will notify you as soon as placement is available for your child.**

I am interested in the following site locations (Placement will depend on availability of slots):

Able2 A'Don Allen BOCES Broad Street EDFC Libertad Any Site

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Economic Opportunity Program, Inc.

*Strengthening the fabric of our community*

Main Office:  
650 Baldwin Street  
Elmira, NY 14901  
Phone (607) 734-6174  
FAX (607) 733-8126

Schuyler County Office:  
112 6th Street  
Watkins Glen, NY 14891  
Phone: (607) 535-2468  
Fax (607) 535-9859

[www.cseop.org](http://www.cseop.org)

[www.facebook.com/EconomicOpportunityProgram](https://www.facebook.com/EconomicOpportunityProgram)

## EOP Birth to Five School Readiness Program Consent for Release of Information

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

I hereby authorize EOP Birth to Five School Readiness Program to obtain or release information to the following providers:

### Services

Birth to Five School Readiness Program

Center of Excellence (New Day Program)

Community Food For Jobs Programs & Bistro

Energy Services Bureau

Ernie Davis Community Center

Family Support Services

Literacy Volunteers of Chemung & Schuyler Counties

Primary Healthcare Provider

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dental Provider

\_\_\_\_\_  
\_\_\_\_\_

Child's Local School District/Early Intervention

CIDS

DSS

Chemung County Public Health

Other Agencies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This authorization is valid for the entire 20 20 School year.

Parent/Guardian Signature

Date



Est. 2018



Helping People. Changing Lives.

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NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**CHILD IN CARE MEDICAL STATEMENT**

**To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner**

Name of Child: _____	Date of Birth: _____ / /	Date of Examination: _____ / /
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**Immunizations required for entry into day care**

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).  Yes  No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date / /	5 <sup>th</sup> Date / /
Polio (IPV or OPV)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date / /	
Haemophilus influenzae type B (Hib)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date OR 1 <sup>st</sup> Date (if given on or after 15 months of age) / /	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date / /	
Hepatitis B	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /		
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /			
Varicella (also known as Chicken Pox)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /			

**Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A**

Type of Immunization: _____	Date: _____ / /	Type of Immunization: _____	Date: _____ / /
Type of Immunization: _____	Date: _____ / /	Type of Immunization: _____	Date: _____ / /
Type of Immunization: _____	Date: _____ / /	Type of Immunization: _____	Date: _____ / /

**Tests**

Tuberculin Test Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Mantoux Results:  Positive  Negative \_\_\_\_\_ mm  
 TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.  
 If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Attach lead level statement  
**Lead Screening (Include All Dates and Results)**

1 year \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary  
 2 years \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary

**Most recent date of lead screening (if different from above):**  
 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary

**Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.**  
 If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

