Eligibility Criteria

How Do I Know If My Child Is Eligible?

Head Start/Early Head Start: Part-Time Option
(Child attends 2-3 days/week)
• Child is 6 weeks – 5 years old
• Child lives in Hennepin County
• Family receives MFIP cash, SSI, or meets income guidelines (see below)
• Children with diagnosed disabilities (and an IEP) are eligible regardless of income. Special needs or foster care children ages 6 weeks – 5 years who live in Hennepin County are also eligible.

Head Start: Full-Time Option
(Child attends 5 days/week)
• Child is 3–5 years old
• Child lives in Hennepin County
• Family is eligible for a child-care subsidy because the parent(s)/guardian(s) work or go to school, or because the child has diagnosed disabilities or special needs.

Early Head Start: Pregnant Mom Option
• Pregnant woman, any age
• Mom lives in Hennepin County
• Family, along with unborn baby, meets income guidelines

Early Head Start: Full-Time Option
(Child attends 5 days/week)
• Child is 6 weeks – 3 years old
• Child lives in Hennepin County
• Family is eligible for a child-care subsidy because the parent(s)/guardian(s) work or go to school, or because the child has diagnosed disabilities or special needs.

Federal Income Guidelines 2016

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Max Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,880</td>
</tr>
<tr>
<td>2</td>
<td>$16,020</td>
</tr>
<tr>
<td>3</td>
<td>$20,160</td>
</tr>
<tr>
<td>4</td>
<td>$24,300</td>
</tr>
<tr>
<td>5</td>
<td>$28,440</td>
</tr>
<tr>
<td>6</td>
<td>$32,580</td>
</tr>
<tr>
<td>7</td>
<td>$36,730</td>
</tr>
<tr>
<td>8</td>
<td>$40,890</td>
</tr>
</tbody>
</table>

For each additional person, add $4,160.

How To Enroll

Please bring the following forms:

✓ Current Physical Examination and Immunization Records. Fill out Section I of the enclosed Physical & Immunization Record. Have your doctor complete and sign the rest.

✓ Dental Examination. If your child has a dentist have them fill out and sign the enclosed Dentist Report.

✓ Insurance Cards. Bring your child's medical and/or dental insurance card.

✓ Emergency Information. Be prepared to provide names, addresses, and phone numbers of three emergency contacts.

✓ Proof of Income. Bring official documentation of income. For example: Minnesota Family Investment Plan (MFIP), Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Foster Care or Unemployment Compensation. If you are employed, bring a W-2 form, tax return, check stub, or other income verification.

* Pregnant mom enrollment only requires proof of income.

✓ If your application is not complete we will not be able to enroll your child.
Questions marked with a star (*) will not affect you as an applicant. They are voluntary to meet federal reporting requirements and to help us serve you better. All other questions are mandatory for enrollment.

### Program Information

<table>
<thead>
<tr>
<th>School Year</th>
<th>Program</th>
<th>Possible Site</th>
<th>Processing Application</th>
<th>Application Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Child Information

<table>
<thead>
<tr>
<th>Child ID</th>
<th>First Name</th>
<th>Middle</th>
<th>Last Name</th>
<th>Birthdate</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
</table>

*Ethnicity (check one):*  
- Hispanic or Latino  
- Not Hispanic or Latino

*Race (check all that apply):*  
- American Indian or Alaska Native  
- Asian  
- Black, African, or African American  
- Native Hawaiian or Other Pacific Islander  
- White

### Household Information

<table>
<thead>
<tr>
<th>Parent or Guardian First Name</th>
<th>Parent or Guardian Last Name</th>
<th>Relationship to Child</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Guardian in Home First Name</th>
<th>Other Guardian in Home Last Name</th>
<th>Relationship to Child</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Street Address:

City:  
State:  
Zip:  
Home Phone:  

Source(s) of income (check all that apply):  
- MFIP  
- SSI  
- SS  
- GA  
- Foster Care  
- Other...

*Type of housing (check one):*  
- Unsubsidized Rental Housing  
- Home Ownership  
- Institutional Care (i.e. Nursing Home, State Hospital, etc.)  
- Section 8 or Other Rental Subsidized Housing  
- Permanent Supportive Housing  
- Shelter Plus Care / Bridges Rental

*Residential Treatment facility*  
- With Friends/Relatives: by choice  
- With Friends/Relatives: could not find housing  
- Transitional Housing Program  
- Emergency Shelter

*Primary language used in household (check one):*  
- Cambodian  
- Hmong  
- Oromo  
- Somali  
- Swahili  
- Vietnamese  
- English  
- Laotian  
- Russian  
- Spanish  
- Thai

*Language read by head of household (check one):*  
- I do not read  
- Cambodian  
- Hmong  
- Oromo  
- Somali  
- Swahili  
- Vietnamese  
- English  
- Laotian  
- Russian  
- Spanish  
- Thai  
- Other

*Is a parent in the household currently:*  
- In School?  
- Yes  
- No  
- If Yes,  
- Full Time  
- Part Time

- In Training?  
- Yes  
- No  
- If Yes,  
- Full Time  
- Part Time

- Working?  
- Yes  
- No  
- If Yes,  
- Full Time  
- Part Time

### Pick Up/Drop Off

If the child will be transported to or from a different address from the household address above, specify:

<table>
<thead>
<tr>
<th>Pick Up Address</th>
<th>Responsible Adult</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drop Off Address</th>
<th>Responsible Adult</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PICA History

Referral Agency ___________________________ School District ___________________________

List any PICA/Head Start program(s) this child has attended in the past:

__________________________________________

Program ___________________________ School Year ____________

List any PICA program(s) this child’s sibling(s) have attended in the past:

__________________________________________

Program ___________________________ School Year ____________

Family Status

Total number of adults and children in family: ___________________________

*Who does this child live with (check one)?

☐ Single parent-female ☐ Two Parents ☐ Relative

☐ Single parent-male ☐ Grandparents ☐ Foster care

Diagnosed Disabilities

Does your child have an ECSE Plan? ____________ Yes/No ____________ Description ____________________________

Is there a significant diagnosed medical disability? ____________ Yes/No ____________

Is there a significant mental health condition? ____________ Yes/No ____________

Program Meals

The program you are applying for is Head Start. Depending on the session your child is enrolled in, he/she will have classes two or three days per week, for six hours per day.

<table>
<thead>
<tr>
<th>Session Days</th>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THU</th>
<th>FRI</th>
<th>Meals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lunch</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Breakfast</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>Snack</td>
</tr>
</tbody>
</table>

If this is NOT correct, please indicate when your child will attend:

<table>
<thead>
<tr>
<th>Session Days</th>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THU</th>
<th>FRI</th>
<th>Meals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Breakfast</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Snack</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lunch</td>
</tr>
</tbody>
</table>

I certify that the information in this application is, to the best of my knowledge, complete and correct. I understand that providing false information could cause this application to be denied or cause my child’s enrollment in this program provided by Parents in Community Action, Inc., to be suspended. I understand that completion of this application does not guarantee enrollment.

_________________________ Date ___________________________

Signature of Parent/Guardian

If the parent/guardian is under age 18, a parent or guardian over age 18 must sign:

_________________________ Date ___________________________

Signature of Adult Parent/Guardian

USDA is an equal opportunity provider and employer.

Copy to: Parent/Child Advocate file Application Points

©2012 Parents In Community Action, Inc.
## Child Physical

### Child's Details

<table>
<thead>
<tr>
<th>Child's Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Address</th>
<th>Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child's Medical Insurance Name</th>
<th>Child's Medical Insurance Number</th>
<th>MN Health Care ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Early and Periodic Screening Diagnosis and Treatment (EPSDT) Exam Required

Starred items (*) are required by Federal Head Start regulations and recommended by the American Academy of Pediatrics for children 3-5 years old. Enter date if date of test is other than "exam date" recorded below.

### Test Results

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Age*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height (CM)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (Kg)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematocrit or HB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing (Type of Test)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision (Type of Test)*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments

- Physical Examination/Assessment

<table>
<thead>
<tr>
<th>Item</th>
<th>Normal For Age</th>
<th>Abnormal</th>
<th>Not Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Posture, Gait</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Speech</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Head</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Skin</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Ears</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Nasal, Mouth, Pharynx</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Dental</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Heart</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Lungs</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Abdomen (Include Hemia)</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Genitalia</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Bones, Joints, Muscles</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Neurological/Social</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Gross Motor</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Fine Motor</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Cognitive</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Self-Help Skills</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Social Skills</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Glands (Lymphatic/Thyroid)</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
<tr>
<td>Developmental Assessment</td>
<td>NA</td>
<td>AB</td>
<td>NE</td>
</tr>
</tbody>
</table>

### Findings, Treatments, and Recommendations

Please Complete Individualized Child Care Plan (ICCP) for chronic health issues.

<table>
<thead>
<tr>
<th>Abnormal Findings/Diagnoses</th>
<th>Treatment Plan and Recommended Follow-Up or Results</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note to physician**: Please fill out all items in Health Record.

Specify any condition that may result in an emergency situation:

How is child's overall physical status?

Specify type and dose of any current medication or therapies:

Describe any allergies:

Describe any dietary restrictions:

Describe any dietary recommendations:

Describe any diagnosed disabilities:

Please print or type physician or nurse practitioner's name and telephone number:

Print MD/AP Name: [Name]

Exam Date: [Date]

Phone: [Phone]

MD/AP Signature: [Signature]

Page 4 of 12
Child Care Immunization Form
Must be on file before a child attends child care

Name _______________________________ Birthdate _______________________________

Date of Enrollment _______________________________

Minnesota law requires children enrolled in child care to be immunized against certain diseases or have a legal medical or conscientious exemption on file.

Parent/Guardian:
You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease or laboratory evidence of immunity, and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status, section 2A to document medical exemptions (including a history of varicella disease), and 2B to document a conscientious exemption.

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

<table>
<thead>
<tr>
<th>Type of Vaccine</th>
<th>Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, and Pertussis (DTaP, DTP)</td>
<td></td>
</tr>
<tr>
<td>3 doses during 1st year (at 2-month intervals)</td>
<td></td>
</tr>
<tr>
<td>4th dose at 12-18 months</td>
<td></td>
</tr>
<tr>
<td>5th dose at 4-6 years</td>
<td></td>
</tr>
<tr>
<td>Indicated vaccine type: DTaP or DTP</td>
<td></td>
</tr>
</tbody>
</table>

| Polio (IPV, OPV) |
| 2 doses in the first year |
| 3rd dose by 18 months |
| 4th dose at 4-6 years |

| Measles, Mumps, and Rubella (MMR) |
| Required for children 15 months and older |
| 1st dose on or after 1st birthday |
| 2nd dose at 4-6 years |

| Haemophilus influenza type b (Hib) |
| 2-3 doses in the first year |
| 1 dose required at 12 months or older |
| For unvaccinated children 15-59 months, 1 dose is required |
| Not required for children 5 years or older |

| Varicella (chickenpox) |
| Required for children 15 months or older |
| 1st dose on or after 1st birthday |
| 2nd dose at 4-6 years |

| Pneumococcal Conjugate Vaccine (PCV) |
| Required for children age 2-24 months |
| 3 doses in the first year |
| 4th dose after 12 months |
| At least 1 dose is recommended for children 24-59 months in child care |

| Hepatitis B (hep B) |
| 2-3 doses in the first year |
| 3rd dose (final dose) by 18 months |

| Hepatitis A (hep A) |
| 2 doses separated by 6 months for children 12 months and older |

| Recommended |
| Rotavirus (2-3 doses between 2 and 6 months) |
| Influenza (annually for children 6 months or older) |
Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or conscientious)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Children who are 15 months or older:
For children who are 15 months or older and who have received all the immunizations required by law for child care.

   I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.

Signature of Parent/Guardian OR Physician/Nurse Practitioner/Physician Assistant/Public Clinic  

_________________________________________ Date

B. Children who are younger than 15 months:
For children who are younger than 15 months OR have not received all required immunizations.

   I certify that the above-named child has received the immunizations indicated. In order to remain enrolled, this child must receive all required vaccines within 18 months from initial enrollment date. The dates on which the remaining doses are to be given are:

Signature of Physician/Nurse Practitioner/Physician Assistant/Public Clinic  

_________________________________________ Date

2. Exemptions to Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:
No child is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a child to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

   I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

Signature of physician/nurse practitioner/physician assistant  

_________________________________________ Date

* History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in ______________(year)

Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)

B. Conscientious exemption:
No child is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the child or others they come in contact with. In a disease outbreak, children who are not vaccinated may be excluded in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

   I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s).
  ☐ I am opposed to all vaccines.
   ☐ I am opposed only to vaccines indicated below.

_________________________________________ Date

Signature of parent or legal guardian

_________________________________________ Date

Subscribed and sworn to before me this:  
__ day of __________ 20__

Signature of notary (A copy of the notarized statement will be forwarded to the commissioner of health.)

Developed by the Minnesota Department of Health – Immunization Program

www.health.state.mn.us/immunize

(12/13)
Physician treating child's condition:

Name ____________________________ Title ____________________________

Clinic ________________________________________________________________

Address ______________________________________________________________

Phone # 1 ______________________ Phone # 2 _______________________

1. Diagnosed Medical Condition:
   a. When was your child first diagnosed? ________________
   b. Is it an ongoing health issue? ☐ Yes ☐ No
   c. How often does it occur? ____________________________
   d. What symptoms and behaviors does your child experience?

2. Treatment and Medications (Complete MEDICATION PERMISSION Form)
   a. Routine treatment(s) and medication(s):

   b. As Needed (PRN) treatment(s) and medication(s):

3. Emergency Care: If your child does not respond to medication and treatment, the emergency plan is:

4. Child's knowledge:
   a. What is your child's understanding of the medical condition?

   b. Does your child understand about any restrictions at day care?

   c. Can your child tell the teacher when treatment and medication is needed? ☐ Yes ☐ No

   d. Does your child cooperate with treatment and medication? ☐ Yes ☐ No

5. Additional information and/or Health Care Provider's recommendations:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Parent Signature/Date ________________________________________________

Health Care Provider Signature/Date ____________________________________
Asthma Action Plan

Site: ______ Room: ______

Patient Name: ___________________________ # ______ Weight: ______ DOB: ______ Peak Flow: ______

Doctor or Nurse Practitioner Name: ___________________________

Clinic Name: ___________________________ Phone: ______ Asthma Severity: ______

Symptom Triggers: ___________________________

---

**Green Zone**

"Go All Clear!"
- Breathing is easy
- Can play, work, and sleep without asthma symptoms

Peak Flow Range
(80%-100% of personal best)
______ to ______

The **Green Zone** means take the following medicine(s) every day:

**Controller Medicine(s):**

Dose: ___________________________

**Spacer Used:**

Take the following medicine if needed 10-20 minutes before sports, exercise, or any other strenuous activity:

---

**Yellow Zone**

"Caution..."
- Wake up at night
- Cough or wheeze
- Chest is tight

Peak Flow Range
(50%-80% of personal best)
______ to ______

The **Yellow Zone** means keep taking your Green Zone controller medicine(s) every day and add the following medicine(s) to help keep the asthma symptoms from getting worse.

**Reliever Medicine(s):**

Dose: ___________________________

Use Quick Reliever 2-4 puffs, every 20 minutes for up to 1 hour or use nebulizer once. If your symptoms are not better or you do not return to the GREEN ZONE after 1 hour follow RED ZONE instructions. If you are in the Yellow Zone for more than 12-24 hours, call your provider. If your breathing symptoms get worse, call your provider.

---

**Red Zone**

"STOP!" "Medical Alert!"
- Medicine is not helping
- Nose opens wide to breathe
- Breathing is hard and fast
- Trouble walking
- Trouble talking
- Ribs show

Peak Flow Range
(Below 50% of personal best)
______ to ______

The **Red Zone** means start taking your Red Zone medicine(s) and to call your doctor NOW! Take these medicines until you talk with your doctor. If your symptoms do not get better and you can't reach your doctor, go to the emergency room or call 911 immediately.

**Reliever Medicine(s):**

Dose: ___________________________

---

I give my permission for this asthma action plan to be used by the following, and for them to share information with each other about my child's asthma on year beginning today, so that they can work together to help my child manage his/her asthma. This plan, when signed and dated, may replace or supplement the school's/daycare's consent to administer medication form, and allows my child's medicine to be administered at school/daycare.

☐ My child's school/School Health Office
☐ My child's clinic/hospital
☐ My child's day care provider: __________
☐ La Crèche
☐ Visiting nurse/Home care agency
☐ Insurance case management/Education program
☐ Coach

☐ Student may carry and use this medicine at school after approval by the School Nurse
☐ My child is allowed to self-administer medications

Date: ___________________________ Parent Signature: ___________________________

Entered By: ___________________________ MD/NP/PA Signature: ___________________________
La Crecche Early Childhood Centers, Inc.
1800 Olson Memorial Hwy
Minneapolis, MN 55411
(612) 377-1786

Child Emergency Card

Name
Birth Date
Gender

Address
City
Zip
Parent/Guardian First
Parent/Guardian Last

Pick Up Address
Pick Up Contact
Notes

Drop Off Address
Drop Off Contact
Notes

Child’s Health Insurance
Health Insurance ID
MN Health Care ID
Child’s Dental Insurance
Dental Insurance ID

Doctor’s Office/Clinic
Doctor’s Name

Address
City
Phone

Hospital

Address
City
Phone

Dentist’s Office
Dentist’s Name

Address
City
Phone

IN CASE OF EMERGENCY
THE FOLLOWING ADULTS ARE AUTHORIZED TO SERVE AS CONTACTS. MY CHILD MAY ALSO BE RELEASED TO THESE PARTIES.

Parent or Guardian First Name
Parent or Guardian Last Name
Relationship to Child

Other Guardian in Household First Name
Other Guardian in Household Last Name
Relationship to Child

Home

Full Name
Address
City/ST
Relationship
School/Work name
School/Work Contact
Phone Numbers
Type

Full Name
Address
City/ST
Relationship
School/Work name
School/Work Contact
Phone Numbers
Type

Full Name
Address
City/ST
Relationship
School/Work name
School/Work Contact
Phone Numbers
Type

In case of medical/dental emergency I hereby authorize Parents In Community Action, Inc. (PICA) staff to take my child to a health facility for treatment. I also authorize any licensed medical practitioner to provide whatever treatment is deemed necessary. I accept responsibility for any costs arising from such treatment, which is covered by insurance and/or medical assistance.

Parent/Guardian Signature
Date

In the event of an emergency, we will make every effort to contact you or one of the Emergency Contacts listed above. Your child will NOT be released to anyone other than those adults listed on this form. Please allow 48 hours for changes to go into effect.

June 2016 - 5th
Dear Parent/Guardian:

To ensure good oral health, every child one year and older must have a dental examination within the last six months, or no later than 90 days after the child starts school. If your child does not have a regular dentist, you may choose to have your child seen at PICA through Children’s Dental Services.

If your child does have a dental provider, please have them complete the section below and bring it with you to registration.

<table>
<thead>
<tr>
<th>Dentist Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>This child received the following treatment in my office:</td>
</tr>
<tr>
<td>- Dental exam</td>
</tr>
<tr>
<td>- X-rays TAKEN</td>
</tr>
<tr>
<td>- X-rays READ</td>
</tr>
<tr>
<td>- Cleaning</td>
</tr>
<tr>
<td>- Topical fluoride application</td>
</tr>
<tr>
<td>- Sealant</td>
</tr>
<tr>
<td>- Fillings</td>
</tr>
<tr>
<td>- Emergency</td>
</tr>
<tr>
<td>- Extractions</td>
</tr>
<tr>
<td>- Steel crowns</td>
</tr>
<tr>
<td>- Space maintainers</td>
</tr>
<tr>
<td>- Other, explain:</td>
</tr>
</tbody>
</table>

- ALL treatments ARE complete.

- ALL treatments are NOT complete – the following is still needed:

  | TAKE X-rays | Fillings |
  | READ X-rays | Extractions |
  | Topical fluoride application | Steel crowns |
  | Cleaning | Space maintainers |
  | Sealant | Other, explain: |

Next Appointment
DATE:

PRINT Dentist’s Name          Dentist’s Signature          Dentist’s Telephone          Date of Exam

Parent Signature

Date
INFORMATION REGARDING THERAPY SERVICES

Speech-Language Therapy, Occupational Therapy and Physical Therapy services are provided for children at La Creche Early Childhood Centers through Health Dimensions Rehabilitation (HDR).

I authorize HDR to screen my child after admission to La Creche Early Childhood Centers. The screening is a courtesy service arranged by La Creche Early Childhood Centers (you will not be charged for the screening). In addition, I authorize complete evaluation and therapy services if deemed necessary by HDR staff. Funding for these services are explored through insurance and other resources. I understand that evaluation results and therapy recommendations will be provided.

Child's Name: ___________________________ Parent/Guardian: ___________________________

Child's Soc. Sec. #: ______________________ Parent/Guardian Soc. Sec. #: ______________________

Address: ________________________________________________________________

Child's Date of Birth: ___________________________ Phone: ___________________________

Type of Insurance (check one):
- Medical Assistance (MA)
- MEDICA
- Metropolitan Health (MHP)
- Health Partners
- U-Care
- Other: ___________________________

Policy #: ___________________________

Does your policy have a deductible or does it pay only a part of the service?
- Yes
- No

Amount: ___________________________

I give permission to contact my child's physician to discuss screening results and obtain physician's order to complete a full evaluation.

Child's Physician: ___________________________ Phone: ___________________________

Clinic: ___________________________ Phone: ___________________________

I certify the above information is a complete and accurate account of all medical insurance policies covering my child and will notify you of any changes. I authorize the release of information for exchange between La Creche Early Childhood Centers and HDR staff to address any needs of my child, and as needed to process any claims. Your signature authorizes HDR to provide therapy at the stated rates and to release information to any insurance company, adjuster, or their representative, to determine the payment of benefits.

ASSIGNMENT OF BENEFITS: Your signature also authorizes direct payment of medical benefits to HDR. If the patient's current policy prohibits direct payment to the provider of service, your signature directs the insurance company to issue payment for these services in the patient's name, to Health Dimensions Rehabilitation, Inc., 1994 East Rum River Dr. S., Cambridge, MN 55008. Your signature indicates that you have received a copy of HDR's Privacy Notice.

I agree to pay for services rendered to this patient that are not covered by private insurance/HMO or due to a lapse in coverage.

Signature of Parent/Guardian ___________________________ Date ___________________________

**Please detach Privacy Policy and keep for your records**