



## CARD HEAD START / EARLY HEAD START

### AGREEMENT FOR SERVICES

CARD Head Start/Early Head Start's objective is to ensure that all necessary and recommended health services are received by every child so that each individual is capable of functioning at their full potential. Each aspect of the child's well-being will be considered when meeting this objective. Physical, emotional, cognitive and social-emotional health are all part of your child's well-being.

#### OBJECTIVE GOALS:

All children enrolled in the program are up to date on the state's recommended schedule of Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

The current EPSDT guidelines require a checkup at the following ages: 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, 4 years, and 5 years.

#### Program staff agrees to:

Assist parent/guardian in the application process for Sooner Care (Medicaid)  
Assist parent/guardian in finding a continuous source of medical care  
Provide information and educational resources regarding the EPSDT schedule  
Provide a safe and healthy environment in which each child can learn  
Provide parent/guardian with feedback on each child's progress

#### Parents/Guardians agree to:

- \*Take their child for all recommended medical and dental examinations and follow-up services when a concern is found.
- \*Provide program staff with copies of results from these appointments and current immunization records.
- \*Keep their child's immunizations up to date as required by state law
- \*Ask questions to understand the EPSDT schedule
- \*Provide a doctor's statement that explains all necessary procedures, treatments or medications to be performed at school
  - A) **All medications must have a Physician's statement before being administered at school. This includes prescribed and over-the-counter medications and products.**
  - B) **All food allergies must have a current statement from a Physician regarding the allergy on file with Nutrition Services before dietary exceptions can be made.**

Request assistance from program staff to meet these requirements

#### What this all means:

Taking your child in for check-ups when they are well allows the doctor or other practitioner to focus on making sure your child is healthy and growing as expected. Developmental milestones are assessed and if a concern is found intervention services can be started. When problems are found early, often consequences can be prevented. When treatment is started early, children have a better chance at success with living and learning.

If your child has any medical condition that requires staff to provide on-site care for these needs, written instructions must be provided.

Oklahoma State law requires Early Childhood Program Staff to report any suspected cases of child abuse.

I enter into this "Agreement for Services with CARD Head Start/Early Head Start understanding the importance of my involvement in my child's healthcare.

**These agreements shall remain in effect for the duration of enrollment unless revoked in writing, by Parent to CARD.**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



**CARD HEAD START / EARLY HEAD START**  
**AGENCY EXPECTATION FOR EARLY CHILDHOOD PROGRAMS**

Each family is required to turn in one signed copy of this agreement prior to the start of the program year. CARD Head Start/Early Head Start is committed to providing high quality programming to our families. In order to deliver this level of quality we utilize a combination of Federal, state and private dollars. The cost to serve one child in our program is as follows: 23,000 dollars a year for Infant / Toddlers services and 14,000 dollars for our Pre-K children. In order to guarantee that we are good stewards of the monies entrusted to us, we must ensure that those participating in our programs are receiving all of its benefits. In order to do this, we have developed a set of expectations that will help you and your child to achieve this goal. Our expectations are that you:

**\*See that your child attends regularly.** Failure to attend regularly could result in your child losing their slot and being dropped from the program. Most importantly, a child must be here in order to receive the benefits of the program. When a child misses five unexcused days, the Enrollment Coordinator will send a letter to the parent. After 10 unexcused absences, a second letter is sent placing the child on the waitlist until arrangements can be made for the child to attend on a regular basis.

**\*Be on time.** Being on time and staying for the full day and not only impacts the child's learning but their nutrition as well. We serve a nutritious breakfast and lunch during the day. Coming in late or picking up early could result in your child missing breakfast and/or lunch. If the child arrives early or leaves, late extended care fees may be applied after regular classroom hours.

**\*Abandonment: (first occurrence)** 1.) Call all home and alternative numbers provided by parent.2.) Discuss consequences of failure to pick up child.3.) After 3:30 teacher will notify DHS that child has been abandoned and request child to be taken into their custody. **(Second occurrence)** 1.) Call all alternate numbers provided by parents.2.) After one hour, notify DHS that the child be taken into their custody. Again extended day fees may apply.

**\*Child Abuse, Neglect and Human Trafficking**

CARD Head Start/Early Head Start is a reporting agency and is required by Oklahoma Law to report injuries or behavior to DHS when child abuse, neglect or human trafficking is suspected. It is our goal to work with parents/guardians to provide safety to all children.

**\*Keep your child's immunizations, physical and dental check-ups current and up to date.** You agree to handle any of these needs that arise and provide documentation to classroom staff.

**\*Establish a medical home.** It is a Head Start/Early Head Start requirement that families have an ongoing source of family health care. If you do not have a primary care doctor, you agree to work with staff to establish one.

**\*Ensure that we always have current contact information so you can be reached in an emergency. Be an active participant in home visits and parent conferences provided by teachers and staff.** You are expected to participate in two home visits and two parent conferences during the school year.

**\*Special Needs.** Work with staff to implement any special services your child may need, such as Mental Health & Disabilities, Nutrition etc.

**\*Maintain on-going communication with school staff.** This consists of both face-to-face and written communication and includes the Family Partnership Agreement.

**I agree to work with the Site and Classroom staff in meeting these expectations.**

**These expectations shall remain in effect for duration of enrollment unless revoked in writing, by parent to CARD.**

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**CARD HEAD START / EARLY HEAD START**

**AGREEMENT FOR SERVICES**

**CHILD'S NAME** \_\_\_\_\_

**CONSENT FOR HEALTH SERVICES** \_\_\_\_\_

As partial fulfillment of my agreement for services with CARD HEAD START/ EARLY HEAD START, I hereby agree that my child:

- 1.) Shall receive all of the health services required by the HEAD START Performance Standards, within the mandated time frame from the first day of attendance. These services may be provided by Early Childhood Programs staff or by collaborative and /or contracted providers. Providers might include area public school systems, university medical centers, and /or affiliated agencies. I understand that the provision of the services may require my child to leave the HS premises/room with the approved service provider, and that these services may include:

Developmental Screening/Observation	Height/Weight Assessment
Social/Emotional /Behavioral / Mental Health Observations	Dental Exam
Vision Screening	Well-Child Exam with Lead, Hgb and B/P
Hearing Screening	Speech/Language

- 2.) Shall brush his/her teeth daily in the center he/she attends, with an ADA approved fluoride toothpaste and toothbrush provided by CARD Head Start/Early Head Start.

As partial fulfillment of my partnership with CARD Head Start/Early Head Start, I (**parent**) hereby agree and /or understand that:

- 1.) I will receive information regarding my child's health status, screenings observations and evaluations; information will be shared with collaborative and/or contracted providers, which may include area public school systems, university medical centers and /or affiliated agencies.
- 2.) I will take my child for all recommended medical and dental examinations and follow-up services when a concern is found; and I will provide program staff with copies of results from these appointments.
- 3.) I will request assistance from CARD program staff to meet requirements.
- 4.) I may be asked to sign specific release of information forms to assist Early Childhood Programs staff in obtaining updated health information.

**TICK REMOVAL** \_\_\_\_\_

In the event that a tick is found on my child while @, HS/EHS. I authorize staff to remove.

**EMERGENCY PREPAREDNESS** \_\_\_\_\_

In the event of an emergency, we will relocate to an off-site location.

**FIELD TRIPS** \_\_\_\_\_

Permission for Transport or Walking Field Trip, Bye-Bye Buggy approval according to class schedule- times posted in classrooms, daily with weather permitting and within one-mile radius.

**Authorization for Emergency Treatment to Minors** \_\_\_\_\_

I, the undersigned parent or legal guardian of CHILD does hereby authorize any emergency x-ray, examination, anesthetic, dental, medical or surgical diagnosis or treatment by any physician or dentist licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of CARD Head Start/Early Head Start, the temporary custodian of the minor. It is understood that this emergency consent is given in advance of any specific diagnosis or treatment being required.

**Permission to Transport child** \_\_\_\_\_

I understand that if CHILD has a medical emergency while at CARD Head Start/Early Head Start, that 911 will be called to transport him/her immediately to the nearest hospital to the extent possible, transport will be provided to the specified hospital by HS/EHS Staff.

**Permission to Photograph Child** \_\_\_\_\_

I authorize CARD to photograph CHILD for promotional and marketing purposes for Early Childhood Programs.

**These consents shall remain in effect for the duration of enrollment unless revoked in writing, by Parent, to CARD.**

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

CHILD NAME: \_\_\_\_\_



## CARD HEAD START / EARLY HEAD START

### NOTICE TO PARENTS

### GOOD MORNING HEALTH CHECK

Our center requires that we protect the health and safety of all children who participate in our program. Therefore, all children are visually inspected or checked for problems that may be harmful to themselves or others. Visual observation and checking may include any or all of the following symptoms or potential problems:

- |                            |                          |
|----------------------------|--------------------------|
| *Fevers (Temp. over 100.4) | *Severe Cough            |
| *Unusual Skin Rash         | *Bleeding                |
| *Open Wounds               | * Injuries/Bruises/Lumps |
| *Head Lice                 | * Vomiting               |
| *Diarrhea                  | * Other Health Problems  |

If any of these symptoms are observed when you bring your child to the center or are noticed later in the day, we may ask you to pick your child up and /or obtain a signed doctor's release before returning. We know this can be inconvenient, but it is necessary for the protection of all other children. Some symptoms require being symptom free for 24 hours before returning.

#### **(Effective for the duration of Enrollment)**

Parent / Guardian Signature:

\_\_\_\_\_ Date \_\_\_\_\_

Staff Signature:

\_\_\_\_\_ Date \_\_\_\_\_

CHILD NAME: \_\_\_\_\_



## CARD HEAD START / EARLY HEAD START

### Agreement for services

I do hereby give my permission to share information with the public school for developmental screenings/evaluation results.

A summary of my child's health records will be given to me at the end of the Head Start/Early Head Start school year. My child's Assessment copies will also be forwarded/transitioned to the public school or next placement, if I request it, and sign ED39b. If I have a child with special needs, I understand I may contact the Head Start Disabilities Manager and request in writing a transition meeting with the public school on Head Start form DB-017.

I have read and understand the above statements. I understand all health-related information in this agreement may include, but is not limited to, protected health information or identifiable health records applicable to entities covered by the Health Insurance Portability and Accountability Act (HIPAA Privacy Rule), and revised April 2003.

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

### Child and Adult Care Food Program (CACFP) Enrollment Form

1. Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
2. Normal Days In Attendance: (Circle)  
Sunday Monday Tuesday Wednesday Thursday Friday
3. Head Start Facilities Only: Indicate session and sign and date form: (Circle)  
A.M. P.M. All Day
4. Normal Meals Eaten: (Circle)  
Breakfast A.M. Snack Lunch P.M. Snack

#### Agreement is effective for Duration of Enrollment

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

### Parent Handbook

I received a copy of the Parent Handbook

- Digital Copy       Physical paper copy

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