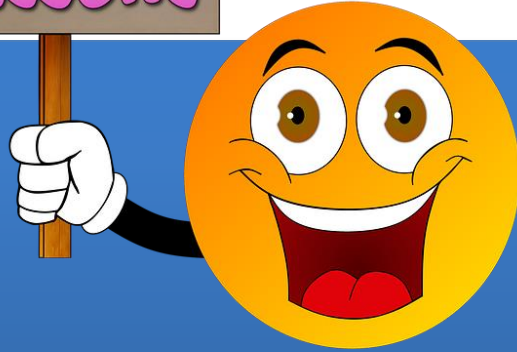
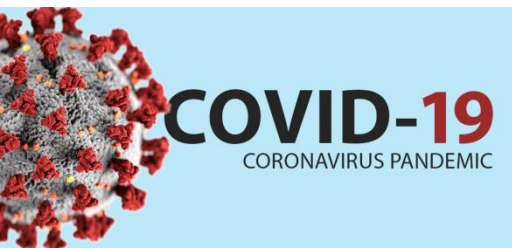


WELCOME



# St. Clair County Head Start





# Safety Procedures

- Please observe all signs and reminders to wear mask and observe social distancing of 6ft.
- Parents will bring children to the marked entrances/bus to be checked and signed in.
- All children will have their temperature checked before entrance. Parents will be asked about possible exposure to covid-19.
- Children are not required to wear mask.

# Arrival & Pick-up

- Arrival 7:30 – 8:00am
- Pick-up 1:30 – 2:00pm
- Buses will arrive at 7:30am and leave campus at 2:00pm. Individual Bus stop schedules will be given to parent's of bus riders.
- No changes to transportation will be accepted over the phone.





# Classroom Rules

Our staff will teach children how to manage their behavior to be successful in the classroom. We appreciate your help to foster the following behaviors:

We use walking feet.

We use inside voices in the classroom and halls.

We use gentle hands and kind words to our friends.

We take care of our classroom and materials.



# Health & Dental



- All enrolled children must have 3 forms on file:  
**Physical Form**      **Up-to-date**      **Dental Form**

St. Clair County Head Start  
 21685 U. S. Hwy. 231 N. • Old Coal City School  
 P. O. Box 641  
 Pell City, Alabama 35125  
 Phone: (205) 338-9694 ext.105      Fax: (205) 338-3215

Yearly EPSDT Medical Screening

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

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Hearing \_\_\_\_\_ Vision \_\_\_\_\_

Hemacrit / Hemoglobin \_\_\_\_\_ Lead \_\_\_\_\_ Urinalysis \_\_\_\_\_ Allergies \_\_\_\_\_

Private \_\_\_\_\_ Self Pay \_\_\_\_\_ Primary Health Coverage \_\_\_\_\_ Medicaid \_\_\_\_\_ All Kids \_\_\_\_\_

Physical Examination Date: \_\_\_\_\_ Finding, treatments & recommendation \_\_\_\_\_

	Normal	Abnormal
General Appearance		
Gross dental (teeth/gums)		
Head/Scalp/Skin		
Eyes/Ears/Nose/Throat		
Chest/Lungs/Heart		
Abdomen		
Speech		
Neurological/Social		

Health care Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_

Address (Please print or stamp): \_\_\_\_\_ Phone Number: \_\_\_\_\_

I hereby give permission to release this information to SCCHS Program: \_\_\_\_\_

Revised 2013

## Immunization Form

FIGURE 1. Recommended immunization schedule for persons aged 0-6 years — United States, 2007

Vaccine	Age	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
Hepatitis B <sup>1</sup>	HepB	HepB	HepB	See footnote 2	HepB	HepB Series						
Rotavirus <sup>3</sup>	Rota	Rota	Rota									
Diphtheria, Tetanus, Pertussis <sup>4</sup>	DTaP	DTaP	DTaP	DTaP	DTaP							
Haemophilus influenzae type b <sup>4</sup>	Hib	Hib	Hib	Hib	Hib							
Pneumococcal <sup>5</sup>	PCV	PCV	PCV	PCV	PCV							
Inactivated Poliovirus	IPV	IPV	IPV	IPV	IPV							
Influenza <sup>6</sup>	Influenza (Yearly)											
Measles, Mumps, Rubella <sup>7</sup>	MMR											
Varicella <sup>8</sup>	Varicella											
Hepatitis A <sup>9</sup>	HepA (2 doses)											
Meningococcal <sup>10</sup>	MPSV4											

FIGURE 2. Recommended immunization schedule for persons aged 7-18 years — United States, 2007

Vaccine	Age	7-10 years	11-12 YEARS	13-14 years	15 years	16-18 years
Tetanus, Diphtheria, Pertussis <sup>1</sup>	Tdap	Tdap	Tdap			
Human Papillomavirus <sup>2</sup>	HPV (3 doses)	HPV (3 doses)	HPV Series			
Meningococcal <sup>3</sup>	MPSV4	MCV4	MCV4			
Pneumococcal <sup>4</sup>	PPV	PPV	PPV			
Influenza <sup>5</sup>	Influenza (Yearly)	Influenza (Yearly)	Influenza (Yearly)			
Hepatitis A <sup>6</sup>	HepA Series	HepA Series	HepA Series			
Hepatitis B <sup>7</sup>	HepB Series	HepB Series	HepB Series			
Inactivated Poliovirus <sup>8</sup>	IPV Series	IPV Series	IPV Series			
Measles, Mumps, Rubella <sup>9</sup>	MMR Series	MMR Series	MMR Series			
Varicella <sup>10</sup>	Varicella Series	Varicella Series	Varicella Series			

THE NATIONAL CENTER ON Health

### Head Start Oral Health Form—Children

Patient Information

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Parent's/guardian's name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

This practice is the child's dental home:  Yes  No

Current Oral Health Status

Does the child have any teeth with untreated decay?  Yes (decay)  No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?  Yes  No

Are there treatment needs?  Yes, urgent  Yes, not urgent  No treatment needs

Oral Health Care Services Delivered During Visit

<b>Diagnostic/Preventive Services</b>	<b>Counseling/Anticipatory Guidance</b>	<b>Restorative/Emergency Care</b>
Examination: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fillings: <input type="checkbox"/> Yes <input type="checkbox"/> No
X-rays: <input type="checkbox"/> Yes <input type="checkbox"/> No		Crowns: <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Referral to Specialty Care</b>	Extractions: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cleaning: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency care: <input type="checkbox"/> Yes <input type="checkbox"/> No
Fluoride varnish: <input type="checkbox"/> Yes <input type="checkbox"/> No		Other: _____ (Please specify)
Dental sealants: <input type="checkbox"/> Yes <input type="checkbox"/> No	(Please specify specialist)	(Please specify)

Future Oral Health Care Services

All treatment completed:  Yes  No      Next recall date: \_\_\_\_\_ / \_\_\_\_\_ (month/year)

More appointments needed for treatment?  Yes  No

If yes: Approximate number of appointments needed: \_\_\_\_\_ Next appointment: Date: \_\_\_\_\_ Time: \_\_\_\_\_

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name (please print) \_\_\_\_\_ Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

Practice name \_\_\_\_\_ Address \_\_\_\_\_

Provider signature \_\_\_\_\_ Date of service \_\_\_\_\_

This document was prepared under grant #90HC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Health. This publication is in the public domain, and no copyright can be claimed by persons or organizations.

# Nutrition

- Each child will receive a nutritious breakfast, lunch and snack provided by our USDA nutrition program.
- If your child has a food allergy , you must bring documentation from their physician.  
**No** substitutions in meals will be provided without a note from your doctor.
- No food from home is allowed.





# Nutrition

This form must be completed and signed by every parent. →→→



**CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) FY \_\_\_\_\_**

**Part 1. Enrolled Children: list names of all enrolled children**

Names of all enrolled children: Use additional pages if necessary (First and Last)	BIRTH DATE MM/DD/YYYY	CHECK IF IN HEAD/EVEN START	CHECK IF FOSTER CHILD	CHECK IF HOMELESS CHILD
/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Part 2. Benefits:** If any member of your household received SNAP (food stamps) or TANF cash assistance, provide the name and case number for the person who receives benefits. If no one receives these benefits, skip to part 3.  
 NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_

**Part 3. Total Household Gross Income —You must tell us how much and how often**

**B. Gross income and how often it was received**  
 For example \$200/week or \$150/twice a month

A. Name — First and Last (List only household members not listed in Part 1)	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. Other Income	5. Check if no income
\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>	
\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>	
\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>	
\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>	
\$ / /	\$ / /	\$ / /	\$ / /	<input type="checkbox"/>	

**Part 4. Signature and Last Four Digits of Social Security Number (Adult must sign) - An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number and mark the "I do not have a Social Security Number" box. (See Privacy Act Statement below)**  
 I certify that all information on this form is true and that all income is reported. I understand that the center will get Federal funds based on the information I give; that center officials may verify the information on the form; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Sign here: \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Last four digits of Social Security Number:  X X - X X - \_\_\_\_\_  I do not have a Social Security Number

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Part 5. Participant's ethnic and racial identities (optional)**

<input type="checkbox"/> Mark one ethnic identity:	<input type="checkbox"/> Mark one or more racial identities:	
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other

**Don't fill out this part. This is for official use only.**  
 Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Household size: \_\_\_\_\_ Total Annual Income: \_\_\_\_\_ SNAP/TANF Household: \_\_\_\_\_

Determination for: Free Meals \_\_\_\_\_ Reduced-Price Meals \_\_\_\_\_ Paid Meals \_\_\_\_\_ # Foster free \_\_\_\_\_ # Head/Even Start Free \_\_\_\_\_  
 # Homeless Free \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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# Disability & Mental Health Services

- All Children will be screened for developmental milestones, speech, hearing, vision and behavior. Referrals will be made based on results of screening and Parent/Teacher observation.
- Services for children with disabilities will be provided by our local school systems.
- A mental health consultant will be on campus and available to our children and families.





# Important Information



- All parents must provide a photo ID to pick up a child. Only persons on the pick-up list , with a valid ID will be allowed to sign children out.
- We must have a valid phone number and address for each enrolled child at all times.
- Changes to your child's record can only be made in person by the child's parent or legal guardian.
- For notices about school closures please sign up for 'Notify Me', check our schools website: [www.stclaircountyheadstart.com](http://www.stclaircountyheadstart.com) or listen to **WBRC Fox 6** or **WFHK 94.1 the River**.

*Important*

# Communication



- Monthly calendars and other communication will be sent home in your child's weekly folder.
- Notify me Messaging service
- Website: [stclaircountyheadstart.com](http://stclaircountyheadstart.com)
- St. Clair County Head Start Facebook page
- Please make sure your phone and email information is up-to-date at all times.



**Important**

# Communication

- Main line : 205-338-9694 Head Start Director: ext. 102
- Fax : 205-338-3215
- Manager extensions:
  - Family Services ext.115
  - Education ext. 113
  - Health ext. 105
  - Parent Engagement ext. 104
  - Bus /Transportation ext. 121
  - Disability/Mental Health ext. 108
  - Receptionist ext. 116
  - Nutrition ext. 120

**Please call the receptionist if your child will be absent before 9:00am.**



## Be INVOLVED

- Volunteer : Fill out an application and get 3 letters of reference.

Get a physical and TB test.

Have a criminal background check including:

ABI/FBI , Child abuse and neglect Registry clearance, National Registry Sex Offender Search.

- Attend monthly Parent meetings
- Serve on the Policy Council