



ABORIGINAL HEAD START



For Office Use Only:

Program Site: _____

Child's ID Number: _____

Class: _____ **AM** _____ **PM**
_____ **New** _____ **Returning**

Start Date: _____

Intake Date: _____

School Year: _____

CHILD AND FAMILY INFORMATION

Child's Legal Name:

(First) (Middle) (Last)

Other Known Names (If any): _____

Child's Date of Birth: _____ **Gender:** _____ **Male** _____ **Female**
(Month/Day/Year)

Name of Primary Caregiver:

(First) (Last)

Relationship to Child: _____

Address: _____ **Suite #:** _____ **Postal Code:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email Address: _____

Name of Additional Caregiver (if any):

(First) (Last)

Relationship to Child: _____

Address: _____ **Suite #:** _____ **Postal Code:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

How many times have you moved in the last year? _____

Age of the primary Parent/Caregiver?

_____ Under 20 years old _____ 30-40 years old
_____ 20-30 years old _____ Over 40 years old

What is the education level of the primary caregiver of the child?

Grade: _____

Residents living in the home?

_____ Mother (bio)	_____ Father (bio)	_____ Child's Sibling(s)
_____ Step-Mother	_____ Step-Father	_____ Child's Cousin(s)
_____ Child's Grandmother	_____ Child's Uncle	Other: _____
_____ Child's Grandfather	_____ Child's Aunt	_____

How many siblings does your child have? _____

Names and ages of siblings:

Name: _____	Age: _____
Name: _____	Age: _____
Name: _____	Age: _____
Name: _____	Age: _____

Is this your child's first Head Start program? _____ Yes _____ No

If NO: Date when child last attended program: _____
(Month/Day/Year)

Name and Location of program: _____

ABORIGINAL LEARNER DATA COLLECTION INITIATIVE

*it is mandatory that this question is included on registration forms, however answering the question is optional;

If you wish to declare that your child is an Aboriginal person, please specify:

_____ 331 Status Indian/First Nations	_____ 334 Inuit	_____ Do not wish to declare
_____ 332 Non-Status Indian/First Nations	_____ 333 Métis	

ALTERNATE PICK UP/EMERGENCY CONTACT INFORMATION

***PLEASE NOTE - A PARENT LIVING IN THE HOME IS NOT CONSIDERED AN ALTERNATE PICK UP,**
AND THE EMERGENCY CONTACTS MUST LIVE WITHIN EDMONTON CITY LIMITS
AND HAVE A WORKING LOCAL PHONE NUMBER

Contact #1:

(First)

(Last)

Address: _____

Suite #: _____

Postal Code: _____

Home Phone: _____

Cell: _____

Work: _____

Relationship to Child: _____

Contact #2:

(First)

(Last)

Address: _____

Suite #: _____

Postal Code: _____

Home Phone: _____

Cell: _____

Work: _____

Relationship to Child: _____

I, the Parent/Primary Caregiver, give my consent for the persons listed above to pick up my child from the bus or school with proof of identification and prior notification to both the bus driver and classroom teacher. Further, the persons listed above will act as my child's emergency contacts in the event of my absence.

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____

(Month/Day/Year)

Is anyone denied access to the child? _____ **Yes** _____ **No**

Who is denied access to the child? _____

Are there court documents to support the above? _____ **Yes** _____ **No**

If applicable - Have custody documents been provided? _____ **Yes** _____ **No**

INCOME DECLARATION

ANNUAL FAMILY INCOME:

<input type="checkbox"/> LESS THAN \$12,000	<input type="checkbox"/> \$12,000 - \$15,000	<input type="checkbox"/> \$15,001 - \$18,000
<input type="checkbox"/> \$18,001 - \$21,000	<input type="checkbox"/> \$21,001 - \$24,000	<input type="checkbox"/> \$24,001 - \$27,000
<input type="checkbox"/> \$27,001 - \$30,000	<input type="checkbox"/> \$30,001 - \$33,000	<input type="checkbox"/> \$33,001 - \$36,000
<input type="checkbox"/> \$36,001 - \$39,000	<input type="checkbox"/> \$39,001 - \$42,000	<input type="checkbox"/> OVER \$42,000

SOURCE OF INCOME A:

<input type="checkbox"/> EMPLOYMENT	<input type="checkbox"/> ALBERTA WORKS	<input type="checkbox"/> STUDENT FINANCE
<input type="checkbox"/> EMPLOYMENT INSURANCE	<input type="checkbox"/> CHILD SUPPORT	<input type="checkbox"/> CHILD TAX
<input type="checkbox"/> AISH/DISABILITY	<input type="checkbox"/> CANADA PENSION PLAN	<input type="checkbox"/> WCB

Does your current income meet the financial needs of your family? ☐ Yes ☐ No

HEALTH INFORMATION

Does your child have any special needs we should know about? (special diet, language problems, particular fears, etc.)

☐ Yes ☐ No

Has your child had previous assessments? (speech & language, OT, etc.)

☐ Yes ☐ No

What family issues should we be aware of that have been occurring in the home and affecting your child?

Does your child have a family doctor? ☐ Yes ☐ No, we go to a Medicentre

Doctor's Name:

Type: ☐ Family ☐ Pediatrician ☐ Specialist (ear, nose, throat, etc.)

☐ Other:

Doctor's/Medicentre Phone Number: _____

Doctor's/Medicentre Address: _____

Alberta Health Care Number: _____

Birth Certificate Number: _____

Treaty Number (if applicable): _____

What reserve is your child registered to or will be registered to? _____

Is your child's immunizations up to date? _____ Yes _____ No _____ Don't know

If immunized outside of Edmonton, where? _____

Does your child have any allergies? _____ Yes _____ No

1 Allergy: _____ Reaction: _____

Medicine/Treatment: _____

2 Allergy: _____ Reaction: _____

Medicine/Treatment: _____

3 Allergy: _____ Reaction: _____

Medicine/Treatment: _____

Does your child need an EpiPen? _____ Yes _____ No

Does your child have asthma? _____ Yes _____ No

***Please note that if you have said yes to your child having asthma and/or needing an EpiPen then a rescue inhaler and/or an EpiPen will need to be provided (and kept at school) prior to your child starting the program**

Is your child on regular medication? _____ Yes _____ No

What medication? _____

How Often? _____

How is the medicine administered? _____

Are there any side effects? _____ Yes _____ No

Description: _____

COMMUNITY RESOURCES AND SERVICES

Do you presently have involvement with another agency? _____ Yes _____ No

If yes, which Agency? _____

Do you need to know about more resources and services in your community for your child and family?
_____ Yes _____ No _____ Not sure

Have your children experienced any form of trauma or abuse? _____ Yes _____ No

If yes, please explain: _____

Do you currently have Children Services involvement? _____ Yes _____ No

Children Services worker: _____
(first) (last)

Phone Number: _____ Email: _____

Social worker: _____
(first) (last)

Phone Number: _____ Email: _____

Family Support worker: _____
(first) (last)

Phone Number: _____ Email: _____

PERSONAL AND SOCIAL DEVELOPMENT

Is the mother tongue of either parent/caregiver an Aboriginal Language? _____ Yes _____ No

Does either parent/caregiver speak an Aboriginal Language fluently? _____ Yes _____ No

Does your child speak an Aboriginal Language fluently? _____ Yes _____ No

What is the primary language spoken in the home? _____

What is the primary language your child speaks? _____ English _____ Other: _____

What do you hope that Head Start will offer you as a parent/caregiver? (Choose as many as you wish)

_____ To meet other parents

_____ To learn better parenting strategies

_____ To learn about Aboriginal culture

_____ To learn some of the local Aboriginal language

_____ To learn how to help my child learn

_____ Another reason - please explain: _____

How did you hear about Aboriginal Head Start? (Choose as many as you wish)

_____ Word of mouth: Through friends / family

_____ Through past participants

_____ Head Start flyer What business/location did you find our flyer at? _____

_____ Facebook advertisement

_____ Social Media advertisement

_____ Google Search

_____ Other: _____

CAREGIVER SURVEY: HELP US GET TO KNOW YOUR CHILD

As the caregiver, you know your child the best, therefore your input and involvement into your child's education is very important. Please fill out the following.

What three words describe your child?

What are your child's strengths? What is your child good at?

What are your child's interests? What does your child like to do? (dance, sing, look at books, outside play, dress up, build with Lego, play with dolls, etc.)

What areas would you like your child to grow in? (use words instead of hitting, following directions, sharing with friends, speaking clearly, talk more, etc.)

Does your child display any behaviors that are of concern to you?

Is there any information that could help us gain a better understanding of your child?

PARENT/CAREGIVER DELEGATION OF POWER AND DUTY

Consent to ordinary medical and dental care:

This authority includes treatment for minor illnesses and injuries and other procedures that are performed routinely and do not require hospitalization.

The Head Start staff have the authority to admit the child to hospital but not to authorize any treatment or tests except according to the following clause:

Consent to emergency treatment or surgical procedures. This authority includes immediate measures necessary to preserve the child's life, health and physical wellbeing. The authority must be used only if contacting the parents or caregivers will delay treatment enough to endanger the child's life. After giving treatment, the staff must immediately notify the parents or caregivers.

Delegation of Powers in Case of Emergency

Child's Legal Name:

_____ (First) _____ (Middle) _____ (Last)

Date of Birth: _____ Gender: _____ Male _____ Female
(Month/Day/Year)

Band/First Nation: _____

Treaty Number: _____

Alberta Health Care Number: _____

I, the Parent/Primary Caregiver, delegate the Powers and Duties set out above in this delegation to the staff of the Aboriginal Head Start Program regarding my child.

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____

(Month/Day/Year)

ONLINE AND VIRTUAL LEARNING

I, the Parent/Primary Caregiver, understand that Aboriginal Head Start may provide programming, at any time, for my child, through a virtual program platform if required. I understand that active participation is essential and agree to participate in online activities as required and expected. All information shared (both from the program and from families) has the possibility to be seen by everyone enrolled in the online group. Aboriginal Head Start cannot guarantee that the information will remain confidential as all families participating will have access to the same information as you and may share this on other social media platforms. Aboriginal Head Start will not be responsible or liable for misconduct of images or information shared in the Virtual Classroom. We ask that all images, videos and instructions be used for what they are intended for and to refrain from any misconduct of information.

Direct teaching in the classroom is our primary mode of teaching. Our secondary online mode of teaching is available in the event our primary mode is unachievable. While participating in the online learning, children may receive materials delivered to their home so that they can participate in the program. It is the expectation of our online programming to have parent participation by joining weekly ZOOM calls and connecting via email and Facebook Site groups regularly. While your child will receive benefits of an online program, direct education may be difficult as the classroom teacher is working with in-person children attending program. When participating in our primary direct teaching in the classroom forum, transportation boundaries will be adhered to. The program will ensure to provide valuable learning opportunities that engage, challenge and support the development of your child!

By signing below, you show understanding of the above statement and agree to participate in the programming provided, either through the secondary online program or through the primary direct teaching in the classroom.

Facebook Name: _____

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____

(Month/Day/Year)

Child:

Name: _____

D.O.B. _____

(Month/Day/Year)

HEALTH PROMOTION AND ASSESSMENT PERMISSION

I, the Parent/Primary Caregiver, hereby authorize the following agencies to observe my child in the Head Start program and provide necessary documentation and consultation to Aboriginal Head Start staff in order to enhance my child's learning in the classroom.

**Please initial beside all services you are in agreement with*

_____ Alberta Health Services
_____ Child Adolescent and Family Mental Health (CASA)
_____ Glenrose Hospital (Assessment Facility)
_____ Edmonton Student Health Initiative Program (ESHIP)

I understand that as part of the services provided by Head Start, these services and screenings may be completed with and/or provided for my child.

**Please initial beside all services you are in agreement with*

_____ Measurement of Height and Weight
_____ Dental Screening
_____ Hearing Screening
_____ Vision Screening
_____ Brigance Inventory of Early Childhood Development II (IED-II)
_____ Safe Preschoolers Education & Awareness Kit (S.P.E.A.K.)
_____ Speech and Language Referral/Assessment, if required
_____ Occupational Therapist Referral/Assessment, if required
_____ Physical Therapist Referral/Assessment, if required

I also give permission for the information collected to be used by Head Start and the above agencies for educational, research and statistical purposes. I understand that the information will be coded in such a way that the identities of individual children and parents will be kept confidential for research and statistical purposes.

Initials

I hereby give my consent and agree to the above screening(s) and services indicated with my initials.

Parent/Caregiver:

Child:

Name: _____

Name: _____

Signature: _____

D.O.B. _____

(Month/Day/Year)

Date: _____

(Month/Day/Year)

COLLECTION AND RELEASE OF INFORMATION

I understand that the Head Start may release the following information on my child to Early Education Programs and/or institutions and may collect the following information from previous Early Education Programs and/or institutions that will support my child's educational programming:

- *Individual Program Plan
- *Speech and Language Report, if applicable
- *Occupational Therapist Report, if applicable
- *Physical Therapist Report, if applicable

Initials

I understand that the Head Start may collect the following information from previous Early Education Programs and/or institutions that will support my child's educational programming:

- *Individual Program Plan
- *Speech and Language Report, if applicable
- *Occupational Therapist Report, if applicable
- *Physical Therapist Report, if applicable

Initials

I understand that the information collected by Head Start will be kept confidential.

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____
(Month/Day/Year)

Child:

Name: _____

D.O.B. _____
(Month/Day/Year)

TRANSPORTATION

Does your child require transportation?

_____ **Yes**

_____ **No, caregiver will be providing transportation**

PLEASE NOTE: Child's residence and/or child care provider must be located in the bus boundaries to receive bus services.

If yes to program transportation, check which one appl

_____ **Home - Home**

_____ **Home - Daycare**

_____ **Daycare - Daycare**

_____ **Daycare - Home**

Number of siblings on bus:

The following people have permission to sign my child on and off the bus:

Please list yourself as the primary caregiver and then list those who will be consistently signing your child on and off the bus. We do understand that there may be extenuating circumstances where someone other than those listed below may have to sign for your child (with prior notification and photo ID)

Primary Caregiver #1:

(First)

(Last)

Primary Caregiver #2:

(First)

(Last)

Caregiver #3:

(First)

(Last)

Caregiver #4:

(First)

(Last)

If your child will be attending a child minding program, please complete the following section:

Daycare/Dayhome Name:

Daycare/Dayhome Address:

Daycare/Dayhome Phone Number:

TRANSPORTATION PROCEDURES

The amiskwaciy Cultural Society provides the Aboriginal Head Start Program with four 24 passenger school busses and access to the program's spare bus if needed. These vehicles are used to transport those children who are registered in our program and who live within the designated boundaries set forth by the Aboriginal Head Start Program.

Estimated hours for pick up: Between 8:00am - 9:00am for both our Kihew Group (Tuesday/Thursday classes) and our Muskwa Group (Wednesday/Friday classes).

Estimated hours for drop off: Between 3:00pm - 4:00pm for both our Kihew Group (Tuesday/Thursday classes) and our Muskwa Group (Wednesday/Friday classes).

The bus will pick up/drop off your child at home or/at the designated child care facility.

Parents/Guardians are **required** to bring the child to the bus upon pick up and meet the bus upon drop off. **The bus drivers are not allowed to leave the bus at any time.**

The bus will stop at each home for exactly **3 minutes**. **Please have your child dressed and ready for the bus.** If your child is not ready to go or no one attempts to signal the driver, she/he will carry on with the route and there will be no reattempt at any later time.

Drop off – If no one is home at time of drop off, the driver will attempt to call parent/guardian. The bus driver will then make a second attempt at the end of the route. If still no one is available to receive the child, the Family Support Worker will attempt to contact emergency phone numbers and if still no one is available, they will then contact the Children's Services Crisis Line.

A transportation permission form must be signed for all children who ride the bus.

If a parent/guardian has an alternate caregiver receiving their child upon drop off or pick up from school, teachers **MUST** be informed verbally and in written form. Individuals will be required to show proper identification.

If your child will not be riding the bus on any given day, the bus driver **MUST** be notified the night before or at least half an hour before s/he arrives at your residence.

If your child is sick or away from school and will not be riding the bus for any number of days, the drivers **MUST** be contacted in order to resume bus riding for his/her child

TRANSPORTATION PERMISSION

I, the Parent/Primary Caregiver, understand the transportation procedures and hereby give consent for my child to be transported by the Aboriginal Head Start Program for the Academic School Year.

Parent/Caregiver:

Child:

Name: _____

Name: _____

Signature: _____

D.O.B. _____

(Month/Day/Year)

Date: _____

(Month/Day/Year)

FILED TRIP BLANKET PERMISSION

The following form is a Blanket Permission Form which will allow your child to attend and be transported by the Aboriginal Head Start bus to ANY and ALL field trips in and around the Edmonton City limits. Regularly scheduled field trips and activities will be listed on your child's monthly classroom calendar that is handed out at the beginning of each month, and this form will grant permission for your child to attend.

I do understand the above and hereby give my permission for my child to attend ANY and ALL program planned field trips and activities during the Academic School Year.

I do give permission for my child to be transported by the Aboriginal Head Start bus to and from ANY and ALL program planned field trips and activities during the Academic School Year.

I do authorize the Aboriginal Head Start program staff to obtain emergency medical treatment for my child in cases of emergency.

I also understand that I WILL NOT hold the Aboriginal Head Start program liable for injury to my child during ANY or ALL of these planned field trips and activities without just cause.

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____
(Month/Day/Year)

Child:

Name: _____

D.O.B. _____
(Month/Day/Year)

AUDIO/VISUAL RECORDING CONSENT

NO CONSENT GIVEN

I, the Parent/Primary Caregiver of the child listed below, do hereby acknowledge that the Aboriginal Head Start and the amiskwaciy Cultural Society may use, reproduce or distribute any photographs, slides, video or other similar material associated with the program and related events and activities for promotional and archival purposes. There is no time limit to this consent; however, the consent can be revoked at any time with written notice to the Program Manager. Audio and visual recordings will be securely stored at the amiskwaciy Cultural Society office.

PLEASE NOTE: Children in care will need written consent from their Social Worker

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____
(Month/Day/Year)

Child:

Name: _____

D.O.B. _____
(Month/Day/Year)

WAIVER

As the Parent/Primary Caregiver, I hereby understand that the Aboriginal Head Start Program, and the amiskwaciy Cultural Society will not be responsible for the following:

- *Lost or stolen and/or Damage of personal items.
- *Any occurrence, after program hours where a child has been dropped off at specified childcare location. (i.e.: Home, daycare, babysitter)
- *Restricting contact without legal documentation on file. (Both office and school files)

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____
(Month/Day/Year)

Child:

Name: _____

D.O.B. _____
(Month/Day/Year)

PARENT/PRIMARY CAREGIVER PARTICIPATION AGREEMENT

Parent participation plays a major role for the success of the Aboriginal Head Start Program. Your participation as a parent/primary caregiver will benefit the Program as well as yourself and your child. The parent/primary caregiver portion of the Program requires you to become involved. We attempt to be flexible in order to accommodate your hours available. Parent participation is crucial for the continued success of our Head Start program.

I, the Parent/Primary Caregiver, do agree to fulfill my parental/primary caregiver obligation to the Aboriginal Head Start Program. I understand that my participation in the Program will benefit my child and myself as a parent/primary caregiver. This participation may include in person or virtual via program media platforms. I will become involved in the following ways:

- 1** I will attend parent/primary caregiver gatherings/functions subject to program policies and procedures.
- 2** I will ensure my child attends Head Start on a regular basis.
- 3** I will contact the bus driver when my child will not be taking the Head Start Bus.
- 4** I will permit home-visits by Head Start staff regarding my child to access community services subject to program policies and procedures..
- 5** I will volunteer a minimum of 9 hours in the Head Start Program. This could include participation in online meetings, classroom participation, fieldtrips, making play-dough, material preparation or any of the listed below.
- 6** I am willing to contribute to the program by sharing my skills, talents and knowledge in (check as many as apply to you) :

_____ **Traditional foods**

_____ **Storytelling**

_____ **Drumming**

_____ **Crafts**

_____ **Singing**

_____ **Personal Career**

_____ **Other:**

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____

(Month/Day/Year)

ORIENTATION AGREEMENT

This is to verify that I, _____ (first and last name of caregiver) have had the opportunity to go over all the information shared in the Aboriginal Head Start program with a family support worker. I fully understand all information shared and have asked the necessary questions for me to understand what it takes to have my child participate in the Head Start program. I have been informed and completed the following:

_____ **Overview of the application form**

Provided the program with a copy of:

- _____ the child's **Alberta Health Care Card**
- _____ the child's **Birth Certificate**
- _____ the **Delegation of Powers** (if required)
- _____ the child's **Treaty Status Card** (optional)

_____ **Documents Pending:**

- _____ the child's **Alberta Health Care Card**
- _____ the child's **Birth Certificate**
- _____ the **Delegation of Powers** (if required)

_____ **Medication:**

- _____ child requires an **inhaler** and it **has been provided**
- _____ child requires an **inhaler**, but it is **not available**
- _____ child requires an **epi pen** and it **has been provided**
- _____ child requires an **epi pen**, but it is **not available**

<input type="checkbox"/>	Signing of all Parental Consent forms
<input type="checkbox"/>	I understand all Program Policies and Procedures and was given an opportunity to ask questions
<input type="checkbox"/>	I understand the 9 hours commitment for volunteering in the program
<input type="checkbox"/>	I will inform the Aboriginal Head Start program of any changes to parent/caregiver or emergency contact information as soon as they occur
<input type="checkbox"/>	I understand that the program is obligated by law to report to the appropriate authorities should they suspect any form of abuse
<input type="checkbox"/>	I understand that I must inform Aboriginal Head Start if my child has been exposed to anyone with a positive result to any outbreak, epidemic or pandemic that is currently occurring within our city
<input type="checkbox"/>	I understand that if my child is experiencing any new symptoms to a current outbreak, epidemic or pandemic that a staff member may put a mask or other required PPE (personal protective
<input type="checkbox"/>	I understand that this is a "fluid" document and changes may be made to the intake procedures at any time
<input type="checkbox"/>	If I should have any further questions or concerns relating to my child or the program in any way, I will contact my Family Support Worker directly.

If I should have any further questions or concerns relating to my child or the program in any way, I will contact my site family support worker to discuss matters directly.

Parent/Caregiver:

Name: _____

Signature: _____

Date: _____

(Month/Day/Year)

Interviewer:

Name: _____

Signature: _____

Date: _____

(Month/Day/Year)