Sabine Early Childhood Community Network Lead Agency
Enrollment Application 2025 – 2026

REGISTRATION DATE: _____ Enrollment Date: _____

Child's First Name: _____ Child's Last Name: _____
Middle Name: _____ Date of Birth_____

Social Security #_____ Gender: ___ Male ___ Female

Primary Language in the Home: _____ English _____ Other (please specify)
Ethnicity: ___White ___ Black/African American ___ Asian ___ Hispanic/Latino
___ American Indian ___ Native Hawaiian/Pacific Islander ___ Other

Physical Address_____
City_____ State: Louisiana Zip_____
Mailing Address: _____
Email address_____ Phone #:_____

TRANSPORTATION: ___ Parent will bring ___ Ride Bus
Head Start Bus_____Bus Number 1_____ Bus Number 2 _____

My child has my permission to ride the bus to and from school_____
(Parent Signature)

COORDINATED ELIGIBILITY DETERMINATION:

___ SPSB UNIVERSAL PRESCHOOL ___ Faithlynn's Learning Academy

RECEIVED COPY OF:
___Child's Birth Certificate
___ Louisiana Driver's License(parent/guardian)
___ Social Security Card
___Verification of Residency
___Income Verification
___ Insurance Card

ELIGIBILITY
___ Head Start
___ LA-4
___ 8G
___ Local

CERTIFICATION: I certify that this information is true. If any part is false, my participation in this agency's program may be jeopardized. I also understand the information in this application will be held in strict confidence with the Sabine Parish School Board. My signature below is in agreement that any person listed on the emergency list has my permission to receive my child from the bus or from school.

Parent/Guardian Signature:_____ Date_____

Person with whom the child lives:_____

MOTHER:

Last Name: _____ First Name:_____

Street Address:_____ City:_____ Louisiana Zip_____

HOME PHONE: _____ Cell Phone:_____ Work #:_____

FATHER:

Last Name: _____ First Name:_____

Street Address:_____ City:_____ Louisiana Zip_____

HOME PHONE: _____ Cell Phone:_____ Work #:_____

FAMILY & HOUSEHOLD INFORMATION:

Brothers & Sisters	Date of Birth	
1		
2		
3		
4		
5		
Other members:	Date of Birth	Relationship
1		
2		
3		

Does your child have any suspected or identified disabilities? If so, please list them below.

___ No, my child does not have a suspected or identified disability.

___ Yes, Identified Disability:_____

Suspected Disability:_____

Behavioral Needs/Mental Health:_____

Does your child have any food allergies? ___ Yes ___ No

Does your child have any other allergies? ___ Yes ___ No

Does your child have any dietary restrictions? ___ Yes ___ No

Does your child have any special needs or health concerns? ___ Yes ___ No

Please explain any "Yes" answer here

Child's Doctor:_____

Child's Dentist:_____

INDIVIDUALS TO CONTACT IN CASE OF AN EMERGENCY:

NAME:	RELATIONSHIP:	PHONE NUMBER:

My child has permission to be released to the following individuals, childcare facilities or transportation services in addition to emergency contact persons listed above. (Please notify the individuals on the list that they may be asked to show proof of identity)

NAME (FIRST AND LAST)	RELATIONSHIP

Is there a parent/guardian that MAY NOT pick up your child? ___ Yes ___ No *MUST have a court order

Consent for Child's Emergency Medical/Dental Treatment – Screenings & Examinations

I give my consent for the emergency of medical or dental treatment for my child by any licensed physician or dentist while under the care of the Sabine Parish School Board preschool programs and for transport of the child to and from the source of emergency treatment. I also give my consent for my child to receive screenings to identify concerns regarding a child's vision, hearing, developmental, behavioral, mental health, motor, communication, social, cognitive and emotional needs or concerns.

Parent Signature:_____ Date:_____

HOUSEHOLD INFORMATION/ELIGIBILITY WORKSHEET

Primary Parent/Guardian:_____
Live with Child ___ Yes ___ No
Employed or in School: ___ Employed ___ In School ____ Neither Employed or in School
Place of Employment_____ (must have 2 consecutive check stubs)

Secondary Parent/Guardian:_____
Live with Child ___ Yes ___ No
Employed or in School: ___ Employed ___ In School ____ Neither Employed or in School
Place of Employment_____ (must have 2 consecutive check stubs, if you live in the same household with the child)

Number of adults in the household who support children financially____

Family Type:
___ 2 parent family
___ Single parent family
___ Foster Family
___ Other family type: Specify _____

Number of adults in family: _____ Number of children: _____

Income verified by:
____ 2 consecutive check stubs
How often do you receive pay:
___ Weekly ___ Twice a month ____ Every 2 weeks ___ Monthly
Yearly Gross income: $_____
____ An official letter from employer
____ SNAP/TANF (must include child's name and valid effective dates)
____ SSI benefits
____ Declaration of Income for Irregular Employment
____ Zero Income
____ Current foster care placement agreement from DCFS
____ Families in a temporary living arrangement due to loss of house or economic hardship
____ Other (Current year income tax documentation W2/Tax documentation)

Sabine Parish Universal Preschool
Family Partnership Assessment- 1 2025 - 2026

Child's Name: **School:**

Parent/Guardian:

Phone #: **Email address:**

Family Type: ☐ Both parents in the same household ☐ Mother only ☐ Father only
☐ Primary parent and stepparent ☐ Foster ☐ Grandparents ☐ Relative(s) ☐ Other

Does the family receive any of the following services?
☐ WIC ☐ SNAP ☐ TANF ☐ SSI

Can Head Start help you with any of the following services? ☐ Yes ☐ No
☐ Transportation ☐ Housing ☐ Food ☐ Clothing ☐ Medical/Dental ☐ Child Care

Can Head Start provide information in the following areas? ☐ Yes ☐ No

Health & Nutrition	Mental Health	Education	Financial Literacy
☐ Prenatal/Postpartum	☐ Stress/Depression	☐ Family Literacy	☐ Budgeting
☐ Breastfeeding	☐ Domestic Violence	☐ GED/Adult EDUC	☐ Managing Credit/Debt
☐ Education Medical Health	☐ Child Abuse/Neglect	☐ College	☐ Opening a bank account
☐ Education Dental Health	☐ Marriage	☐ Parenting	☐ Retirement Planning
☐ Home Safety	☐ Divorce	☐ Job Search	☐ Child Support
☐ Effects of Tobacco use	☐ Anger	☐ Transition from preschool/Kindergarten	
	☐ Alcohol/Drug Abuse Prevention/Treatment		

Are you interested in information in the following areas? ☐ Yes ☐ No
☐ Stages of child development ☐ Screen time
☐ Children with challenging behaviors ☐ Child positive discipline
☐ Parenting a child with a disability ☐ Male/ Fatherhood Engagement

Has there been any big changes in your child or family's life in the last 6 months?
☐ Death ☐ Parent incarcerated ☐ Financial ☐ Homeless ☐ No transportation ☐ Separation
☐ Substance abuse ☐ Currently expecting Baby's Due Date:_____

Challenges my child may experience during school:
☐ Non-Verbal / Speech Concerns ☐ Frequent toileting accidents ☐ Separation anxiety
☐ Suspected or identified disability ☐ Cultural/Religious beliefs
☐ Behavioral ☐ Other

How often is your child on tablet, phone, computer, or television?
☐ Rarely 0-2 hrs. ☐ Often 3-5 hrs. ☐ Always 6-8 hrs.

My child currently has an IEP: ☐ Yes ☐ No

My child has been evaluated by another clinic or agency, and I have a report: ☐ Yes ☐ No

Sabine Parish Universal Preschool
Family Partnership Assessment- 2 2025 – 2026

Child's Name:

My family goal is:

- ☐ To enroll in school: __College ___GED/Adult Education
- ☐ To complete school (I am already enrolled) _____
- ☐ To read to my child daily/ start a book library
- ☐ To find a job
- ☐ To rent / own my home
- ☐ To complete my child's medical and/dental form
- ☐ Family meal nights
- ☐ Explore new foods
- ☐ Reduce screen time
- ☐ Maintain 85% attendance

☐ *Other*

My goal is: _____

_____

Strategies for accomplishing the goal:

☐ _____

☐ _____

☐ _____

☐ _____

Assigned Responsibilities

Responsible Party	Target Date	Completion Date

Parent(s)/Guardian(s) Signature:	**Date:**
Preschool Staff Signature:	**Date:**

Sabine Parish Universal Preschool
Family Partnership Assessment- 3 2025 - 2026

Child's Name: **Date:**

☐ Home Visit ☐ Center Visit ☐ Registration ☐ Other: _____

The family received information for:

☐ Transportation_____ ☐ Dental_____
☐ Medical_____ ☐ Food_____
☐ Clothing_____ ☐ Housing_____
☐ Child Care_____ ☐ Prenatal/Postpartum Care _____

Health/ Nutrition	***Financial Literacy***	***Mental Health***	***Education***
☐ Nutrition Information ☐ Health Information: asthma, diabetes, allergy, seizures etc. ☐ Preventive medical/oral health ☐ Home safety ☐ Information on consequence of drugs/tobacco/alcohol use	☐ Banking Basis ☐ Financial Planning ☐ Managing credit & debt ☐ Budgeting ☐ Child Support ☐ Tax Credits / Tax filing	☐ Stress/Depression ☐ Domestic Violence ☐ Child Abuse/Neglect ☐ Toilet Training ☐ Marriage Education ☐ Divorce ☐ Anger ☐ Alcohol/Drug Abuse Prevention/ Treatment	☐ Parenting Education ☐ Family Literacy ☐ GED, Adult Education ☐ College ☐ Job Search ☐ Transition between HS to Kindergarten

Other:

☐ Child discipline
☐ Children with challenging behaviors
☐ Stages of child development
☐ Parenting a child with disability
☐ Grandparents raising grandchildren
☐ Single parenting
☐ Blended families
☐ Screen time
☐ Male/ fatherhood engagement

Additional Notes:

Parent/Guardian Signature: _____

Family Engagement Staff: _____

Sabine Parish Universal Preschool
Parent Survey 2025 - 2026

Parent(s)/ Guardian(s) Name: _____

Child's Name: _____ School: _____

Sabine Universal Preschool offers various opportunities for parents to network and get involved in the program. Please take the time to fill out this short survey so we can better serve your needs and get to know your family.

1. What is the best time for you to attend a preschool parent meeting?
   ☐ 9:00 AM ☐ 10:00 AM ☐ 11:00 AM

2. What is the best way to communicate with you in regards to upcoming events & parent trainings?
   ☐ Student folder
   ☐ Social media
   ☐ Students Google Classroom
   ☐ Email

3. I am interested in being a classroom volunteer ☐ Yes ☐No

4. Do you have adequate transportation? ☐ Yes ☐No

5. What is the highest level of education have you completed? ☐ Less than high school graduate ☐ High school degree or GED
   ☐ An associate degree, vocational school, or some college ☐ An advanced degree or baccalaureate degree
   ☐ Interested in furthering your education? ☐ Yes ☐No

6. ☐ At least one parent/guardian is a member of the United military on active duty ☐ No
   ☐ At least one parent/guardian is a veteran of the United States military ☐ No

7. ☐ At least one or more parent/guardian is employed
   ☐ Is one or more parent/guardian in job training
   ☐ Is one or more parent/guardian in school (GED, associate degree, baccalaureate degree, or advanced degree)
   ☐ Neither/No parent/guardian is employed, in job training, or in school at enrollment (unemployed, retired, or disabled)

8. Parent trainings are offered once a month. **Check which topic**(s) interest you the MOST.

Health & Safety	Child Growth & Development	Family Engagement & Education
☐ Child Health ☐ Nutrition ☐ Toilet Training ☐ Child & Pedestrian Safety ☐ Disaster Preparedness ☐ Child Abuse Prevention	☐ Positive Discipline ☐ Language & Literacy ☐ Development Milestones ☐ Brain Development ☐ Managing Challenging Behaviors ☐ Social-Emotional Development ☐ School Readiness ☐ Kindergarten Transition ☐ Understanding Child & Parent Temperament	☐ Volunteering ☐ Parenting Skills ☐ Supporting Children with Disabilities ☐ Job Skills & Training ☐ Parent as Teachers ☐ Stress & Time Management

I acknowledge that a variety of opportunities are offered by the program for my family to participate and be involved in my child's learning and development.

Parent(s)/ Guardian(s) Signature: _____ Date: _____

Sabine Parish Universal Preschool
2025-2026 Child Health Information

Child's Name: School:
Parent/Guardian:
Phone #: Email address:
Does your child have a dentist: ☐ Yes ☐ No Name of child's dentist:
Does your child have a pediatrician or primary care provider: ☐ Yes ☐ No Name of child's doctor:
Please check the type of health insurance your child has: ☐ Private ☐ Medicaid/LaCHIP ☐ None
Please check the type of dental insurance your child has: ☐ Private ☐ Medicaid/LaCHIP ☐ None
Does your child have any major health conditions? ☐ Yes ☐ No ☐ Seizures ☐ Asthma ☐ Fainting ☐ Diabetes ☐ Severe nose bleeds ☐ Other:
Is your child currently taking any medications? ☐ Yes ☐ No If yes, please list the medication, dose, how they take it and what it is for below: _____ _____
Does your child have any allergies? ☐ Yes ☐ No ☐ Seasonal ☐ Insect Bites ☐ Food ☐ Other
Are there any foods your child cannot eat? Religious Beliefs ☐ Yes ☐ No Medical ☐ Yes ☐ No Other
Do you vaccinate your child? ☐ Yes ☐ No If so, are shot records up to date? ☐ Yes ☐ No **If you do not vaccinate sign an exemption today**
Are there any other health conditions that get in the way of your child's everyday activities? ☐ Yes ☐ No
List any other information health information about your child: _____ _____

Sabine Parish School Board

Universal Preschool Programs

Dear Parent or Guardian,

It is a Head Start federal requirement that all children get an initial health and dental screening documented on the forms attached to participate in our preschool program. The blue form is the dental form and must be filled out by the child's dentist, and the green form is the health form which must be filled out by the child's primary care provider. **Both forms should be filled out and returned by June 15th, 2025 to our main office.** Your child will not be allowed to attend school until we confirm that both forms are on file with us.

You may drop off forms physically at our main office which is housed at Many Elementary School. You may fax in your forms to 318-256-0385. If you fax in any forms call our office at 318-256-6143 to confirm we received them.

You may mail forms to:

Sabine Universal Preschool Center
attn: Sarah Andries/ Brittany Founds
P.O. Box 1079
Many, LA 71449

If your child has allergies to food or other items, takes medications regularly, or has any serious medical condition, please reach out to our main office for additional forms. I will be happy to discuss any questions or concerns you have about your child's health. I am here to keep all of our students healthy and safe!

Sincerely,

Sarah Andries, BSN, RN
Sabine Universal Pre-K
Health, Safety, and Nutrition Facilitator

P. O. Box 1079
1501 Natchitoches Hwy.
Many, LA 71449
(318) 256-6143 Fax (318) 256-0385

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

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No

Other: _____
(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.

ATTENTION PROVIDER:

Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including BLOOD LEAD TEST. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child. Please complete all boxes, sign and date, and return this form to the parent.

HEAD START PHYSICAL EXAM (TO BE COMPLETED BY PROVIDER)

PHYSICAL EXAM PERFORMED TODAY (PLEASE CHECK ONE) 3 Yr ☐ 4 Yr ☐ 5 Yr ☐

CHILD'S NAME	DATE OF BIRTH	CENTER

HEALTH CARE PROVIDER INFORMATION

PHYSICAL EXAMINATION ADMINISTERED BY (TYPE OR PRINT NAME)	SIGNATURE

CLINIC/TYPE OF PRACTICE	TELEPHONE NUMBER	DATE OF EXAM

ADDRESS

EXAMINATION RESULTS

HEIGHT: Inches | WEIGHT: lbs/oz | BLOOD PRESSURE

EXAM	Normal	Abnormal	EXAM	Normal	Abnormal	EXAM	Normal	Abnormal
Skin			Mouth/Teeth/ Oral Health Assessment			Genitalia		
						Neurologic		
Head			Throat			Extremities		
Neck			Chest			Motor Ability		
Lymph Nodes			Lungs			Psychological		
Eyes			Heart			Speech		
Ears			Back			Developmental		
Nose			Abdomen			Behavioral		

Vision Acuity		Right	Left	Both	Hearing Screening		Frequency (Hz)	Right (db)	Left (db)
Date		/	/	/	Date		1000 Hz	dB	dB
							2000 Hz	dB	dB
Test Type					Test Type		3000 Hz	dB	dB
							4000 Hz	dB	dB

Hemoglobin

☐ **No Risk, screening not required** (perform if at risk & complete below)

DATE	HGB(g/dl)	TREATMENT ☐ Anemia ☐ Iron Prescribed

Lead

DATE	LEAD LEVEL (mcg/dl)	☐ No Risk

Medicaid requires a lead test between 24 & 72 months if not done at 24 months.

Screening of TB Risk Factors

☐ **Risk factors NOT present: TB SKIN TEST NOT REQUIRED**

☐ Risk factors present: Mantoux TB skin test performed

DATE GIVEN	RESULTS mm	☐ Non Significant	☐ Significant	DATE READ

DATE OF CHEST X-RAY	☐ Normal	☐ Abnormal	RX DATE

Lead Risk Assessment

☐ At Risk ☐ No Risk

Immunizations

GIVEN TODAY ☐ Yes ☐ No List:_____

Provided	Yes	No
Anticipatory Guidance Provided		
Fluoride Varnish Applied		

Diagnosis/Abnormal Findings

Treatment/Restrictions/Recommendations for School

Does the child have asthma? ☐ Yes ☐ No

MEDICATIONS REQUIRED AT SCHOOL ☐ Yes ☐ No **(If yes, Medication Administration form needed)**

Child is physically and emotionally able to participate in program ☐ Yes ☐ No **(If no, please explain in space above)**

TYPE OF MEDICATION AND PURPOSE

7/18 **Distribution:** **White – Child's File** **Canary – Parent**

Form #78 Head Start Physical Exam (NCR)

Date Received Physical Completed Form:_____ **Staff Name:**_____