Youth & Family Services ™

YFS Child Development Center

- 120 E. Adams St., Suite 100 Rapid City, SD 57701
  (605) 342-4233

YFS Home-Based Head Start

- 1920 N. Plaza Blvd.
  Rapid City, SD 57702
  (605) 342-4195
  (800) 568-0202

YFS Rapid City Head Start

- 120 E. Adams St., Suite 100 Rapid City, SD 57701
  (605) 342-4233
- 410 E. Monroe St.
  Rapid City, SD 57701
  (605) 341-6448
- 421 Don Williams Dr.
  Box Elder, SD 57719
  (605) 341-6448

Youth & Family Services Child Development Center and Head Start® Programs

ENROLLMENT APPLICATION

We are pleased that you are applying for our program! Youth & Family Services Head Start is a comprehensive program that provides early childhood education, access to health services and resources, meals and snacks, and advocacy services for enrolled families.

YFS Head Start recognizes parents as the primary educators of their children and actively encourages family partnerships. Through involvement in our program, you will have many opportunities to learn and grow with your child. We look forward to sharing the YFS Head Start experience with you and your family.

STEP 1 **Complete this application**

STEP 2 **Call our offices to schedule a registration appointment.**

Please plan to bring the following documentation to your appointment:

- ❑ Completed application (mandatory for enrollment)
- ❑ Family's proof of income (mandatory for enrollment)
- ❑ Proof of birth
- ❑ Immunization record (current for age as required by SD school immunization law 13-28-7.1)

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Youth & Family Services
Child Development Center and
Head Start Enrollment Application

For CDC Program Use

GrowthStep #:_____ Enrolled Date:_____

Classroom:_____ Age:_____ RCAS:_____

CHILD INFORMATION

First	Middle	Last
Street		City
State	Zip	County
Mailing Address (if different than living address)		
Date of Birth	Gender (circle) Male Female	Primary Language Spoken in Child's Home
Race (please circle all that apply) American Indian/Alaskan Native Black or African American White Asian Native Hawaiian/Pacific Islander		Ethnicity Is this Child Hispanic/Latino? Yes No
Health/Dental Care Information (circle all that apply) Oyate Health Services Medicaid/CHIP Private health insurance Private dental insurance Oyate Dental Services Tri Care No health insurance No dental insurance		
Child's Doctor		Name of Clinic
Child's Dentist		Name of Clinic

PARENT/GUARDIAN WHO RESIDES IN CHILD'S HOME

First	Middle	Last
Date of Birth	Relationship to Child	
Cell Phone ( )	Work Phone ( )	Message Phone ( )
Email		
Employment	Are you employed? (circle) Yes / No If yes, where: _____ If yes, please circle: Full Time / Part Time / Seasonal / Retired / Disabled Are you an active member of the U.S. Military? (circle) Yes / No Are you a veteran of the U.S. Military? (circle) Yes / No	
Education	Please circle highest level completed: Less than high school graduate / high school graduate or GED/ associate degree, vocational school, or some college/ advanced degree or bachelor's degree Are you currently attending school or training if yes, where? _____	
Is this parent covered by health insurance? (circle) Yes / No		

PARENT/GUARDIAN WHO RESIDES IN CHILD'S HOME (IF APPLICABLE)

First	Middle	Last
Date of Birth	Relationship to Child	
Cell Phone ( )	Work Phone ( )	Message Phone ( )
Email		
Employment	Are you employed? (circle) Yes / No If yes, where: _____ If yes, please circle: Full Time / Part Time / Seasonal / Retired / Disabled Are you an active member of the U.S. Military? (circle) Yes / No Are you a veteran of the U.S. Military? (circle) Yes/ No	
Education	Please circle highest level completed: Less than high school graduate / high school graduate or GED/ associate degree, vocational school, or some college/ advanced degree or bachelor's degree Are you currently attending school or training/ if yes, where? _____	
Is this parent covered by health insurance? (circle) Yes / No		

Please list all other persons living in the child's home who are **NOT** included on the previous page.				
Name	Relationship to Child	Date of Birth	Phone Number	Emergency Contact
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

BIOLOGICAL MOTHER/FATHER: LIST HERE IF SHE/HE DOES NOT LIVE IN THE HOME

Name	Address	Phone #
Name	Address	Phone #

Have you ever been married to this person? (circle)
No
Yes, on the pick-up list
Yes, NOT on the pick-up list due to legal documents prohibiting pick up

Is this person and emergency contact for this child? (circle) Yes / No (this may not exclude this person from having access to the child)

EMERGENCY CONTACTS/AUTHORIZATION TO RELEASE CHILD

Persons listed below must be at least 13 years of age. Each person you list will be granted access to your child including visitations, drop-offs, and pick-ups at/from YFS programs and facilities. Persons listed are approved to receive information in regards to your child as needed unless restricted in writing by their parent/guardian. Persons listed will be utilized as alternate points of contact for emergencies. Required to list at least one local contact.

Full Name	Relationship to Child		
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	
Full Name	Relationship to Child		
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	
Full Name	Relationship to Child		
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	
Full Name	Relationship to Child		
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	
Full Name	Relationship to Child		
Address	City	State	Zip
Cell Phone ( )	Home Phone ( )	Work Phone ( )	

CHILD INFORMATION

It is the policy of Youth & Family Services to not discriminate on the basis of race, sex, age, color, national origin, or disabilities in the provision of services and employment. YFS does not discriminate in the provision of services to children with disabilities, including children with diabetes, in all YFS programs, including but not limited to child care, camps, before-after-school programs, classes and recreational programs; the provision of reasonable modifications, including diabetes management, is not limited to urgent, non-routine situations.

List any food allergies/intolerances your child has:_____

Is your child on any special diet prescribed by a health care professional or do you restrict foods because of religious preference? (circle) Yes / No

If yes, please describe:_____

List any skin allergies/intolerances your child has:_____

List any health concerns that may limit activity such as asthma, hearing, vision conditions, high blood pressure, previous surgery, disabling conditions, or other. Write 'none' if nothing applies:_____

Does the identified health concerns require accommodations or modifications? (circle) Yes / No

If yes, please request YFS' Reasonable Accommodations/Modifications packet from program staff. This packet must be completed and returned to the program director before the request can be reviewed.

Do you have any concerns about your child's overall health, development, speech, or social skills? (circle) Yes / No

If yes, please describe:_____

Has your child ever received an evaluation for health or developmental concerns? (circle) Yes / No

If yes, when and where did the evaluation take place:_____

Did the evaluation result in eligibility for the child and family to receive Early Intervention Services? (circle) Yes / No

If yes, is the child currently on an IFSP or IEP? (circle) Yes / No

If yes, please provide a copy of the most current plan for HS and EHS children.

Is your child currently receiving services to address any special needs? (circle) Yes / No

If yes, who is the service provider (example Lifescape):_____

Is your child potty-trained? ☐ Yes (requirement for school-age program) ☐ No

If no, does your child wear diapers or pull–ups? (N/A for School Age) ☐ Yes - size_____ ☐ No

Does your child attend public school? (circle) Yes / No If yes, Where: _____ Current grade: _____

If enrolled in RCAS preschool, circle the days of the week your child attends: M /T /W /TH /F Time: _____

Does your preschooler ride a RCAS school bus? (circle) Yes / No

CUSTODIAL INFORMATION

Who has PHYSICAL custody of this child:_____

Who has LEGAL custody of this child:_____

If DSS has physical or legal custody of this child, who is the caseworker:_____

Is there a protection/restraining order in effect regarding this child? (circle) Yes / No

If yes, please explain and provide a copy with your application:_____

Are there any special visitation orders we should be aware of: (circle) Yes / No

If yes, please explain and provide a copy with your application: _____

PREVIOUS ENROLLMENT INFORMATION

Has anyone in your family previously been enrolled in Early Head Start or Head Start? (circle) Yes / No

If yes, please circle all that apply: YFS Early Head Start / YFS Head Start / YFS Child Development Center / YFS Home-Based / Non-YFS program

ADDITIONAL INFORMATION

What is your current living situation: (circle) Own / rent / motel / shelter or mission / lives with relative /other:_____

How long have you lived at this address:_____

Does your family have access to a reliable means of transportation: (circle) Yes / No

If yes, is it a: (circle) Private vehicle / friend's or relative's vehicle / public transportation

How many vehicles do you have in your household:_____

Are there any concerns or family situations that we should be aware of to help meet your child's needs? (e.g. recent divorce, parental health, a crisis situation, etc.) (circle) Yes / No

If yes, please describe:_____

_____

_____

If you or your partner are currently pregnant, would you like information about YFS' Early Head Start/Home-Based prenatal program? (circle) Yes / No

If your child has younger siblings in the home, would you like information about YFS' Early Head Start? (circle) Yes / No

Does your family receive any of the following types of services or financial assistance? Please circle all that apply.

SSI (Supplemental Security Income) Child Support TANF If yes, please list caseworker:_____

Child Care Assistance SNAP/Food Stamps WIC No Services

How did you hear about our program? _____

Youth & Family Services Consent Form

Child's Name:_____

Please check each of the following items:

	Yes	No	
1			I authorize Youth & Family Services (YFS) to include information about my child/family in YFS programming. I understand this information is distributed to program staff and other enrolled families. This information may include, but is not limited to: child/family name, child/family photographs, child/family achievements or successes, birthdays, and participation in program activities.
2			I authorize my child to participate and accompany his/her class on field trips, including to locations with animals. A parent, guardian, or another responsible adult must supervise children enrolled in YFS' Home-Based Head Start during field trips.
3			I authorize Youth & Family Services to photograph/video me, my child and/or my family. I understand that photographs and footage may be used for the purposes of publicity, illustration, commercials, and in the advertising of a product or service directly related to Youth & Family Services. (Children in custody of the South Dakota Department of Social Services are an automatic "No".)
4			I authorize Youth & Family Services to conduct screenings on my child. This includes, but is not limited to: concepts, language, physical, and social/emotional development.
5			I authorize Youth & Family Services and/or personnel from a collaborating agency to observe my child.
6			I authorize Youth & Family Services to consult with mental health experts to support my child's mental health and social/ emotional well-being.
7			I authorize Youth & Family Services and/or personnel from a collaborating agency to conduct a health screening on my child. I understand that this screening may include height, weight, vision, hearing, and blood pressure for my child.
8			I authorize Youth & Family Services to release my address and/or phone number to collaborating agencies for program use related to screening and assessments.
9			I authorize Youth & Family Services to provide a "Certification of Immunization" and the "Kindergarten Transition Record" to my local school as part of records required for kindergarten registration.
10			I authorize Youth & Family Services to transfer my child's/family's record within Youth & Family Services programs in the event that my child/family transfers/participates from one program option to another.

Confidential Statement

Information shared with Youth & Family Services will be kept strictly confidential unless its release is authorized in writing. These forms will be maintained in locked files.

- I hereby authorize Youth & Family Services to transport my child for all program purposes. Youth & Family Services staff will ensure that children are safely secured in their seats and assist them with buckling seatbelts.
- I hereby give my consent for emergency medical treatment and transportation while my child is in the care of Youth & Family Services. I am aware and understand that I will be responsible for the payment of any medical treatment.
- I understand I have the right to the information in my child's file. Files are kept for three years.
- I hereby release Youth & Family Services from all legal responsibilities or liability that may arise for acts I have authorized.
- I understand that all enrolled Head Start children will be entered into the South Dakota Student Information System to conduct longitudinal studies of the effectiveness of Head Start.
- I understand that Youth & Family Services Head Start uses photographs of my child and on-site cameras for the purpose of safety.
- I would like a copy of this consent form: (circle) Yes / No

Signature(s)_____ Date:_____

Signature(s)_____ Date:_____

Youth & Family Services Head Start/Early Head Start Health History

Child's Name: _____ Date of Birth: ____/____/____ Classroom: _____

Allergies:_____ Medication Allergies:_____ Food Allergies:_____

Child's Physician: _____ Date of Last Appointment: _____ Has Appointment Scheduled:_____

Child's Dentist: _____ Date of Last Appointment: _____ Has Appointment Scheduled:_____

Insurance: □ T-19/CHIP □ Tri-Care □ Oyate □ None □ Private: _____

□ I have little or no knowledge regarding this child's health history.

PREGNANCY/BIRTH HISTORY

		Yes	No	Unsure	Explain "Yes" Answers
1	Did the mother have any health problems during this pregnancy or during delivery?				
2	Did the mother have regular prenatal doctor visits during this pregnancy?				
3	Was the child born outside of a hospital?				
4	Was the child born more than 3 weeks early or late?				
5	What was the child's birth weight? What is the child's current weight?				Birth weight: _____lbs. _____ oz. Current weight: _____lbs. _____ oz.
6	Were there any complications with the child at birth?				
7	Was there an extended hospital stay for medical reasons?				
8	If the child is younger than 1 year, is your baby on formula? If breastfed, check "no".				If on formula, what type/brand:
9	Is the mother currently pregnant?				
10	If yes to number nine, would you like information or an application for YFS' Early Head Start?				
11	Did the mother of the child experience any of the following medical problems during birth/pregnancy? (Circle all that apply) Diabetes Pregnancy-induced high blood pressure C-Section Other:				
12	During pregnancy, did the mother of the child use any of the following? (Circle all that apply) Prescription drugs Alcohol Drugs Tobacco Products Caffeine				

HOSPITALIZATIONS AND ILLNESS

		Yes	No	Unsure	Explain "Yes" Answers
1	Has the child ever been hospitalized or had a surgical procedure?				
2	Has the child ever had a serious accident or illness? (i.e. broken bones, head injuries, burns, poisonings, falls, etc.)				

HEALTH HISTORY / CONCERNS

		Yes	No	Unsure	Explain "Yes" Answers (use additional sheet if needed)
1	Does the child have frequent respiratory tract infections? (colds, cough, runny nose, sore throat)				
2	Does the child appear to have difficulty with their eyes/seeing? (squints, crossed eyes, sits close to television, clumsy)				
3	Is the child wearing or supposed to wear glasses?				If yes, when was their last checkup:
4	Does the child have any problems with their ears/hearing? (frequent ear infections, ear aches, etc.)				Does the child have ear tubes or hearing aids? If yes, where and when did they receive them:
5	Do you have any concerns about the child's speech? (difficult to understand, misses letters, non-verbal, etc.)				
6	Has the child ever had a high fever or seizures? Which?				If yes, when did this last occur:
7	Is the child taking medication for seizures?				If yes, what medication:
8	Has the child ever had any infectious diseases? (chicken pox, measles, mumps, scarlet fever, polio, etc.)				Please list:

		Yes	No	Unsure	Explain "Yes" Answers (use additional sheet if needed)
9	Has the child ever had any of the following: bleeding tendencies, heart disease, liver disease, diabetes, epilepsy, sickle cell disease, rheumatic fever, anemia, pneumonia, bronchitis, asthma				Please list:
10	Has the child ever had or frequently has any of the following: urinary tract infections, nausea, vomiting, diarrhea, constipation, stomach pains, pinworms				Please list:
11	Does the child have any allergies? What symptoms do they get? (rash, itching, swelling, difficulty breathing, sneezing, etc.)				If yes, please list symptoms:
	(a) When eating any foods?				Which foods:
	(b) When taking any medications?				Which medications:
	(c) When near animals, fur, dust, pollen?				Please list:
	(d) When bitten or stung by insects, spiders, etc.?				Please list:
12	Is the child taking any medication(s) for allergies or have an emergency treatment procedure?				If yes, Head Start will need a copy of the emergency procedure including medications. Parent/guardian initials: _____
13	If you answered yes to any of the above conditions, did a doctor or other health professional tell you the child has (had) this?				Which condition(s):
14	If the child has any of the above conditions, do any of these conditions get in the way of the child's everyday activities?				Describe how:
15	Does the child have any identifying birthmarks? (scars, Mongolian spots, other)				What/where:
16	Is the child taking any medication on a regular basis?				What medication(s): Dose:

YFS CHILD SAFETY

		Yes	No	Unsure	
1	Is your child exposed to secondhand cigarette or cigar smoke?				If yes, please circle all that apply: At home In the car At friends/relatives At daycare
2	Is your infant/toddler car seat the correct size for your child?				
3	If you have guns or other hunting equipment, are they kept in a locked area?				
4	Do you have functional smoke alarms in your home?				
5	Are medications and personal care products kept out of reach of children or stored in a locked area?				
6	Are hazardous materials kept out of reach from children or stored in a locked area? (cleaners, laundry products, paints, poisons, etc.)				
7	Do you have approved safety gates at the top and bottom of your stairs?				
8	Do you have outlet covers in your home?				

Parent/guardian signature: _____ Date: _____

Reviewer signature: _____ Date: _____

ANNUAL REVIEW AND UPDATES: PLEASE REVIEW AND UPDATE BOTH SIDES OF THIS FORM AND SIGN/DATE BELOW.*

Parent/guardian signature: _____ Date: _____

Reviewer signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

Reviewer signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

Reviewer signature: _____ Date: _____

**Parent/guardian must explain, initial, and date changes made during annual review.*

Revised 02/08/24

Youth & Family Services Head Start/Early Head Start
Over-The-Counter Permission Form

I give permission for my child, _____, to use the following over-the-counter preparations, should the need arise:

Please Initial	
	Antiseptic wash
	Disinfecting/antibacterial towelettes
	Sunscreen lotion or spray (may contain PABA)
	Insect repellent (may contain DEET)
	Antibiotic wound ointment
	Antibacterial soap
	Diaper cream/baby wipes
	Topical antihistamine lotion (applied to the skin)
	Toothpaste containing fluoride (tooth brushing is monitored by staff)
	Unscented lotion/Vaseline

If your child has had an allergic reaction to any of the above items, please circle the item and explain below:

_____

This is a sample list of the more common items we stock. If your child has had an allergic reaction to **any** other over-the-counter preparation, please indicate below:

This consent is valid during your child's enrollment. Please notify the nurse immediately of any changes or of any medical condition that arises. I hereby release Youth & Family Services from all legal responsibility or liability that may arise from the act authorized above.

_____ _____
(Signature of Parent/Guardian) (Date)

_____ _____
(Signature of Parent/Guardian) (Date)