Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division

Health Insurance Portability and Accountability Act (HIPAA) Privacy Practices

Head Start/Early Head Start Center: _____

Child's Name: _____ **Date of Birth:** _____

I, _____ have received a copy of the Miami-Dade County Notice of Privacy Practices.

_____ _____
Signature **Date**

Yo, _____ he recibido la copia Condado de Miami-Dade Aviso de practicas en respeto de la privacidad.

_____ _____
Firma **Dia**

I, _____ recevoi copi de Conte Miami-Dade, Avi Régleman sou Enfómasyon Pésonél.

_____ _____
Signé **Jodia**

Miami-Dade County
Community Action & Human Services Department
Head Start/Early Head Start Division
Consents and Permissions Form

Date completed: _____

Child Name: _____ **Date of Birth:** _____

Health Consents and Information Release:	**Parents Initials**
☐ Vision Screening	_____
☐ Hearing Screening	_____
☐ Speech Screening	_____
☐ Developmental and Behavior Screening	_____
☐ Blood Pressure Screening	_____
☐ Height and Weight Screening	_____
☐ Anemia (Hemoglobin) Screening	_____
☐ Lead Screening	_____
☐ Vaccines	_____
☐ Oral Health/Dental Evaluation	_____
☐ Medical/Dental/Emergency Consent	_____
☐ First aid treatment for minor injuries	_____
☐ Share health records with the school system and health services providers'	_____
☐ Other: Specify _____	_____

Education Permissions/Releases:	**Parents Initials**
☐ Classroom Observations	_____
☐ Accompany class on field trips	_____
☐ For my child to be in a class photo or photo of classroom activity	_____
☐ Volunteer classroom assistance from CAHSD Foster Grandparent Program or other approved volunteers'	_____

Enrollment Consents and Permissions Signatures

I, _____, hereby give permission to the Head Start/Early Head Start Program to provide the above-mentioned services to my, _____. I understand that by initialing, permission is granted for the specific services.

Parent/Guardian Signature: _____ Date: _____/_____/_____

Relationship (e.g., Legal guardian, Mother, Father) to child: _____

Staff Signature: _____ Date: _____/_____/_____

Print Staff Name: _____

Revised: 04/2017 REP

Miami-Dade County
Community Action & Human Services Department
Head Start/Early Head Start Division
Enrollment – Dietary History Form

Date Completed: _____/_____/_____ Child's Name: _____ Date of Birth: _____

Interviewer/Staff: _____ Parent Interviewed: _____

A. **Infants:**
Eating frequency (times per day): |____|____| Amount consumed in 24 hours: |____|____|____| ounces

Type of food milk:* ☐ Formula: _____ ☐ Breast Milk ☐ Milk ☐ Other: Specify _____

***Miami-Dade Community Action and Human Services Department Head Start Program participates in the Child Care Food Program and will provide the above listed formula.**

Feeding Method: ☐ Breast Fed ☐ Bottle Fed ☐ Other: Specify _____

B. **Toddlers:**
Eating Frequency (times per day): |____|____| What age did the child begin doing each of the following?

Eat solid food: |____|____| months Drink from a cup: |____|____| months Feed self: |____|____| months

Favorite Foods: _____

Least Favorite Foods: _____

	Yes	No	
Does your child take vitamins/mineral supplements?	☐	☐	If yes, what type? _____
Were the supplements prescribed by the physician?	☐	☐	
Does the supplement contain minerals?	☐	☐	If yes, which minerals? _____
*Are there foods that your child cannot eat?	☐	☐	If yes, which foods? _____
*What happens if the food is eaten?			_____
*Does your child require a special diet?	☐	☐	If yes, what type? _____
*Does your child eat anything other than food?	☐	☐	If yes, what is it? _____
*Is there food that you do not want your child to eat?	☐	☐	If yes, which food? _____
*Is there food forbidden for religious or personal reasons?			Please indicate: _____
*Does your child have trouble chewing or swallowing?			Please indicate: _____
*Does your child have problems with constipation or diarrhea?			Please indicate: _____

Food Frequency (daily):

How often does your child consume milk, cheese, and yogurt? _____

How often does your child consume meat, poultry, fish, eggs, legumes, nuts? _____

How often does your child consume rice, grits, bread, cereal, tortillas? _____

How often does your child consume green, yellow, orange vegetables? _____

How often does your child consume fruits and fruit juice? _____

How often does your child consume oil, butter/margarine, shortening? _____

How often does your child consume cakes, cookies, soft drinks, candies? _____

Parent/Guardian Signature: _____ Interviewer Signature: _____

Revised: Feb 2016cw

Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division

MEDICAL/DENTAL EMERGENCY CONSENT FOR MINOR

Child's Name: _____ Birth Date: _____ Age: _____

Home Address: _____ Phone Number: _____

Child Care Center: _____

Child Lives with which parent? _____

Father's Name: _____ Mother's Name: _____

I, _____, _____ give permission for emergency medical and/or
Relationship to child
oral/dental services be provided to my _____as indicated by an appropriate licensed professional. Further, I, _____ give permission, without reservation, for health professional to provide emergency care to my child, and for Head Start to transport my child to and for these services as necessary. I understand that the services provided are deemed necessary or advisable by appropriate licensed professionals. I will be informed of further professional medical and/oral health services that require consent for diagnosis, treatment and/or procedures for a specific medical or oral/dental condition.

		YES	NO
1.	The child is presently under the care of a physician or taking any medication?	☐	☐
2.	The child is subject to prolonged bleeding?	☐	☐
3.	The child has been treated for heart trouble, diabetes, asthma, epilepsy, rheumatic fever, tuberculosis, syphilis, kidney disease, or liver involvements (hepatitis) or any immune deficiencies?	☐	☐
4.	The child has experienced an allergic reaction to aspirin, Novocain, Penicillin or any other drug (i.e., rash, itching or fainting)?	☐	☐
5.	The child has previous medical or oral/dental treatments.	☐	☐
6.	The child suffers from anemia?	☐	☐
7.	The child is in good health at the present?	☐	☐

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Date

Note: This form is valid for the duration of the child's enrollment in the Head Start/Early Head Start Program.

Revised: April 2017 REP

Miami-Dade County
Community Action & Human Services Department
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PARENT AGREEMENT FORM

I AGREE:

		YES	NO
1.	To provide my child's eligibility documents for proof of age and family income, physical examination, immunizations, dental examination, hemoglobin or hematocrit, lead screening, and to keep all such information current and up-to-date throughout the duration of my participation in the program.	☐	☐
2.	To comply with standards as described in the publication, **Know Your Child Care Center.**	☐	☐
3.	To allow pictures of my child to be used in newspapers, displays, bulletin boards, educational publications, films and television presentations for educational, training, and recruitment activities.	☐	☐
4.	To attend the scheduled parent committee meetings on a regular basis. I will also volunteer my time and services to the program as often as possible.	☐	☐
5.	That as a parent, I will accompany my child to their health/dental providers if needed.	☐	☐
6.	That my child may accompany his / her class on scheduled field trips.	☐	☐
7.	That my child will be in attendance every day that he/she is able. I will contact the center when my child cannot attend.	☐	☐
8.	To keep my child at home whenever he/she is affected by a contagious condition or on the advice of Community Action & Human Services Head Start/Early Head Start Division, Delegate Agency staff or health care providers.	☐	☐
9.	To allow Head Start/Early Head Start staff to make home visits during the school year at my convenience.	☐	☐
10.	That if my child is enrolled in an H.M.O./Medipass program, I will be responsible for ensuring that all required health services are completed and a copy of the outcome is returned to the Head Start Program.	☐	☐

To the best of my knowledge, the information on this form is correct. I understand that if any information is found to be incorrect such as: address, telephone number, and/or family size, I am obligated to notify the program immediately. I understand that these records are confidential and that only those persons working directly with my child or family will have access to them. No records will be released to any other agency without written permission from the parent or guardian.

_____ _____

Signature of Parent or Guardian Date Signature of Staff Date

ORIGINAL: To Parent

Community Action and Human Services Department
Head Start/Early Head Start Division

CHILD ABUSE REPORTING REQUIREMENTS
PARENT AGREEMENT OF UNDERSTANDING

This document sets out the legal reporting requirements for all Miami-Dade Community Action & Human Services Department and Delegate Agencies Head Start/Early Head Start Program employees:

- Every employee that works in a child care setting has the legal and ethical responsibility to report suspected child abuse and/or neglect to the proper authorities.
- An individual who knowingly and willfully fails to report or who knowingly and willfully prevents another from reporting are guilty of a misdemeanor and may be prosecuted under Florida Statute Section s.39.201(1), F.S. Any person or agency reporting a case of child abuse in good faith cannot be prosecuted (is immune from any liability).
- IT IS NOT NECESSARY TO HAVE PROOF THAT A CHILD IS ABUSED OR NEGLECTED BEFORE REPORTING CONCERNS. AS MANDATED REPORTERS, WE ARE OBLIGATED TO REPORT WHEN THERE IS "REASONABLE CAUSE TO BELIEVE OR SUSPECT" THAT A CHILD HAS BEEN ABUSED OR NEGLECTED BY PARENT(S) OR CARETAKER(S). IF A PARENT BRINGS THEIR CHILD TO THE CENTER AND THERE ARE INDICATIONS THAT THE CHILD MAY HAVE BEEN ABUSED, THE PARENTS SHOULD INFORM THE STAFF OF WHAT CAUSED THE PROBLEMS.
- The Miami-Dade Community Action & Human Services Department and Delegate Agencies Head Start/Early Head Start Programs complies with Federal and State Laws on Child Abuse and Neglect by ensuring that through the report, the child will be protected and the family will receive the services needed.
- The Miami-Dade Community Action & Human Services Department and Delegate Agencies Head Start/Early Head Start Program employees have the responsibility to cooperate with the local Florida Department of Children and Families (DCF) officials who may appear at the center to investigate a case of suspected child abuse or neglect.

I HAVE READ AND UNDERSTAND THE ABOVE REQUIREMENTS REGARDING SUSPECTED CHILD ABUSE AND NEGLECT REPORTING:

_____ _____
Parent/Guardian Name (Print) Date

_____
Parent/Guardian Signature

_____ _____
Staff Name (Print) Date

_____
Staff Signature

Original-parent/copy-folder Revised: March 2016cw

Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division

Disciplinary Practices Including Positive Behavior Support Procedures
In compliance with Florida Statute section 402.305 (12)(a)(1-3)

The following provides guidance to all Community Action and Human Services Department (CAHSD) Head Start/Early Head Start staff, volunteers and contractors in the requirement for **suppor**t of **positive behavior** and the definition of **acceptable discipline methods** as required by the **State of Florida**. The program will provide all children with support for positive behavior that is conducive to the development of **social competence in young children** in the classroom environment. It provides for the safety and well-being of all children and staff.

1. CAHSD Head Start/Early Head Start staff will provide all children with support for **positive behavior** that is conducive to the development of social competence in an atmosphere that provides safety to all children and staff and an environment in the classroom in which opportunities for learning are optimized. **Children shall not be subjected to discipline which is severe, humiliating,** threatening **or frightening.** Children shall not be shamed, ridiculed or spoken to harshly, abusively or with profanity. Further, **spanking or any other form of physical punishment is prohibited.**

2. Staff will directly teach classroom rules, expectations and behavioral requirements to children on a daily basis at the beginning of the program year and reinforce throughout the day and year. Requests to children will be stated in a positive way, recognizing and effectively praising appropriate behavior. **Redirection** is the first method to be utilized when a child begins to display inappropriate behavior. Children **will not be isolated using "time out"** or other such techniques **which prevent a child** from participating in **scheduled activities** and **routines**. For children who present more aggressive and disruptive behaviors, staff will meet with **parents** to develop a formal **individualized plan** of addressing the child's behaviors that center on concerted efforts by staff to identify and **reinforce appropriate** behaviors for the child, when they occur.

3. Staff should **observe and document situations** that are known to trigger inappropriate behavior anticipate the behavior and have a **plan** to address these situations **before** they occur. CAHSD Head Start/Early Head Start staff will identify children that have demonstrated potentially negative or challenging behaviors in the classroom or at home. Through documented observations, and in collaboration with **parents**, staff will develop strategies that provide for the **individual needs** of the child to find socially acceptable ways in which the child may obtain or remove the causal factors of challenging behaviors and to provide support for positive productive emerging behaviors. **The program's disciplinary practices shall never be associated with food, rest or toileting.**

4. CAHSD Head Start/Early Head Start staff, volunteers and contractors **will not engage** in the **physical restraint** of any child, unless there is a real and present danger of serious injury to the child, other children or staff. When such restraint is used, full and complete documentation of the incident and the actions taken must be reported immediately to the Program Director, Center Director and Grantee administration.

5. Children **shall not be permitted** to intimidate or harm others, harm themselves or destroy property. If a child is having extreme difficulty with self-control, try to lead them from the room. If he or she does not want to go; then distance the group form the child. Consultation and team planning for such children must be scheduled.

I acknowledge that the above **Disciplinary Practices Including Positive Behavior Support procedures** have been reviewed with me and I have been provided a copy of this document.

_____	_____
Parent Signature	Staff Signature
_____	_____
Date	Date

Original-parent/copy-folder *Revised. 4-2017cc*