Preschool & Childcare for your Family

Apply today!

Now accepting applications for 2025-2026 school year

How to apply:

Fill out the attached Application

Or complete the online application at:
champlainvalleyheadstart.org/apply-now

Provide documentation of your income from the last 12 months:

- W-2 form, Federal tax return - Form 1040, or Pay stubs
- Reach Up / RUFA
- 3SquaresVT/SNAP benefits
- Supplemental Security Income (SSI)
- Foster Care Custody Order / Agreement

Income eligibility may apply. Find more information at:
champlainvalleyheadstart.org/apply-now/are-you-eligible

Submit the Application

- Email the Application and income documents to apply-cvhs@cvoeo.org
- Or mail or drop off the Application and copy of the income documents to our Burlington office:

  Champlain Valley Head Start
  255 South Champlain St, Suite 10
  Burlington, VT 05401

Next steps:

Once the application is submitted, we will call you to confirm we have the required income documents.

Questions?

Contact us with questions about eligibility or how to apply!

Or submit an Interest Form on our website.

802-752-9397
apply-cvhs@cvoeo.org
champlainvalleyheadstart.org

CHAMPLAIN VALLEY Head Start

cvoeo

APPLICATION

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

CHILD'S INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	GENDER
				☐ MALE ☐ FEMALE ☐ OTHER
NICKNAME / PREFERRED NAME				

NEED FOR CHILD CARE

Does your family need full-day and/or full-year care for this child (because you are working or in job training)? ☐ Yes ☐ No

If full-day and/or full-year care is not available, are you able to accept a part-time program for your child? ☐ Yes ☐ No

Is your child **currently** receiving full or part time care in (check one)?

Family child care home	☐ Full	☐ Part
Child care center/classroom	☐ Full	☐ Part
Public school pre-K program	☐ Full	☐ Part
Home/another home with relative or other adult	☐ Full	☐ Part
None	☐ Full	☐ Part

If your child is **currently** receiving child care, please specify the name of this program:

My child is currently (check one):

- ☐ Receiving Child Care Financial Assistance
- ☐ Is eligible for Child Care Financial Assistance but not yet receiving
- ☐ Has no financial support for child care

CHILD'S LANGUAGE

The language(s) my child speaks is (are):

The best way to describe the amount of English my child speaks or understands is:

- ☐ None
- ☐ A few words
- ☐ Many words
- ☐ English is the primary language my child speaks

FOOD OR DIETARY RESTRICTIONS FOR CHILD

- ☐ No pork
- ☐ Vegetarian
- ☐ Vegan
- ☐ Other:_____

CHILD'S RACE & ETHNICITY

Race (check all that apply)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other (please specify):

Ethnicity (check one)

- ☐ Hispanic/Latino Origin
- ☐ Non-Hispanic/ Non-Latino Origin

DEVELOPMENT & LEARNING

Check any of the following which apply to your child

- ☐ Autism
- ☐ Developmental Delay
- ☐ Emotional/Behavioral Disability
- ☐ Hearing Impairment / Deafness
- ☐ Impairment of Motor Function
- ☐ Visual Impairment / Blindness
- ☐ Other Health Impairment (please specify):

_____

_____

My child has or has had (please check, if applicable):

- ☐ IEP Date:_____ Completed at/by:_____
- ☐ IFSP Date:_____ Completed at/by:_____
- ☐ Comprehensive Evaluation Date:_____ Completed at/by:_____

Please specify any concerns you may have about your child's behavior or development:

_____

_____

_____

_____

SSI

Does this child receive SSI (Supplemental Security Income?)

☐ Yes ☐ No

CUSTODY/COURT ORDERS

Custody status of this child:

- ☐ One parent has sole legal custody
  Parent's Name:_____
- ☐ Parents are divorced/separated and share legal custody
- ☐ Parents are together, both have custody
- ☐ Child is in the custody of the State of Vermont
  DCF Caseworker:_____
- ☐ Child is in the custody of a legal guardian
- ☐ Other:

Are there any court orders regarding the custody of this child, including DCF or other guardianship orders/documents?

- ☐ No
- ☐ Yes. CVHS must have a copy of this order on file.
  Please include a copy with this application.

APPLICATION Family Information

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start

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FAMILY HOUSING & LANGUAGE

HOUSING ☐ Yes ☐ No Can you and your child go the SAME PLACE, EVERY NIGHT to sleep in a SAFE & SUFFICIENT SPACE?

☐ Yes ☐ No Does your family have stable long-term housing? *(check no if you are currently staying in a shelter/transitional housing*

LANGUAGE The primary language our family speaks at home is:

PARENT/GUARDIAN INFORMATION: 1

FIRST NAME	LAST NAME	DATE OF BIRTH
PREFERRED NAME		GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO CHILD:

☐ MOTHER/FATHER ☐ FOSTER MOTHER/FATHER ☐ GUARDIAN ☐ OTHER:

LIVING ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

PHONE #1: ☐ HOME ☐ CELL ☐ WORK NOTES:

PHONE #2: ☐ HOME ☐ CELL ☐ WORK NOTES:

EMAIL:

Do you have reliable transportation? ☐ Yes ☐ No **Which type?** ☐ Public (bus) ☐ Car ☐ Walking ☐ Other:

DIRECTIONS TO HOME:

EMPLOYMENT

U.S. Military Status

☐ I am currently a member of the U.S. Military

☐ I am a former member of the U.S. Military (Veteran)

☐ I am not/have never been a member of the U.S. Military

Employment Status

☐ Employed Full-time ☐ Unemployed

☐ Employed Part-time ☐ Retired

☐ Employed Seasonally ☐ Disabled

Days & hours you work:

_____

EDUCATION

Job Training/School Status

☐ Not in job training or school

☐ In job training (please provide the name of the program):

_____

☐ In school (please provide the name of the school or program):

_____

Education Level

☐ Less than high school graduate

☐ High school graduate or GED

☐ Some college, vocational school, or Associate's Degree

☐ Bachelor's Degree or advanced degree

LANGUAGE

The language(s) that I speak is (are):

☐ Arabic ☐ English ☐ Maay Maay ☐ Somali

☐ Bhutanese ☐ French ☐ Mandarin ☐ Spanish

☐ Bosnian ☐ Karen ☐ Nepali ☐ Swahili

☐ Burmese ☐ Kirundi ☐ Pashto ☐ Vietnamese

☐ Dari ☐ Lingala

☐ Other: _____

Preferred language for interpreter:

_____

Preferred interpreter:

_____

If English is not your primary language, please mark the choice below that best describes your interpretative needs:

☐ I do not need an interpreter

☐ I would like an interpreter to help complete paperwork only

☐ I would like an interpreter for most/all communication

SSI

Does this adult receive SSI (Supplemental Security Income?)

☐ Yes ☐ No

APPLICATION Family Information

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

PARENT/GUARDIAN INFORMATION: 2

FIRST NAME	LAST NAME	DATE OF BIRTH
PREFERRED NAME		GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RELATIONSHIP TO CHILD:
☐ MOTHER/FATHER ☐ FOSTER MOTHER/FATHER ☐ GUARDIAN ☐ OTHER:

LIVING ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

PHONE #1: ☐ HOME ☐ CELL ☐ WORK NOTES:

PHONE #2: ☐ HOME ☐ CELL ☐ WORK NOTES:

EMAIL:

Do you have reliable transportation? ☐ Yes ☐ No **Which type?** ☐ Public (bus) ☐ Car ☐ Walking ☐ Other:

DIRECTIONS TO HOME:

EMPLOYMENT

U.S. Military Status

☐ I am currently a member of the U.S. Military
☐ I am a former member of the U.S. Military (Veteran)
☐ I am not/have never been a member of the U.S. Military

Employment Status

☐ Employed Full-time
☐ Employed Part-time
☐ Employed Seasonally
☐ Unemployed
☐ Retired
☐ Disabled

Days & hours you work:

_____

EDUCATION

Job Training/School Status

☐ Not in job training or school
☐ In job training (please provide the name of the program):

_____

☐ In school (please provide the name of the school or program):

_____

Education Level

☐ Less than high school graduate
☐ High school graduate or GED
☐ Some college, vocational school, or Associate's Degree
☐ Bachelor's Degree or advanced degree

LANGUAGE

The language(s) that I speak is (are):

☐ Arabic ☐ Bhutanese ☐ Bosnian ☐ Burmese ☐ Dari ☐ English ☐ French ☐ Karen ☐ Kirundi ☐ Lingala ☐ Maay Maay ☐ Mandarin ☐ Nepali ☐ Pashto ☐ Somali ☐ Spanish ☐ Swahili ☐ Vietnamese
☐ Other: _____

Preferred language for interpreter:

_____

Preferred interpreter:

_____

If English is not your primary language, please mark the choice below that best describes your interpretative needs:

☐ I do not need an interpreter
☐ I would like an interpreter to help complete paperwork only
☐ I would like an interpreter for most/all communication

SSI

Does this adult receive SSI (Supplemental Security Income?)

☐ Yes ☐ No

APPLICATION Household Information

HEAD START & EARLY HEAD START PROGRAMS

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HOUSEHOLD INFORMATION

Please list all people living in the home with the family who were not listed previously:

NAME OF PERSON 1:

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

Does this person currently receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

RELATIONSHIP TO CHILD:
- ☐ Aunt/Uncle
- ☐ Cousin
- ☐ Grandparent
- ☐ Sibling
- ☐ Step-parent (legally married to child's parent/guardian)
- ☐ Unrelated child
- ☐ Unrelated adult (including non-married partners of child's parent/guardian)

NAME OF PERSON 2:

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

Does this person currently receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

RELATIONSHIP TO CHILD:
- ☐ Aunt/Uncle
- ☐ Cousin
- ☐ Grandparent
- ☐ Sibling
- ☐ Step-parent (legally married to child's parent/guardian)
- ☐ Unrelated child
- ☐ Unrelated adult (including non-married partners of child's parent/guardian)

NAME OF PERSON 3:

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

Does this person currently receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

RELATIONSHIP TO CHILD:
- ☐ Aunt/Uncle
- ☐ Cousin
- ☐ Grandparent
- ☐ Sibling
- ☐ Step-parent (legally married to child's parent/guardian)
- ☐ Unrelated child
- ☐ Unrelated adult (including non-married partners of child's parent/guardian)

NAME OF PERSON 4:

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

Does this person currently receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

RELATIONSHIP TO CHILD:
- ☐ Aunt/Uncle
- ☐ Cousin
- ☐ Grandparent
- ☐ Sibling
- ☐ Step-parent (legally married to child's parent/guardian)
- ☐ Unrelated child
- ☐ Unrelated adult (including non-married partners of child's parent/guardian)

NAME OF PERSON 5:

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

Does this person currently receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

RELATIONSHIP TO CHILD:
- ☐ Aunt/Uncle
- ☐ Cousin
- ☐ Grandparent
- ☐ Sibling
- ☐ Step-parent (legally married to child's parent/guardian)
- ☐ Unrelated child
- ☐ Unrelated adult (including non-married partners of child's parent/guardian)

NAME OF PERSON 6:

DATE OF BIRTH

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

Does this person currently receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

RELATIONSHIP TO CHILD:
- ☐ Aunt/Uncle
- ☐ Cousin
- ☐ Grandparent
- ☐ Sibling
- ☐ Step-parent (legally married to child's parent/guardian)
- ☐ Unrelated child
- ☐ Unrelated adult (including non-married partners of child's parent/guardian)

APPLICATION Eligibility/Income

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

ELIGIBILITY

Please answer the following questions. If you answer **YES** to any of the questions, your family may be eligible to receive Head Start services.

Is this child currently in foster care (in the custody of the State of Vermont)? ☐ Yes ☐ No

Is your family currently experiencing homelessness (Staying in a shelter, hotel, car, campground, transitional housing unit, or sharing the housing of others due to loss of housing or economic hardship)? ☐ Yes ☐ No

Is your family **currently** receiving the following benefits:

Reach Up: ☐ Yes ☐ No 3SquaresVT/SNAP benefits: ☐ Yes ☐ No Supplemental Security Income (SSI): ☐ Yes ☐ No

CASE MANAGERS

Please list NAME, PHONE, and EMAIL for case managers.

Reach Up: _____

DCF: _____

USCRI: _____

Other: _____

INCOME

If you answered NO to all of the questions above, please complete the following section.

For each type of income that your family received within the last 12 months, you will need to supply documentation.

PARENT/GUARDIAN: 1

NAME OF PARENT/GUARDIAN

Type of Income (check all that apply)	**Have you received this income for all of the last 12 months?**	**How often do you receive this income?**	**Gross Amount** (before taxes)
☐ Military Income	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Self-Employment Income	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Unemployment Compensation	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Wages: Job 1	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Wages: Job 2	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Wages: Job 3	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Other:	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____

PARENT/GUARDIAN: 2

NAME OF PARENT/GUARDIAN (IF LIVING IN THE HOUSEHOLD)

Type of Income (check all that apply)	**Have you received this income for all of the last 12 months?**	**How often do you receive this income?**	**Gross Amount** (before taxes)
☐ Military Income	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Self-Employment Income	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Unemployment Compensation	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Wages: Job 1	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Wages: Job 2	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Wages: Job 3	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____
☐ Other:	☐ Yes ☐ No: _____mos.	☐ Annually ☐ Monthly ☐ Bi-weekly ☐ Weekly	$_____

APPLICATION Additional Information

HEAD START & EARLY HEAD START PROGRAMS

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CHAMPLAIN VALLEY Head Start

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IMMEDIATE FAMILY NEEDS

Please use this space to tell us about any current circumstances affecting your family that may impact your need for immediate school and/or child care for your child.

_____

_____

PRIOR PARTICIPATION IN CVHS

Did this child participate in CVHS's Early Head Start? ☐ Yes ☐ No

Have any of this child's siblings ever participated in the CVHS Head Start or Early Head Start? ☐ Yes ☐ No

If yes, please provide the sibling's name: _____

OUTREACH

Where did you hear about Champlain Valley Head Start (CVHS)? Please check one:

☐ Brochure Poster ☐ CVHS Social Media ☐ Friend/Family Member

☐ CVHS Teacher/Home Visitor ☐ CVHS Website ☐ Newspaper/Magazine Ad

☐ CVHS Collaborative Partner ☐ DCF (Family Services Division)

☐ Service Provider (such as Reach Up, VNA, WIC, please specify): _____

☐ Other (please specify): _____

PARENT/GUARDIAN SIGNATURE

This application signifies the family's desire to enroll the child in the Early Head Start or Head Start program. Following completion of this application, the application will be processed and Champlain Valley Head Start will notify the family as to whether the child has been enrolled in the program, and the starting date for services.

By signing below, I, the parent/guardian, indicate that:

I agree to comply with the rules and regulations of the program.

I certify that the information I have provided on and in support of this application is accurate and truthful to the best of my knowledge. I understand that intentionally providing false, inaccurate, or incomplete information may result in a loss of my family's eligibility to participate in the program.

I consent to have my child participate in all health and developmental screenings or non-invasive exams (including, but not limited to: hearing and vision screenings, heights and weights, visual oral health screening) conducted by Champlain Valley Head Start staff, consultants, collaborative partners or others working in conjunction with Champlain Valley Head Start, to help assure compliance with all federal and state regulations. These may take place outside of the classroom. All screening and exam results and recommendations will be shared with me by the program.

I consent to have my child receive his/her special education and/or mental health services, as outlined in his/her IEP, IFSP/One Plan, and/or treatment plan, during Head Start classroom time. I understand that these services may be provided by special educators, including speech/language pathologists, occupational therapists, physical therapists, and individual assistants, or early childhood mental health professionals and may take place outside of the classroom.

I understand that the Head Start program utilizes the services of early childhood mental health consultants in order to better provide quality education services by increasing the social and emotional well-being of children. I consent to have my child participate in the services provided by the early childhood mental health consultants. The program will notify me in advance of any services provided individually to my child.

I understand that Champlain Valley Head Start sometimes records video and/or takes photographs of programs in operation and the participants present for the following purposes: (1) to support the professional development of teachers and staff; (2) to assist the Behavioral Support Specialist in supporting teaching teams who are working with children with challenging behaviors; and 3) as documentation for child outcomes observation and assessment. Additional permissions may be requested for individual children. All videos will be deleted at the conclusion of the process. Video recordings will not be shared outside of CVHS and its collaborative teaching and child care partners. I consent to have my child participate in a classroom where video recording may occur for the purposes outlined above.

Was this application completed with the help of another person other than the parent/guardian indicated below?

☐ No ☐ Yes: please provide name: _____ Organization (if applicable): _____

Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION & RELEASE

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

RELEASE OF INFORMATION

Head Start & Early Head Start are national programs. Federal regulations require that we obtain certain information in order to determine eligibility for the program and to provide services. In order to best serve your child and family, we sometimes need to share information, in verbal, written, or electronic format, with other agencies. Except as allowed in this authorization and release, Champlain Valley Head Start will not communicate or disseminate any confidential child or family information to organizations or entities outside the organization.

By signing this release, I authorize Champlain Valley Head Start to exchange information with, release information to, and/or obtain information from, the following organizations .

You must check all boxes ☐ that apply if you would like us to be able to speak/share information with these organizations:

☐ Yes ☐ No **The local school district and/or CIS agency responsible for comprehensive evaluation and development of an IFSP or IEP (if needed) for the purpose of**:

- Obtaining documentation of my child's comprehensive evaluation and/or IFSP or IEP in order to provide individualized education services to my child
- Coordinating educational services for my child

☐ Yes ☐ No **The local District Office of the Economic Services Division that administers TANF (Reach Up) and SNAP (3SquaresVT) benefits for the purpose of**:

- Obtaining TANF and/or SNAP documentation to determine eligibility for the Head Start program
- Coordinating the family goal setting process
- Contacting my family if direct communication methods fail

☐ Yes ☐ No **The local school district in which the participant resides for the purpose of**:

- Completing Act 166 / Pre-K registration, including providing documentation for the purposes of proving residency and date of birth of the child
- Determining the status of the child's Act 166 / Pre-K registration

☐ Yes ☐ No **The local Community Care Support Agency that administers the Child Care Financial Assistance program for the purpose of**:

- Obtaining Child Care Financial Assistance documentation to determine eligibility for specific Head Start program options.
- Coordinating the enrollment of my child in Head Start and/or its collaborative partner sites

☐ Yes ☐ No **The local District Office of the Family Services Division for the purpose of**:

- Obtaining documentation to determine eligibility for the Head Start program
- Coordinating family safety/support services

☐ Yes ☐ No **Other** (please specify): _____

USE OF PHOTOGRAPHS/VIDEO

☐ Yes ☐ No I give my permission to Champlain Valley Head Start or its funders/partners to use photos and/or video of my child and/or family with the understanding that my child/family will not be identified by name. Photos or video may be used in newsletters, websites, social media, brochures or other recruitment/outreach/fundraising/promotional materials or reports.

CHILD'S INFORMATION

CHILD'S LEGAL NAME	CHILD'S DATE OF BIRTH

PARENT/LEGAL GUARDIAN'S NAME (PRINTED)

Parent/Guardian Signature: _____ Date:_____

HEALTH RELEASE

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

RELEASE OF HEALTH & SCREENING INFORMATION

Head Start & Early Head Start are national programs. Federal regulations require that these programs obtain documentation to facilitate up to date health requirements for children and pregnant women and any follow up care needed.

Except as allowed in this authorization and release, Champlain Valley Head Start (CHVS) will not communicate or disseminate any confidential child or family information to organizations or entities outside of CVHS and our collaborative partner child care and school sites.

I hereby authorize Champlain Valley Head Start to:

Obtain the following information from health care providers and state registries for the below named child/pregnant woman:

- medical and dental records (including follow-up care with specialists)
- lead and hemoglobin test results
- immunization records
- developmental screening results
- prenatal and postpartum documentation for pregnant women enrolled in EHS

The above information may be either electronic, written or verbal and will be released to:

Champlain Valley Head Start Health or Special Needs Coordinator, Nurse Consultant or Tooth Tutor
255 South Champlain Street, Suite 10
Burlington, VT 05401
(802) 651-4180 X215

Share and discuss results of my child's Head Start screenings (vision, hearing, growth, oral health, and developmental) and health records with my child's health care providers and/or state registries or CVHS collaborative partners in order to provide/support services for my child/family.

Share my child's growth assessment, enrollment and oral health status with WIC and its Public Health Dental Hygienists. If my child is transitioning to public school: share my child's oral health status with the public school Tooth Tutor.

I acknowledge that:

- I may revoke this consent at any time (by contacting CVHS at the address or telephone number above) except to the extent that action has been taken in reliance on it before I revoked it.
- This consent will expire on December 31, 2026.

THE FOLLOWING AUTHORIZATION IS FOR:

CHILD'S LEGAL NAME OR PREGNANT WOMAN'S LEGAL NAME	DATE OF BIRTH

I am the: ☐ Parent ☐ Legal Guardian ☐ DCF Authorized Representative of the above-named child

PRINTED NAME

Parent/Guardian Signature: _____ Date:_____

EMERGENCY

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start

A Program of Champlain Valley Office of Economic Opportunity

CHILD'S HEALTH INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH

Does your child have a doctor? ☐ No ☐ Yes, **Doctor's Name**: | PHONE

Does your child have a dentist? ☐ No ☐ Yes, **Dentist's Name**: | PHONE

Does your child have any health conditions? ☐ No ☐ Yes
Please list conditions: | SYMPTOMS

Does your child take any medications? ☐ No ☐ Yes
Is medication needed on site? ☐ No ☐ Yes | Please list medications:

Does your child have any allergies (including medications, food, bee stings, etc.)?
☐ No known allergies ☐ Yes, please list: | SYMPTOMS

HEALTH INSURANCE

Does your child have health insurance? ☐ No ☐ Yes, please check type:
☐ Medicaid/Dr. Dynasaur ☐ Private ☐ Other: _____

PERMISSION TO PICK UP/PERMISSION TO TRANSPORT

By signing on the Parent/Guardian signature line below, I give my permission for my child to be transported in the event of an emergency. Additionally, I give my permission for my child to be released to the following people for the purposes of pick-up and/or transportation to/from CVHS activity sites. (Include the child's other parent/guardian/family members who may be likely to transport the child.) The parent/guardian understands that his/her child will only be released to persons identified on the following list. Anyone who is unknown to CVHS staff must show identification. I give my permission for my child to be transported to and from CVHS activities by any transportation service with whom CVHS may contract for transportation of children in the CVHS program, and to release the name and address of my child to transportation services contracted by CVHS for the purpose of CVHS activities.

In the event of an emergency, I authorize the staff or collaborative partners of Champlain Valley Head Start to seek any necessary treatment or emergency medical care for my child.

Emergency Contacts: Vermont State Early Childhood Program Licensing Regulations require that at least two (2) emergency contacts, other than the legal parent(s)/guardian(s), be identified.

Emergency Contact People must be able to transport the child in the event of an emergency if the CVHS parent or legal guardian cannot be reached. Emergency contacts must be aware they are designated as such. Emergency contacts unknown to CVHS staff must produce identification before a child is released.

EMERGENCY CONTACT & OTHER PEOPLE AUTHORIZED TO PICK UP CHILD

FIRST CONTACT NAME		RELATIONSHIP TO CHILD	☐ Emergency Contact ☐ Authorized Pick Up
PHONE NUMBER	ALTERNATE PHONE NUMBER	ADDRESS	
SECOND CONTACT NAME		RELATIONSHIP TO CHILD	☐ Emergency Contact ☐ Authorized Pick Up
PHONE NUMBER	ALTERNATE PHONE NUMBER	ADDRESS	
THIRD CONTACT NAME		RELATIONSHIP TO CHILD	☐ Emergency Contact ☐ Authorized Pick Up
PHONE NUMBER	ALTERNATE PHONE NUMBER	ADDRESS	
FOURTH CONTACT NAME		RELATIONSHIP TO CHILD	☐ Emergency Contact ☐ Authorized Pick Up
PHONE NUMBER	ALTERNATE PHONE NUMBER	ADDRESS	

Parent/Guardian Signature: _____ Date: _____

ANTICIPATED PROGRAM OPTIONS LIST

HEAD START & EARLY HEAD START PROGRAMS

UPDATED JANUARY 2025

CHAMPLAIN VALLEY Head Start
A Program of Champlain Valley Office of Economic Opportunity

Attention: Please look for updates for programs.

Instructions: Please use the **CHOICE** column to select your first, second, and third choice options by indicating **1**, **2**, and **3** before the name of the site. Please also indicate below whether you have transportation to this site.

CHOICE	Do you have transportation to the preferred sites selected below? ☐ Yes ☐ No	AGES SERVED: PREGNANT WOMEN	BIRTH–1 YEAR	1–2 YEARS	2–3 YEARS	3 & 4 YEARS	TOWN	DAY	TIME	SESSION	TOWN RESIDENT	ACT 166 APPROVED	CHILD CARE SUBSIDY
ADDISON COUNTY													
	Home Visiting Program (throughout the county) *	●	●	●	●	●	All	1 visit/week		Full Year			
	Otter Creek Child Center		●	●	●		Middlebury	Mon–Fri	7:30am–5:30pm	Full Year			●
	Addison County Early Learning Center: Early Head Start			●	●		New Haven	Mon–Fri	8:30am–2:30pm	Full Year			
	Addison County Early Learning Center: Head Start					●	New Haven	Mon–Fri	8:30am–2:30pm	Sep–Jun		●	
CHITTENDEN COUNTY													
	Home Visiting Program (throughout the county) *	●	●	●	●	●	All	1 visit/week		Full Year			
	Family Connections Program	●	●	●	●		Burlington	2 days/week	9am–12pm	Full Year			
	Burlington Children's Space: Early Head Start		●	●	●		Burlington	Mon–Fri	8am–4pm	Full Year			●
	Burlington Children's Space: Head Start					●	Burlington	Mon–Fri	8am–4pm	Full Year		●	●
	Franklin Square Early Learning Center					●	Burlington	Mon–Fri	8:30am–2:30pm	Sep–Jun		●	
	King Street Center: Early Head Start			●	●		Burlington	Mon–Fri	8am–2pm	Full Year			●
	King Street Center: Head Start					●	Burlington	Mon–Fri	8am–2pm	Full Year		●	●
	Riverside Early Learning Center: Early Head Start			●	●		Burlington	Mon–Fri	8:30am–2:30pm	Full Year			
	Riverside Early Learning Center: Head Start					●	Burlington	Mon–Fri	8:30am–2:30pm	Sep–Jun		●	
	Winooski Early Learning Center					●	Winooski	Mon–Fri	8:30am–2:30pm	Sep–Jun		●	
FRANKLIN & GRAND ISLE COUNTIES													
	Home Visiting Program (throughout the counties) *	●	●	●	●	●	All	1 visit/week		Full Year			
	St. Albans Early Learning Center: Early Head Start		●	●	●		St. Albans City	Mon–Fri	8:30am–2:30pm	Full Year			
	St. Albans Early Learning Center: Head Start					●	St. Albans City	Mon–Fri	8:30am–2:30pm	Sep–Jun		●	

* Home-Visiting for all counties: birth to age 3 is year around, ages 3–5 is school year only.

We will make every attempt to place your child within your preferred option based on program availability, eligibility, and selection criteria.

ADDISON COUNTY

Middlebury
Otter Creek Child Center
150 Weybridge Street

New Haven
Addison County Early Learning Center
87 Rivers Bend Road

Home Visiting Program
90 Minute visit, once a week
At the family's home

CHITTENDEN COUNTY

Burlington
Burlington Children's Space
241 North Winooski Avenue

Franklin Square Early Learning Center
55 Franklin Square

King Street Center
87 King Street

Riverside Early Learning Center
669 Riverside Avenue

Family Connections Program
265 College Street

Winooski
Winooski Early Learning Center
87 Elm Street

Home Visiting Program
90 minute home visit once a week

FRANKLIN & GRAND ISLE COUNTIES

St. Albans City
St. Albans Early Learning Center
39 Barlow Street

Home Visiting Program
90 Minute visit, once a week
At the family's home