



**Tribal Early Childhood Program for Expectant Families,
Infants, Toddlers and Preschoolers**

P.O. Box 67 * 2899 Hwy. 47
Lac du Flambeau, WI 54538
(715) 588-9291 phone * (715) 588-9576 fax
www.ldfheadstart.com website
Become our friend on Facebook!

(SY 23-24)

Dear Parent/Guardian,

This letter is to inform you that now is the time for you to complete the application and intake forms for school year 2023-2024.

Please keep in mind that we are unable to process your application without the following documentation:

1. Application for School Year 2023-2024
2. Income Verification: Last 30 day paystubs or 2022 tax return
3. Verification of Tribal Membership.
4. Intake documents (which are included with the application)
5. Emergency Card

Please call 715.588.4333 or 715.588.9291 if you have any questions. Please leave a detailed message and someone will return your call as soon as possible.

Deb Hagamon
ERSEA/Family Service Manager
(Eligibility, Recruitment, Selection, Enrollment, Attendance)
715.588.4333
debra.hagamon@ldftribe.com



Child Applicant Information

Child's Legal Name: Last _____ First _____ Middle _____

Child's Sex: Male/Female (Circle one) Child's Date of Birth: _____

Child's Ethnicity: Hispanic? Yes/No (circle one) Race: AI/AN Asian Black White
Pacific Islander (circle one)

Child's Primary Health Provider: _____

Child's Primary Dental Provider: _____

Additional Applicant

Child's Legal Name: Last _____ First _____ Middle _____

Child's Sex: Male/Female (Circle one) Child's Date of Birth: _____

Child's Ethnicity: Hispanic? Yes/No (circle one) Race: AI/AN Asian Black White
Pacific Islander (circle one)

Adult Information

Name	Relationship	D.O.B	Gender/Race	Hispanic
				Y or N
				Y or N

Circle one: Single Parent/Two Parent Family Foster Grandparents Other

Employment

Proof of income will need to be provided for all parents/guardians living in the same household.

Are parents/guardians employed? Yes/No (circle one)

Annual Income

If yes, who? _____ Full-time/Part-time (circle one)

Additional _____ Full-time/Part-time (circle one)

Family Information

Home address _____ City _____ Zip _____

Mailing address (if different) _____ City _____ Zip _____

Phone

Name:	Home	Cell	Work

Primary Language: _____

Insurance provider: _____

Circle any or all that apply: Active Military/Referred

Circle any or all that apply: TANF/SSI

Zaasijiwan Head Start

Phone: 715-588-4333

Fax: 715-588-9576

Email: debra.hagamon@ldftribe.com



**OFFICE
USE ONLY**



Date Received: _____ Staff Initials: _____ Application # _____ Site: _____

This application does not ensure enrollment. You will be notified regarding the status of your application as soon as possible.



**HEAD
START**

Additional Child

Child's Legal Name: Last _____ First _____ Middle _____

Child's Sex: Male/Female (Circle one) Child's Date of Birth: _____

Child's Ethnicity: Hispanic? Yes/No (circle one) Race: AI/AN Asian Black White
Pacific Islander (circle one)

Additional Child

Child's Legal Name: Last _____ First _____ Middle _____

Child's Sex: Male/Female (Circle one) Child's Date of Birth: _____

Child's Ethnicity: Hispanic? Yes/No (circle one) Race: AI/AN Asian Black White
Pacific Islander (circle one)

Additional Child

Child's Legal Name: Last _____ First _____ Middle _____

Child's Sex: Male/Female (Circle one) Child's Date of Birth: _____

Child's Ethnicity: Hispanic? Yes/No (circle one) Race: AI/AN Asian Black White
Pacific Islander (circle one)

Additional Child

Child's Legal Name: Last _____ First _____ Middle _____

Child's Sex: Male/Female (Circle one) Child's Date of Birth: _____

Child's Ethnicity: Hispanic? Yes/No (circle one) Race: AI/AN Asian Black White
Pacific Islander (circle one)

Parent Signature _____ Date _____

Zaasijiwan Head Start

Phone: 715-588-4333

Fax: 715-588-9576

Email: debra.hagamon@ldftribe.com



Please answer the following questions as completely as possible. It will help us determine the urgency of your family's needs.

Has this child been previously enrolled in?

- ☐ Head Start
- ☐ Early Head Start

Was the child born 3 or more weeks premature?

- ☐ Yes
- ☐ No

Is a sibling currently enrolled in EHS/HS?

- ☐ Yes If yes, who?
- ☐ No

Parent/Guardian disabled?

- ☐ Yes
- ☐ No

List the number of immediate family members in the household _____.

Is the child an enrolled tribal member or descendant?

- ☐ Yes If yes, complete: Eligibility Certification Form
- ☐ No

Is your family served by another community agency (WIC,SNAP/FoodShare,TANF)?

- ☐ Yes if yes, who? _____
- ☐ No

Are you a teen parent?

- ☐ Yes
- ☐ No

Are you doubled up, sharing housing due to loss of housing or economic hardship?

- ☐ Yes if yes, complete: Child/Family Housing Questionnaire
- ☐ No

Are you living in emergency shelters, motels, cars, parks, public spaces or substandard housing?

- ☐ Yes if yes, complete: Child/Family Housing Questionnaire
- ☐ No

Is a household member acquiring/learning another language in addition to English?

- ☐ Yes if yes, which language?
- ☐ No

What is your highest level/grade completed? **(Both parent/guardians-List individuals)**

- ☐ Associate's
- ☐ Bachelor's
- ☐ Some college
- ☐ GED
- ☐ High School Diploma
- ☐ Masters

Please check any environmental issues affecting the child/family.

- ☐ Diagnosed Disability/IEP/IFSP/Mental Health Diagnosis
- ☐ Developmental Concern
- ☐ Behavioral Concern
- ☐ Social/Emotional Concern
- ☐ Full time work/school
- ☐ Part time work/school
- ☐ Childcare Needed
- ☐ Living with Custodial Grandparent/Relative/Kinship
- ☐ Death of Parent/Guardian/Caregiver
- ☐ Family Crisis (domestic abuse, neglect, AODA, incarceration, probation/parole, death, illness)
- ☐ Pregnant Parent/Guardian
- ☐ Parent without a high school diploma or equivalent
- ☐ No Transportation/Use Public Transportation

Additional forms **MUST be completed to complete the application interview process** Check all that have been completed

- ☐ Emergency Card
- ☐ Income Verification Form (If receiving income)
- ☐ Zero Income Statement (if not receiving income from any source)
- ☐ Child/Family Housing Questionnaire (If family is homeless)
- ☐ Tribal Eligibility Certification (if tribal member or descendant)
- ☐ Intake
- ☐ SNAP/FoodShare/Food Distribution Authorization

Zaasijiwan Head Start program includes many family support services. Parents will be asked to work with the program by: Completing a Family Partnership Agreement, helping with classroom activities, participating in regular home visits, ensuring their child attends regularly, communicating with program staff and by obtaining regular health and dental care for their child.

Parent/Guardian Signature: _____ Date: _____

Family Services Department Signature: _____

Date: _____



Zero Income Statement for School Year 2023-2024

This statement is to certify that I am not receiving income from any source whatsoever.

- ☐ I am not employed through any private or public employer.
- ☐ I am not receiving unemployment compensation benefits.
- ☐ I am not receiving Social Security benefits or any type of annuity benefits.
- ☐ I am not receiving Temporary Disability Assistance Payments for Adults, Temporary Cash Assistance, or Pension or Veteran's Benefits.

*****If more than one adult in the household is claiming "zero income" you will need to provide a signed copy of this form for each adult member.*****

If your total family income is "0" and has been for at least one (1) month prior to the date of this application, please explain how you are meeting your living expenses.

⇒ How do you pay for your housing/utilities?

⇒ How do you pay for clothing?

⇒ How do you pay for transportation?

I understand that in signing this form I am knowingly and willingly reporting that I have a "zero income" household. I also understand that by signing this form I am not reporting any false or fraudulent information.

I certify that this information is true, complete, and correct.

Parent/Guardian Signature

Date

Family Services Signature

Date

Income Verification for School Year 2023-2024

I certify that I have provided the following income documentation for my family
Proof of income is required with your application. No family may be enrolled without required documentation.

- | | |
|---|---|
| <input type="checkbox"/> Federal Income Tax [1040] \$ _____
<input type="checkbox"/> W2 Statement \$ _____
<input type="checkbox"/> Payroll check stub \$ _____ | <input type="checkbox"/> Written statements from employers
<input type="checkbox"/> Other, specify _____ |
|---|---|

Family member #1 monthly income _____
 Family member #2 monthly income _____
 Total household monthly income _____
X 12

Total household annual income \$ _____ **Number in Family** _____

2021 POVERTY / FAMILY INCOME GUIDELINES FOR HEAD START PROGRAMS [EXCEPT FOR HEAD START PROGRAMS IN ALASKA AND HAWAII]

Size of Family Unit	Annual Income
1	\$14,580
2	\$19,720
3	\$24,860
4	\$30,000
5	\$35,140
6	\$40,280
7	\$45,420
8	\$50,560

For family units with more than 8 members, add \$5,140 for each additional member.

Child's Eligibility is: over income _____ under income _____

Under penalty of perjury, I affirm that I am the parent or legal guardian of the child applying for Zaasijiwan Head Start 0 to 5, and that, to the best of my knowledge, all the information that I have provided is complete and correct. I understand that if I deliberately misrepresent my family circumstances, my family may not be eligible for further services.

Parent/Guardian Signature

Date

Family Services Signature

Date





Child/Family Housing Questionnaire for SY 2023-2024

Your child may be eligible for additional services through the federal McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

1. Where are you and your family currently staying? **Check one box**

- ☐ Sharing the housing of another family (i.e., doubling-up) due to loss of housing, economic hardship or similar reason.
- ☐ Living in a motel, hotel, trailer park, or campground because we cannot afford or find affordable housing.
- ☐ Staying in an emergency or transitional shelter.
- ☐ Living in a vehicle of any kind; in an abandoned building or substandard housing without running water/electricity; or in a park, bus or train station.

2. Please check all that apply.

- ☐ Child is living with an adult that is not a parent or legal guardian.
- ☐ Child is awaiting foster care placement.
- ☐ None of the above. Child is my own child.

3. Please describe the child who "lacks a fixed, regular, and adequate nighttime residence."

Name of Child/Children			Male/Female	Date of Birth
First	Middle	Last		

The undersigned certifies that the information provided above is accurate.

Parent/Guardian Signature

Date

Physical Address

City

State

Zip

Phone number

Head Start Use Only

FS Manager: Based on the above information (where one or less of the "None of the above" boxes are checked) and a brief interview with this family, I attest that to the best of my knowledge the child is eligible for benefits under the McKinney-Vento Act.

Family Services Signature

Date



U.S. Department of Education
Office of Indian Education
Washington, DC 20202
TITLE VI ED 506 INDIAN STUDENT ELIGIBILITY CERTIFICATION FORM

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count. You are not required to complete or submit this form. However, if you choose not to submit a form, your child cannot be counted for funding under the program. This form should be kept on file and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

STUDENT INFORMATION

Name of the Child _____ **Date of Birth** _____ **Grade** _____
(As shown on school enrollment records)

Name of School _____

TRIBAL ENROLLMENT

Name of the Individual with tribal enrollment: _____
(Individual named must be a descendent in the first or second generation)

The individual with tribal membership is the: _____ Child _____ Child's Parent _____ Child's Grandparent

Name of tribe or band for which individual above claims membership: _____

The Tribe or Band is (select only one):

- _____ Federally Recognized
- _____ State Recognized
- _____ Terminated Tribe (Documentation required. Must attach to form)
- _____ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994. (Documentation required. Must attach to form)

Proof of enrollment in tribe or band listed above, as defined by tribe or band is:

A. Membership or enrollment number (if readily available) _____ OR

B. Other Evidence of Membership in the tribe listed above (describe and attach) _____

Name and address of tribe or band maintaining enrollment data for the individual listed above:

Name _____ **Address** _____
City _____ **State** _____ **Zip Code** _____

ATTESTATION STATEMENT

I verify that the information provided above is accurate.

Name Parent/Guardian _____ **Signature** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Email Address _____ **Date** _____

INSTRUCTIONS FOR THE ED 506 FORM

FOR APPLICANTS:

PURPOSE: To comply with the requirements in 20 USC 7427(a), which provides that: "The Secretary shall require that, as part of an application for a grant under this subpart, each applicant shall maintain a file, with respect to each Indian child for whom the local educational agency provides a free public education, that contains a form that sets forth information establishing the status of the child as an Indian child eligible for assistance under this subpart, and that otherwise meets the requirements of subsection (b)".

MAINTENANCE: A separate ED 506 form is required for each Indian child that was enrolled during the count period. A new ED 506 form does **NOT** have to be completed each year. All documentation must be maintained in a manner that allows the LEA to be able to discern, for any given year, which students were enrolled in the LEA's school(s) and counted during the count period indicated in the application.

FOR PARENTS/GUARDIANS:

DEFINITION: Indian means an individual who is (1) A member of an Indian tribe or band, as membership is defined by the Indian tribe or band, including any tribe or band terminated since 1940, and any tribe or band recognized by the State in which the tribe or band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

STUDENT INFORMATION: Write the name of the child, date of birth and school name and grade level.

TRIBAL ENROLLMENT INFORMATION: Write the name of the individual with the tribal membership. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one name: either the child, child's parent or grandparent, for whom you can provide membership information.

Write the name of the tribe or band of Indians to which the child claims membership. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally-recognized tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. If Terminated Tribe or Organized Indian Group is elected, additional documentation is required and must be attached to this form.

- **Federally Recognized-** an American Indian or Alaska Native tribal entity limited to those Indigenous to the U.S. The Department of Interior maintains a list of federally-recognized tribes, which OIE can provide you upon request.
- **State Recognized-** an American Indian or Alaska Native tribal entity that has recognized status by a State. The U.S. Department of Education does not maintain a master list. It is recommended that you use official state websites only.
- **Terminated Tribe-** a tribal entity that once had a federally recognized status from the United States Department of Interior and had that designation terminated.
- **Organized Indian Group-** Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Write the enrollment number establishing the membership of the child, if readily available, or other evidence of membership. If the child is not a member of the tribe and the child's eligibility is through a parent or grandparent, either write the enrollment number of the parent or grandparent, or provide other proof of membership. Some examples of other proof of membership may include: affidavit from tribe, CDIB card or birth certificate. Write the name and address of the organization that maintains updated and accurate membership data for such tribe or band of Indians.

ATTESTATION STATEMENT: Provide the name, address and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

The Department of Education will safeguard personal privacy in its collection, maintenance, use and dissemination of information about individuals and make such information available to the individual in accordance with the requirements of the Privacy Act.

PAPERWORK BURDEN STATEMENT According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W203, Washington, D.C. 20202-6335. OMB Number: 1810-0021 Expiration Date: 02/29/2020.

Home Phone: _____ Cell Phone: _____		Zaasijiwan Head Start EMERGENCY CARD	
Email: _____			
Student Name: (Last Name, First Name)		(Circle One) M F	Birth Date: ____/____/____ (Circle One) EHS/HS
Height: _____		Lives with: (Choose One)	
Weight: _____		<input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Other	
Hair Color: _____		OTHER/Name: _____	
Eye Color: _____		Relationship to Student: _____	
Child's Physical Address: _____		Any legal documents regarding guardianship? YES NO	
Mailing Address: _____		City/State/Zip _____	
Father's Name/Day Phone # _____		City/State/Zip _____	
Mother's Name/Day Phone # _____		Father's Employer with Phone # _____	
		Mother's Employer with Phone # _____	

Name & Phone Number of Person(s) with permission to transport my child to or from school.

If I can not be reached in the event of illness, injury or transportation needs, please contact the following individuals to receive my child and current health information in the order listed. They must be able to provide transportation. (Please have the person's permission before you list them.)

Name/Relationship: _____	Phone Number/Address: _____
Name/Relationship: _____	Phone Number/Address: _____
Name/Relationship: _____	Phone Number/Address: _____

Did your child ever have or does your child now have:								
Yes	No	Check Each Item	Yes	No	Check Each Item	Yes	No	Check Each Item
		Allergies			Physical Disability			Frequent Headaches
		Arthritis			Eye Glasses/Contacts			Heart Condition
		Asthma			Epilepsy/Seizures			Meningitis
		Bedwetting			Frequent Earaches			Kidney Problems
		Bone, joint, or muscle problems			Frequent colds or sore throats			Excessive gain or loss of weight
		Chickenpox			Frequent Stomach Aches			Skins Problems
		Diabetes			Hay Fever			Tuberculosis
		Attention Deficit Disorders (ADD)			Emotional problems or depression			Tumors, growths, cysts, cancer
		Hearing Problems			ENTER DATE OF LAST TETANUS SHOT: ____/____/____			

Are there any other health problems or family matters that would be helpful for the school nurse to know about? NO YES, Explain Please

Check each item YES or NO. Every item checked YES must be fully explained at right.

YES	NO	EXPLANATION
		Does the child take routine medication? If yes, give type, amount, and reason.
		Do you know of any reason to limit your child's physical activities?
		Has your child had any severe reactions or allergies to drugs, foods, bites or stings?
		Any special emergency instructions?
		Please call and speak with the school nurse at 588-9291.

It is my understanding that if emergency treatment is required and I cannot be reached, school authorities may assume responsibility of notifying the doctor indicated and/or Emergency Medical Services unless I have provided written notice to the contrary to the program director.

DOCTOR AND/OR CLINIC NAME: _____	Phone number: _____
Signature of Parent/Guardian: _____	Date Signed: _____



Authorization to Release and Obtain Information

2899 Highway 47 * Lac du Flambeau * WI * 54538 * (715)588-9291 * FAX: (715)588-9576

Name of Child _____ Date of birth _____

Name of Parent _____ Date of birth _____

SNAP as Public Assistance for Head Start Eligibility

***Families eligible for or receiving benefits from SNAP (FoodShare) and FDPIR (Food Distribution Program on Indian Reservations) will be included in categorical eligibility for Head Start services.

The Administration for Children and Families (ACF) strives to ensure that programs minimize the burden on families seeking public assistance and to coordinate benefit programs in such a way that families who are eligible for one benefit program can more easily participate in other services for which they are eligible. ACF issued an Information Memorandum (IM) to set forth its interpretation of the phrase "public assistance" in Sec. 645 of the Head Start Act to include the Supplemental Nutrition Assistance Program (SNAP). Adopting this interpretation will make it easier for eligible families to enroll children in Head Start services by allowing families to demonstrate proof of SNAP receipt or eligibility to enroll in Head Start and will simplify the process of determining program eligibility for grantees. For the purposes of Head Start eligibility determination, the Office of Head Start (OHS) will expand its interpretation of "public assistance," as used in the Head Start statute, to include SNAP and FDPIR.

Economic Support Agency PO Box 67, Lac du Flambeau, WI 54538

☐ SNAP/FoodShare verification

Food Distribution Program PO Box 67, Lac du Flambeau, WI 54538

☐ Food Distribution verification

Signature of Parent/Guardian

Date

Parent/Guardian Authorization/Permission

This authorization is valid for SY 23-24 (expires July 31, 2024). I understand that I may revoke this authorization at any time by submitting written notice of withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release the information.

Families who only received P-EBT benefits will not count as public assistance for Head Start categorical eligibility.



Authorization to Screen, Obtain, and Release Information

2899 Highway 47 • Lac du Flambeau • WI 54538 • 715-588-9291 Fax 715-588-9576

Name of Child _____ Date of Birth ____/____/____

HIPPA – Compliant authorization to screen, obtain, exchange, or release health, education information and/or use of child's photograph/video for ZHS activities:

Zaasijiwan Head Start 0 to 5 Program PO Box 67, Lac du Flambeau, WI 54538

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Health/Oral Health Screening and Results | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mental Health and Developmental Screening and Results | |
| <input type="checkbox"/> Blood/Lab Screening and Results | |

Peter Christensen Health Center PO Box 67, Lac du Flambeau, WI 54538

- | | |
|---|---|
| <input type="checkbox"/> Health Records and Examination Results | <input type="checkbox"/> Referral follow-up |
| <input type="checkbox"/> All Screening/Rescreening and Results | <input type="checkbox"/> Other _____ |

Peter Christensen Dental Clinic PO Box 128, Lac du Flambeau, WI 54538

- | | |
|---|---|
| <input type="checkbox"/> Dental Screening and Results | <input type="checkbox"/> Referral/follow-up |
| <input type="checkbox"/> Dental Examination/Treatment and Results | <input type="checkbox"/> Other _____ |

Marshfield Clinic – Minocqua Center and FHC 9601 Towline Road, Minocqua, WI 54548

- | | |
|---|--|
| <input type="checkbox"/> Health Records and Examination Results | <input type="checkbox"/> All Screening/Rescreening and Results |
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Referral follow-up | |

Human Service Center 705 E Timber Drive, Rhinelander, WI 54501

- | | |
|---|---|
| <input type="checkbox"/> Developmental screening and results | <input type="checkbox"/> Referral follow-up |
| <input type="checkbox"/> Individual Family Service Plans (IFSP) | <input type="checkbox"/> Other _____ |

Lac du Flambeau Public School 2899 Highway 47, Lac du Flambeau, WI 54538

- | | |
|---|---|
| <input type="checkbox"/> All official student records and reports | <input type="checkbox"/> All Health Records and Screening Results |
| <input type="checkbox"/> Individualized education plans (IEP) and related reports | <input type="checkbox"/> Other _____ |

Family Resource Center PO Box 67, Lac du Flambeau, WI 54538

- | | |
|--|--|
| <input type="checkbox"/> Psychological observation reports | <input type="checkbox"/> Behavioral observations |
| <input type="checkbox"/> Referral follow-up | <input type="checkbox"/> Other _____ |

GLITC PO Box 9, Lac du Flambeau, WI 54538

- ☐ Permission to share family information for referral of services.

Family Services PO Box 67, Lac du Flambeau, WI 54538

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Guardianship/Custodial/Placement Documents | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Referral follow-up | |

Parental / Guardian Authorization/Permission

This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. This authorization also gives permission for ZHS and community care partners to perform required screenings and observations of participants. I recognize that these records, once received by the agency, may not be protected by the HIPPA Privacy Act and may become educational records protected by the Family Educational Rights and Privacy Act-FERPA with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to participate in this program. I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the information I have authorized to be used or disclosed by this authorization form. Arrangements to inspect this information can be made by contacting the Zaasijiwan Head Start-ZHS Director.

Signature of Parent or Guardian

Date

(Fax or photocopy effective as original)(Copies to parent/guardian, physician or other health care provider releasing the protected health information, school official requesting/receiving the protected health information, student SpEd file. Information also to be used to maintain health status record for participants in a Federal program.)