

Chi cho otsk ati (House of Children) Enrollment Application

Please check the programs you are interested in: BabyFACE Birth-3 Child Care Head Start

CHILD'S NAME (Last, First, MI)	D.O.B.	AGE	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female
CHILD'S ETHNIC ORIGIN <input type="checkbox"/> Hispanic or Latino origin <input type="checkbox"/> Non-Hispanic or Non-Latino origin	CHILD'S RACE <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Biracial/Multiracial <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other		
CHILD'S SSN	CHILD'S TRIBAL ID	HOME PHONE #	CELL PHONE #
CHILD'S PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
CHILD'S MAILING ADDRESS	CITY	STATE	ZIP CODE
LANGUAGE SPOKEN IN HOME <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	WHO HAS CUSTODY OF CHILD? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parents <input type="checkbox"/> Other: _____	MARITAL STATE OF GUARDIAN <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	FAMILY SIZE
INDIVIDUALS LIVING AT RESIDENCE WITH CHILD: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Non-relatives <input type="checkbox"/> Significant Other <input type="checkbox"/> Other Relatives (aunts, uncles, etc.)	D.O.B.	MOTHER'S SSN	
MOTHER/GUARDIAN'S NAME (Last, First)	EMPLOYER PHONE #	EMPLOYER ADDRESS	
MOTHER'S PLACE OF EMPLOYMENT	D.O.B.	FATHER'S SSN	
FATHER/GUARDIAN'S NAME (Last, First)	EMPLOYER PHONE #	EMPLOYER ADDRESS	
FATHER'S PLACE OF EMPLOYMENT			

Child is/has:

- Enrolled Quileute Tribal Member
- Quileute Tribal Descendent (not enrolled)
- Native American/descendent enrolled in a Federally Recognized Tribe
- Native American/descendent enrolled in Tribe **not** Federally Recognized
- Disability-IFSP
- Disability-IEP
- Disability-Documented but no IEP
- Disability-Behavioral/Mental Health Issues
- Prekindergarten
- 3 Years Old
- Returning Student
- CPS Referral
- Other Agency Referral

Check all that apply to family:

- TANF services
- WIC services
- SSI
- Teen Parent
- Single Parent
- Homeless
- Family Drug/Alcohol Abuse
- Disabled Parent/Sibling
- Foster Parent
- At or Below Poverty Guidelines
- Between 100% -130% of Poverty Guidelines
- Both Parents are High School Non Graduates
- One Parent is a High School Non Graduate
- Family Lives and/or Works in La Push

List names and birthdates of other **children** living in the home:

Name: _____

Name: _____

Name: _____

Name: _____

D.O.B. _____

D.O.B. _____

D.O.B. _____

D.O.B. _____



**Quileute Head Start
TRANSPORTATION INFORMATION FORM**

****This form must be updated in order for ANY changes to be made to your child's bus route. Please request a new form in advance (i.e. if you move, change of babysitter, etc.) Any changes that are not listed on this form will NOT be accepted. ****

Pick up Location

Name & Phone Number

Physical Address

Drop Off Location

Name & Phone Number

Physical Address

Please list people who can be contacted in case no one is home at the time of drop off.
Please prioritize this list in the order in which you would like these individuals to be contacted.

1) Name: _____ Phone #: _____

Physical Address: _____

2) Name: _____ Phone #: _____

Physical Address: _____

3) Name: _____ Phone #: _____

Physical Address: _____

4) Name: _____ Phone #: _____

Physical Address: _____

5) Name: _____ Phone #: _____

Physical Address: _____

Parent/Guardian Signature

Date

**Quileute Head Start
CONSENT FORM**

Child's Name: _____ **Age:** _____ **DOB:** _____

Chi cho otsk ati has my permission for the following:

- In an emergency, the Chi cho otsk ati staff has permission to call an ambulance or transport my child to a physician or hospital.
- In an emergency, the Chi cho otsk ati staff has permission to make medical decisions concerning my child, except for these restrictions:

My child may be given the following non-prescribed topical medication:

- First Aid Ointment
- Band Aid/Bandages
- Sunscreen

My child may be taken on field trips or to dental appointments/health screenings by bus or a staff member's personal vehicle under proper supervision and use of a car seat:

- Yes
- No

My child may be photographed for publication or news purposes:

- Yes
- No

My child's photograph may be posted on Quileute Head Start's Facebook page:

- Yes
- No

I give permission to the Chi cho otsk ati to screen my child and/or obtain examinations for:

- Developmental
- DECA (QHS)
- Vision
- Hearing
- Dental
- Behavioral (observation)

Parent/Guardian Signature

Date

**Quileute Head Start
RELEASE OF INFORMATION FORM**

Child's Name: _____ **Age:** _____ **DOB:** _____

I authorize for your agency to release the following information to Quileute Head Start and Child Care:

- Medical Records
- Well Child Examinations
- Immunization Records
- Dental Records
- Certification of Indian Blood
- Developmental Screenings
- Child's School Records
- WIC Information
- TANF Information
- DSHS Information

I also give permission for any of the records/information listed above to be released to the school I choose to send my child to once he/she leaves Quileute Head Start or Child Care. My consent is voluntary and is valid for 12 months from the date of my signature.

Parent/Guardian Signature

Date of Consent

Relationship to Child

**Quileute Head Start
EARTHQUAKE AND DISASTER FORM**

Child's Name: _____ **Age:** _____ **DOB:** _____

Medical Needs: _____

In the case of an earthquake or other disaster, my child may be released to the following individuals:

	Name	Phone #	Relationship To Child
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

Please also provide the name and phone # of an individual who lives out of the area:

	Name	Phone #	Relationship To Child
1)	_____	_____	_____

*****It is important to contact the people you have listed above and let them know that you have placed them on this list. *****

Parent/Guardian Signature

Date

Topical Fluoride Permission Form

Dear Parent or Guardian,

Over 80% of American Indian and Alaska Native Head Start children have dental cavities. However, cavities can be prevented through the use of fluoride, dental sealants, and xylitol.

We will provide a fluoride varnish program for Head Start children this year. Because your child is a minor, your consent is needed to allow your child to receive this preventive service.

Fluoride Varnish

Procedure: A high concentration fluoride varnish is painted directly onto the teeth.

Benefits: Fluoride Varnish coats the outside of the tooth and can provide some cavity-fighting power for up to 3 months.

Parental Permission

I give my son or daughter, _____, permission to have fluoride varnish placed on his or her teeth multiple times in a year by a trained staff or provider with prescription or standing orders. I understand the Fluoride Varnish program is a preventive program and the product is safe and effective.

Please list any physical conditions that the school should be aware of (asthma, allergies, recurring illnesses, disabilities, chronic illnesses, etc.):

Fluoride Varnish:

I do **NOT** want my child to have fluoride varnish applied.

I **DO** want my child to have fluoride varnish applied.

Parent or Guardian Name (print) _____

Signature _____ Date _____

Telephone Number _____

You can prevent cavities at home.
Brush daily with a fluoride toothpaste.

MEDICAL INFORMATION

Does your child have health insurance? Yes or No Type: _____

(Please provide a copy of your insurance card or medical coupon)

Does child have any existing medical problems? Yes or No

Explain: _____

List medication: _____

Does child have any allergies? Yes or No

Specify: _____

Medication: _____ Other: _____

Child's Physician: _____ Phone: _____

Describe any mental or physical challenges.

Describe any health concerns.

INDIAN HEALTH SERVICE

I give authorization to any licensed physician or qualified medical person to treat my child in an emergency, and give medical treatment and/or hospitalization as needed. The Quileute Head Start and Child Care Staff has my permission to act on my behalf in case of an emergency to treat my child.

Signature: _____ Date: _____

Quileute Head Start Waiver for Medical Screening

I request a Waiver for my child, _____, to not be required to participate in the following medical screenings:

- _____ Hematocrit Screening
- _____ Lead Screening
- _____ Physical
- _____ Dental
- _____ Hearing & Vision Screening

At this time I am declining any assistance from Quileute Head Start for the screenings marked above.

Parent/Guardian Signature

Date

Health/Family Services Manager

Date

CHILD HEALTH RECORD:

FORM 2A, HEALTH HISTORY

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER:

CHILD'S NAME: _____		SEX: _____	BIRTHDATE: _____
PERSON INTERVIEWED: _____		DATE: _____	RELATIONSHIP: _____
NAME OF INTERVIEWER: _____		TITLE: _____	
PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1 DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?			
2 DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3 WAS CHILD BORN OUTSIDE OF A HOSPITAL?			
4 WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5 WHAT WAS CHILD'S BIRTH WEIGHT?			_____ lbs., _____ oz.
6 WAS ANYTHING WRONG WITH CHILD AT BIRTH?			
7 WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?			
8 DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9 IS MOTHER PREGNANT NOW?			<i>(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)</i>
HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS
10 HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11 HAS CHILD EVER HAD A SERIOUS ACCIDENT <i>(broken bones, head injuries, falls, burns, poisoning)?</i>			
12 HAS CHILD EVER HAD A SERIOUS ILLNESS?			
HEALTH PROBLEMS	YES	NO	EXPLAIN <i>(Use additional sheets if needed)</i>
13 DOES CHILD HAVE FREQUENT SORE THROAT, COUGH, URINARY INFECTIONS OR TROUBLE URINATING, STOMACH PAIN, VOMITING, DIARRHEA?			
14 DOES CHILD HAVE DIFFICULTY SEEING <i>(Squint, cross eyes, look closely at books)?</i>			
15 IS CHILD WEARING <i>(or supposed to wear)</i> GLASSES?			<i>(If "yes")</i> WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16 DOES CHILD HAVE PROBLEMS WITH EARS/HEARING <i>(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?</i>			
17 HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND <i>(Rear end, anus, butt)</i> WHILE ASLEEP?			
18 HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?			<i>If "yes" ask:</i> WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____
19 IS CHILD TAKING ANY OTHER MEDICINE NOW? <i>(Special consent form must be signed for Head Start to administer any medication)</i>			WHAT MEDICINE? _____ <i>(If "yes")</i> WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? _____ HOW OFTEN? _____
20 IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			<i>(PHYSICIAN'S NAME: _____)</i>
21 HAS CHILD HAD BOILS, CHICKENPOX, ECZEMA, GERMAN MEASLES, MEASLES, MUMPS, SCARLET FEVER, WHOOPING COUGH?			
22 HAS CHILD HAD HIVES, POLIO?			
23 HAS CHILD HAD ASTHMA, BLEEDING TENDENCIES, DIABETES, EPILEPSY, HEART/BLOOD VESSEL DISEASE, LIVER DISEASE, RHEUMATIC FEVER, SICKLE CELL DISEASE?			<i>If "yes", transfer information to Forms 1 and 5.</i>
24 DOES CHILD HAVE ANY ALLERGY PROBLEMS <i>(Rash, itching, swelling, difficulty breathing, sneezing)?</i> a. WHEN EATING ANY FOODS? _____ b. WHEN TAKING ANY MEDICATION? _____ c. WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC? _____			<i>If "yes", transfer information to Forms 1 and 5.</i> WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT? DESCRIBE HOW:
25 <i>(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask)</i> DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			WHEN?
26 ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE: WHEN?

* If starred (*) questions have "yes" answers, go to question 25.

CHILD HEALTH RECORD:

FORM 2B, HEALTH HISTORY (Continued)

PERSON INTERVIEWED: _____ DATE: _____ RELATIONSHIP: _____
 NAME OF INTERVIEWER: _____ TITLE: _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____ NO, _____ YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? _____ NO, _____ YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH).

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET?

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? _____ NO, _____ YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. (INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).

a. WOULD YOU SAY YOUR CHILD BEGAN TO _____ EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO _____?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP				
(b) CRAWL				
(c) WALK				
(d) TALK				
(e) FEED AND DRESS SELF				
(f) LEARN TO USE THE TOILET				
(g) RESPOND TO DIRECTIONS				
(h) PLAY WITH TOYS				
(i) USE CRAYONS				
(j) UNDERSTAND WHAT IS SAID TO HIM/HER				

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? _____ NO, _____ YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____ NO, _____ YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

Student's Name: _____

SUPPORT AND COOPERATION AGREEMENT

A child needs his/her parent or guardian's help and guidance in order to get the most of educational opportunities. Therefore, as a parent/guardian I agree to cooperate in the following ways:

1. I understand that I must complete my child's entire enrollment application before he/she can attend Head Start or Child Care.
2. I understand that I must submit a current well-child examination, or provide proof that an appointment is scheduled, and an up-to-date immunization record for my child before they begin school or Child Care.
3. I understand that I must provide proof of income, and I will allow QHS or Child Care to verify income with my employer.
4. I understand that I must provide proof of my child's birth date if requested.
5. I understand that I am responsible for any necessary follow-ups required for the dental, hearing, vision, and medical needs of my child as soon as necessary.
6. I understand that if my child is sick, I must pick my child up within an hour of being notified of the reason.
7. If my child was sent home with lice, my child will be checked by the Health Manager or Child Care Manager before returning to class or daycare.
8. I will call QHS if my child will be absent for any reason. If my child misses 3 days in a row, I am responsible for calling the center to let the bus know when my child will return to school.
9. I understand that I have the right to bring any concerns to the attention of my child's teacher or to the program supervisor or Child Care staff.
10. I will try to attend Parent Committee meetings and to participate in Policy Council, or Child Care on other committees.
11. I will volunteer when I can as an assistant in the classroom or at special events. My involvement at Head Start and Child Care as a volunteer is very important.
12. If I leave my child in someone else's care, I will notify QHS and Child Care in advance and provide them with the caregiver's information.
13. I will spend time with my child to talk about school. We will make time to do things together.
14. I will let my child know that education is important and will provide encouragement for my child.
15. I will see that my child attends QHS on a regular basis. It is important that QHS maintain an 85% overall attendance rate. It is also very important that my child have a stable daily routine.
16. I will make a payment in a timely manner if my child attends Child Care.

Parent/ Guardian Signature Date

QHS or Child Care Staff Signature/Date

Dental Treatment/Transportation Authorization Form

The Quileute Head Start is working with the La Push Dental Clinic to provide dental care for each student, throughout the school year. If permission is given, your child may be seen for dental check-ups, cleanings, x-rays, fluoride treatments, sealants, and or simple fillings (which may require anesthetic). Some of these treatments are applied at the school; other treatments are at the dental clinic. If your child should need extensive dental work the parent/guardian will be contacted.

If you have any further questions contact the dental clinic at 374-6984 or Quileute Head Start at 374-2631.

Child's name _____ M.I. _____ DOB _____

Parent/Guardian _____ Phone# _____

Mailing address _____

Check the appropriate boxes and initial after the statement.

() I hereby authorize the La Push dental clinic to treat my child at the Head Start or the dental clinic.
Initial _____

() I give my permission for my child to be transported to and from the dental clinic by the clinic staff or Head Start transportation when available. Initial _____

() I do not want my child to participate in the La Push dental treatment. Initial _____

Signature _____ Date _____

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