CHI CHO? O’TSK’ ATI

“House of Children”

Enrollment Application
Childcare/Head Start

Dear Parents and Guardians:

Thank you for your interest in our programs! The following documents are required in order to be considered for our programs. If you would like to bring in the original documents, we would be happy to make copies for you.

- Completed Enrollment Application
- Recent Well Child (within the last year) from your medical provider
- Certificate of Indian Blood (if Applicable)
- Income Verification from ALL sources
- Copy of Medical/Dental Insurance Cards
- Current Copy of Immunizations
Section 1 (Please fill this out as completely as possible, call 374-2631 if you need assistance)

<table>
<thead>
<tr>
<th>CHILD'S NAME (Last, First, MI)</th>
<th>D.O.B.</th>
<th>AGE</th>
<th>GENDER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD’S ETHNIC ORIGIN</th>
<th>CHILD’S RACE (Please choose one)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino origin</td>
<td>American Indian or Alaska Native</td>
</tr>
<tr>
<td>Non-Hispanic or Non-Latino origin</td>
<td>Asian</td>
</tr>
<tr>
<td>Black or African American</td>
<td>Biracial/Multiracial</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD’S TRIBAL ID # (IF APPLICABLE)</th>
<th>CHILD’S TRIBE</th>
<th>HOME PHONE #</th>
<th>CELL PHONE #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD’S PHYSICAL ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD’S MAILING ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>LANGUAGE SPOKEN IN HOME</th>
<th>WHO HAS CUSTODY OF CHILD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>Mother</td>
</tr>
<tr>
<td>Spanish</td>
<td>Father</td>
</tr>
<tr>
<td>Other:</td>
<td>Foster Parents</td>
</tr>
<tr>
<td></td>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDIVIDUALS LIVING AT RESIDENCE WITH CHILD:</th>
<th>MARITAL STATE OF GUARDIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Single</td>
</tr>
<tr>
<td>Father</td>
<td>Married</td>
</tr>
<tr>
<td>Foster Parent</td>
<td>Separated</td>
</tr>
<tr>
<td>Other Relatives (aunts, uncles, etc.)</td>
<td>Divorced</td>
</tr>
<tr>
<td>Other:</td>
<td>Widowed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOTHER/GUARDIAN’S NAME (Last, First)</th>
<th>D.O.B.</th>
<th>MOTHER’S SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>MOTHER’S PLACE OF EMPLOYMENT</th>
<th>EMPLOYER PHONE #</th>
<th>EMPLOYER ADDRESS</th>
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<tbody>
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<table>
<thead>
<tr>
<th>FATHER/GUARDIAN’S NAME (Last, First)</th>
<th>D.O.B.</th>
<th>FATHER’S SSN</th>
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</table>

<table>
<thead>
<tr>
<th>FATHER’S PLACE OF EMPLOYMENT</th>
<th>EMPLOYER PHONE #</th>
<th>EMPLOYER ADDRESS</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

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

Name: __________________________ D.O.B. __________________

Name: __________________________ D.O.B. __________________

Name: __________________________ D.O.B. __________________

Name: __________________________ D.O.B. __________________

Section 2 (To be filled out with Quileute Head Start/Child Care Staff when application is returned)

Child is/has:
- Enrolled Quileute Tribal Member with Certificate of Indian Blood
- Quileute Tribal Descendent (not enrolled)
- Native American/descendant enrolled in a Federally Recognized Tribe
- Native American/descendant enrolled in Tribe not Federally Recognized
- Disability-IFSP
- Disability-IEP
- Disability-Documented but no IEP
- Disability-Behavioral/Mental Health Issues
- Prekindergarten
- Returning Student
- CPS Referral-Case worker
- Other Agency Referral  

Check all that apply to family:
- TANF services ID # ________________
- WIC services-ID # ________________
- SSI
- Teen Parent
- Single Parent
- Homeless
- Family Drug/Alcohol Abuse
- Disabled Parent/Sibling
- Foster Parent
- Both Parents are High School Non Graduates
- One Parent is a High School Non Graduate
- Family Lives and/or Works in La Push
Chi Cho? O’tsk’ Ati
Consent Form

Child’s Name: ________________________________ DOB: __________________

Chi Cho? O’tsk’ Ati Staff have my permission for the following:

☐ In an emergency, Chi Cho? O’tsk’ Ati staff has permission to call an ambulance for my child to be transported to the hospital.

☐ In an emergency, the Chi Cho? O’tsk’ 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 ☐ Insect Bite Ointment

My child may be taken on field trips, walks off-site or to dental appointments/health screening by bus under proper supervision and use of a car seat:

☐ Yes

☐ No

My child may be photographed for publication or newsletter purposes:

☐ Yes

☐ No

My child’s photograph may be posted on Quileute Head Start or Child Care Facebook page:

☐ Yes

☐ No

I give my permission to the Chi Cho? O’tsk’ Ati staff to screen my child and/or obtain examinations for:

☐ Developmental

☐ DECA

☐ Vision

☐ Hearing

☐ Dental

☐ Behavioral

☐ Speech

☐ Nutrition

______________________________________  ______________________
Parent/Guardian Signature            Date
Chi cho? O’tsk’ ati
RELEASE OF INFORMATION FORM

Child’s Name: _________________________ Age: _______ DOB: ____________

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

☐ Medical/Dental Insurance Information
☐ Well Child Examinations
☐ Immunization Records
☐ Dental Records
☐ Certification of Indian Blood
☐ Developmental Screenings
☐ Child’s School Records
☐ WIC Information
☐ TANF Information
☐ DSHS Information
☐ ICW/CPS 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 Quileute Child Care. My consent is voluntary and is valid for the duration of my child’s enrollment in the program.

______________________________  __________________________
Parent/Guardian Signature       Date of Consent

______________________________
Relationship to Child
Chi cho? O’tsk’ ati
SUPPORT AND COOPERATION AGREEMENT

Student’s Name: ________________________________

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.

3. I understand that I must provide proof of income, and I will allow staff to verify income with my employer.

4. I understand that I am responsible for any necessary follow-ups required for the dental, hearing, vision, educational, nutritional, and medical needs of my child as soon as necessary.

5. I understand that if my child is sick, I must pick my child up within an hour of being notified of the reason.

6. 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.

7. I will call 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 them know when my child will return to school.

8. I understand that I have the right to bring any concerns to the attention of my child’s teacher or to the program Director.

9. I will try to attend Parent Committee meetings and to participate in Policy Council or on other committees if my child attends the Head Start.

10. I will volunteer when I can as an assistant in the classroom or at special events. My involvement as a volunteer is very important.

11. If I leave my child in someone else’s care, I will notify staff in advance and provide them with the caregiver’s information.

12. I will let my child know that education is important and will provide encouragement for my child.

13. I will see that my child attends on a regular basis. It is important that we maintain an 85% overall attendance rate. It is also very important that my child have a stable daily routine.

______________________________      ____________________________
Parent Signature                                      Date
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. *

<table>
<thead>
<tr>
<th>Pick up Location</th>
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</thead>
<tbody>
<tr>
<td>Name &amp; Phone Number</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drop Off Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; Phone Number</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

Revised: 6/2011
Chi cho? O’tsk’ ati

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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone #</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
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<tr>
<td>2)</td>
<td></td>
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<td>3)</td>
<td></td>
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<td>4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone #</th>
<th>Relationship to Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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
Chi cho? O’tsk’ ati

Emergency Contacts

The following people are authorized to pick up my child from Chi Cho? O’tsk’ Ati Child Care and Head Start without prior notification, if my child is ill, or in the event of an emergency. I understand that it is my responsibility to update this information with Chi Cho? O’tsk’ Ati staff if personal or family circumstances change:

Childs Name: ____________________________ Parent/Guardians Name: ____________________________

Name: ____________________________ Phone: ____________________________
Relationship to Child: ____________________________

Name: ____________________________ Phone: ____________________________
Relationship to Child: ____________________________

Name: ____________________________ Phone: ____________________________
Relationship to Child: ____________________________

Name: ____________________________ Phone: ____________________________
Relationship to Child: ____________________________

Name: ____________________________ Phone: ____________________________
Relationship to Child: ____________________________

______________________________ ____________________________
Parent Signature Date
### Child Health Record

**Child's Name:**

**Sex:** [ ] Male  [ ] Female

**Birthdate:**

**Person Interviewed:**

**Date:**

**Relationship:**

**Name of Interviewer:**

**Title:**

### Pregnancy/Birth History

1. **Did mother have any health problems during this pregnancy or during delivery?**
   - [ ] Yes  [ ] No

2. **Did mother visit physician fewer than two times during pregnancy?**
   - [ ] Yes  [ ] No

3. **Was child born outside of a hospital?**
   - [ ] Yes  [ ] No

4. **Was child born more than 3 weeks early or late?**
   - [ ] Yes  [ ] No

5. **What was child's birth weight?**
   - [ ] lbs.  [ ] oz.

6. **Was anything wrong with child at birth?**
   - [ ] Yes  [ ] No

7. **Was anything wrong with child in the nursery?**
   - [ ] Yes  [ ] No

8. **Did child or mother stay in hospital for medical reasons longer than usual?**
   - [ ] Yes  [ ] No

9. **Is mother pregnant now?**
   - [ ] Yes  [ ] No

### Hospitalizations and Illnesses

10. **Has child ever been hospitalized or operated on?**
    - [ ] Yes  [ ] No

11. **Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?**
    - [ ] Yes  [ ] No

12. **Has child ever had a serious illness?**
    - [ ] Yes  [ ] No

### Health Problems

13. **Does child have frequent sore throat, cough, urinary infections or trouble urinating, stomach pain, vomiting, diarrhea?**
    - [ ] Yes  [ ] No

14. **Does child have difficulty seeing (squint, cross eyes, look closely at books)?**
    - [ ] Yes  [ ] No

15. **Is child wearing (or supposed to wear) glasses?**
    - [ ] Yes  [ ] No

16. **Does child have problems with ears/hearing (pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?**
    - [ ] Yes  [ ] No

17. **Have you ever noticed child scratching his/her behind (rear end, anus, butt) while asleep?**
    - [ ] Yes  [ ] No

18. **Has child ever had a convulsion or seizure?**
    - [ ] Yes  [ ] No

19. **Is child taking any other medicine now? (Special consent form must be signed for Head Start to administer any medication).**
    - [ ] Yes  [ ] No

20. **Is child now being treated by a physician or a dentist?**
    - [ ] Yes  [ ] No

21. **Has child had: boils, chickenpox, eczema, German measles, meases, mumps, scarlet fever, whooping cough?**
    - [ ] Yes  [ ] No

22. **Has child had: hives, polio?**
    - [ ] Yes  [ ] No

23. **Has child had: asthma, bleeding tendencies, diabetes, epilepsy, heart/blood vessel disease, liver disease, rheumatic fever, sickle cell disease?**
    - [ ] Yes  [ ] No

24. **Does child have any allergy problems? (itching, swelling, difficulty breathing, sneezing)?**
    - [ ] Yes  [ ] No
    - a. When eating any foods?
    - b. When taking any medication?
    - c. When near animals, furs, insects, dust, etc.?

25. **If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask: 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?**
    - [ ] Yes  [ ] No

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?**
    - [ ] Yes  [ ] No

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

**Interviewer: **

Go to Form 4
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 | EARLIER | WHEN EXPECTED | LATER | AGE |
| when you expected, about when you expected, or later than you expected? |
| (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.
**CHILD HEALTH RECORD:**

**FORM 6, NUTRITION**

**CHILD'S NAME:**

**SEX:**

**BIRTHDATE:**

**DIETARY HABITS**

1. **WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE?**

**ARE THERE ANY FOODS YOUR CHILD DISLIKES?**

<table>
<thead>
<tr>
<th>3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) If &quot;yes&quot;, what kind are they?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Do they contain iron?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Do they contain fluoride?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Were they prescribed?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Milk, cheese, yogurt.</td>
</tr>
<tr>
<td>(b) Meat, poultry, fish, eggs; or dried beans, peas, peanut butter.</td>
</tr>
<tr>
<td>(c) Rice, grits, bread, cereal, tortillas.</td>
</tr>
<tr>
<td>(d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes.</td>
</tr>
<tr>
<td>(e) Oranges, grapefruit, tomatoes (fruit/ juice).</td>
</tr>
<tr>
<td>(f) Other fruits and vegetables.</td>
</tr>
<tr>
<td>(g) Oil, butter, margarine, lard.</td>
</tr>
<tr>
<td>(h) Cakes, cookies, sodas, fruit drinks, candy.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Approximate Number of Times a Week (circle the number(s) nearest to parent's answer)</th>
</tr>
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</table>

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<tr>
<th>4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR MEDICAL, RELIGIOUS, OR PERSONAL REASONS?</th>
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<table>
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<tr>
<th>5. IS YOUR CHILD ON A SPECIAL DIET?</th>
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<tbody>
<tr>
<td>(a) What kind?</td>
</tr>
</tbody>
</table>

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<tr>
<th>6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH?</th>
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<tr>
<th>7. DOES YOUR CHILD TAKE A BOTTLE?</th>
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<tr>
<th>8. DOES YOUR CHILD EAT OR CHew THINGS THAT AREN'T FOODS?</th>
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<table>
<thead>
<tr>
<th>9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING?</th>
</tr>
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</table>

| 10. DOES YOUR CHILD OFTEN HAVE: |
| (a) Diarrhea?                   |
| (b) Constipation?               |

<table>
<thead>
<tr>
<th>11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS?</th>
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*Starred answers may require follow-up. Explain details or give additional comments here.

**PARENT/GUARDIAN INTERVIEW**

**13. GROWTH**

<table>
<thead>
<tr>
<th>DATE</th>
<th>AGE</th>
<th>HEIGHT (no shoes, to nearest 1/8 in.)</th>
<th>WEIGHT (light clothing, to nearest 1/4 lb.)</th>
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**14. ANEMIA SCREEN**

<table>
<thead>
<tr>
<th>DATE</th>
<th>HEMOGLOBIN*</th>
<th>OR HEMATOCRIT*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCREENING</td>
<td>RESCREENING</td>
</tr>
</tbody>
</table>

*Hgb less than 11 or Hct less than 34 require follow-up

**15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION**

(Review items 2 through 13. If there are answers in starred (*) areas, or if growth is not within the typical range, check the appropriate box(es) below and consult a nutritionist or physician.)

- Suspect dietary problem or inadequate food intake (from Questions 2 to 12)
- Hgb. less than 11 g/m. or Hct. less than 34% (from Question 14)
- Underweight (weight less than typical, from Growth Chart 1 or 4)
- Overweight (weight greater than typical, from Growth Chart 1 or 4)
- Short for Age (height less than typical, from Growth Chart 2 or 5)
- WL for Ht. (greater or less than typical, from Growth Chart 3 or 6)

COMMENTS (use additional page if needed)

Signature ____________________________ Title ____________________________ Date __________
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: ______________
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, you 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.

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 __________________

-
## PART 1 – CHILDREN’S INFORMATION

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Birthdate</th>
<th>Circle Normal Days/Print Normal Hours of Care</th>
<th>Circle Meals Normally Received</th>
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<tr>
<td></td>
<td></td>
<td>Sun Mon Tu Wed Th Fri Sat</td>
<td>Breakfast A.M. Snack Lunch</td>
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<tr>
<td></td>
<td></td>
<td>Normal Hours to</td>
<td>P.M. Snack Supper Eve. Snack</td>
</tr>
</tbody>
</table>

|              |           | Sun Mon Tu Wed Th Fri Sat                     | Breakfast A.M. Snack Lunch    |
|              |           | Normal Hours to                               | P.M. Snack Supper Eve. Snack  |

|              |           | Sun Mon Tu Wed Th Fri Sat                     | Breakfast A.M. Snack Lunch    |
|              |           | Normal Hours to                               | P.M. Snack Supper Eve. Snack  |

|              |           | Sun Mon Tu Wed Th Fri Sat                     | Breakfast A.M. Snack Lunch    |
|              |           | Normal Hours to                               | P.M. Snack Supper Eve. Snack  |

## PART 2 – CHILDREN’S ETHNIC AND RACIAL IDENTITIES—You Are Not Required to Answer This Part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

**Ethnicity:**
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, sex, age, or disability.

**Race:**
- [ ] White
- [ ] Black or African American
- [ ] Asian
- [ ] American Indian or Alaskan Native
- [ ] Native Hawaiian or Pacific Islander
- [ ] Multi-Racial

## PART 3 – SIGNATURE

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<th>Daytime Phone</th>
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### Year 2

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### Year 3

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