



CHI CHO? O'TSK' ATI
"House of Children"

Enrollment Application



Quileute Head Start

8 By-Yak Loop/PO Box 100
La Push, WA 98350
Office: (360) 374-2631
Fax: (360) 374-5066

Dear Parents and Guardians,

Thank you for your interest in our program! The following documents are required in order to be considered for the program. If you would like to bring in the original documents, we would be happy to make copies for you. Head Start is a federally funded program and these documents are required for our program to continue.

- Recent (within the last year) Well Child Exam results from your child's medical provider.
- Proof of Live Birth (Hospital certificate, state certificate, etc.)
- Certificate of Indian Blood (If applicable)
- Income Verification from ALL sources of income. Examples include: Income tax return, W-2 form, pay stub for a recent month, TANF documentation, proof of SSI payments, child support payments, foster care payment documentation, proof of unemployment benefits, etc.
- Copy of medical and/or dental insurance card
- Copy of Immunizations

If you have any questions/concerns, need help filling out/obtaining these forms or need help scheduling an appointment, please contact us at (360) 374-2631. Thank you and I look forward to seeing you soon.

Rebecca Schwartz
Health and Family Service Manager
Quileute Head Start

Chi cho otsk ati (House of Children) Enrollment Application

Please check the programs you are interested in:

Child Care Head Start

Section 1 (Please fill this out as completely as possible, call 374-2631 if you need assistance)

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 (Please choose one) <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 TRIBE	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 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.)			
MOTHER/GUARDIAN'S NAME (Last, First)	D.O.B.	MOTHER'S SSN	
MOTHER'S PLACE OF EMPLOYMENT	EMPLOYER PHONE #	EMPLOYER ADDRESS	
FATHER/GUARDIAN'S NAME (Last, First)	D.O.B.	FATHER'S SSN	
FATHER'S PLACE OF EMPLOYMENT	EMPLOYER PHONE #	EMPLOYER ADDRESS	

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 (Please check all boxes that apply)

<p>Child is/has:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Enrolled Quileute Tribal Member with Certificate of Indian Blood <input type="checkbox"/> Quileute Tribal Descendent (not enrolled) <input type="checkbox"/> Native American/descendent enrolled in a Federally Recognized Tribe <input type="checkbox"/> Native American/descendent enrolled in Tribe not Federally Recognized <input type="checkbox"/> Disability-IFSP <input type="checkbox"/> Disability-IEP <input type="checkbox"/> Disability-Documented but no IEP <input type="checkbox"/> Disability-Behavioral/Mental Health Issues <input type="checkbox"/> Prekindergarten <input type="checkbox"/> Returning Student <input type="checkbox"/> CPS Referral <input type="checkbox"/> Other Agency Referral 	<p>Check all that apply to family:</p> <ul style="list-style-type: none"> <input type="checkbox"/> TANF services <input type="checkbox"/> WIC services <input type="checkbox"/> SSI <input type="checkbox"/> Teen Parent <input type="checkbox"/> Single Parent <input type="checkbox"/> Homeless <input type="checkbox"/> Family Drug/Alcohol Abuse <input type="checkbox"/> Disabled Parent/Sibling <input type="checkbox"/> Foster Parent <input type="checkbox"/> Both Parents are High School Non Graduates <input type="checkbox"/> One Parent is a High School Non Graduate <input type="checkbox"/> Family Lives and/or Works in La Push
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**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 (including labs, radiology, etc.)
- 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
- Health Insurance Information
- Birth Certificate

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 the duration of my child's enrollment in the program.

Parent/Guardian Signature
Date of Consent

Relationship to Child



Quileute Head Start
Consent Form

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

Quileute Head Start has my permission for the following:

- In an emergency, the Quileute Head Start staff has permission to call an ambulance for transport my child to a physician or hospital.
- In an emergency, the Quileute Head Start has permission to make medical decision 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 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 news purposes:

- Yes
- No

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

- Yes
- No

I give my permission to the Quileute Head Start to screen my child and/or obtain examinations for:

- Developmental
- DECA
- Vision
- Hearing
- Dental
- Behavioral
- Speech
- Nutrition

Parent/Guardian Signature

Date

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.
3. I understand that I must provide proof of income, and I will allow QHS 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.
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 Director.
10. I will try to attend Parent Committee meetings and to participate in Policy Council or 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 as a volunteer is very important.
12. If I leave my child in someone else's care, I will notify QHS in advance and provide them with the caregiver's information.
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 participate in all parent/teacher conferences.

Parent/ Guardian Signature Date

QHS Staff Signature/ Date



Quileute Head Start
8 By-Yak Loop PO Box 100
La Push, WA 98350
Office: (360) 374-2631
Fax: (360) 374-5066
Bus Phone: (360) 640-8067

TRANSPORTATION INFORMATION FORM

This form must be updated for ANY changes to your child's bus route. Please request a new form in advance. Any changes that are not listed on this form will NOT be accepted.

Student Name: _____

Pick Up Location

Name & Phone Number

Physical Address

Drop Off Location

Name & Phone Number

Physical Address

Please list **three** people who can be contacted in case no one is at drop off location listed above. Please prioritize this list in the order in which you would like individuals to be contacted.

1.) Name: _____ Phone Number: _____

Physical Address: _____

2.) Name: _____ Phone Number: _____

Physical Address: _____

3.) Name: _____ Phone Number: _____

Physical Address: _____

(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: _____

Parent Signature

Date



**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

CHILD HEALTH RECORD: *Please Fill out...*

FORM 2A, HEALTH HISTORY

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") WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____</i>
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: WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____</i>
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? <i>(Special consent form must be signed for Head Start to administer any medication).</i>			<i>WHAT MEDICINE? _____ (If "yes") WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? _____ HOW OFTEN? _____</i>
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?
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?			DESCRIBE HOW: 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?

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

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

CHILD HEALTH RECORD: *Please Fill out* 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.

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE? _____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES? _____

	Yes No		12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?	Approximate Number of Times a Week (circle the number(s) nearest to parent's answer)									
				0*	1*	2*	3	4	5	6	7	7+	
3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS? (a) If "yes", what kind are they? _____ (b) Do they contain iron? (c) Do they contain fluoride? (d) Were they prescribed?			(a) Milk, cheese, yogurt. (b) Meat, poultry, fish, eggs; or Dried beans/peas, peanut butter. (c) Rice, grits, bread, cereal, tortillas. (d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes. (e) Oranges, grapefruit, tomatoes (fruit/juice). (f) Other fruits and vegetables. (g) Oil, butter, margarine, lard. (h) Cakes, cookies, sodas, fruit drinks, candy.	0*	1*	2*	3	4	5	6	7	7+	
4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR MEDICAL, RELIGIOUS, OR PERSONAL REASONS?	*												
5. IS YOUR CHILD ON A SPECIAL DIET? (a) What kind? _____	*												
6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH?	*												
7. DOES YOUR CHILD TAKE A BOTTLE?	*												
8. DOES YOUR CHILD EAT OR CHEW THINGS THAT AREN'T FOOD?	*												
9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING?	*												
10. DOES YOUR CHILD OFTEN HAVE: (a) Diarrhea? (b) Constipation?	*												
11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS?	*												

*Starred answers may require follow-up. Explain details or give additional comments here.

PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW

13. GROWTH

DATE	AGE	HEIGHT (no shoes, to nearest 1/8 in.)	WEIGHT (light clothing, to nearest 1/4 lb.)
	____ yrs. ____ mo.		
	____ yrs. ____ mo.		
	____ yrs. ____ mo.		

14. ANEMIA SCREEN

DATE	HEMOGLOBIN*	OR HEMATOCRIT *

* 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 gm. 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)
- Wt. for Ht. (greater or less than typical, from Growth Chart 3 or 6)

COMMENTS (use additional page if needed)

TO BE COMPLETED BY HEAD START STAFF, NUTRITIONIST, OR PROVIDER

Signature _____ Title _____ Date _____

HEALTH

Quileute Head Start
Student Health Registration Form

Student Name _____	Class _____	Gender _____	Date of Birth _____
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MEDICAL: Does your child have a doctor? Yes _____ No _____

Name of child's doctor: _____ Phone Number _____

DENTAL:

Does your child have a dentist? Yes _____ No _____

Name of child's dentist: _____ Phone Number _____

Did your child receive a dental exam in the last 12 months? Yes _____ No _____

INSURANCE:

Does your child have medical insurance coverage? Yes _____ No _____ Name of insurance provider: _____

Does your child have dental insurance coverage? Yes _____ No _____ Name of insurance provider: _____

Medicaid/Apple Health? Yes _____ No _____

MEDICAL HISTORY

Have you ever been told by a physician that your child has:

Asthma _____	Seizure Disorder _____	Bleeding Disorder _____	ADD/ADHD _____
Diabetes _____	Bone/Muscle Disease _____	Skin Condition _____	Learning Disability _____
Heart Condition _____	Mental Health Condition(ex.depression,anxiety) _____	Other _____	

Does your child experience any of the following:

Nose Bleeds _____	Frequent Earaches _____	Overweight for Age _____	Physical Disability _____
Poor Appetite _____	Frequent Stomach Aches _____	Frequent Headaches _____	Fainting Spells _____
Tires Easily _____	Emotional Concerns _____	Underweight for Age _____	Other _____

Do any of the above conditions limit/effect your child at school? _____

LIFE THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes _____ No _____ Describe: _____

If yes, a meeting with the Head Start Health Manager is required. Washington State Law requires medication or treatment orders and a health care plan be in place prior to starting school.

ALLERGIES:

Plants _____
Animals _____ Molds _____ Drugs _____ Bees _____ Food _____ Other _____

**Additional form must be filled out for food allergies*

MEDICATION:

Does your child take any medication? Yes _____ No _____ If yes, name of medication _____

Purpose: _____ Will medication be needed at school? Yes _____ No _____

***If your child needs to take medication at school, please contact the office for the necessary authorization form. This form must be completed prior to any medication being brought to school.**

HEARING/VISION:

Do you have any concerns about your child's hearing? Yes _____ No _____

Do you have any concerns about your child's vision? Yes _____ No _____ Does your child wear glasses? Yes _____ No _____

SPEECH/LANGUAGE:

Do you have any concerns about your child's speech and/or language? Yes _____ No _____

Do others have difficulty understanding your child? Yes _____ No _____ If yes, please explain _____

***Do you have any other health concerns, or are their any mental/physical challenges your child has: _____**

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:

I understand the information given above will be shared with the appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician.

Parent/Guardian 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 _____

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.

Child and Adult Care Food Program ENROLLMENT FORM

PART 1 – CHILDREN'S INFORMATION

Child's Name	Birthdate	Circle Normal Days/ Print Normal Hours of Care	Circle Meals Normally Received		
			Breakfast	A.M. Snack	Lunch
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	P.M. Snack	Supper	Eve. Snack
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast	A.M. Snack	Lunch
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	P.M. Snack	Supper	Eve. Snack
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast	A.M. Snack	Lunch
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	P.M. Snack	Supper	Eve. Snack
		Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____	Breakfast	A.M. Snack	Lunch
		Sun Mon Tu Wed Th Fri Sat 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

Signature of Adult	Date	Print Name of Adult Signing
Mailing Address	City/State/Zip Code	Daytime Phone

Year 2		
Signature of Adult	Updated	Print Name of Adult Signing

Year 3		
Signature of Adult	Updated	Print Name of Adult Signing