CHI CHO? O’TSDK’ ATI

“House of Children”

Enrollment Application
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)

<table>
<thead>
<tr>
<th>CHILD’S NAME (Last, First, M.I)</th>
<th>D.O.B.</th>
<th>AGE</th>
<th>GENDER</th>
<th>CHILD’S ETHNIC ORIGIN</th>
<th>CHILD’S RACE</th>
<th>CHILD’S SSN</th>
<th>CHILD’S PHYSICAL ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>LANGUAGE SPOKEN IN HOME</th>
<th>WHO HAS CUSTODY OF CHILD?</th>
<th>MARITAL STATE OF GUARDIAN</th>
<th>FAMILY SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Hispanic or Latino origin</td>
<td>American Indian or Alaska Native</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>English</td>
<td>Mother</td>
<td>Single</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Non-Hispanic or Non-Latino origin</td>
<td>Asian White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Spanish</td>
<td>Father</td>
<td>Married</td>
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<td></td>
<td>Female</td>
<td></td>
<td>Biracial/Multiracial</td>
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<td></td>
<td>Other</td>
<td>Foster Parents</td>
<td>Separated</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Female</td>
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<td></td>
<td>Other</td>
<td>Other:</td>
<td>Widowed</td>
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<td>Female</td>
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<td>Female</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MOTHER/GUARDIAN’S NAME (Last, First)</th>
<th>D.O.B.</th>
<th>MOTHER’S SSN</th>
<th>EMPLOYER PHONE #</th>
<th>EMPLOYER ADDRESS</th>
<th>FATHER/GUARDIAN’S NAME (Last, First)</th>
<th>D.O.B.</th>
<th>FATHER’S SSN</th>
<th>EMPLOYER PHONE #</th>
<th>EMPLOYER ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</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 (Please check all boxes that apply)

<table>
<thead>
<tr>
<th>Child is/has:</th>
<th>Check all that apply to family:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled Quileute Tribal Member with Certificate of Indian Blood</td>
<td>TANF services</td>
</tr>
<tr>
<td>Quileute Tribal Descendent (not enrolled)</td>
<td>WIC services</td>
</tr>
<tr>
<td>Native American/ descendent enrolled in a Federally Recognized Tribe</td>
<td>SSI</td>
</tr>
<tr>
<td>Native American/ descendent enrolled in Tribe not Federally Recognized</td>
<td>Teen Parent</td>
</tr>
<tr>
<td>Disability-IFSP</td>
<td>Single Parent</td>
</tr>
<tr>
<td>Disability-IEP</td>
<td>Homeless</td>
</tr>
<tr>
<td>Disability-Documented but no IEP</td>
<td>Family Drug/ Alcohol Abuse</td>
</tr>
<tr>
<td>Disability-Behavioral/Mental Health Issues</td>
<td>Disabled Parent/Sibling</td>
</tr>
<tr>
<td>Prekindergarten</td>
<td>Foster Parent</td>
</tr>
<tr>
<td>Returning Student</td>
<td>Both Parents are High School Non Graduates</td>
</tr>
<tr>
<td>CPS Referral</td>
<td>One Parent is a High School Non Graduate</td>
</tr>
<tr>
<td>Other Agency Referral</td>
<td>Family Lives and/or Works in La Push</td>
</tr>
</tbody>
</table>

Revised: 6/2011  
Date Received: __________  
Staff Initials: __________
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
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.

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

14. 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.

15. I will participate in all parent/teacher conferences.

Parent/Guardian Signature  Date  QHS Staff Signature/  Date
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:

<table>
<thead>
<tr>
<th>Childs Name:</th>
<th>Parent/Guardians Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Child:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Child:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Child:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Child:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Child:</td>
<td></td>
</tr>
</tbody>
</table>

**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:

<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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<td>2)</td>
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<td>4)</td>
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<td></td>
</tr>
<tr>
<td>5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please also provide the name and phone # 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
# Child Health Record

## Form 2A, Health History

<table>
<thead>
<tr>
<th>Child's Name:</th>
<th>Sex:</th>
<th>Birthdate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Interviewed:</td>
<td>Date:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Name of Interviewer:</td>
<td>Title:</td>
<td></td>
</tr>
</tbody>
</table>

### Pregnancy/Birth History

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Explain &quot;Yes&quot; Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did mother have any health problems during this pregnancy or during delivery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did mother visit physician fewer than two times during pregnancy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Was child born outside of a hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Was child born more than 3 weeks early or late?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. What was child's birth weight?</td>
<td>lbs., oz.</td>
<td></td>
</tr>
<tr>
<td>6. Was anything wrong with child at birth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Was anything wrong with child in the nursery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Did child or mother stay in hospital for medical reasons longer than usual?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Is mother pregnant now?</td>
<td></td>
<td>(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)</td>
</tr>
</tbody>
</table>

### Hospitalizations and Illnesses

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Explain &quot;Yes&quot; Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Has child ever been hospitalized or operated on?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Has child ever had a serious illness?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health Problems

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Explain (Use additional sheets if needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Does child have frequent sore throat; cough; urinary infections or trouble urinating; stomach pain, vomiting, diarrhea?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Does child have difficulty seeing (squint, cross eyes, look closely at books)?</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>15. Is child wearing (or supposed to wear) glasses?</td>
<td></td>
<td>(If &quot;yes&quot;) Was last checkup more than one year ago?</td>
</tr>
<tr>
<td>16. Does child have problems with ear/s back pain (pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>17. Have you ever noticed child scratching himself or behind (rear end, anus, butt) while asleep?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Has child ever had a convulsion or seizure?</td>
<td>*</td>
<td>If &quot;yes&quot; ask: When did it last happen?</td>
</tr>
<tr>
<td>19. Is child taking medicine for seizures?</td>
<td></td>
<td>What medicine?</td>
</tr>
<tr>
<td>20. Is child taking any other medicine now?</td>
<td>(Special consent form must be signed for Head Start to administer any medication.)</td>
<td>(If &quot;yes&quot;) Will it need to be given while child is at Head Start? How often?</td>
</tr>
<tr>
<td>21. Has child had: boils, chickenpox, eczema, German measles, measles, mumps, scarlet fever, whooping cough?</td>
<td></td>
<td>(Physician's name:</td>
</tr>
<tr>
<td>22. Has child had: hives, polio?</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>23. Has child had: asthma, bleeding tendencies, diabetes, epilepsy, heart disease, liver disease, rheumatic fever, sickle cell disease?</td>
<td></td>
<td>If &quot;yes&quot;, transfer information to Forms 1 and 5.</td>
</tr>
<tr>
<td>24. Does child have any allergy problems (rash, itching, swelling, difficulty breathing, sneezing)?</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>a) When eating any food?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) When taking any medication*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) When near animals, furs, insects, dust, etc.?*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. (If any &quot;yes&quot; 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?</td>
<td>Describe how:</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>Describe:</td>
<td>When?</td>
</tr>
</tbody>
</table>

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

Interviewer: Go to Form 4
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 _______? |

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: Flowchart Section**

**PART 1: TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW**

<table>
<thead>
<tr>
<th>CHILD'S NAME:</th>
<th>SEX:</th>
<th>BIRTHDATE:</th>
</tr>
</thead>
</table>

**DIETARY HABITS**

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

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

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? 

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?**

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

**PART 2: TO BE COMPLETED BY HEALTH PROVIDER, OR NUTRITIONIST**

**12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?**
   - (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.

**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>
<th>SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

**14. ANEMIA SCREEN**

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

**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)

**COMMENTS (use additional page if needed)**

- [ ] 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)

**Signature**

**Title**

**Date**
# Quileute Head Start

## Student Health Registration Form

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Class</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

### 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____
- Diabetes____
- Bone/Muscle Disease____
- Bleeding Disorder____
- ADD/ADHD____
- Skin Condition____
- Learning Disability____
- 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? Yes_____ No_____ Describe: ________________________*

### Life Threatening Conditions

*Does your child have a life-threatening health condition? Yes____ No____ Describe: ________________________*

### 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 there 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_________________
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.

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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<tbody>
<tr>
<td></td>
<td></td>
<td>Sun Mon Tu Wed Th Fri Sat Normal Hours to</td>
<td>Breakfast A.M. Snack Lunch</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>P.M. Snack Supper Eve. Snack</td>
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</tbody>
</table>

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.

- Hispanic or Latino
- Not Hispanic or Latino

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

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

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