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.

Terra Sheriff-Penn
Enrollment Coordinator
Quileute Head Start

For Office Use Only

Date Received: ___________

☐ AM

☐ PM

Chi Cho? O'tsk' Ati

(House of Children)

Quileute Head Start Enrollment Application

Section 1-Child Information

Last Name:	**First:**	**Middle:**
Date of Birth:	**Gender:** ☐ Male ☐ Female	**SSN:**
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Biracial/Multi-racial ☐ Other Race: ____________________ **Child's Tribe:** ______________	**Ethnicity:** ☐ Hispanic or Latino Orgin ☐ Non-Hispanic/Non-Latino Orgin	**Language:** ☐ English ☐ Spanish ☐ Other Language: ____________________ Language Translator Needed? ☐ Yes ☐ No
Physical Address:		
Mailing Address: ☐ Same as physical		

Section 2-Family/Household Information

	Primary Caregiver	**Secondary Caregiver**
Relationship to Child:	☐ Mother ☐ Stepparent ☐ Guardian ☐ Father ☐ Foster ☐ Other	☐ Mother ☐ Stepparent ☐ Guardian ☐ Father ☐ Foster ☐ Other
Name:		
Date of Birth:		
Social Security Number:		
Race:	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Biracial/Multi-racial ☐ Other Race: ______________	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Biracial/Multi-racial ☐ Other Race: ______________

	Primary Caregiver	Secondary Caregiver
Hispanic or Latino:	☐ Yes ☐ No	☐ Yes ☐ No
Lives in Home w/ Child:	☐ Yes ☐ No	☐ Yes ☐ No
Home Phone:		
Cell Phone:		
Education Level:	☐ No Diploma ☐ High School Graduate ☐ GED ☐ College or Advanced Training	☐ No Diploma ☐ High School Graduate ☐ GED ☐ College or Advanced Training
Employment:	☐ Full-Time (35 hrs./week or more) ☐ Part-Time (Under 35 hrs./week) ☐ Unemployed ☐ Retired or Disabled ☐ Seasonally Employed	☐ Full-Time (35 hrs./week or more) ☐ Part-Time (Under 35 hrs./week) ☐ Unemployed ☐ Retired or Disabled ☐ Seasonally Employed
Family Size:		
Language Spoken at Home: ☐ English ☐ Spanish ☐ Other:		
Who has custody of the child: ☐ Mother ☐ Father ☐ Foster Parents ☐ Other:		
Please select the following if they apply to either caregiver above: ☐ Teen Parent ☐ Single Parent ☐ Two Parent Family ☐ Grandparent ☐Active Duty Military ☐ Veteran		

Additional Children in Home (other than the child listed above)

First and Last Name	Date of Birth	Gender
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

Section 3- Eligibility Information

Child is/has:	Check all that apply to family:
☐ Enrolled Quileute Tribal Member w/ CIB ☐ Quileute Tribal Descendant (not enrolled) ☐ Native American Enrolled in a Federally Recognized Tribe ☐ Native American Enrolled in a Non-Federally Recognized Tribe ☐ Disability/IESP ☐ Disability/IEP ☐ Disability- Documented but no IEP ☐ Disability- Behavioral/Mental Health Issues ☐ Returning Student ☐ CPS Referral ☐ Other Agency Referral	☐ TANF Services ☐ WIC Services ☐ SSI ☐ Homeless ☐ Family Drug/Alcohol Abuse ☐ Disabled Parent/Sibling ☐ Foster Parent ☐ Family Lives in or Works in La Push

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 childcare.
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 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 follows-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.
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 meeting 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 important that my child has a stable daily routine.
15. I will participate in all parent/teacher conferences.

______________________________   ______________________________

Parent/Guardian Signature   Date   QHS Staff Signature   Date

Quileute Head Start
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

Adult's Name & Phone Number: ______________________________

Physical Address: ______________________________

Drop-Off Location

Adult's Name & Phone Number: ______________________________

Physical Address: ______________________________

Please list three people that 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**

Quileute Head Start
Emergency Contacts Form

The following people are authorized to pick up my child from 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 Head Start staff if personal or other family circumstances change.

Child's Name: ______________________________ **Parent/Guardian's Name:** ______________________________

1.) Name: __________________________ **Phone:** ____________________

Relationship to Child: ____________________________________

2.) Name: __________________________ **Phone:** ____________________

Relationship to Child: ____________________________________

3.) Name: __________________________ **Phone:** ____________________

Relationship to Child: ____________________________________

4.) Name: __________________________ **Phone:** ____________________

Relationship to Child: ____________________________________

5.) Name: __________________________ **Phone:** ____________________

Relationship to Child: ____________________________________

____________________________________ ________________

Parent/Guardian 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

***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**

Quileute Head Start
Child Health Record

Child's Name: ______________________ **Sex:** ________ **DOB:**____________

PREGNANCY/BIRTH HISTORY	YES	NO	PLEASE EXPLAIN "YES" ANSWERS (USE ADDITIONAL SHEETS IF NEEDED)
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 THREE 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 THEN USUAL?			
9. IS MOTHER PREGNANCE NOW?			
HOSPITALIZATIONS AND ILLNESES			
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT (broken bones, head injuries, falls, burns, poisoning)?			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			
HEALTH PROBLEMS			
13. DOES CHILD HAVE FREQUENT ___ SORE THROAT, ___ COUGH, ___ URINARY INFECTIONS, ___ STOMACH PAIN, VOMMITING, DIARRHEA			
14. DOES CHILD HAVE DIFFICULTY SEEING (squint, cross eyes, look closely at books)?			
15. IS CHILD WEARING (or supposed to wear) GLASSES?			IF YES, WAS LAST CHECK UP MORE THEN ONE YEAR AGO?
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?			
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND (rear end, butt) WHILE ASLEEP?			
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICATION FOR SEISURES?			IF YES, WHEN WAS LAST SEIZURE? ______ WHAT MEDICATION? ______________
19. IS CHILD TAKING ANY OTHER MEDICATION NOW? (special consent form must be signed for Head Start to administer ANY medication)			IF YES, WHAT MEDICINE? ___________ WILL IT BE NEEDED TO BE GIVEN WHILE CHILD IS AT HEAD START? _____ HOW OFTEN? _________
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR DENTIST?			PHYSICIAN'S NAME:
21. HAS CHILD HAD ___ BOILS, ____ CHICKENPOX, ___ ECZEMA, ____ GERMAN MEASLES, ___ MEASLES, ___ MUMPS, ___ SCARLET FEVER, ___ WHOOPING COUGH			
22. HAS CHILD HAD ___ HIVES, ____ POLIO?			

Child Health Record (Continued)

	YES	NO	
23. HAS CHILD HAD ___ASTHMA, ___BLEEDING TENDENCIES, ___ DIABETES, ___ EPILEPSY, ___ HEART/BLOOD VESSEL DISEASE, ___ LIVER DISEASE, ___RHEUMATIC FEVER, ___ SICKLE CELL DISEASE?			
24. DOES YOUR CHILD HAVE ALLERGY PROBLEMS (rash, itching, swelling, difficulty breathing, sneezing)? 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) 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 HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?

PHYSICAL, PSYCHOLOGICAL AND SOCIAL DEVELOPMENT

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

27. CAN YOU TELL ME TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES EXPECIALLY 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 BATHROOM? ____________

31. DOES YOUR CHILD NEED HELP GOING TO THE TOILET DURING THE DAY OR NIGHT OR DOES YOUR CHILD WET HIS/HER PANTS? ___ NO ____ YES, IF YES PLEASE EXPLAIN ____________

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

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

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

35. DOES YOUR CHILD SEEM TO WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? ___ NO ____ YES, IF YES WHAT THINGS SEEM TO CAUSE HIM/HER TO WORRY OR 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. PLEASE MARK THE FOLLOWING AS BEST AS YOU CAN REMEMBER.

WHEN DID HE/SHE BEGIN TO: ____________

	EARLIER	WHEN EXPECTED	LATER	AGE
A. SIT UP W/ OUT HELP				
B. CRAWL				
C. WALK				
D. TALK				
E. FEED/DRESS SELF				
F. USE THE TOILET				
G. RESPOND TO DIRECTIONS				
H. PLAY WITH TOYS				

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO? ___ NO ___ YES, IF YES PLEASE EXPLAIN

38. CHILDREN SOMETIMES CRY WHEN THEY'RE TIRED/HUNGRY/SICK. DOES YOUR CHILD OFTEN CRY OTHER TIMES AND YOU CAN'T FIGURE OUT WHY? ___ NO ___ YES. IF YES PLEASE EXPLAIN____________

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST YEAR? ___NO ___YES. IF YES EXPLAIN____________

40. ARE YOU/YOUR FAMILY HAVING ANY PROBLEMS THAT MIGHT AFFECT YOUR CHILD? ___NO ___YES. IF YES EXPLAIN ____________

Child Health Record (Continued)-Nutrition 6 Form

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/OR MINERAL SUPPLEMENTS? A. IF YES WHAT ARE THEY? ________________	YES	NO
B. DO THEY CONTAIN IRON?		
☐ C. DO THEY CONTAIN FLOURIDE?		
D. WERE THEY PRESCRIBED?		
4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAR FOR MEDICAL, RELIGIOUS OR PERSONAL REASONS? A. PLEASE LIST FOODS ____________________		
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 DIARRHEA?		
11. DOES YOUR CHILD OFTEN HAVE CONSTIPATION?		
12. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS?		

13. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?	APPROXOMITE NUMBER OF TIMES A WEEK (CIRCLE)							
A. MILK, CHEESE, YOGURT	0	1	2	3	4	5	6	7+
B. MEAT, POULTRY, FISH, EGGS, DRIED BEANS OR PEANUT BUTTER	0	1	2	3	4	5	6	7+
C. RICE, GRITS, BREAD, CEREAL OR TORTILLAS	0	1	2	3	4	5	6	7+
D. GREENS, CARROTS, BROCCOLI, SQUASH, SWEET POTATOES	0	1	2	3	4	5	6	7+
E. ORANGES, GRAPEFRUIT, TOMATOES, FRUIT JUICE	0	1	2	3	4	5	6	7+
F. OTHER FRUITS AND VEGTABLES	0	1	2	3	4	5	6	7+
G. OIL, BUTTER, MARGARINE, LARD	0	1	2	3	4	5	6	7+
H. CAKES, COOKIES, SODA, CANDY	0	1	2	3	4	5	6	7+

Quileute Head Start

Student Health Registration Form

Student Name ___________________________ Class_____________ Gender_____________ Date of Birth______________

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 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**___________________

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 preventative service.

Fluoride Varnish

Procedure: A high concentration fluoride varnish is painted directly on to 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 preventative 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 ________________________

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

PART 2 – CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Multi-Racial
☐ Native Hawaiian or Pacific Islander ☐ White

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	Date Updated	Print Name of Adult Signing

Year 3

Signature of Adult	Date Updated	Print Name of Adult Signing

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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MAIL*: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue SW
Washington, D.C. 20250-9410

FAX: 202-690-7442
EMAIL: program.intake@usda.gov

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