Council of Three Rivers American Indian Center, Inc.
Intake Office
201 Rochelle Street, Pittsburgh, PA 15210
Telephone: 412-531-3290 or 412 488-2750
Fax: 412-531-3295 or 412-488-7527

Dear Parent/Guardian:

Thank you for your interest in our COTRAIC Early Childhood Education programs. By completing this application, your child or children will be well on their way to a quality preschool education.

If you have any questions or comments, or need assistance with this paperwork, please feel free to contact the Intake Office at 412-488-2750. Return your completed application for enrollment to the Intake Office or send it by mail.

You must provide proof of your child's age and proof of income with the application. The application will not be processed without these verifications. Proof of income may be any of the following:

*W-2's	*income tax returns	*recent pay stub
*child support records	*foster care records	*DPW printout

Please understand that you must provide proof of employment or enrollment in school or training to be eligible for extended day classes. If you are *not* employed or enrolled in school, the only program option available for your child may be a half-day session. We expect all children to have a minimum of 85% attendance throughout the school year.

All volunteers must have child abuse and criminal clearances.

Kindly spread the word about our Early Childhood Education programs to your friends and neighbors. As our participants, you are our best advocates and recruiters.

We are presently working in partnership with the following childcare centers:

Mt. Washington Children's Center Crafton Community Children's Corner

COTRAIC also provides services for children with disabilities and is accredited by NAEYC'S Academy of Early Childhood programs. Our centers are at the following locations:

Brookline	Dorseyville	Hazelwood
Knoxville	Overbrook	

pennsylvania
PRE-K COUNTS

INITIAL REGISTRATION

1. Child's Name: _____

2. Child's Date of Birth: _____ 3. Child's Gender: _____ Male _____ Female

4. Address: _____

_____ Zip Code _____

5 Home Phone #: _____ 6. Work Phone #: _____

7. Are you currently serving in the United States Military? _____

8. What race/ethnicity do you consider this child? _____

9. What is the family's primary language? _____

Do you speak/understand the English language? _____ Yes _____ No

10. How many Adults _____ and how many Children _____ in your household?

11. Gives names and birth dates of **all children** in the household:

Child's Name: _____ Date of Birth _____

Child's Name: _____ Date of Birth _____

Child's Name: _____ Date of Birth _____

Additional names, please use other side of this form.

12. Disabilities:	None _____	Suspected:	Diagnosed:	Date
Autism		_____	_____	_____
Emotional/behavioral disorder		_____	_____	_____
Health impairment including deafness		_____	_____	_____
Learning disability		_____	_____	_____
Mental retardation		_____	_____	_____
Orthopedic impairment		_____	_____	_____
Seizures (Epilepsy or Febrile)		_____	_____	_____
Speech or language impairment		_____	_____	_____
Traumatic brain injury		_____	_____	_____
Visual impairment including blindness		_____	_____	_____
Other impairment _____		_____	_____	_____
Family History of Diabetes, High Blood Pressure, etc.		_____	_____	_____

13. Does this child currently receive special services for the above indicated? _____ Yes _____ No

If yes, name and phone number of Provider: _____

Circle 1st and 2nd choice of sessions AM (8:00-11:30) PM (12:30-3:30) EXTENDED DAY (8:00-2:00)

Center applying for or at: _____

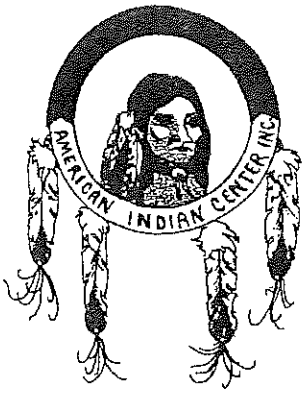
Are you requesting bus transportation for your child? _____ Yes _____ No

Do you receive subsidized child care? _____ Yes _____ No

Are you homeless (Living in a shelter or other temporary housing)? _____ Yes _____ No

** **If answered "yes" we will need notarized documentation/letter.**

Return to: 201 Rochelle Street, Pittsburgh, PA 15210 Phone: 412-488-2750



Council of Three Rivers American Indian Center, Inc.
120 Charles Street, Dorseyville, PA 15238
Telephone: (412) 782-4457
Fax: (412) 767-4808
Singing Winds Site

Intake Office
201 Rochelle Street, Pittsburgh, PA 15210
Telephone: 412-531-3190 or 412-488-2750
Fax: 412-531-3295 or 412-488-7527

APPLICATION

Child's Name: _____

Mother/Guardian: _____

DOB: _____ Email Address: _____

Address: _____

Telephone Number: _____ Cell Phone: _____

Father/Guardian: _____

DOB: _____ Email Address: _____

Address: _____

Telephone Number: _____ Cell Phone: _____

School District of Residence: _____

Type of family:
_____ Two Parent Family
_____ Single Parent Family (Mother/Mother Figure Only)
_____ Single Parent Family (Father/Father Figure Only)
_____ Other Family Type: Specify: _____
_____ Foster Family

Are there any court orders regarding custody/visitation/PFA? _____ Yes _____ No
(If you have answered yes, please provide a copy of the court order or PFA. This information **must** be received before your child/children can start the program.)

Has this child ever been enrolled in Head Start or other child development programs?
_____ Yes _____ No

If Yes, specify which program(s) and date(s) of attendance.

_____ Early Head Start from _____ to _____
_____ Head Start from _____ to _____
_____ Greater Hazelwood Family Center from _____ to _____

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Fax: 412-531-3295 or 412-488-7527

INCOME VERIFICATION

(Certification & Signatures)

Names of Family Members

_____ Adult	_____ Child	_____ Child
_____ Adult	_____ Child	_____ Child
	_____ Child	_____ Child

I certify that the information provided in this application, to the Early Childhood Education Program, is accurate and truthful to the best of my knowledge.

_____ Parent/Guardian Signature _____ Social Security Number _____ Date

_____ Phone Numbers Home _____ Work _____ Message/Cell/Pager

AGENCY USE ONLY

This family meets Head Start income eligibility requirements: _____ Yes _____ No **Family Size:** _____ Adults/Children

This family meets Pre-K Counts income eligibility requirements: _____ Yes _____ No **Family Size:** _____ Adults/Children

METHOD OF VERIFICATION

___ Tax Statement	___ W2 Statement	___ Pay Stubs
___ Income Declaration	___ Foster Care	___ Public Assistance Printout
___ Unemployment	___ Public Assistance Director	
___ Other: Specify _____		

Head Start/Pre-K Determination

_____ Eligible _____ Over Income

USDA Determination

_____ Free _____ Reduced _____ Paid

Income/eligibility certified by:

Signature: _____ Date: _____

Title: _____

Council of Three Rivers American Indian Center, Inc.
120 Charles St. * Dorseyville, Pa. 15238
Ph. 412-782-4457 - Fax 412-767-4808
Singing Winds Site

HEAD START PROGRAM
201 Rochelle Street ** Pittsburgh, PA 15210-2047
Ph. 412-488-2750 * Fax 412-488-7527

Child's Name: _____

As part of my application for service(s) from the Council of Three Rivers American Indian Center, Inc., Singing Winds Head Start, I hereby certify: (Please check the appropriate box.)

	I **AM NOT** American Indian

	I **AM** American Indian and the name of my tribe, band, nation, group, community or Alaskan Native Corporation is:

If you are American Indian, please complete whichever of the following best applies to you:

____ I am an enrolled member of the above tribe; my enrollment number is
____ I am eligible for enrollment, but am not yet enrolled with the above tribe.
____ I am recognized as a member of the above tribe, but my tribe does not enroll.
____ I am a descendant of the above tribe, but I am not enrolled nor eligible for enrollment. I identify as American Indian and am regarded as such by the Indian community in which I live or am a part of.

Present <u>two</u> items from the following list of documentation:

1. Birth Certificate signifying Indian identification.
2. Tribal enrollment information.
3. Letters from two non-related individuals attesting to your claim to Indian identification or descent.
4. Other official governmental document showing identification as Indian.

I CERTIFY THAT THE ABOVE IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature:_____ Date:_____

CODE WORD INFORMATION

Code # _____
(OFFICE USE ONLY)

Child's Name: _____ Room #: _____
(OFFICE USE ONLY)

Parent/Guardian Name(s): _____

Address: _____

_____ _____ _____
HOME Phone Number WORK Phone Number OTHER Phone Number

PERMISSION TO TRANSPORT

I hereby give permission for the staff of the Council of Three Rivers American Indian Center, Inc., to provide transportation for _____ in vehicles belong to the agency, staff members or emergency vehicles. The transportation shall include, but not be limited to travel to and from the center, to and from medical and dental appointments, to and from Head Start field trips, and to and from emergency medical and/or dental facilities.

This consent is valid until: **August 31, 2018**

Parent/Guardian Signature: _____ Date: _____

CODE WORD _____

Please give us a code word for your child. Code words are used for the safety of your child. The people who are allowed to pick up your child will need to be listed here and they will need to know the code word. You need to select a word that is easy for you to remember and then share it with the people you have listed. **DO NOT SHARE THE CODE WORD WITH THE CHILD. WE WILL NOT RELEASE YOUR CHILD TO ANYONE WHO IS NOT LISTED BELOW OR DO NOT KNOW THE CODE WORD. REMEMBER, THE PERSON DROPPING OFF/PICKING UP YOUR CHILD MUST BE 13 YEARS OLD OR OLDER.**

PERSONS PERMITTED TO PICK-UP CHILD **PHOTO ID IS REQUIRED FOR PICK-UP**

Name: _____ Relationship to Child: _____
Legal Name as shown on Identification

_____ _____ _____Home
Phone Number Work Phone Number Address of person picking up child

Name: _____ Relationship to Child: _____
Legal Name as shown on Identification

_____ _____ _____
Home Phone Number Work Phone Number Address of person picking up child

Name: _____ Relationship to Child: _____
Legal Name as shown on Identification

_____ _____ _____Home
Phone Number Work Phone Number Address of person picking up child

CODE WORD FORM

Child's Name: ______________________________ Code # ______________

Parent's Name: ______________________________ Site/Room# ______________

Parent's Signature: ______________________________ Date: ______________

CODE WORD ______________________

_____ NEW FORM ___ ADDITION ____ CHANGE/CORRECTION ____ DELETION

PERSONS PERMITED TO PICK-UP OR DROP OFF CHILD/CHILDREN **PHOTO ID IS REQUIRED**

Name: ______________________________ Relationship to Child: ______________
Legal Name as shown on Identification

Home Phone Number | Work Phone Number | Address of person picking up child

---

Name: ______________________________ Relationship to Child: ______________
Legal Name as shown on Identification

Home Phone Number | Work Phone Number | Address of person picking up child

---

Name: ______________________________ Relationship to Child: ______________
Legal Name as shown on Identification

Home Phone Number | Work Phone Number | Address of person picking up child

---

Name: ______________________________ Relationship to Child: ______________
Legal Name as shown on Identification

Home Phone Number | Work Phone Number | Address of person picking up child

---

Name: ______________________________ Relationship to Child: ______________
Legal Name as shown on Identification

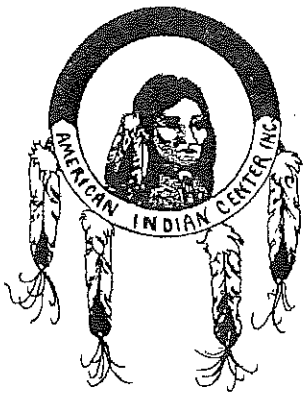
Home Phone Number | Work Phone Number | Address of person picking up child

---

Name: ______________________________ Relationship to Child: ______________
Legal Name as shown on Identification

Home Phone Number | Work Phone Number | Address of person picking up child

---



Council of Three Rivers American Indian Center, Inc.
120 Charles Street, Dorseyville, PA 15238
Telephone: (412) 782-4457
Fax: (412) 767-4808
Singing Winds Site

Intake Office
201 Rochelle Street, Pittsburgh, PA 15210
Telephone: 412-531-3290 or 412-488-2750
Fax: 412-531-3295 or 412-488-7527

PERMISSION TO RELEASE INFORMATION

I give permission for release of all information regarding _____ to the
(Name of Child) (Date of Birth)
Singing Winds Head Start program from the below listed services:

Doctor/Clinic/Hospital Name: _____ Phone: _____ Fax Number: _____
Dentist/Clinic/Hospital Name: _____ Phone: _____ Fax Number: _____
Department of Public Assistance: _____ Phone: _____ Address: _____
Other Name: _____ Phone: _____ Address: _____

This consent will be valid until **August 31, 2018** . A photocopy of this release shall be considered valid.

In granting this permission I understand that all information will be treated in a confidential manner. I release the COTRAIC Early Childhood Education program and its staff from legal liability for disclosing or acquiring any information that I have permitted by signing this form.

I also release the above-mentioned person and/or agencies from legal liability for giving information to the COTRAIC Early Childhood Education program for the period stated above.

_____
Signature

_____ _____ _____ _____
Relationship to child Date Room # Code #

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EMERGENCY TREATMENT FORM

Child's Name: _____ RM # _____ CODE # _____
(OFFICE USE ONLY)

Child's Address: _____

_____ _____
(Parent/Guardian) (Telephone Number)

_____ _____
(Nearest Relative or Friend) (Telephone Number)

_____ _____
(Nearest Relative or Friend) (Telephone Number)

****

Type of Medical Insurance: _____
Insurance #: _____

****

Doctor/Clinic/Hospital _____

Dentist _____

Allergies (to drugs, food, etc.) _____

Current Medications (name, dose) _____

****If medication is needed at school, an Individual Health Plan and Authorization for Medication need to be in place before entry****

Physical Limitations/Special Needs _____

****

I hereby give my permission for the COTRAIC Early Childhood Education Program to secure emergency medical or dental treatment for my child _____ _____
(Child's Name) (Date of Birth)

Also to transport my child to the most appropriate (as determined by Health Care Professional) medical facility. This consent is valid until **August 31, 2018** A photocopy of this consent shall be considered valid.

_____ _____
Signature of Parent/Guardian Date

_____
Relationship to Child

PRENATAL/BIRTH HISTORY of CHILD

Child=s Name: _____

Did you or the child's mother experience any of the following medical problems during the pregnancy?

Check all that apply

___ Pain	___ Swelling	___ Pregnancy-induced hypertension
___ Headaches	___ Fatigue	___ Pre-term labor
___ Hypertension	___ Bleeding	___ C-section
___ Anxiety	___ Sickle cell anemia	___ Diabetes (insulin dependent)
___ Irritability	___ Anemia (Hgb < 10 or Hct < 30)	
___ Stress	___ Don't Know	___ Other, specify: _____

Was this child born in a hospital or clinic?

___ YES ___ NO ___ Don't know

What was this child's birth weight? Or *(nearest estimate is fine)*

_____ pounds _____ ounces

Was this child born . . .

___ More than 2 months early?	___ More than 3 weeks late?
___ 2 months to 3 weeks early?	___ About on time?
___ Don't remember	

As a newborn, did this child stay in the hospital because she/he had medical problems?

___ YES ___ NO (*skip to specific allergies*) ___ Don't know

If YES, how long did the child stay in the hospital?

___ Less than 1 week?	___ Over 1 month?
___ One week to 1 month?	___ Don't remember?

Specify allergies or medical conditions (if applicable)

_____

MEDICAL/SOCIAL-EMOTIONAL HISTORY

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

Hospitalizations & Illnesses	Yes	No	Explain "Yes" Answers
Did mother have abnormal pregnancy? Explain: Child's birth weight:			
Has your child ever been hospitalized or operated on? Explain:			
Has your child ever had a serious illness or accident? A broken bone? Explain:			
Health Problems	**Yes**	**No**	**Explain "Yes" Answers**
Does your child have frequent: • Urinary infections or trouble urinating • Stomach pain, vomiting, diarrhea? Explain:			
Does your child have difficulty seeing (squint, cross-eyes, look closely at books)? Explain:			Name of Eye Doctor: Date last seen:
Does you child wear glasses?			Name of Eye Doctor: Date last seen:
Does your child have problems with ears/hearing (pain in ear, frequent earaches, infections, drainage, hearing loss)?			Name of Physician: Date last seen
Does your child have ear tubes? Date inserted:			Name of Physician: Date last seen
Has child ever had a convulsion or seizure? ___Yes ___No If yes, was convulsion/seizure related to a high fever? ___Yes ___No Is child on medication for this condition?			Name of Physician: When did it happen last? What kind of medication?
Is child taking any other medication? Note: Must have Doctor's statement for prescription medications that must be dispensed while child is in school.			Name of Physician: Date last seen: Type of medication: Reason for medication:
Is a physician or dentist currently treating this child? Why? Next appointment scheduled for:			Physician: Date last seen: Dentist: Date last seen:
Has child had: ☐ Chicken Pox ☐ Hives (See allergy question below)			
Does child have: ☐ Asthma ☐ Bleeding tendencies ☐ Diabetes ☐ Heart/Blood Vessel Disease ☐ Liver Disease ☐ Sickle Cell Disease ☐ Other (Explain)			Name of Physician: Date of last visit: Date of next appointment:
Are there any foods your child should not eat? ☐ Medical (Must have Dr's statement) ☐ Personal ☐ Religious			Name of Physician: Date of last visit:
Does child have any allergy problems (rash, itching, smelling, difficulty breathing, sneezing)? ☐ When eating any foods ☐ When taking any medications ☐ When near animals, fur, insects, dust			
Does your child have a diagnosed disability, with an IEP or IFSP? Explain:			
Are there any conditions that we haven't talked about that get in the way of the child's everyday activities? Describe:			

Physical, Psychological & Emotional Development

These questions will help us better understand your child. Please tell me one or two things that your child is interested in or does especially well?

Does your child nap? When: How long:

- ☐ Yes
- ☐ No

Does your child sleep less than 8 hours per night?

- ☐ Yes (Explain)
- ☐ No

How does your child tell you he/she has to go to the restroom? Explain:

Does your child need help with the bathroom?

- ☐ Yes
- ☐ No

Details:

How does your child respond to adults that he/she doesn't know?

How does your child respond to children he/she doesn't know?

Does your child have any difficulties saying what he/she wants to do or do you have any trouble understanding your child? Explain:

Children sometimes get cranky when they are tired, hungry or sick. Does your child get cranky or cry at other times?

- ☐ Yes
- ☐ No

Have there been any recent changes or problems in your child's life that may affect your child's behavior?

- ☐ Yes (Explain)
- ☐ No

Is your child receiving mental health services?

- ☐ Yes
- ☐ No

If yes:
Physician:
Diagnosis:
Medication:

Signature of Parent/Guardian: _____
Signature

Relationship: _____ Date: _____

Note: Complete special diet form, release of information and/or Individual Health Plan as necessary.

NUTRITIONAL ASSESSMENT of CHILD

Child's Name: _____ Room # _____ Code # _____

Dietary Habits:
Favorite Foods: _____

Least favorite foods: _____

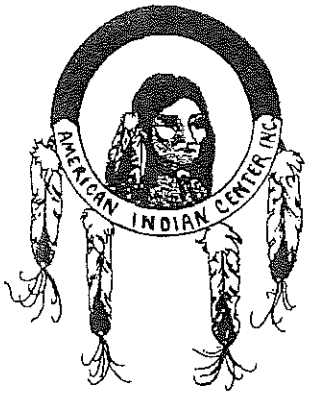
Child's know allergies to foods: _____

Do you receive Supplemental Nutritional Assistance Program (SNAP)? _____
Do you receive Women, Infants, and Children (WIC) a food and nutrition service provided by the State and USDA? _____

	Yes
Child takes vitamin/mineral supplements	____
Supplements contain iron	____
Supplements contain fluoride	____
Supplements were prescribe	____
Foods not eaten for medical, religious or personal reasons	____
Child on a special diet due to medical reasons	____
Change in child's appetite in the past month (If yes, please describe below)	____
Child takes a bottle	____
Child eats or chews things that aren't food	____
Child has trouble chewing or swallowing	____
Child often has:	
Diarrhea	____
Constipation	____
Concerns about what child eats	____

Comments

Do you want a consultation with our Nutrition Coordinator? _____ Yes _____ No
If yes, please let us know the best time to contact you: _____



Council of Three Rivers American Indian Center, Inc.
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Fax: 412-531-3295 or 412-488-7527

Child's Name: _____ Child's Birth Date: _____

Room # _____

Code # _____

CONSENTS:

_____ Vision _____ Hearing _____ Heights & Weights _____ Blood Pressure

_____ Accompany class on field trips _____ Use of the child's photograph _____ Hemoglobin

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Please check if your child has had a history of any of the following:
   __Ear Aches __Wax Build-up in the Ears __Frequent Head Colds __Ear Infections

2. Is your child presently on medication for ear problems?
   YES_____ NO_____ If yes, what?_____

3. Does your child have Ear Tubes?
   YES_____ NO_____ If yes, which ear? Right_____ Left_____

4. When were the tubes put into your child's ears? _____

****

I give permission for my child to have the following screening done by the Health Service Area:

___ Speech & Language Screening

___ Tympanometry Hearing Screening
(Measures movement of the eardrum which indicates the presence of fluid in the ear.)

Staff Use Only

Initial Screening Date	Re-screen Date
P E RS	P E
P R RS PT	P R

_____

Parent/Guardian Signature Date Relationship to Child

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Fax: 412-531-3295 or 412-488-7527

This section is to be given to your doctor and your dentist to complete.

Page 1	Introduction letter to your health care providers. Please let your Doctor/Dentist read this letter.
Page 2	A request for TB testing for parents B please read.
Page 3	Give to your doctor to complete after the physical exam.
Page 4	Child immunization records B to be completed by your doctor.
Page 5	Give to your dentist to complete after dental exam.

Please return the forms as soon as they are completed. Please include on a separate piece of paper the doctor or dentist name and number as well as dates and times of any medical or dental appointments when returning forms to the Head Start. Return forms as they are completed.

If you have any questions please call Family and Community Support Services at (412) 488-2750.

YOUR CHILD'S PHYSICAL NEEDS TO BE A <u>COMPLETE PHYSICAL</u>
Including the Hemoglobin, Lead Screening, Blood Pressure, TB Test and results etc.

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Dear Parents: _____ of Child's Name: _____

Due to the increase of Tuberculosis (TB) in the United States, for the safety of the children, and to comply with Head Start regulations, **WE ARE ASKING ALL PARENTS TO GET A TB TEST!** We rely on you to volunteer in such things as: the classroom, field trips, holiday parties, in various other components. We need documentation of your TB test in order for you to participate in these activities.

You may be able to receive this test from your doctor when you take your child to get his/her physical or from the County Health Department for free. You will need this signed and dated proof of your **NEGATIVE** results.

We thank you in advance for your co-operation.

Sincerely,

Health/Support Specialists

_____
(Parent's Name)

_____
(Type of TB test given) (Date given) (Results of TB Test) (Date of Results)

_____
(Physician's Signature) (Date)

PHYSICAL EXAMINATION/ASSESSMENT

Child's Name: _____ Sex _____ Birth Date: _____

1. RELEVANT INFORMATION *(from Health History, Parent Observation)*

2. SCRENNING TESTS: *Starred items (*) are required by Head Start and recommend by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum AN@, AS@, or AA@ for* NORMAL, SUSPECT, or ATYPICAL/ABNORMAL, respectively.

TEST	DATE	RESULTS	TEST	DATE	RESULTS
a) PRESENT AGE *		_____yrs., _____mos.	g) VISION (type test) ACUITY, ———		
b) HEIGHT (no shoes, to nearest 1/8 A inch) *			RESCREENING—————— STRABISMUS——————		
c) WEIGHT (light clothing to nearest 1/4 lb)			COMMENTS _____		
d) BLOOD PRESSURE			_____		
e) HEMATORCRIT or HEMOGLOBIN *			h) OTHER TESTS (If indicated)		
f) HEARING (type test) * RESULTS R/L RESCREENING COMMENTS	_____ _____ _____	_____ _____ _____	(1) TB _____ (2) Sickle Cell _____ (3) Lead _____ (4) Ova & Parasites _____ (5) Urinalysis _____ (6) Other _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____

3. PHYSICAL EXAMINATION/ASSESSMENT:

	NORMAL (for age)	ABNORMAL	NOT EVAL.	COMMENTS (use additional sheet if necessary)
a) GENERAL APPEARANCE				
b) POSTURE, GAIT				
c) SPEECH				
d) HEAD				
e) SKIN				
f) EYES (1) Externa aspect (2) Optic Fundiscopic (3) Cover Test	_____ _____ _____	_____ _____ _____	_____ _____ _____	
g) EARS (1) Externa: & Canals (2) Tympanic Membranes	_____ _____	_____ _____	_____ _____	
h) NOSE, MOUTH, PHARYNX				
i) TEETH				
j) HEART				
k) LUNGS				
l) ABDOMEN (include hernia)				
m) GENTILALIA				
n) BONES, JOINTS, MUSCLES				
o) NEUROLOGICAL/SOCIAL (1) Gross Motor _____ (2) Fine Motor _____ (3) Communication Skills _____ (4) Cognitive _____ (5) Self-Help Skills _____ (6) Social Skills _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	
p) GLANDS (Lymphatic/Thyroid)				
q) MUSCULAR COORDINATION				
r) OTHER				
s) GENERAL STATEMENT OF CHILD'S PHYSICAL STATUS:				_____ Signature of Doctor _____ Date

FINDINGS, TREATMENTS, AND RECOMMENDATIONS:

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP or RESULTS	DATE
a.			
b.			

DOCTORS: Please put results of TB, Lead, and Hgb/HCT on physical forms. If NOT AT RISK, NOT INDICATED, or NOT MEDICALLY NECESSARY please indicate so on the physical and sign.

IMMUNIZATION RECORD

Child's Name: _____ **Date of Birth:** _____

VACCINES	DATE GIVEN	VACCINES	DATE GIVEN
HEP B (3)		PREVNAR (3)	

DTP (4)		POLIO-OPV (4)	

HIB (4)		VARICELLA (1)	
		ROTO VIRUS (3)	

MMR (1)		TB TEST	RESULTS
HEP A (2)		MCV (1)	

EXEMPTIONS: if a child cannot or should not receive a particular immunization, use one of the following reasons:

A) HAS HAD DISEASE (attach physician's note. Rubella, only a serologic test is a valid exemption.)
B) ALLERGIC TO _____ (specify allergen and attach physician's note).
C) PARENT'S WILL NOT CONSENT (attach parent consent form).

I hereby attest that I have seen documentation of any immunizations the child received prior to enrollment in Head Start.

_____ _____ _____

Signature Title Date

Child Oral Health Assessment

Date Completed: ____/____/_____ Name: _____

Completed By: ☐ Head Start Staff Specify: _____

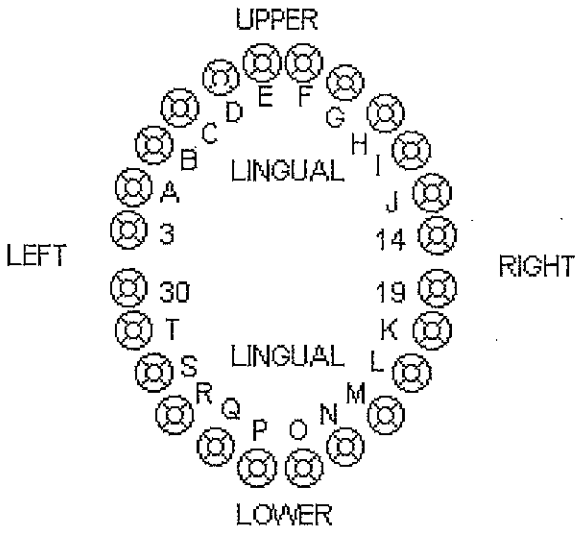
☐ Medical Provider Specify: _____

Assessment Type: ☐ Screening ☐ Assessment

Provider Setting: ☐ Home ☐ Doctor/Clinic ☐ School/Center

☐ Employment ☐ Other: Specify _____

Oral Condition:



Key: Missing Decayed Filled

Flossing Frequency:

☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times Per Day Child Brushes Teeth: |___|___|

Gum Condition:

☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Dental Needs:

☐ No Needs ☐ Treatment ☐ Cleaning
☐ Fluoride Supplement ☐ Oral Hygiene Instruction
☐ Other: Specify _____

Other Options: ☐ Filling ☐ Crown ☐ Cleaning
☐ Braces ☐ Dentures ☐ Other

Provider Signature: _____ **Date:** _____

Print Provider Name: _____

* Please use back of form for general comments.