Intake Form One

Eligible Child Demographic Form

FAMILY NAME: DATE:

SECTION I: BASIC DEMOGRAPHIC DATA

1. Eligible child's name:

First name | MI | Last name #1 | Last name #2

2. Nickname: | 3. Date of birth*: | 4. ID (Agency defined ID if applicable): | 5. SSN: | 6. Gender: ☐Male ☐Female

7. Race*(check only one):

☐American Indian/Alaskan Native ☐White ☐Refused
☐Native Hawaiian or Other Pacific Islander ☐Black or African American ☐Unknown
☐Asian ☐Other ☐Unspecified
☐Bi-racial/Multi-Racial Specify:

8. Ethnicity:

☐HR A21 a.i. Person's ethnicity is Latino or Hispanic *

9. Language spoken at home: Primary*: ☐English ☐Other _____ Secondary: ☐English ☐Other _____

10. How well does the child speak English?
☐Very well ☐Well ☐Not well ☐Not at all

SECTION II: RELATIONSHIPS

11. What is this person's relationship to other eligible child(ren)?

Eligible child #1 — Relationship to child
Eligible child #2 — Relationship to child
Eligible child #3 — Relationship to child

FOR 11: USE THE FOLLOWING TERMS TO SPECIFY THE RELATIONSHIP TO THE ELIGIBLE CHILD:

Biological Parent ☐ | Aunt/Uncle ☐
Foster Parent ☐ | Sibling ☐
Step Parent ☐ | Step/half Sibling ☐
Grandparent ☐ | Other Relative ☐
Godparent ☐ | No Biological or Legal Relationship ☐
Legal Guardian ☐

SECTION II: CHILD INFORMATION

12. Concerns about child's overall health and development? ☐Yes ☐No

12 a. Describe concerns:

Concerns expressed by:
☐Family member ☐Medical provider ☐Program staff ☐Soc svc agency ☐Primary care provider ☐Other:

13. Child to be cared for by someone other than the head of household in addition to Head Start (check all that apply):

☐Older sibling under age 12 ☐Adult nonrelative in nonrelative's home ☐Relative ☐Other: Specify
☐Older sibling age 12 or older ☐Adult nonrelative in child's own home ☐Childcare center ☐Not yet arranged

SECTION IV: ADDRESSES

14. Address (1) Street: City: State: Zip: Effective Date:

(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other

Home phone #1: Home phone #2:

15. Address (2) Street: City: State: Zip: Effective Date:

(Check all that apply) ☐Living ☐Mailing ☐Pick-up ☐Drop-off ☐Other

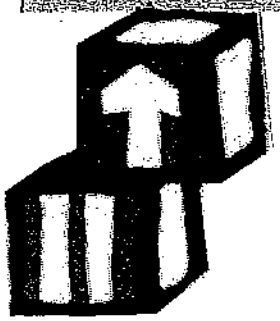
Home phone #1: Home phone #2:

AGENCY USE ONLY - Current Program Enrollment

Program Applying for:	Program Type:	Status:	Status Date:
Center:	Class:	Start Date:	Income Eligibility Date:

Other Programs/Services/Financial Assistance Received

Program:	Program Type:	Start Date:	End Date:
Program:	Program Type:	Start Date:	End Date:



HO-CHUNK HEAD START

Intake Form Two

Family Member Demographic Form

FAMILY NAME: **DATE:**

SECTION I: BASIC DEMOGRAPHIC DATA

1. Person's role in household*: ☐ Mother/Mother Figure ☐ Father/Father Figure ☐ Household Member ☐ Resides outside of home

2. Family member's name:

First name | MI | Last name #1 | Last name #2

3. Nickname: | **4. Date of birth*:** | **5. ID (agency defined ID if applicable):** | **6. SSN:** | **7. Gender:** ☐ Male ☐ Female

8. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | **9. Email address:**

10. Race(check only one)*:
☐ American Indian/Alaskan Native
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ Bi-racial/Multi-racial
☐ White
☐ Black or African American
☐ Other
Specify:
☐ Refused
☐ Unknown
☐ Unspecified

11. Ethnicity:
☐ PIR A21 a.i. Person's ethnicity is Latino or Hispanic*

12. Language spoken at home: Primary*: ☐ English ☐ Other _____ Secondary: ☐ English ☐ Other _____

13. How well does the person speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all

SECTION II: RELATIONSHIPS

14. What is this person's relationship to eligible child(ren)?

Eligible child #1 — Relationship to child
Eligible child #2 — Relationship to child
Eligible child #3 — Relationship to child

FOR 14 USE THE FOLLOWING TERMS TO SPECIFY THE RELATIONSHIP TO THE ELIGIBLE CHILD:
☐ Biological Parent ☐ Aunt/Uncle
☐ Foster Parent ☐ Sibling
☐ Step Parent ☐ Step/half Sibling
☐ Grandparent ☐ Other Relative
☐ Godparent
☐ Legal Guardian ☐ No Biological or Legal Relationship

SECTION III: ADULT INFORMATION

15. Applicant currently pregnant? ☐ Yes ☐ No | **16. Due Date:** | **17. Prenatal Care Provider:**

18. Adult training questions:
Attended Vocational Training, Trade or Business School: ☐ Yes ☐ No ☐ N/A
Received certificate or license: ☐ Yes ☐ No ☐ N/A
Participated in Government Training Program: ☐ Yes ☐ No ☐ N/A
Training program(s) attended (check all that apply):
☐ JOBS ☐ Job Corps
☐ JTPA ☐ Other: Specify (if Other):
Willing to Pursue Additional Education/Job Training: ☐ Yes ☐ No ☐ N/A

19. Teen parent questions:
Person is a Teen Mother ☐ Yes ☐ No ☐ N/A
Attended Parent Program in School ☐ Yes ☐ No ☐ N/A
Enrolled in Teen Parent Program ☐ Yes ☐ No ☐ N/A
Teen Mother Dropped out of School ☐ Yes ☐ No ☐ N/A
Reason:

SECTION IV: ADDRESSES

20a. Address Street: | City: | State: | Zip: | Effective Date:

(Check all that apply) ☐ Living ☐ Mailing ☐ Pick-up ☐ Drop-off ☐ Other

Home phone #1: Home phone #2:

20b. Address Street: | City: | State: | Zip: | Effective Date:

(Check all that apply) ☐ Living ☐ Mailing ☐ Pick-up ☐ Drop-off ☐ Other

Home phone #1: Home phone #2:

SECTION V: OCCUPATION

21. Person's primary occupational status(check only one)*: Start Date*: End Date:

Paying job:
☐ Full-time (more than 34 hrs per week)
☐ Part-time
☐ Seasonal - Non-agricultural
☐ Seasonal - Agricultural
☐ Employed and in school

Unemployed:
☐ With past employment experience
☐ With no previous employment experience

Other:
☐ Homemaker
☐ Unable to work due to disability
☐ Retired
☐ Not applicable

In school; full time and employed part time:
☐ Towards high school diploma/GED
☐ Towards trade/business qualification
☐ Towards college degree
☐ Towards postgraduate degree
☐ Other
☐ In school and employed

In job training program:
☐ Training program with salary
☐ Training program without salary

Employed full-time and in school part-time:
☐ Towards high school diploma/GED
☐ Towards trade/business qualification
☐ Towards college degree
☐ Towards postgraduate degree
☐ Other
☐ In school and employed
☐ Employed and in school

School Full Time
☐ In school and employed
☐ Towards High School Diploma/GED
☐ Towards trade/business qualification
☐ Towards college degree
☐ Towards postgraduate degree
☐ Other

SECTION VI: EDUCATION

22. Highest level of education (check only one)*: Effective Date*:

☐ No school completed
☐ Less than or equal to 4th grade
☐ 5th-8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ 12th grade (no diploma)
☐ High School graduate/GED
☐ Some college (but no degree)
☐ Associate degree in college
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate degree

Complete one copy for each family member who is not eligible for Head Start.

Intake Form Three

Income and Employment Worksheets

FAMILY NAME: **DATE:**

SECTION I: FAMILY EMPLOYMENT and INCOME DATA

Number of adults:____ Number of children:____ ☐ Approved for USDA/CACFP eligibility determination

Number of adults contributing to income:____

Head of Household **Name:**

Record employment details for past 24 months.	Employer Name, Street, City, State, Zip, and Work Phone	Income Source **	Frequency (circle one)	Amount
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
			Total Income for HOH:	

Other Family Member's Employment History (if applicable) **Name:**

Record employment details for past 24 months.	Employer Name, Street, City, State, Zip, and Work Phone	Income Source **	Frequency (circle one)	Amount
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
			Total Income for OFM:	

Other Family Member's Employment History (if applicable) **Name:**

Record employment details for past 24 months.	Employer Name, Street, City, State, Zip, and Work Phone	Income Source **	Frequency (circle one)	Amount
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
from: to:			Weekly, Every 2 weeks, Twice a month, Monthly, Annually	
			Total Income for OFM:	

** Use the following abbreviations (In bold) for Income Source:

Agricultrual - **Ag**
Non-Ag - **Non-Ag**
Public Assistance - **PA**
Social Security or Pension - **SS**
Supplemental Security Insurance - **SSI**
Child Support/ Alimony - **CS**
Foster Care/ Adoption Subsidy - **FC**
Unemployment Insurance - **UnEmp**
Other Unearned - **Other**

TOTAL FAMILY INCOME: **

* *Reminder - Specify family income as child's eligibility income in program enrollment.*

Intake Form Four

Family Information

FAMILY NAME: _____ DATE: _____

Head of Household for this Family: Date of Initial

FAMILY INFORMATION

Migrant Family ☐ Migrant ☐ Seasonal

If MHS: Qualifying move in past two years? ☐ Yes ☐ No | Type of Move: ☐ Inter-state ☐ Intra-state

1. Family type (check only one)*:

☐ Two parent family
☐ Single parent family (mother figure only)
☐ Single parent family (father figure only)
☐ Foster family
☐ Single parent family (mother figure only) living with partner
☐ Single parent family (father figure only) living with partner
☐ Other relative(s)
☐ Other family type: Specify

2. Types of Services or Financial Services Received

☐ No Services Received ☐ Child Support / Alimony ☐ Medical Financial Assitance ☐ Public Assistance/Welfare* Date Rcd: _____
☐ Energy Program Assistance ☐ EPSDT ☐ Public Housing Assistance ☐ Supplemental Security Income* Applied? ☐Yes ☐No
☐ Food Stamps ☐ Foster Care/Adoption Subsidy ☐ Unemployment Insurance ☐ WIC*
☐ Other: Specify: ☐ Other: Specify:

3. Type of housing (check only one):

☐ House ☐ Mobile home/trailer ☐ Hotel/motel room ☐ Migrant housing
☐ Apartment ☐ Community shelter ☐ Homeless/no housing ☐ Other:

4. Housing payment arrangement (check only one):

☐ Exchange services for housing ☐ Rent housing ☐ Receive subsidized housing
☐ Make no payment for housing ☐ Own housing ☐ Other: Specify

5. Length at current address: ☐ less than 6 mths ☐ 1 - 2 yrs ☐ 6 - 12 mths ☐ More than 2 yrs

6. Number of moves in the past 12 months: _____

7. Homeless in past 12 months *(including currently homeless)* *: ☐ Yes ☐ No

7a. Length of time homeless: ☐ Less than 1 month ☐ 3-6 months ☐ 1-3 months ☐ More than 6 months

7b. Family acquired housing during enrollment year*: ☐ Yes ☐ No

8. Family currently has means of transportation: ☐ Yes ☐ No

9. Family has alternate means of transportation: ☐ Yes ☐ No

Check First box for Primary and Second box for Alternate means of Transportation.

☐ ☐ Private Vehicle (car, truck, van) ☐ ☐ Friend/Relative's vehicle
☐ ☐ Public Transportatin ☐ ☐ City Bus
☐ ☐ Taxi ☐ ☐ Parent Transport
☐ ☐ School Bus ☐ ☐ Other

10. Family referred from:

11. Comments:

12. Current Family Income: ☐ Over Income ☐ Under Income

PARENT

I certify that information provided is correct to the best of my knowledge and is subject to verficiation. I am also aware that I may be subject to terminalion from the program if the information verified disqualifies me from eligibility.

_____
Applicant Signature/Firma del Aplicante:

_____
Print Name of Applicant/Nombre (Use letra Imprenta)

Date/Fecha: _____

STAFF

Eligibility Determination Statement I hereby do certify that the family is eligible to participate in the H.S. Program. Furthermore, I attest that I have examined the documents (checked) below and certify that the family is eligible in accordance with Head Start regulations and Eligiblity-Recruitment-Selection Enrollment-Attendance policies.

Documents Reviewed (check all that apply):

☐ 1040 Form ☐ W-2 Statement ☐ Pay Stubs ☐ Income Declaration ☐ Unemployment
☐ IC Supplement ☐ Public Assistance (TANF, ect) ☐ Child Care Assistance ☐ SSI
☐ Social Security ☐ Grants / Scholarships ☐ Foster Care ☐ Employment
☐ Child Support/Alimony ☐ Unemployment Compensation ☐ Financial Aid
☐ Documentation of No Income ☐ Other
☐ Written Statements from Employer SNAP/Food Share/EBT

AGENCY SIGNATURES

Center Director's Certification Signature: _____
Certification Date: _____

Staff's Eligibility Verification Signature: _____
Verification Date: _____

Print Name of Center Director: _____

Print Name of Staff Member: _____

HEAD START SCREENING AUTHORIZATION FORM

I, _____ give permission for my child, _____, to receive routine screenings and physical assessments from the Ho-Chunk Nation Health Department in accordance with the Head Start Program requirements while he/she is participating in the program. These necessary screenings include annual hearing, vision, height, weight, blood pressure and any other screenings that may be deemed necessary by the program.

I understand that I will need to provide, for the Head Start Program, a signed physical and dental form within the first 30 days of my child's attendance. If I do not, the Head Start Program will contact me in writing after 30 days of no report of appointment date or submission of completed health forms. You will additionally be contacted up to two more times within the next 90 days for lack of submission of the above listed forms. If you have not submitted those signed forms before January 1, we will contact the County Public Health Department for assistance for your family.

_____ _____

Parent/Guardian Signature required Date

Department of Education
PO Box 667
Black River Falls, WI 54615

Center Name:_____
Child's Name:_____

Child Seat Restraints

I give my permission to the Head Start Staff to buckle my child in. I am giving this permission due to the five point restraint seat belts, and the positioning of the buckle.

_____ _____

Parent/Guardian Signature Date

Intake Form Five

Eligible Child Health Form

FAMILY NAME: **Date:**

Child Health Information

Eligible child's name:

First Name	*Last Name*	*D.O.B.*

Medical Insurance Providers

*Insurance Type: ☐ Child Health Insurance Program (CHIPS)
☐ Medicare / Medicaid
☐ Private
☐ no coverage

Insurance Provider Name: _____

Policy Number: _____

*Insurance Effective Date: _____ *Insurance Expiration Date: _____

*Primary Insurance: ☐ Yes ☐ No ☐ N/A

Include Dental Coverage? ☐ Yes ☐ No ☐ N/A

Medical and Dental Providers & Exam Status

*Current Medical Provider: _____ Phone # _____

Date of last well exam _____

Current Dental Provider: _____ Phone # _____

Date of last dental exam _____

*Disabilities	Evaluated by	*Suspected Yes No N/A	*Identified Yes No N/A	Date
☐ Autism				
☐ Emotional / Behavioral disorder				
☐ Health Impairment				
☐ Hearing impairment, including deafness				
☐ Learning disability				
☐ Mental retardation				
☐ Multiple Disabilities				
☐ Non-categorical/developmental delay				
☐ Orthopedic Impairment				
☐ Speech or language impairment				
☐ Traumatic brain injury				
☐ Visual impairment, including blindness				

Lead Exposure Risk Assessment Questionnaire for Children

In addition to the required testing of all children for lead with a blood lead test at one year of age and again at age two, assessment of risk for lead exposure should be done at each well-child visit or at least annually for each child six months to six years of age. The questions below serve as a risk assessment tool based on currently accepted public health guidelines. Children found to be at risk for lead exposure should receive a blood lead test whenever such risk is identified.

Questions	Answer Yes	Answer No
1. Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent or ongoing renovation or remodeling? **Note**: This could include a day care center, preschool, and the home of a babysitter or a relative.	☐	☐
2. Has your family/child ever lived outside the United States or recently arrived from a foreign country?	☐	☐
3. Does your child have a brother/sister, housemate/playmate being followed or treated for lead poisoning?	☐	☐
4. Does your child frequently put things in his/her mouth such as toys, jewelry, or keys? Does your child eat non-food items (pica)? **Note**: This may include toys or jewelry products that have been recalled by the Consumer Products Safety Commission (CPSC) due to unsafe lead levels: www.nyhealth.gov/environmental/lead/recalls	☐	☐
5. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? **Note**: Jobs include house painting, plumbing, renovation, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making or shooting firearms and collecting lead or pewter figurines.	☐	☐
6. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead? **Note**: May need to alert parent/caregiver if such an industry is local.	☐	☐
7. Does your family use products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter? **Note:** Lead has been found in traditional medicines such as Ayurvedic medicine, liga, greta, azarcon, litargirio, and in cosmetics such as kohl, surma, and sindoor. Lead exposure risk is higher with old, imported, painted, cracked or chipped china, and in low-fired and terra cotta pottery, often made in Latin America and the Middle East.	☐	☐

If the answer to any of the above questions is YES, then the child is considered to be at risk for lead exposure and should receive a blood lead test.

- Ask any additional questions that may be specific to a particular community (or population) e.g. high risk zip code, refugee child recently arrived in the United States, children with behavioral and/or developmental disabilities, children who receive Medicaid or children entering foster care.
- Ask if any of the above conditions are expected to change in the future (e.g. house remodeling).
- Tailor appropriate anticipatory guidance to the child and family.

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

Health History and Emergency Care Plan

Use of form: This form is voluntary and meets the requirements in DCF 250.04(6)(a)1., DCF 251.04(6)(a)6., and DCF 252.41(4)(a)6. of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian may complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance (mm/dd/yyyy)

Home Address (Street, City, State, Zip Code)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number
Name	Primary Telephone Number	Work Telephone Number	Secondary Telephone Number

PHYSICIAN / MEDICAL FACILITY INFORMATION

Physician Name	Medical Facility Address	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 250.07(6)(h)6., Authorizations shall be reviewed periodically and updated as necessary. Per DCF 251.07(6)(g)3., authorizations shall be reviewed every 6 months and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
   - ☐ No specific medical condition
   - ☐ Any disorder, including Cognitively Disabled, LD, ADD, ADHD, or Autism
   - ☐ Asthma
   - ☐ Cerebral palsy / motor disorder
   - ☐ Diabetes
   - ☐ Epilepsy / seizure disorder
   - ☐ Gastrointestinal or feeding concerns, including special diet and supplements

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication – Child Care Centers* should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

CHILD HEALTH RECORD: FORM 2A, HEALTH HISTORY

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

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 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 THAN USUAL?	☐	☐	
9. IS MOTHER PREGNANT NOW?	☐	☐	*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*

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 *(broken bones, head injuries, falls, burns, poisoning)?*	☐	☐	
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?	☐	☐	

HEALTH PROBLEMS	YES	NO	EXPLAIN *(Use additional sheets if needed)*
13. DOES CHILD HAVE FREQUEST ☐ SORE THROAT; COUGH ☐ URINARY INFECTIONS OR TROUBLE URINATING; ☐ STOMACH PAIN, VOMITING, 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 CHECKUP MORE THAN 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, anus, butt)* WHILE ASLEEP?	☐	☐	
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	☐*	☐	*(If "yes") ask: WHEN DID IT LAST HAPPEN? WHAT MEDICINE?*
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*	☐	☐	WHAT MEDICINE? _____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? HOW OFTEN
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A 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?	*		
23. HAS CHILD HAD: ☐ ASTHMA, ☐ BLEEDING TENDENCIES ☐ DIABETES, ☐ EPILEPSY, ☐ HEART BLOOD VESSEL DISEASE, ☐ LIVER DISEASE, ☐ RHEUMATIC FEVER, SICKEL CELL DISEASE? ☐	*		*If "yes", transfer information to Forms 1 and 5.*
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)?*	*		*If "yes" transfer information to Forms 1 and 5.*
a. *WHEN EATING ANY FOODS?* _____			WHAT FOODS?
b. *WHEN TAKING ANY MEDICATION?* _____			WHAT MEDICINE?
c *WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC?*			WHAT THINGS?
			HOW DOES CHILD REACT?
25 *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:.) DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONSAL 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 EVERY-DAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE· WHEN?

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

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 OESN'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 SEEM TO 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 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 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, HUNGARY, 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 PROBLEMSNOW THAT MIGHT AFFECT YOUR CHILD? ☐ NO, ☐ YES IF "YES" PLEASE DESCRIBE

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? ☐ NO, ☐ YES IF "YES" PLEASE DESCRIBE

CHILD HEALTH RECORD: FORM 6, NUTRITION

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

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE? _____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES?

	Yes	No
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?	☐	☐

12. ABOUT HOW OFTEN DOES YUR 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)*

(a) Milk, cheese, yogurt.	0* 1* 2* 3 4 5 6 7 7+
(b) Meat, poultry, fish, eggs; or Dried beans/peas peanut butter.	0* 1* 2* 3 4 5 6 7 7+
(c) Rice, grits bread, cereal, tortillas.	0* 1* 2* 3 4 5 6 7 7+
(d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes.	0* 1* 2 3 4 5 6 7 7+
(e) Oranges, grapefruit, tomatoes (fruit/juice).	0* 1* 2* 3 4 5 6 7 7+
(f) Other fruits and vegetables.	0* 1* 2 3 4 5 6 7 7+
(g) Oil, butter margarine, lard.	0* 1* 2 3 4 5 6 7 7+*
(h) Cakes, cookies, sodas, fruit drinks, candy.	0 1 2 3 4 5 6 7 7+*

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

15. HOUSEHOLD INFORMATION *(Please complete for family and household members).*

	BIRTH DATE	LIVES WITH CHILD YES	LIVES WITH CHILD NO	FAMILY MEMBERS' HEALTH PROBLEMS
FATHER		☐	☐	
MOTHER		☐	☐	
BROTHERS & SISTERS *(oldest first)* (1)		☐	☐	
(2)		☐	☐	
(3)		☐	☐	
OTHER *(Specify relationship)* (1)		☐	☐	
(2)		☐	☐	
(3)		☐	☐	

Head Start Transportation/Medical Emergency Card

Pursuant to 45 CFR Part 1310 – Head Start Transportation Regulations (Section 1310.10 (g)) we are required to release children to their legal parent or legal guardian or another individual that has been identified in writing.
Please list the persons who you give permission to take your child off the bus, also list their phone number and relationship to child. No one under the age of 18 will be allowed to take your child off the bus, unless you are the parent.

These names will also be used for emergency contacts.

Name	Relationship	Phone
1.		
2.		
3.		
4.		

This permission also includes transportation for field trips, provided that I am notified in advance of this. My signature below indicates that the student listed below and I, as parent or legal guardian of the student, hold the Ho-Chunk Nation and its employees acting within the scope of employment and authority using reasonable care in transportation harmless from liability.

PARENT SIGNATURE: _____ **DATE:** _____

Disability, Medical Condition, Allergies: _____

_____

Effects of disability on bus transportation: _____

_____

Special Directions to driver/assistant for controlling or directing the student: _____

_____

Medication the student is taking on a regular basis: _____

_____

Parent's/Guardian's Signature _____ Date _____

Parent or Guardian phone numbers: #1_____ #2 _____

CONSENT FOR CHILD'S EMERGENCY MEDICAL/DENTAL TREATMENT

I, _____ hereby give my consent for emergency medical or dental treatment of the child listed below as deemed necessary by any licensed professional while under the care of the Head Start Program and for the transport of the child to and from the source of emergency treatment.

Name of Child_____ Birth Date _____

Signature_____ Date _____ Relationship to Child _____

Name of Medical Provider_____ Phone Number _____

Address of Medical Provider_____

Ho-Chunk Head Start

Parental Custody Issues

Dear Parent(s):

An increasingly large number of children are members of families that have experienced divorce. Generally the custodial and non-custodial parents both continue to have certain parental rights. Occasionally the court issues restraining orders against one of the parents in the custody agreement. Frequently the school gets caught in the middle and does not know what parental rights the custodial and non-custodial parents possess. Unless we have a copy of a court order that specifies restraints against the parental rights of the non-custodial parent, the school will assume that both parents may continue to exercise parental rights.

IF APPLICABLE
COMPLETE AND RETURN WITH YOUR ENROLLMENT APPLICATION

CONFIDENTIAL INFORMATION

Date: _____

Student(s): _____ _____
_____ _____

Custodial Parent: _____
Address: _____
Telephone: _____

Non-Custodial Parent: _____
Address: _____
Telephone: _____

Has the court issued orders that restrict the non-custodial parent from receiving school information, visiting the child or the child's teachers, or picking up the child at school? Yes ☐ No ☐ If yes, please provide the Center Director with a copy of the court order. The document will be maintained as a confidential record.

FAMILY POLICIES AGREEMENT

HOURS OF OPERATION

Hours of operation are from 8:00 AM to 4:00 PM Monday through Friday. Children attend the center from 8:30 AM to 3:00 PM Monday through Thursday. The Ho-Chunk Head Start Program provides transportation for the children. However, if you wish to bring your child, we ask that you not bring them prior to 8:15 AM. We would like to invite you to spend time at the center whenever you have a chance.

If the center should have to close for any reason, we will notify you as soon as possible. If there should be inclement weather, we will follow the local school district closings.

BUS PICK UP AND DROP OFF

Our program serves children and families who live within a 12-mile radius of each Center. Because of this, if you live beyond that point, you will need to find consistent child care within this service area, or transport your child to a consistent pick up point and be at a drop off point to meet your child.

Bus pick up is between 7:30 AM and 8:30 AM.

Drop off is between 3:00 PM and 4:30 PM. The driver will not drop off your child unless an adult comes to the bus. If no adult is home to come to the bus, your child will be returned to the Head Start Center. ***Child protection will be notified if an authorized person has not picked up your child by 4:00 PM.***

Due to the length of bus routes no alternate pick-up and drop-off points will be allowed. We will pick-up and drop-off only at the designated locations.

SOCIAL MEDIA EXPECTATIONS

The Head Start Program requests that if you are visiting the Head Start Center, or accompanying us on a field trip, that you will avoid photographing any child other than your own. If you happen to get a snapshot of another child with your own child, we request that you would not post that photo to a social media site.

Although social media can be a wonderful thing to one person, to another it can be very scary. As parents, we innocently photograph our children, and proudly post their sweet little images on social media sites to share with our family and friends…perhaps unaware that there are strangers out there that may gain access to that information and use it inappropriately.

HEALTH STANDARDS

Parents will be notified immediately if their child becomes ill. Sick children will be isolated within our sight or hearing and made as comfortable as possible. Any ill child will need to be picked up from the center within ½ hour of being contacted. If the child is not picked up within that time frame, the emergency contact person on the child's enrollment form will be called.

A doctor's written permission to return to school is required when a child has had a communicable disease (such as chicken pox, measles), or if the child has been absent for more than three days.

MEDICATION

The Head Start Staff will administer medications. Prescriptive and non-prescriptive medication will only be given to children if parents have completed the authorization form provided. All

medicine must be in its original container bearing the label with child's name, dosage and administration directions. We will not exceed the age-related dosage on the label of any medication without a written doctor's authorization. Blanket authorizations, such as dispensing Tylenol at our discretion, will not be allowed.

Prior to applying sunscreen or insect repellant to a child, we will obtain a written authorization from the child's parent. The authorization shall include the brand and the ingredient strength.

EMERGENCIES

We will call you, or the person you listed as the "Emergency Contact Person", immediately if your child gets hurt or is ill at school. If your child has incurred a minor injury we will utilize first aide to treat it, and you will be contacted as to the injury. For major injuries we will follow the emergency medical procedure.

ABSENTEEISM

We ask that you please call the center by 7:00 AM if your child will not be in attendance for the day. We want to convey the importance of school attendance to children. Too many "unexcused" absences may tell your child that school is not important. Excessive absenteeism will result in your child being dropped from the program and being placed on the bottom of the waiting list, per the attendance policy.

EVALUATING YOUR CHILD

The teachers will evaluate the children in September, February, and April using the Teaching Strategies GOLD (TSG) Assessment. Because each child is different, we want to implement long-range goals for each child. The TSG Assessment is the tool that we use to evaluate your child in the areas of cognition, language and motor skills. Parent/Teacher meetings are held following each evaluation. We will discuss with you the results of the TSG. We will also ask for input from you as to how we can work together to assist your child's development.

HOME VISITS

The staff will make a minimum of two (2) home visits each school year. This is in addition to two (2) Parent/Teacher conferences. The home visits are designed to keep you and the staff up to date with information on your child.

DRESS FOR PLAY

Please dress your child in weather appropriate clothing. We also ask that you keep a set of clothes at the Center in case of "accidents".

My signature indicates that I have read and understand the above.

_____ _____

Parent/Guardian Signature **Date**

SIGN AT THE BOTTOM TO SIGNIFY THAT THIS AGREEMENT MEETS WITH YOUR APPROVAL. PLEASE PLACE A CHECK BY ALL OF THE STATEMENTS THAT MEET WITH YOUR APPROVAL.

I AGREE TO THE FOLLOWING:

Yes No

☐ ☐ That my child, _____, may participate in all health activities, including dental hygiene, that are offered as part of the school program.

☐ ☐ That any picture taken of my child may be used in newspapers, displays, bulletin boards or other types of educational publications.

☐ ☐ That my child may accompany his/her class on all scheduled field trips and that I will be notified of impending trips.

☐ ☐ That my child will attend class everyday that he/she is able from 8:30 AM to 3:00 PM. I also understand that excessive absenteeism will result in my child being dropped from the program.

☐ ☐ I understand that my child will only be transported by bus if I have a designated pick up and drop off point that is within a 12 mile radius of the Head Start Center.

☐ ☐ I will allow staff to visit my home during the school year at my convenience.

☐ ☐ I am interested in volunteering in the Head Start Program.

☐ ☐ I will try to attend center activities and parent meetings.

☐ ☐ I understand that I have the right to review, dispute, or correct records maintained on my family.

☐ ☐ I agree to allow the school to use my child's date of birth for classroom activities.

Signature of Parent/Guardian: _____ **Date:** _____