

FORT BELKNAP HEAD START/EARLY HEADSTART PROGRAM

2025-2026 SCHOOL YEAR

NEW & RETURNING STUDENT APPLICATION



Gilbert Horn Sr. Early Childhood Center Agency Service Area: (406) 353-2827 & (406) 353-4125 EHS

Ramona King Center Hays Service Area: (406) 673-3387

Three Strikes Center Lodgepole Service Area: (406) 673-3307

Fort Belknap Head Start & Early Head Start Program Student Application 0 to 3 and 3 to 5 years old

"It is not required that your child be potty trained to attend Head Start Program"

Application Check list: "All applications will be accepted but will NOT be processed until all highlighted areas and required documentation is turned in and signed!" 1.

6.

7.

Medical Insurance HS & EHS

HMK, Medicaid, Chips, Blue Cross Etc.

Tribal Enrollment or Proof of Descendency

A copy will be taken

Complete Application

Application must be completed and turned with all required

Proof of Income:

Pay stubs, last year's tax returns, W-2 Forms, TANF

letter/benefits, Unemployment, Veteran's benefits, etc.

and dated signatures by the parent/guardian.

2.

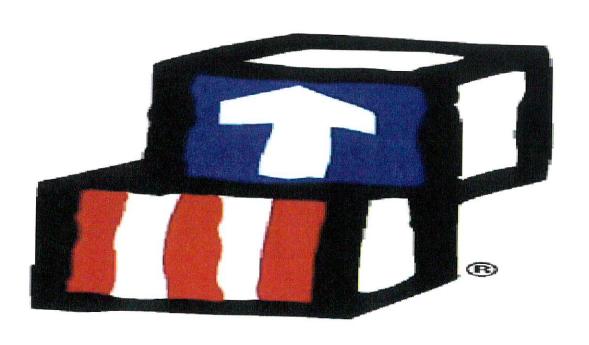
3.	Immunization Record		8.							
	Must be up to date, A copy will be taken (To be hand	ed in	0.	Any Court Orders						
	with application)	eu III		Custody papers, restraining orders, divorce papers, or any						
	The second of th			other legal document that involves your child. (An actual court document/order signed by a judge. A petition is						
				not considered a legal court document)						
4.	Child's Physical (HS) or Well Child Checkup (EH	HS)	9.	Dental Exam HS						
	Must be up to date with Hematocrit/Hemoglobin resu	ılts		Forms attached						
	posted. A copy will be taken (To be handed in no later	than		. Sime diadriod						
5.	30 days of handing in application) Form attached									
3.	<u>Birth Certificate</u> A copy will be taken	'	10.	Letter of disability (if applicable)						
A ST	HEAD START & FARLY LIE			For applying child						
	HEAD START & EARLY HEA	MOSTAF	RT O	PTIONS 0-3 OR 3-5 YEARS						
Hoo	Flease check the box on the right for th	e progra	am an	d center you want your child to attend						
	u Start Program:	<u>E</u>	<u>Early</u>	Head Start Program:						
Cilia	ren 3 years old by September 10th, 2025 or no	B	3irth to	age 3 years by September 10th, 2025						
	than 5 years old by September 10th, 2025.	P	Pregna	ant women can also be eligible						
	ter Based Option:	<u>H</u>	Home	Base Option:						
Class	room setting	lr	nstruc	tion is based out of the child's home/place of						
		re	residence, once a week for 1 1/2 hours							
New	Student Application		Returning Student Application							
	Gilbert Horn Sr. Early C	hildhod	od C	enter (GHSECC):						
	231 Chippewa Ave. Fort	Belknap	Ager	ncy Service Area						
	Ramona Kin	g Cent	ter (F	RKC):						
	180 John Capture	Rd, Hay	/s Ser	vice Area						
	Three Strike									
	138 Medicine Bear Ro	d. Lodge	enole!	Service Area						
Certifi	ication: I have carefully reviewed the documents a	nd inform	matio	a I have provided with B. 4 B. v.						
O CCIT C/	early field Start application and by signing this for	m cortif	fu to t	he heat of much most at the state of the sta						
	ration regarding enginitry provided be me is true a	nd corre	oct. I a	SO understand information was 11 1						
Other	y confidential and is available to me within 24 hour	rs of adv	vance	notice.						
Name	e of Child:			DOB:						
Ciama	ature of Barrello									
Signa	ature of Parent/Guardian:			Date:						
Signa	ture of Staff Member:		-							
O.Sine	italio of otali member:	P. U.S.		Date:						

Family & Child Information:

Gender (Please Circle): Male Female Is your child a NEW student to Head Start/Early Head Start Program Has child been previously enrolled at another Head Start Program (If Yes what Program, Dates, & Location? Pre-K program? Is your child transitioning from Early Head Start or Pre-K program? Is your child transitioning from Early Head Start or Pre-K program? Is your child transitioning from Early Head Start to Head Start? Yes or No Parent/Guardans: Last Name First (Please Fill out, for PIR) Popeaes) DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Children: Last Name First DOB: Sex: M/F Relationship to child: Primary Hone #: Emergency Phone #: Emergency Phone #: Pick Up and Drop off Address: (If riding the bus) HS Only: Email Address: Emergency Phone #: Permary Health Coverage (Please Circle All That Apply) Provide a Copy Medical Mechadicifichips Blue Cross Healthy Montana Kids (Hilk%) Doctor/Medical Home (Please Circle All That Apply) Native American/Jaseka Native Bluinhook Clinic-Havre Montana Healthcare-Havre Benefis Pediatric-Greatfalls Other If answered other please list facility and city: Race Ethnicity: (Please Provide Copy of Tribal Enrollment for Eligibility Purposes) If Alation/Caradian Native Figure Primary Language? Yes or No Are you currently or have ever served in the Military? Fencient Primary Language? Yes or No Military Background: Are you currently or have ever served in the Military? Fenswered yes Please list branch and years served? Education Grade Level (Please cir	Applicant Child's Legal Name:					-			
Security Standard New Student to Head Start Program Head Start Progr	Gender (Please Circle):	Male		Fema	le				
Has child been previously enrolled at another Head Start/Early Head Start or Pre-K program? If Yes what Program, Dates, & Location? Frey program? Frey program. Frey what Program. Frey program. Frey what Program. Frey program. Frey what Program. Frey program. Frey program. Frey what Program. Frey what Program. Frey program	Is your child a NEW student to Head Start/Early Head Start Program		r No	Please circle Head Start Program					
another Head Start/Early Head Start or Pre-K program? Is your child transitioning from Early Head Start to Head Start? Yes or No Parent/Guardians: Last Name First (Please Fit out or Pix DOB: Sex: M/F Relationship to child: Purposea) Children: Last Name First DOB: Sex: M/F Relationship to child: Purposea; DDB: Sex: M/F Relationship to child: Purposea	Has child been previously enrolled at	Yes o	r No	·	vhat Program	Dates & Locat	ogram ion?		
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Any Other Tribal language Spoken: Please List: Primary Language? Yes or No French: Primary Language? Yes or No Spanish: Primary Language? Yes or No If answered English as primary language how well can your child speak (English Proficiency)? Please circle best answer None Little Moderate Proficient Military Background: Are you currently or have ever served in the Military? Yes or No If answered yes Please list branch and years served? Education Grade Level (Please circle the best answer) Dropped out of high school High school Diploma GED/Hi Set Some College	English: Primary Language?					anguage?	Ves or No		
French: Primary Language? Spanish: Primary Language? Yes or No Yes or No Any other language spoken? Please list: Primary Language Yes or No Any other language spoken? Please list: Primary Language? Yes or No Any other language spoken? Please list: Primary Language? Yes or No Military Background: Are you currently or have ever served in the Military? Military Background: Are you currently or have ever served in the Military? Education Grade Level (Please circle the best answer) Dropped out of high school High school Diploma GED/Hi Set Some College			Any Othe	r Tribal la	anguage Spok	en: Please	163 01 140		
Spanish: Primary Language? Yes or No Any other language spoken? Please list: Primary Language? Yes or No If answered English as primary language how well can your child speak (English Proficiency)? Please circle best answer None Little Moderate Proficient Military Background: Are you currently or have ever served in the Military? If answered yes Please list branch and years served? Education Grade Level (Please circle the best answer) Dropped out of high school High school Diploma GED/Hi Set Some College			List:		Primary La		Yes or No		
If answered English as primary language how well can your child speak (English Proficiency)? Please circle best answer None Little Moderate Proficient Military Background: Are you currently or have ever served in the Military? If answered yes Please list branch and years served? Education Grade Level (Please circle the best answer) Dropped out of high school High school Diploma GED/Hi Set Some College							Yes or No		
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Education Grade Level (Please circle the best answer) Dropped out of high school High school Diploma GED/Hi Set Some College	If answered yes Please list branch and years ser	ved?					Yes or No		
Dropped out of high school High school Diploma GED/Hi Set Some College	· · · · · · · · · · · · · · · · · · ·		ass of	olo 4h	o heat a				
Onlie College	Dropped out of high school	High school	Dinlomo						
John College Control Light Control Con		nal School/Tr	aining			Some College			
				232 00	. ۲۰				

Associates Degree (Field of Study:	Bachelor's Degree (Field of
Master's Degree	Study:
	PHD/Doctorate
Employment Stati	us: (Please check all that apply)
Full Time	Part Time
Seasonal/Temporary	Disabled (Receive Benefits? Yes: No:)
Unemployed (Receive Benefits? Yes:No:_	Self Employed (Occupation:
Retired (Receive Benefits? Yes:No:)	Homemaker
Family tyr	e (Check all that apply)
Two Parent Family	
Single Parent Family (mother figure only)	Grandfather raising child(ren) Grandmother raising child(ren)
Single Parent Family (father figure only)	(Both) Grandparents raising child(ron)
Foster Family (must provide legal documentation	on) Other:
Blended Family (step family)	Parent(s) serving in military
Additional Family Information: Does v	our family have any special circumstances, concerns or needs?
Abusive home situation, alcohol, drugs, spouse	abuse Applicant is a foster child
Applicant currently is under the protection of ch	ild Child's parent(s) are currently incarcerated
welfare services (Social Services)	parameter and surrountly indulodiated
Current address is temporary living arrangement	nt due First time parent
to loss of housing or economic hardship Fill ou	<u>f</u>
Homeless Verification Form	
Parent has a disability/special need Please Describe:	Parent has no work experience and or secondary
Recent death in the family within last 12 months	education (college courses)
Child is currently living with Grandparents	
Family is in need of childcare/wrap around.	Family would like school be 5 days a week.
	Parent/guardian(s) suffer from PTSD
Current Assistance or Benefits Rec	
TANF/477 (Family:Child Only:)	Food Stamps (Family:Child Only:)
General Assistance (G/A)	LIEAPP
Commodities (Family:Child Only:)	Social Security
Local Food Bank (Family: Child Only:)	Disability Benefits
WIC:	Alimony/Spousal Support
Child Support	Wrap Around Program
Child Care Program	
	Do not receive services
Current Housing Information: (Pleas	e check all that apply)
House (Private Ownership)	Homeless/No housing (You do not have your own
	permanent night time place of residence) *Need
Apartment Complex	Homeless Verification Form*
	Living with relatives/Friends
Renting (Low Rent, Mutual Help, Landlord etc)	Other
Child Health History O	loctions in (Discosti L. W. C.)
Does your child have or suffer from frequent colds?	uestionnaire (Please circle Y or N)
Does your child have or suffer from allergies and or se	Yes or No
Does your child have or suffer from frequent ear infec	1000110
Does your child have any difficulty seeing?	
Does your child currently wear glasses?	Yes or No
	Yes or No
Does your child have difficulty with speech/communic	ation skills? Yes or No Yes or No
Does your child have difficulty with speech/communic Does your child have any behavioral issues?	resorno
Does your child have difficulty with speech/communic	
Does your child have difficulty with speech/communic Does your child have any behavioral issues? If yes please list:	
Does your child have difficulty with speech/communic Does your child have any behavioral issues? If yes please list: Does your child have or suffer from colic? (EHS only)	Yes or No
Does your child have difficulty with speech/communic Does your child have any behavioral issues? If yes please list:	Vec an Na

Jose your child have breathing problems or asthma? I answered yes does your child have to use a nebulizer or inhaler? I answered yes does your child have to use the breathing medication on a daily basis? I yes or No I yes does your child acconvulsion or seizures? I yes does your child take medication for seizures? I yes or No Jose your child currently take medication for any possible medical condition? Yes or No I yes Please List: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes Please List Reason: I yes or No I yes please attach a opy for our records. I yes or No	Doop your shild tale. I ill a control of the contro	
As your child have breathing problems or asthma? In answered yes does your child have to use a nebulizer or inhaler? In answered yes does your child have to use a nebulizer or inhaler? In as your child ever had a convulsion or seizures? Yes or No yes does your child take medication for seizures? Yes or No yes your child currently take medication for any possible medical condition? Yes or No Yes Please List: It is your child ever had surgery or been hospitalized? Yes or No Yes Please List Reason: It is your child been diagnosed with a possible disability? If ye of Disability: If ye of Disability: If yes describe describe: If yes describe: If y	Does your child take daily naps? If answered yes how long?	Yes or No
Answered yes does your child have to use a nebulizer or inhaler? Answered yes does your child have to use the breathing medication on a daily basis? As your child ever had a convulsion or seizures? Yes or No Yes Please List: As your child ever had surgery or been hospitalized? Yes or No Yes Please List Reason: As your child been diagnosed with a possible disability? Yes Please List Reason: As your child been diagnosed with a possible disability? Yes or No	Does your child have breathing problems or asthma?	
Arswered yes goose your child have to use the breathing medication on a daily basis? As your child ever had a convulsion or seizures? Yes or No Joes your child currently take medication for seizures? Yes or No Yes Please List: As your child ever had surgery or been hospitalized? Yes Please List Reason: As your child been diagnosed with a possible disability? Type of Disability: Type of Disability: Speech? If yes describe: Developmental delay? If yes describe: Weight Issues? If yes describe: Weight Issues? If yes describe: Yes or No	If answered yes does your child have to use a nebulizer or inhaler?	
reas your child ever had a convulsion or seizures? Yes or No Yes Please List: Also your child take medication for any possible medical condition? Yes or No Yes Please List: Also your child ever had surgery or been hospitalized? Yes or No Yes Please List Reason: Yes or No Yes Please List Reason: Yes or No Yes Please List Reason: Yes or No	If answered yes does your child have to use the breathing medication on a daily basis?	
Yes or No Yes or No Yes or No Yes or No Yes Please List: Idas your child ever had surgery or been hospitalized? Yes Please List Reason: Yes or No Yes or No Yes or No Yes or No Yes or No	Has your child ever had a convulsion or seizures?	
As your child ever had surgery or been hospitalized? Yes or No Yes Please List: As your child ever had surgery or been hospitalized? Yes Please List Reason: As your child been diagnosed with a possible disability? Type of Disability: IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? If yes please attach a popy for our records. Yes or No Pesch; Pesch yes describe: Dental? If yes describe: Developmental delay? If yes describe: Yes or No As anything wrong with your child at birth? Yes or No We please describe: As anything wrong with the child in the nursery? Yes or No We please describe: As anything wrong with the child in the nursery? Yes or No We please describe: As anything wrong with the child in the nursery? Yes or No	If yes does your child take medication for seizures?	
As your child ever had surgery or been hospitalized? Yes or No Yes Please List Reason: Italias your child been diagnosed with a possible disability? Italias your child been diagnosed with a possible disability? Italias your child been diagnosed with a possible disability? Italias your child been diagnosed with a possible disability? Italias your child been diagnosed with a possible disability? Yes or No Italias your child been diagnosed with a possible disability? Italias your child been diagnosed with a possible disability? Yes or No	Does your child currently take medication for any possible medical condition?	
Yes Please List Reason: Jas your child been diagnosed with a possible disability? Yes or No Jis your child been diagnosed with a possible disability? Yes or No Jis your child been diagnosed with a possible disability? Yes or No Jis your child been diagnosed with a possible disability? Yes or No Jis your child Education Plan) or IFSP (Individual Family Service Plan)? If yes please attach a opy for our records. Jo you have any concerns about your child's: Yes or No Jearning? If yes describe:	If Yes Please List:	100 01 110
Yes Please List Reason: Jas your child been diagnosed with a possible disability? Yes or No Jis your child been diagnosed with a possible disability? Yes or No Jis your child been diagnosed with a possible disability? Yes or No Jis your child been diagnosed with a possible disability? Yes or No Jis your child Education Plan) or IFSP (Individual Family Service Plan)? If yes please attach a opy for our records. Jo you have any concerns about your child's: Yes or No Jearning? If yes describe:	Has your child ever had surgery or been hospitalized?	Vacanti
.) Type of Disability: .) IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? If yes please attach a opy for our records. Io you have any concerns about your child's: .) Speech? If yes describe: .) Hearing? If yes describe: .) Usion? If yes describe: .) Developmental delay? If yes describe: .) Developmental delay? If yes describe: .) Weight Issues? If yes describe: .) Weight Issues? If yes describe: .) Weight Individual Family Service Plan)? If yes please describe: .) Weight Issues? If yes describe: .) Yes or No yes please describe: Yes or No yes or No as anything wrong with your child at birth? yes please describe: Yes or No Yes or No yes please describe: Yes or No Yes or No Yes or No yes please describe: Yes or No	If Yes Please List Reason:	res or No
.) Speech? If yes describe: .) Hearing? If yes describe: .) Vision? If yes describe: .) Dental? If yes describe: .) Developmental delay? If yes describe: .) Behavioral Issues? If yes describe: .) Weight Issues? If yes describe: .) Weight Issues? If yes describe: .) wo other health or development concerns? yes please describe: re you or your partner currently pregnant? /as your child born premature? If yes how many eeks? // As anything wrong with your child at birth? // Yes or No // Yes or No // Yes or No // Yes anything wrong with the child in the nursery? // Yes or No	Has your child been diagnosed with a possible disability? a.) Type of Disability: b.) IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? If yes please attach a copy for our records.	Yes or No
Hearing? If yes describe: Dental? If yes describe: Developmental delay? If yes describe: Yes or No yes please describe: Yes o	Do you have any concerns about your child's:	Yes or No
.) Vision? If yes describe:) Dental? If yes describe:) Developmental delay? If yes describe:) Behavioral Issues? If yes describe:) Weight Issues? If yes describe: yes please describe: yes or No yes please describe: Yes or No yes please describe: yes or No yes or No yes please describe: yes or No yes or No yes please describe: yes or No	h) Hearing? If yes describe:	
Dental? If yes describe: Developmental delay? Developmental delay? If yes describe: Developmental delay. Development	Nicion Office and the state of	
Developmental delay? If yes describe: Dehavioral Issues? If yes describe: Dehavioral Issues? If yes describe: Descri	d) Dental? If yes describe:	
Weight Issues? If yes describe: ny other health or development concerns? yes please describe: re you or your partner currently pregnant? /as your child born premature? If yes how many eeks? /as anything wrong with your child at birth? yes please describe: /as anything wrong with the child in the nursery? yes please describe: /as anything wrong with the child in the nursery? yes please describe: /a mother and child stay in the hospital longer than usual?	f.) Developmental delay? If was describe:	
re you or your partner currently pregnant? //as your child born premature? If yes how many eeks? //as anything wrong with your child at birth? //as anything wrong with the child in the nursery?	g.) Behavioral Issues? If yes describe:	
re you or your partner currently pregnant? Yes or No	h.) Weight Issues? If yes describe:	
yes please describe: re you or your partner currently pregnant? Yes or No Yas your child born premature? If yes how many eeks? Yes or No Yas anything wrong with your child at birth? yes please describe: Yes or No	Any other health or development concerns?	
re you or your partner currently pregnant? Yes or No	If yes please describe:	Yes or No
/as your child born premature? If yes how many eeks? /as anything wrong with your child at birth? yes please describe: /as anything wrong with the child in the nursery? yes please describe: /as anything wrong with the child in the nursery? yes please describe:		
res of No /as anything wrong with your child at birth? yes please describe: /as anything wrong with the child in the nursery? yes please describe: /a mother and child stay in the hospital longer than usual?	Was your child born premature? If yes how many	
yes please describe: 'as anything wrong with the child in the nursery? yes please describe: 'd mother and child stay in the hospital longer than usual? Yes or No	weeks?	Yes or No
yes please describe: 'as anything wrong with the child in the nursery? yes please describe: 'd mother and child stay in the hospital longer than usual? Yes or No	Was anything wrong with your child at hirth?	
'as anything wrong with the child in the nursery? Yes or No d mother and child stay in the hospital longer than usual?	If yes please describe:	Yes or No
yes please describe: d mother and child stay in the hospital longer than usual?		
d mother and child stay in the hospital longer than usual?	Was anything wrong with the child in the nursery?	Yes or No
d mother and child stay in the hospital longer than usual? yes please state reason: Yes or No	If yes please describe:	163 01 140
yes please state reason:	Did mother and child stay in the hospital longer than usual?	Vac or Na
	If yes please state reason:	1 62 OL MO



EMERGENCY CONTACT AND PARENTAL PICK UP & DROP OFF CONSENT

Child's Name:	Date of Birth:
Physical Address:	
Mailing Address:	
Mother/Legal Guardian's Name:	Home Number:
Physical Address: Mailing Address:	Cell Number:
Work Address:	Emergency Number: Work Number:
Father/Legal Guardian's Name:	Home Number:
Physical Address:	Cell Number:
Mailing Address:	Emergency Number:
Work Address:	Work Number:
Emergency Contact Person #1:	Primary Contact Number:
Physical Address:	Cell Number:
Emergency Contact Person #2:	Primary Contact Number:
Physical Address:	Cell Number:
Emergency Contact Person #3:	Primary Contact Number:
Physical Address:	Cell Number:
Physician/Medical Care	Contact Number:
Health Insurance Carrier & Policy Numb	per:
Person	n's authorized to pick up child:
Name & Relationship to child:	Contact Number:
Name & Relationship to child:	Contact Number:
Name & Relationship to child:	Contact Number:
Name & Relationship to child:	Contact Number:

PARENT'S RIGHTS AND RESPONSIBLITIES AGREEMENT

RIGHTS:

- 1. Take part in major policy decisions affecting planning and operations of the program.
- 2. Have access to programs/resources based around family strengthening, parent involvement, improved health, and wellness.
- 3. Be treated with respect, dignity, and always feel welcome by teachers and staff members.
- 4. Be informed regularly about my child's progress and or incidents while at Head Start.
- 5. Expect guidance for my child from the teachers and staff that will help his/her individual development.
- 6. Have the chance to learn all aspects of the program including budget, education and job requirements that can lead to possible employment opportunities.
- 7. Volunteer work is an essential component of Head Start. It is your right as a parent/guardian to be a volunteer.
- 8. Expect complete confidentiality among teachers and staff in matters relating to my child at all times.

RESPONSIBILITY:

- Learn all facets of the program in order to help make possible policy changes, resolutions, and the necessary steps needed to carry them out.
- 2. Accept Head Start as an opportunity through which I can improve my life and the lives of my children.
- 3. Participate in the program as an observer, volunteer, paid employee, and or establish a partnership where services provided will vastly improve curriculum components.
- 4. Provide leadership by taking part in elections, parent committee meetings, and encourage parent involvement.
- 5. Welcome teachers and staff into home in order to discuss ways I can help my child's development in relation to school readiness transition.
- 6. Work with teachers, staff, and other parents in a cooperative manner.
- 7. Provide guidance to my children in a loving and protective manner.
- 8. Offer constructive criticism, participate in program evaluations, and defend against unfair condemnation.
- 9. Participate in all program activities/socializations that can improve health, education, family strengthening/involvement, and overall individual wellness.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS.

Parent/Guardian Signature:	Date:
Staff Signature:	Date:

Release of Liability Statement

IT IS THE MISSION OF THE FORT BELKAP HEAD START/EARLY HEAD START PROGRAM TO HAVE ESTABLISHED POLICIES AND PROCEDURES THAT ARE ALWAYS TOTALLY COMMITTED TO THE HEALTH, SAFETY, AND WELFARE OF EACH AND EVERY CHILD ENROLLED ALONG WITH THEIR PARENTS/ FAMILIES.

HOWEVER, I AM ALSO AWARE THAT ANY AND ALL ACTIVITIES CAN POSSIBLY BE HAZARDOUS AND POSSIBLE INJURIES/DEATH CAN OCCUR. I AM VOLUNTARILY PARTICIPATING IN ANY AND ALL ACTIVITIES WITH KNOWLEDGE OF THE POSSIBLE DANGERS INVOLVED AND AGREE TO ASSUME ANY AND ALL RISKS OF BODILY INJURY, DEATH, OR PROPERTY DAMAGE, WHETHER THOSE RISKS ARE KNOWN OR UNKNOWN.

I release the Fort Belknap Head Start/Early Head Start Program and the Fort Belknap Indian Community Council from any and all actions, claims, or demands that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives now have, or may have in the future, for injury, death, or property damage related to (i) my participation these activities, (ii) the negligence or other acts, whether directly connected to these activities or not, and however caused, by any releasee, or (iii) the condition of the premises where there activities occur, whether or not I am then participating in the activities.

I also agree that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives will not make a claim against, sue, or attach the property of any releasee in connection with any of the matters covered by the foregoing release.

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT IS A RELEASE OF LIABILITY AND AN AGREEMENT BETWEEN THE FORT BELKNAP HEAD START PROGRAM, THE FORT BELKNAP INDIAN COMMUNITY COUNCIL, AND I THE PARENT/GUARDIAN. I HEREBY SIGN IT OF MY OWN FREE WILL.

Parent/Guardian Signature:	Date:
Staff Signature:	Date:

Head Start application form updated by Ronald F. Doney Jr. FSM April 2025



Fort Belknap Head Start/Early Head Start Income Eligibility & Verification Form

Child's Name:	auon form									
Current Household Informatio	on (Pleas	Child's Age by Sept.10 th 2025: se list all DOB of all people "living" in the household)								
Parent/Guardians: Last Name First	100 C T T T T T T T T T T T T T T T T T T	DOB:	Sex: M/F	in the nousehold)						
		202.	Jex. IVI/F	Relationship to child:						
Children: Last Name First		DOB:	Sex: M/F	Relationship to child:						
				to crimic.						
Is anyone in the household curren	tly pregn	ant?		Yes or No						
Family Hou	sehold In	come (Please	CIRCLE all that	annly)						
Employed full time-z parent family	THE PERSON NAMED IN STREET	Unemployed	receive unemploy	ment henefite						
Employed full time-single parent		TANF/477 be	nefits	ment benefits						
Part-Time employment-2 parent family	1	SSI benefits								
Part-time employment single parent		Disability ber	nefits							
Seasonal employment			ompensation bene	fite						
Military Benefits		Unemployed	No income	iits						
Retirement Benefits		Food Stamps (please provide proof card, document, etc.)								
WIC		McKinney/Ve	nto Eligible (Immedia	ot Card, document, etc.)						
Tribal Er	rollment ((Automatically I	ncome Eligible	ate Enrollment)						
**TO BI	COMPL	ETED BY HEA	D START STAFF	**						
Copy of income verifica	tion doc	uments receiv	ed: (Please CIR	CLF all that apply)						
1040 FORM		Disability ben	ofite	от ан тас арргу)						
W2-Statment		Workmen's co	omneneation bone	fito						
Current wage stub		Workmen's compensation benefits Child support/Alimony payments								
Income declaration		No income								
Unemployment Benefits		SSI Benefits								
Public Assistance (TANF/477)		Retirement Benefits								
Military Benefits WIC		Food Stamps (please provide proof card, document, etc.)								
		McKinney/Vento Eligible								
Gross Annual Income Amount: (Gro	ss/Net Pay A	Amount)								
Eligibility Verification: (Circle)		Income	e Eligible:	Over Income						
This child is eligible to participate in	n the									
orogram?			es	No						
Type of eligibility interview conduct	ed:	100 医中心的过程形式 计算机 化等级	erson	Telephone						
Date:		Time:		Phone:						
Parent/Guardian: I certify that the information provided is true/correct	Parent/Gua	ardian Signature:	Date:							

Type of eligibility interview conducted:

Date:

Parent/Guardian: I certify that the information provided is true/correct to the best of my knowledge and is subject to verification by Head Start Staff.

Head Start Staff: I certify that I received information from and interviewed the parent/guardian with the intake application process. All information provided is accurate and true to the best of my knowledge.

Staff Signature:

Date:

Date:

Date:

*Federal Indian Programs may serve up to 48% of their enrollment with children whose incomes would be considered over-come if all the other slots are already filled and there is a direct need in order for the program to be at 100% full enrollment. Also children who are enrolled from a federally recognized tribe will be automatically be considered income eligible 1302.12

Consent/Refusal for Health Services & Emergency Treatment HS/EHS Programs

I,, tests and examinations checked understand these services are de- informed of any results that are n with an up-to-date immunization or dental examinations/procedure after the signed date. The purpos	pelow, and for emed necest ot normal. I a record, updates es done on m	r transport sary or adv Iso underst ed physical v child with	of the child isable by the tand that is recording the contract of the coast with	to and e Head ny res n, and vear T	d Start program and sponsibility to provid I updated record of this consent is valid	as need d that I v de Head	ed. I vill be Start
Child's Name:					Date of Birth:		
Medical Insurance Coverage?					N.a.	Ш	
Medical Insurance name and	Insurance na			es or	NO		
card number: (Provide copy)	Insurance ca						
Please circle YES or NO to the	services lie	tod holow	V=Consor		discount N. O		
Developmental Screening	SCI VICES IIS	Y or N	Dantel C	it is g	iven N=Consent i	s not gi	
Medical Examination (If Necessar	1/1	YorN	Dental Sc				Y or N
Speech Screening/Follow ups	у)		Height & V	/veign	t BMI (Body Mass I	ndex)	Y or N
Hearing Screening/Follow ups		YorN	I.B. Test	(Turbe	erculosis) HS Only		Y or N
Brush teeth daily with fluoride		Y or N	Vision scr	eening	g/Follow ups		Y or N
Mental & Behavioral Health Scree	ning and	Y or N Y or N	Emergend	y Firs	t Aide/CPR Treatm	<u>ent</u>	Y or N
any follow ups	and	TOTN	Planned c	iassro	om field trips HS O	nly	Y or N
Permission to use my child's phot any HS/EHS related activity, flyers advertisement, recruitment, paren FB online site, etc.	s,	Y or N	Crisis Cou	ınselir	ng (If necessary)		Y or N
Follow up treatment/screenings/examination testing (if necessary)	s/diagnostic	Y or N	administer	OBIN/ ed if r	ave HEMATOCRIT tes not done during first ation? (slight finger	t initial	Y or N
Medical Home Please List: (examedical Center etc.)			priyotodi oz	· Carring	adorr: (Siight iniger	poke)	<u></u>
Dental Home Please List: (exam Group, etc)							
Does your child currently take any	medications'	?	-		Yes or N	lo.	
If yes please list the current medic bee sting kits)	ation(s) and o	dosage: (in	cluding		133 311		
Do you give Fort Belknap Head St medication to your child if its deem	ied necessari	v?			Yes or N		
Certification: I have carefully reviewed knowledge all information provided is confidential and will only be utilized b	true and corre	ct. I also und	nation I have derstand infor	provid matio	ed is accurate and to n provided will be kep	the best ot strictly	of my
Parent/Guardian Signature:				Date) ;		
Staff Signature:				Date):		

Permission to Release Confidential Information I authorize the Fort Belknap Head Start/Early Head Start Program to obtain the following information specified below: Please circle Yes or No: Education: Yes No Health/Medical: Yes No Psychological: Yes No Social Services: Yes No Speech Language: Yes No Income: Yes No Other: Yes No Information will be used for the following purpose: 1. Determine eligibility 2. Develop an individual service plan 3. Provide special services if he/she qualifies 4. Determine appropriate program for placement while child is enrolled in Head Start and/or Early Head Start Program. I have been fully informed of the program's request for my consent. I understand that my consent is voluntary and may be revoked at any time. I also understand all information requested will be kept strictly confidential and used only by authorized personnel. This release of information will expire one year from the date signed below. Child's name: Parent/Guardian Signature:___ Address: Telephone Number:

Head Start Staff:

Fort Belknap Head Start/Early Head Start Child Screening, Physical Examination Assessment

Child's Name:							SEX:						
DOB:								e Numbe	er				
Head Start	Center												
Address:					• .			·			·····		
		TO	BECC	MPLET	ED B	YHEALT	H CARE P	ROVIDE	D				Washington
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	WEIGH								l bolo-		Inch		%
EXA			AL ABI	NORMAL		EXAM	NORMAL	ABNORM	Lbs/oz			for age (%
Blood Pressure		3 (November 2)			Oral H	D. DOCKS N. C. S. V. P 5 A 5 P.	NORWAL	ABNURIV	10.00	EXAM	NORMAL	ABNOR	MAL
Skin	(900)	 	-		Assess				Genit: Neuro				
Neck					Throat				Extre			 	
Head Lymph Nodes		ļ			Chest					Ability	 	 	
Eyes		 -			Lungs Heart					nological			
Ears					Back		- 		Speed			 	
Nose					Abdom	en			Muscl		 	 	
NETIPOLOGIO	AL JOOOLAL	NODA	al Saba		States States States	P. W. Colon C. Compress May 17 September 19 and			1				
NEUROLOGIC Gross Motor:	HEISOCIAL	- NOWING	AL ABI	UKMAL		4.4	COMME	NTS (Use a	dditional s	sheet if nec	essary)		
Fine Motor:													
Communication	Skills:												
Cognitive: Self-Help Skills:		 	-										
Social Skills:		 	-										
	VISIC	N ACT	LITY	(AGE 3	4 Υ					io wor	- 200	ed Asian Indian Maria Cara	S. Dodinis November
Test Type:	F	Right:	100 100 100 100 100	Left:	2.7	Both	Test Type	Erogu	riency (Hz)	VG (AGE			112
		_			Ì	-5] Took Type		000 Hz	Rigr	nt (db)	Left (d	
		1		1		1		20	000 Hz	·	db		dt dt
					ĺ				00 Hz		db		db
	HEMO	GI ORI	N/HEN	MATOCI) 2[ਜੋ			40	00 Hz		db	Printer and concession	db
HGB(g/dl)	00 S. Marine S. M. 1954	<u> </u>	Risk A		Y or N	<u></u>	Lead Level	(moa(dl):		LEAD.		5 To 1	
Treatment:	· · · · · · · · · · · · · · · · · · ·		Follow			<u> </u>		(inegral).			igh Lead Le	vels Y O	<u>r N</u>
			1011047	up.			Treatment:			Follow-up	:		
	Screer	ning of	TB R	isk Fac	tors:				Imm	unizatio	- vnc		14.5
o Risk	actors NO	T presei	nt: TB S	KIN TEST	LNOT	REQUIRED	Given Today	r	Yes	Secretary of the second	// IO	<u> </u>	
o_Risk	actors pre	sent: Ma	intoux 1	ΓB skin Te	st Perf	ormed				_			
Date Given	Results	Signit	icant	Non Sign	nificant	Date Read	DATE (OR A	GE) NEXT	PHYSICAL	. IS DUE:			
		Y	or N	Yor	N								
Date Chest Xray	Ne	ormal	A	bnormal	RXD	ate							
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			l Sporme	YorN al Finding			 	N-03-000 Page 1-400	rezeli desenza	A CONTRACTOR OF THE PARTY OF TH	New Colonial Control of the Control		
	, Diagi	JOSISIAL	JI JOI II I	ara muning	ΙΣ.		. Treat	menvRes	trictions/	Recomm	endations	for Scho	iol:
See Alexander and Carlot See Secret Consider Co. Co. Sep. 200	Control Specification Control	di 2014 di amerikan	100	-	CHECKE WEST					Section 199			
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MEDICATIONS I	REQURIED	AT SCHO	OOL:				<u></u>						
Y or N													
TYPE OF MEDIC	ATION AN	D PURPO	OSE;		_								
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A MARKET MARKET	E COL	NEKA	VL/O	AILME	ו עו:	UN CHIL	D'S OVER	RALLIPH	iysic <i>i</i>	AL STA	TUS:	AND THE	77.17
											BALLET STREET, ST. P. STREET, SEC.	A STATE OF THE PARTY OF THE PAR	recorded St.
	<u> </u>												Í
Physician's Si	gnature:	-					Date:						



Head Start Oral Health Form

Patient Information					
 Pregnant woman's/child's name					
		Date of birtl	h	Phone	number
Address This practice is the pregnant wom	nan's/child's dental home: 🗖 `	City Yes □ No		State	Zip code
Current Oral Health Status					
Does the pregnant woman or chil Does the pregnant woman or chil crowns, or extractions?	d have any teeth that have pre I No um disease? □ Yes □ No	eviously been t	reated for decay,	o (decay includin	free) g fillings,
Oral Health Care Services Do	elivered During Visit				
Examination: Yes No X-rays: Yes No Risk assessment: Yes No Cleaning: Yes No Fluoride varnish: Yes No Dental sealants: Yes No	Counseling/Anticipator Yes No Referral to Specialty Ca Yes No (Please specify specialist)		Restorative/I Fillings: Crowns: Extractions: Emergency ca Other: (Please	□ Y€ □ Y€ re: □ Y€	es No es No es No
Future Oral Health Care Serv	rices				
All treatment completed:	atment? □ Yes □ No pointments needed: Ne	ext appointme			(month/year)
Oral Health Provider's Conta	ct Information and Signat	ure			
Provider name (please print)	Phor	ne number	Fax nı	umber	
Practice name	Addr	ess			
Provider signature	Date	of service			

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Nutrition Form (HS/EHS) "Please fill out top form"

Chil	d's Name	:					Sex an	d Cur	rent A	ge:					
<u> </u>				······································	DIE	TARY F	JADITE								
1.	List you	r chi	ld's favori	te foods?	DIL	IANIF	IADIIS								
2.	List food	ds yo	ur child d	oes not				·							
<u></u>	like:														
					Please Chec	k Yes o	r No						Ye		- Al-
3.	Does yo	ur cl	hild take v	ritamins and n	nineral suppler	ments?							16	5	No
	A) If yes	pleas	se identify v	what											
	kind?		ntain Iron?			 -									
			prescribed												
4.	Are then	e an	v foods vo	our child shou	ld not out for n									*	
5.	5. Is your child on a special Diet?														
A) What Kind?														*	
6.	6. Does your child still breast feed or drink breast milk on a regular basis? If yes how many times a														
	day:														
7.	Does yo	ur cł	nild eat ba	by food produ	ucts? If yes ple	ase								*	
	list:														
8.	Has ther	e be	en a big c	hange in you	r child's appeti	te in the	past mon	th?				-		*	
9.	Does you	<u>ur</u> cr	ilid take a	bottle/formula	a? If ves pleas	e list bra	and?:							*	
10.	Does you	<u>ur cr</u>	illd chew (or eat things t	hat aren't food	?								*	
11.	Does you	ur cr	ilid have t	rouble chewir	ng or swallowin	ig?								*	
12. 13.	Do you r	atba	any conc	erns about wh	nat your child e	eats whil	e at HS/El	HS Progra	ım?					*	
13.	following	food	w many c	ays a week y	our child eats	a food fr	om the	Plea	ase c	rcle n	umbe	r of ti	mes a	wee	k
	TOHOWING	1000	i groups:					you	r chile	eats	from	each	of the	food	
а.	Dairy Pro	oduc	ts/milk_fo	ormula choos	e, yogurt, etc.		· · · · · · · · · · · · · · · · · · ·	grou			· · ·	· · · ·	7 1		
b.	Meat no	ultry	fish ead	s dried bean	se, yogurt, etc. s/peas, peanu); ! D. #4==		0*	1*	2*	3	4	5	6	7+
C.	Rice, arit	s. br	ead cere	al, tortillas, fry	sipeas, peanu	Butter		0*	1*	2*	3	4	5	6	7+
	Greens.	carro	ots broce	ali sauseh ai	umpkin, sweet	nototoo		0*	1*	2*	3	_4_	5	6	7+
e.	Oranges.	gra	pe fruit to	omatoes, (fruit	inica)	potatoe		0*	1*	2*	3	4	5	6	7+
f.	Other fru	its a	nd vegeta	bles	i juice)		·	0*	1*	2*	3	4	5	6	7+
g.	Oil, marg	arine	e, butter, I	ard				0*	1*	2*	3	4_	5	6	 7+
h.	Cakes, c	ookie	es, sodas,	fruit drinks. c	andy, koolaid		·	0*	1*	2*	3	4	5	6	7+
		Gro	owth Char	t (Staff Only)	- Interviolation			Anemi			_	4	5	6	7+
Date	,	Ag		HEIGHT	WEIGHT	1		Date		HEM(
				(no shoes	(light clothing			Date		I ILIVIC	JGLO	DIM	LIEW.	OR	CRIT
				to nearest	to nearest 1/4								I I LIV	ATC	CKII
	Year	·e	Months	1/8 in.)	<u>lb.)</u>	1									
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Staff	Initials:			Staff Title:					-	Date					
Staff	Initials:			Staff Title:					-	Date		-			
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(Revie	witems 2	throu	գությունը	are are arrawers	s in the (*) areas	s. or if arc	wth is not	within the t	2) VIC	tatt On	<i>ly)</i> obool	c Alba a			
	40 to 40 to 6		danaon not c	n priyololari.		, o g.c	onthi lo flot (with the t	ypicai	range,	GHEC	t the a	ippropi	rate i	ooxes
	Suspect c	lietai	ry problen	n or inadequa	te food intake		Overwe	eight (weig	ht are	ater th	an tvo	ical, fr	om ara	with o	hart
	from ques	tions	2 to 12)				1 or 4)								
	ngo, iess Indonuci	unar	1 1 1 gm. o	r Hct less tha	n 34%		Short for	or age (hei	ght le	ss thar	typica	al fron	n grow	h cha	art)
Comm	onder well	yııı (weigni less	s than typical from	om growth chart)	Wt. for I	Ht. (greate	r or le	ss thai	n typic	al fron	n grow	th ch	art)
adilli	icilis. (use	- auc	лионаг рад	e II needed)											
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