FORT BELKNAP HEAD START/EARLY HEADSTART PROGRAM

2025-2026 SCHOOL YEAR

NEW & RETURNING STUDENT APPLICATION

Teaching Children Supporting Families

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.	**Complete Application** Application must be completed and turned with all required and dated signatures by the parent/guardian.	**6.**	**Medical Insurance HS & EHS** HMK, Medicaid, Chips, Blue Cross Etc.
2.	**Proof of Income:** Pay stubs, last year's tax returns, W-2 Forms, TANF letter/benefits, Unemployment, Veteran's benefits, etc.	**7.**	**Tribal Enrollment or Proof of Descendency** A copy will be taken
3.	**Immunization Record** Must be up to date, A copy will be taken (To be handed in with application)	**8.**	**Any Court Orders** Custody papers, restraining orders, divorce papers, or any 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 (EHS)** Must be up to date with **Hematocrit/Hemoglobin** results posted. A copy will be taken (To be handed in no later than 30 days of handing in application) Form attached	**9.**	**Dental Exam HS** Forms attached
5.	**Birth Certificate** A copy will be taken	**10.**	**Letter of disability (if applicable)** For applying child

HEAD START & EARLY HEADSTART OPTIONS 0-3 OR 3-5 YEARS

Please check the box on the right for the program and center you want your child to attend

Head Start Program: Children 3 years old by September 10th, 2025 or no more than 5 years old by September 10th, 2025.		**Early Head Start Program:** Birth to age 3 years by September 10th, 2025 Pregnant women can also be eligible	
Center Based Option: Classroom setting		**Home Base Option:** Instruction is based out of the child's home/place of residence, once a week for 1 1/2 hours	
New Student Application		**Returning Student Application**	

Gilbert Horn Sr. Early Childhood Center (GHSECC): 231 Chippewa Ave. Fort Belknap Agency Service Area	
Ramona King Center (RKC): 180 John Capture Rd, Hays Service Area	
Three Strikes Center (TSC): 138 Medicine Bear Rd, Lodgepole Service Area	

Certification: I have carefully reviewed the documents and information I have provided with my Fort Belknap Head Start/Early Head Start application and by signing this form, certify to the best of my knowledge and belief that all information regarding eligibility provided be me is true and correct. I also understand information provided will be kept strictly confidential and is available to me within 24 hours of advance notice.

Name of Child:	**DOB:**
Signature of Parent/Guardian:	**Date:**
Signature of Staff Member:	**Date:**

Family & Child Information:

Applicant Child's Legal Name:			
Gender (Please Circle):	Male	Female	
Is your child a NEW student to Head Start/Early Head Start Program	Yes or No	Please circle Head Start Program Please circle Early Head Start Program	
Has child been previously enrolled at another Head Start/Early Head Start or Pre-K program?	Yes or No	If Yes what Program, Dates, & Location?	
Is your child transitioning from Early Head Start to Head Start?		Yes or No	

Parent/Guardians: Last Name First (Please Fill out for PIR purposes)	DOB:	Sex: M/F	Relationship to child:

Children: Last Name First	DOB:	Sex: M/F	Relationship to child:

Current Mailing Address:	
Current Physical Address:	Primary Phone #:
Pick Up and Drop off Address: **(If riding the bus) HS Only:**	
Email Address:	Emergency Phone #:
Best way to contact you: **(Please circle)** Email, Primary Phone, Cell Phone, Text Message, Other	

Primary Health Coverage (Please Circle All That Apply) Provide a Copy

Medicaid Medicaid/Chips Blue Cross Healthy Montana Kids (HMK)	Private Insurance No Insurance State Funded Insurance Other

Doctor/Medical Home (Please Circle)

Lil River Health Center-Agency Eagle Child Health Center-Hays Sweet Medical Center-Harlem/Chinook Bullhook Clinic-Havre Northern Montana Healthcare-Havre Benefis Pediatric-Greatfalls Other

If answered **other** please list facility and city:

Race Ethnicity: (Please Circle All That Apply)

Native American/Alaska Native (Please Provide Copy of Tribal Enrollment for Eligibility Purposes)

Is child and or parent(s) currently enrolled? Yes or No	If Yes What Tribe?

1st Nation/Canadian Native Hispanic or Latin Black or African American

European German/Decent Asian Native Hawaiian or Pacific Islander White/Caucasion Other

Language(s): (Please circle all that apply)

English: Primary Language? Yes or No	Assiniboine (Nakota): Primary Language? Yes or No
Gros-Ventre (AAH-AH-NI): Primary Language? Yes or No	Any Other Tribal language Spoken: Please List:_____ Primary Language? Yes or No
French: Primary Language? Yes or No	German: Primary Language Yes or No
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? **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

Vocational School/Training Job Corps

Associates Degree (Field of Study:_____)	Bachelor's Degree (Field of Study:_____)
Master's Degree	PHD/Doctorate

Employment Status: (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 type (Check all that apply)

	Two Parent Family		Grandfather raising child(ren)
	Single Parent Family (mother figure only)		Grandmother raising child(ren)
	Single Parent Family (father figure only)		(Both) Grandparents raising child(ren)
	Foster Family (must provide legal documentation)		Other:_____
	Blended Family (step family)		Parent(s) serving in military

Additional Family Information: Does your 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 child welfare services (Social Services)		Child's parent(s) are currently incarcerated
	Current address is temporary living arrangement due to loss of housing or economic hardship ***Fill out Homeless Verification Form***		First time parent
	Parent has a disability/special need Please Describe:_____		Parent has no work experience and or secondary education (college courses)
	Recent death in the family within last 12 months		Child's parents are recently divorced/seperated
	Child is currently living with Grandparents		Family would like school be 5 days a week.
	Family is in need of childcare/wrap around.		Parent/guardian(s) suffer from PTSD

Current Assistance or Benefits Received: (Please check all that apply)

	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

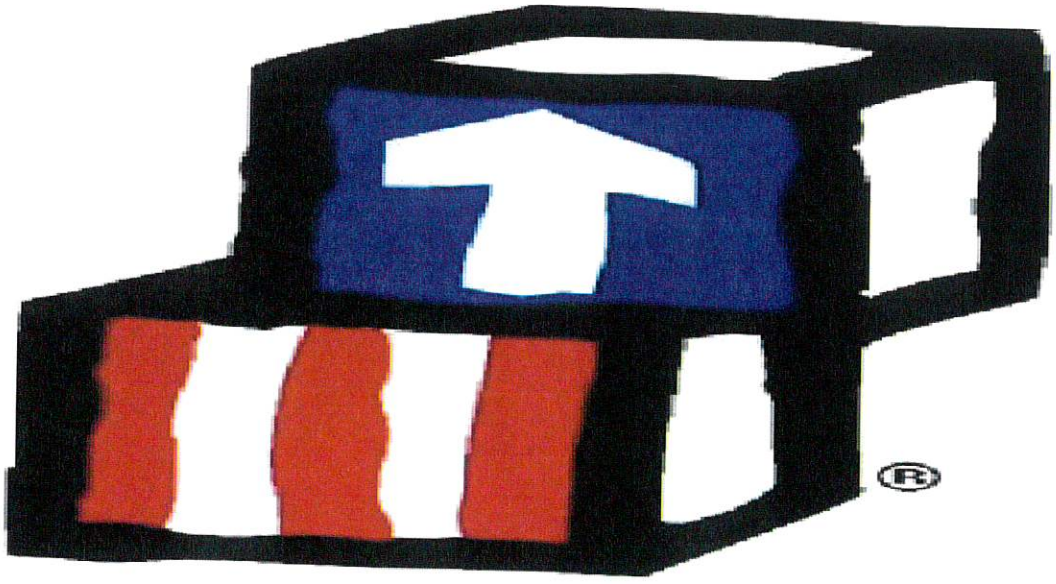
Current Housing Information: (Please check all that apply)

	House (Private Ownership)		**Homeless/No housing** (You do not have your own permanent night time place of residence) ***Need Homeless Verification Form***
	Apartment Complex		Living with relatives/Friends
	Renting (Low Rent, Mutual Help, Landlord etc)		Other

Child Health History Questionnaire (Please circle Y or N)

Does your child have or suffer from frequent colds?	**Yes or No**
Does your child have or suffer from allergies and or seasonal allergies?	**Yes or No**
Does your child have or suffer from frequent ear infections?	**Yes or No**
Does your child have any difficulty seeing?	**Yes or No**
Does your child currently wear glasses?	**Yes or No**
Does your child have difficulty with speech/communication skills?	**Yes or No**
Does your child have any behavioral issues?	**Yes or No**
If yes please list:	
Does your child have or suffer from colic? (EHS only)	**Yes or No**
Does your child suffer from diaper rash? (EHS only)	**Yes or No**
Does your child have a skin condition or suffer from skin rash? If yes please list:_____	**Yes or No**

Does your child take daily naps? If answered yes how long? _____	Yes or No
Does your child have breathing problems or asthma?	Yes or No
If answered yes does your child have to use a nebulizer or inhaler?	Yes or No
If answered yes does your child have to use the breathing medication on a daily basis?	Yes or No
Has your child ever had a convulsion or seizures?	Yes or No
If yes does your child take medication for seizures?	Yes or No
Does your child currently take medication for any possible medical condition?	Yes or No
If Yes Please List:	
Has your child ever had surgery or been hospitalized?	Yes or No
If Yes Please List Reason:	
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
Do you have any concerns about your child's: a.) Speech? If yes describe:_____ b.) Hearing? If yes describe:_____ c.) Vision? If yes describe:_____ d.) Dental? If yes describe:_____ f.) Developmental delay? If yes describe:_____ g.) Behavioral Issues? If yes describe:_____ h.) Weight Issues? If yes describe:_____	Yes or No
Any other health or development concerns? If yes please describe:_____	Yes or No
Are you or your partner currently pregnant?	Yes or No
Was your child born premature? If yes how many weeks?_____	Yes or No
Was anything wrong with your child at birth?	Yes or No
If yes please describe:	
Was anything wrong with the child in the nursery?	Yes or No
If yes please describe:	
Did mother and child stay in the hospital longer than usual?	Yes or No
If yes please state reason:	



EMERGENCY CONTACT AND PARENTAL PICK UP & DROP OFF CONSENT

THIS FORM MUST BY TAKEN WITH THE CHILD WHEN EMERGENCY MEDICAL CARE IS NEEDED

Child's Name:	Date of Birth:
Physical Address:	
Mailing Address:	

Mother/Legal Guardian's Name:	Home Number:
Physical Address:	Cell Number:
Mailing Address:	Emergency Number:
Work Address:	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 Number:

Person'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:
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:

1. 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

Teaching Children
Supporting Families

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

Child's Name:	Child's Age by Sept.10th 2025:

Current Household Information (Please list all DOB of all people "living" in the household)			
Parent/Guardians: Last Name First	DOB:	Sex: M/F	Relationship to child:
Children: Last Name First	DOB:	Sex: M/F	Relationship to child:

Is anyone in the household currently pregnant? **Yes or No**

Family Household Income (Please CIRCLE all that apply)	
Employed full time-2 parent family	Unemployed-receive unemployment benefits
Employed full time-single parent	TANF/477 benefits
Part-Time employment-2 parent family	SSI benefits
Part-time employment single parent	Disability benefits
Seasonal employment	Workmen's compensation benefits
Military Benefits	Unemployed No income
Retirement Benefits	Food Stamps (please provide proof card, document, etc.)
WIC	McKinney/Vento Eligible (Immediate Enrollment)
Tribal Enrollment (Automatically Income Eligible)	

****TO BE COMPLETED BY HEAD START STAFF****

Copy of income verification documents received: (Please CIRCLE all that apply)	
1040 Form	Disability benefits
W2-Statment	Workmen's compensation benefits
Current wage stub	Child support/Alimony payments
Income declaration	No income
Unemployment Benefits	SSI Benefits
Public Assistance (TANF/477)	Retirement Benefits
Military Benefits	Food Stamps (please provide proof card, document, etc.)
WIC	McKinney/Vento Eligible
Gross Annual Income Amount: (Gross/Net Pay Amount)	

Eligibility Verification: (Circle)	Income Eligible:	Over Income
This child is eligible to participate in the program?	Yes	No
Type of eligibility interview conducted:	In-Person	Telephone
Date:	Time:	Phone:

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.	Parent/Guardian Signature:	Date:
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:

*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, _____,hereby give my **consent** for the child listed below to receive the screening tests and examinations checked below, and for transport of the child to and from the services as needed. I understand these services are deemed necessary or advisable by the Head Start program and that I will be informed of any results that are not normal. I also understand that is my responsibility to provide Head Start with an up-to-date immunization record, updated physical examination, and updated record of any medical and or dental examinations/procedures done on my child within the past year. This consent is valid for one year after the signed date. The purpose of this consent has been explained to me.

Child's Name:		**Date of Birth:**	
Medical Insurance Coverage?	**Yes or No**		
Medical Insurance name and card number: (Provide copy)	Insurance name: Insurance card number:		

Please circle **YES** or **NO** to the services listed below: **Y**=Consent is given **N**=Consent is not given

Developmental Screening	**Y or N**	Dental Screening	**Y or N**
Medical Examination (If Necessary)	**Y or N**	Height & Weight BMI (Body Mass Index)	**Y or N**
Speech Screening/Follow ups	**Y or N**	T.B. Test (Turberculosis) HS Only	**Y or N**
Hearing Screening/Follow ups	**Y or N**	Vision screening/Follow ups	**Y or N**
Brush teeth daily with fluoride	**Y or N**	Emergency First Aide/CPR Treatment	**Y or N**
Mental & Behavioral Health Screening and any follow ups	**Y or N**	Planned classroom field trips HS Only	**Y or N**
Permission to use my child's photograph in any HS/EHS related activity, flyers, advertisement, recruitment, parent training, FB online site, etc.	**Y or N**	Crisis Counseling (If necessary)	**Y or N**
Follow up treatment/screenings/examinations/diagnostic testing (if necessary)	**Y or N**	Permission to have **HEMOGLOBIN/HEMATOCRIT** test administered if not done during first initial physical examination? (slight finger poke)	**Y or N**
Medical Home Please List: (example IHS, Sweet Medical Center etc.)			
Dental Home Please List: (example IHS, Havre Dental Group, etc)			

Does your child currently take any medications?	**Yes or No**
If yes please list the current medication(s) and dosage: (including bee sting kits)	
Do you give Fort Belknap Head Start permission to administer medication to your child if its deemed necessary?	**Yes or No**

Certification: I have carefully reviewed the documents and information I have provided is accurate and to the best of my knowledge all information provided is true and correct. I also understand information provided will be kept strictly confidential and will only be utilized by authorized personnel.

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:_____

Date:_____

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

Child's Name:		SEX:	
DOB:		Phone Number	
Head Start Center			
Address:			

TO BE COMPLETED BY HEALTH CARE PROVIDER

HEIGHT: Inches (%)

WEIGHT: Lbs/oz (%)BMI for age (%)

EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL
Blood Pressure (age 3+)			Oral Health Assessment			Genitalia		
Skin			Throat			Neurologic		
Neck			Chest			Extremities		
Head			Lungs			Motor Ability		
Lymph Nodes			Heart			Psychological		
Eyes			Back			Speech		
Ears			Abdomen			Bones		
Nose						Muscle Coordination		

NEUROLOGICAL/SOCIAL	NORMAL	ABNORMAL
Gross Motor:		
Fine Motor:		
Communication Skills:		
Cognitive:		
Self-Help Skills:		
Social Skills:		

COMMENTS (Use additional sheet if necessary)

VISION ACTUITY (AGE 3+)

Test Type:	Right:	Left:	Both
	/	/	/

HEARING (AGE 3+)

Test Type:	Frequency (Hz)	Right (db)	Left (db)
	1000 Hz	db	db
	2000 Hz	db	db
	3000 Hz	db	db
	4000 Hz	db	db

HEMOGLOBIN/HEMATOCRIT

HGB(g/dl)	Risk Anemia Y or N
Treatment:	Follow-up:

LEAD

Lead Level (mcg/dl):	**Risk of High Lead Levels** Y or N
Treatment:	Follow-up:

Screening of TB Risk Factors:

- Risk factors NOT present: TB SKIN TEST NOT REQUIRED
- Risk factors present: Mantoux TB skin Test Performed

Date Given	Results	Significant Y or N	Non Significant Y or N	Date Read

Date Chest Xray	Normal Y or N	Abnormal Y or N	RX Date

Immunizations

Given Today: Yes or NO

DATE (OR AGE) NEXT PHYSICAL IS DUE:

Diagnosis/Abnormal Findings:

Treatment/Restrictions/Recommendations for School:

MEDICATIONS REQURIED AT SCHOOL:
Y or N

TYPE OF MEDICATION AND PURPOSE:

GENERAL STATEMENT ON CHILD'S OVERALL PHYSICAL STATUS:

Physician's Signature:	**Date:**

NATIONAL CENTER ON
Early Childhood National Centers
Early Childhood Health and Wellness

Head Start Oral Health Form

Patient Information

Pregnant woman's/child's name _____ Date of birth _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the pregnant woman's/child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the pregnant woman or child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the pregnant woman or child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Does the pregnant woman have gum disease? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No

Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Patient, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

This document was prepared under grant #9OHC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Early Childhood Health and Wellness.

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

Child's Name:		Sex and Current Age:	

DIETARY HABITS

1.	List your child's favorite foods?	
2.	List foods your child does not like:	

	Please Check Yes or No	Yes	No
3.	Does your child take vitamins and mineral supplements? A) If yes please identify what kind?_____ B) Do they contain Iron? C) Were they prescribed?		
4.	Are there any foods your child should not eat for medical, religious, or personal reasons?	*	
5.	Is your child on a special Diet? A) What Kind?	*	
6.	Does your child still breast feed or drink breast milk on a regular basis? If yes how many times a day?:_____	*	
7.	Does your child eat baby food products? If yes please list:_____	*	
8.	Has there been a big change in your child's appetite in the past month?	*	
9.	Does your child take a bottle/formula? If yes please list brand?:_____	*	
10.	Does your child chew or eat things that aren't food?	*	
11.	Does your child have trouble chewing or swallowing?	*	
12.	Do you have any concerns about what your child eats while at HS/EHS Program?	*	

	13. Please list how many days a week your child eats a food from the following food groups:	Please circle number of times a week your child eats from each of the food groups							
a.	Dairy Products (milk, formula, cheese, yogurt, etc.):	0*	1*	2*	3	4	5	6	7+
b.	Meat, poultry, fish, eggs, dried beans/peas, peanut Butter	0*	1*	2*	3	4	5	6	7+
c.	Rice, grits, bread, cereal, tortillas, frybread	0*	1*	2*	3	4	5	6	7+
d.	Greens, carrots, broccoli, squash, pumpkin, sweet potatoe	0*	1*	2*	3	4	5	6	7+
e.	Oranges, grape fruit, tomatoes, (fruit juice)	0*	1*	2*	3	4	5	6	7+
f.	Other fruits and vegetables	0*	1*	2*	3	4	5	6	7+
g.	Oil, margarine, butter, lard	0*	1*	2*	3	4	5	6	7+
h.	Cakes, cookies, sodas, fruit drinks, candy, koolaid	0*	1*	2*	3	4	5	6	7+

Growth Chart *(Staff Only)*

Date	Age		HEIGHT (no shoes to nearest 1/8 in.)	WEIGHT (light clothing to nearest 1/4 lb.)
	Years	Months		

Anemia Screen *(Staff Only)*

	Date	HEMOGLOBIN	OR HEMATOCRIT
Screening			
Rescreening			

*Hgb less than 11 or Hct less than 34 require follow-up

Staff Initials:		Staff Title:		Date:	
Staff Initials:		Staff Title:		Date:	
Staff Initials:		Staff Title:		Date:	

CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION *(Staff Only)*

(Review items 2 through 13 if there are answers in the (*) areas, or if growth is not within the typical range, check the appropriate boxes below and consult a nutritionist or physician.)

	Suspect dietary problem or inadequate food intake (from questions 2 to 12)		Overweight (weight greater than typical, from growth chart 1 or 4)
	Hgb, less than 11 gm. or Hct less than 34%		Short for age (height less than typical from growth chart)
	Underweight (weight less than typical from growth chart)		Wt. for Ht. (greater or less than typical from growth chart)

Comments: *(use additional page if needed)*

Signature:		Title:		Date:	