Return this completed form to: Grand Traverse Band of Ottawa & Chippewa Indians Head Start & Early Head Start
2605 N. West Bayshore Drive, Peshawbestown, MI 49682, (231) 534-7650

This Form Must Be Completed for All Head Start/GSRP & Early Head Start Center Based Applicants

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address

Adult/Parent/Guardian's Phone Number

Signature of Adult/Parent/Guardian

Date Signed

Non-Discrimination Statement

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

GTB Benodjenh Head Start/Early Head Start

LETTER OF UNDERSTANDING

Regarding _____ attendance, illness, and emergency contact information
(Child's Name)

I, _____ understand the following:
(Parent/Guardian Name)

The Head Start/Early Head Start serves less than half of the eligible population. For every enrolled child, there is at least one eligible child who will not be served due to limited space.

The Head Start/Early Head Start program costs me nothing, it is free of charge yet will provide my child and family with over $10,000 worth of services.

Along with the privilege of being a part of this preschool program comes my responsibility to adhere to the following requirements of the Head Start/Early Head Start Program:

*** If my child must miss, I will notify program personnel as instructed in the parent handbook. I understand that Head Start requires an average daily attendance rate of 85%.**

*** My child will be replaced by a child from the waiting list for excessive absences.**

*** In the event of illness, it is my responsibility to keep my child at home when they are sick and/or have any of the symptoms listed on page 19 in the Parent Handbook.**

*** If my child becomes ill while at school, it is my responsibility to pick up my child or make arrangements to have another person pick my child up from Head Start/Early Head Start within <u>30 MINUTES</u> of being contacted.**

*** It is also my responsibility to keep my child's emergency contact information up to date and to provide phone numbers of at least two people who live in close proximity of the Benodjenh Center who can be contacted to pick my child up in the event of an illness/emergency when I cannot be reached.**

Parent/Guardian Signature_____ Date_____

GTB EARLY HEAD START, HEAD START & GSRP
2600 N. Strongheart Way
Suttons Bay, MI 49682
(231)534-7650 FAX (231)534-7583

CONSENT FOR PARTICIPATION

Child's Name:_____

I, the undersigned, hereby give permission to the Grand Traverse Band Early Head Start and Head Start Program to:

PLEASE INITIAL:

_____ Release and Obtain Health Records of my child to and from my child's primary care physician and dental care provider.

_____ Obtain and share information regarding my child with DHS

_____ Obtain and share information regarding my child with Health Department/WIC

_____ Obtain and share information regarding my child with GTB Behavioral Health Services

_____ Obtain and share information regarding my child with AFS

_____ Obtain and share information regarding my child with Pine Rest/Mental health Therapist_____.

_____ Allow my child to participate in Head Start's free Health Care program which could include all or some of the following:

❖Immunization Clinic	❖Dental Examination
❖Physical Examination	❖Speech Evaluation & Therapy
❖Hearing and Vision Testing	❖Height & Weight Measurements
❖Developmental Screening	❖Tooth brushing daily with Fluoridated Toothpaste
❖ Hemoglobin & Blood Pressure Screening	❖Referrals to other agencies for Disability
❖Child observations and/or staff consultations regarding my child with Mental Health Consultant, Nutrition Consultant, and/or Nursing Consultant if needed.	

_____ Release my name and phone number, and the name, birth date, address, and pertinent Head Start file contents of my child to the school of my choice:_____. This will be done when my child is age eligible for Kindergarten Round-Up activities.

_____ To take photographs and/or videos of my child/family which may be used in displays, recruitment, or other types of news/educational publications. Occasionally local news media may take photographs or video of the children.

_____ Release my child's name on a class list which will be distributed to all parents/guardians. Allow my child's name to appear in class, program or promotional material.

_____ Allow Head Start/Early Head Start staff to apply sunscreen (SPF 45) to my child before going outside in spring/summer months.

This consent is valid for one year after the date signed. In signing this document, I am fully aware of the items listed and concur that the above consent is in the best interest of my child.

_____ _____

Signature of Parent/Guardian Date

CHILD INFORMATION CARD

GTB Early Head Start, Head Start & GSRP

******THIS FORM MUST BE COMPLETELY FILLED OUT AND SIGNED!!!******

Name of Child (last, first, middle int.)		Name of Parents		
Allergies, if any		Address, number and street		
Date of birth	Home phone number	City	State MI	Zip Code
1. Parents Location when child is in care		Hours of Employment	Phone Number	
Address Number and Street		City	State MI	Zip Code
2. Parents Location when child is in care		Hours of Employment	Phone Number	
Address number and street		City	State MI	Zip Code

Persons other than the parent who are located within 30 minutes of the Benodjenh Center and can be notified in an emergency situation when the parent is not available.

Name		Phone number (REQUIRED)	
Address Number and Street	City	State MI	Zip Code
Name		Phone number (REQUIRED)	
Address Number and Street	City	State MI	Zip Code

Names of persons other than parent to whom child may be released.

Name	Name
Name	Name

I Hereby give permission to the GTB Benodjenh Center to secure emergency medical and/or emergency surgical treatment for the above named minor child in care. Non-emergency medical or elective surgical treatment is not included in this authorization. This includes care by a physician or dentist and transportation to and from the source of emergency treatment. This does not include the right to perform surgical operations without my further consent, except in the case of emergency and when after an effort has been made to locate me I have been found unavailable.

Please indicate if your child as any of the following conditions which could be important in an emergency:

___Severe Asthma ___Diabetes ___Allergic to Insect Bites ___Allergic to Medications ___Seizures

Other:

Signature of parent or guardian	Date

Date of child's most recent DTP (tetanus) shot:		Name of Child's Dentist:	
Name of child's Physician or health clinic		Office Hours	Phone Number
Address number and street	City	State	Zip Code
Hospital Preferred for medical treatment	Health insurance policy and number		

I hereby give permission to the GTB Benodjenh Center for my child to be transported in a vehicle and/or participate in field trips.

Signature of parent or guardian	Date

GTB Benodjenh Early Head Start, Head Start & GSRP

2605 N.W. Bayshore Dr.,
Peshawbestown, MI 49682
Phone 231-534-7650 Fax 231-534-7583

Transportation Information

To insure that your child is picked up and dropped off at the proper place, please fill in the correct information:

Child's Name: _____

Address: _____

_____

Telephone: _____

Child will get to the program by:

☐ **Bus (Child MUST be at least 20 lbs. AND 1 year old. Bussing for Early Head Start is only available to children living on the Reservation)**

☐ **Parent will transport**

If child will ride bus, please complete the following:

DAY OF WEEK	MORNING PICK UP ADDRESS	AFTERNOON DROP OFF ADDRESS
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		

Please give directions to the location(s) your child will be picked up and/or dropped off:

_____

_____

_____

_____

If there are any changes in the above schedule, please contact the Benodjenh Head Start staff as soon as possible at 534-7650. If there is no one at your home or drop off site, your child will be brought back to Benodjenh Center and will be signed into the Child Care program until you come to pick them up. **You will be charged for child care costs starting from the time that Head Start ends (3:00 p.m.) until the time you sign your child out of Child Care.**

If you have any further questions or concerns, please contact any of the Benodjenh Head Start staff.

Rev. 4/2014

Michigan Department of Education
Child and Adult Care Food Program

Formula/Food Sign-Off Statement

Dear Parent,

Your childcare center participates in the Child and Adult Care Food Program (CACFP). The CACFP is a child nutrition program of the United States Department of Agriculture (USDA). Childcare centers are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, this child care center offers formula and other required infant food to all enrolled infants. The iron-fortified infant formula(s) provided for infants until they turn one year of age is:

Enfamil with Iron
(Insert Name of Formula)

As the parent or guardian, you may decline the formula offered by the center and supply the infant's formula yourself. However, when your infant turns one year of age, the center will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler-age children.

To assist us in your infant formula and food preferences, please complete the questions below by checking one item each in the formula and solid food sections.

Please Check Your Preferences:
Formula or Breast Milk: (check up to two)

- ☐ I want the center to provide formula for my infant.
- ☐ I will bring iron-fortified infant formula for my infant.
- ☐ I will bring expressed breast milk for my infant.
- ☐ I will come to the center to breast feed my infant.

Solid Food: (check one)

- ☐ I want the center to provide solid food for my infant when s/he is developmentally ready for it.
- ☐ I will bring solid food for my infant when s/he is developmentally ready for it.

Infant's Name: _____ Birth date: _____

Parent/Guardian Signature: _____ Date: _____

Non-Discrimination Statement

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)
If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.
Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

HEAD START EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT

AGE 1 MONTH THROUGH 5 YEARS

CHILD'S NAME:	**SEX:**	**BIRTHDATE:**
PARENT/GUARDIAN NAME AND ADDRESS:		**PHONE:**
HEAD START CENTER NAME AND ADDRESS:	GTB Head Start/Early Head Start 2605 N.W. Bayshore Dr. Suttons Bay, MI 49682	**PHONE:** (231) 534-7650 **FAX:** (231) 534-7583

PART I: To be completed before and during Physical Examination/Assessment

1. RELEVANT HISTORY AND ADDITIONAL INFORMATION *(from Health History, Parent/Teacher Observations. Also enter Primary Physician name and address if form will be sent to a different provider)*

2. SCREENING TESTS: *All items are required by Head Start and recommended by the American Academy of Pediatrics for age 1 Month through 4 Year well child visits. At a minimum, check appropriate boxes in RESULTS/DATE column. Enter date if done previously. Provide comments on: services needed, suspect or atypical results and reasons services were not performed.*

TEST	RESULTS / DATE	COMMENTS
A. Present Age	Yrs. Mos.	Well Child Visit Age: ☐3-5days ☐1m ☐2m ☐4mo ☐6mo ☐9mo ☐12mo ☐15mo ☐18mo ☐24mo ☐30mo ☐3 Yr ☐4Yr ☐5Y
B. Immunization Review	☐Up to date ☐Immunizations Needed ☐Review Not Performed	Immunizations given today:
C. History	☐Performed ☐Not Performed	
D. Blood Pressure *(Perform at 3 Yr., 4 Yr., and 5Yr.)*	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
E. Height _____ Weight _____ BMI_____ *(No shoes, to nearest 1/8 in.)*	☐ BMI >90% or ☐ BMI <10% ☐ Concern ☐No Concern	
Head Circumference *(though 24 mo.)*_____	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
F. Hearing	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
G. Vision *(Test at Each Visit starting at 1 mo. - Must be Objective Test at 3 Yr. and 4 Yr.)*	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
H. Developmental Assessment	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
I. Autism Screening *(Perform at 18 & 24 mo.)*	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
J. Blood Lead *(Perform at 12 & 24 Mo. If never tested, perform between 3 Yr. and 5 Yr.)*	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
K. Hematocrit or Hemoglobin *(perform at 12 mo, risk assess after 12 mos. with appropriate action)* Hgb._____ Hct. _____	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
L. Cholesterol *(Test High Risk child at 24 Mo. and 4 Yr.)* ☐ High Risk ☐ Low Risk	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
M. Dental Inspection	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
N. Nutritional Assessment	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
O. Tuberculin (TB) Test[1] *(Perform if High Risk)* ☐ High Risk ☐ Low Risk	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
P. Interpretive Conference	☐Performed ☐Not Performed	
Q. Anticipatory Guidance	☐Performed ☐Not Performed	
R. Injury Prevention	☐Performed ☐Not Performed	

1. Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.

PART II: To be completed by Health Care Provider During and After Physical Examination/Assessment

2. PHYSICAL EXAMINATION / ASSESSMENT: *All items are required by Head Start and recommended by the American Academy of Pediatrics for children age 1 month through 4 years. Please check appropriate columns (Normal for Age; Atypical; or Not Evaluated) and provide comments on: services needed, atypical results/scores; behavior/mental health problems and reasons for items not evaluated.*

	Normal for Age	Atypical	Not Evaluated	COMMENTS *(Use additional sheets if necessary.)*
A. General Appearance				
B. Posture, Gait				
C. Speech				
D. Head				
E. Skin				
F. Eyes:				
(1) External Aspects				
(2) Optic Fundiscopic				
(3) Cover Test				
G. Ears:				
(1) External & Canals				
(2) Tympanic Membranes				
H. Nose, Mouth, Pharynx				
I. Teeth				
J. Heart				
K. Lungs				
L. Abdomen *(include hernia)*				
M. Genitalia				
N. Bones, Joints, Muscles				
O. Neurological / Social				
(1) Gross Motor				
(2) Fine Motor				
(3) Communication Skills				
(4) Cognitive				
(5) Self-Help Skills				
(6) Social Skills				
P. Glands *(Lymphatic/Thyroid)*				
Q. Muscular Coordination				
R. Other				

S. General Statement on Child's Medical Status (Please note any allergies):

Should the child's activity be restricted due to physical defect or illness? ☐Yes ☐No If yes, check below and explain degree of restriction:
☐Classroom ☐Playground ☐Gym ☐Swimming ☐Sports ☐Camp ☐Other

4. FINDINGS, TREATMENTS AND RECOMMENDATIONS

ABNORMAL FINDINGS / DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS	DATE

PHYSICIAN NAME AND ADDRESS (PLEASE PRINT):

PHONE:

FAX:

Signature

Date

Revised 4/12

CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

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

HEAD START CENTER: GTB Benodjenh Center PHONE: (231)534-7650

ADDRESS: 2605 NW Bayshore Drive Suttons Bay, MI 49682 FAX: (231)534-7583

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No____ Unknown____ Yes____
   - Fluoridated water? No____ Unknown____ Yes____
   - Fluoride Supplement diet? (tablets____, liquid____) No____ Unknown____ Yes____

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

PART I. TO BE COMPLETED BY HEAD START STAFF

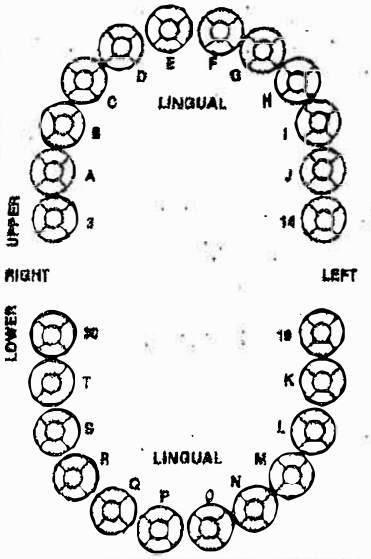
3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____ Date last visit_____
4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____
5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type_____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___			
Heart/Vascular Dis.	___	___			

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing ( ), decayed ( ), or filled ( ); indicate restorations you perform in item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___is, ___is not) complete. If not, explain here, as well as items checked.
   _____
   _____
   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

   Signature_____ Date_____

INTERVIEWER: GO TO FORM 6

GTB Benodjenh Head Start Center
2600 N. Strongheart Way, Suttons Bay, MI 49682
Phone 231-534-7650 Fax 231-534-7583

Treatment: Upon acceptance into the program, the parents are to be made aware that dental screening and treatment is mandatory and not optional.

Referral is determined by what insurance coverage is in effect:

1. The following Clinics below accept Medicaid:

Dental Clinics North
2600 N. LaFranier Rd., Suite B
Traverse City, MI 49686

Mancelona Clinic
205 Grove Street
Mancelona, MI 49659

Petoskey Clinic
3434 M-19 Suite B
Harbor Springs, MI 49740

East Jordan Clinic
601 Bridge Street
East Jordan, MI 49727

**Any of these clinics can be reached by dialing 1-877-321-7070 (toll free)

2. For Tribal Members, the GTB Clinic also accepts Medicaid:

GTB Dental Clinic
2300 N. Stallman Rd.
Peshawbestown, MI 49682
(231) 534-7211

2. Insurance Coverage such as Blue Cross/Blue Shield:
Individual Dentists should be contacted.

3. GTB Contract Health Funding:

This funding is only available to GTB Tribal members. Any dental appointments must be pre-approved by the GTB Contract Health Office prior to scheduling. Please contact MaryJo McSauby at 231-534-7931 or Stella Chippewa at 231-534-7210 for additional information.

Rev. 4/15