YANKTON SIOUX TRIBE HEAD START

WELCOME PARENTS AND CAREGIVERS TO THE YST HEAD START PROGRAM

The Head Start Program recognizes parents and caregivers as the primary educator of their children. Through your involvement in the program you will have many opportunities to learn and grow with your child. We look forward to sharing the Head Start Experience with you and your family.

To complete the enrollment process, we need the following information

- ✓ ***Child's Birth Record***
- ✓ ***Complete Enrollment Packet***
- ✓ ***Degree of Indian Blood or Letter of Pending***
- ✓ ***Dental Screening***
- ✓ ***Family's Proof of Income***
- ✓ ***IEP (if child is Special Needs)***
- ✓ ***Immunization Record***
- ✓ ***Medicaid Card***
- ✓ ***Physical Examination***

For further information regarding Head Start please call:
605-384-3423

Approved by:_____ Date:_____

YANKTON SIOUX TRIBE HEAD START

608 Kids Corner Dr.
Marty, South Dakota 57361

Applicant & Family Member Information

Applicant

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Primary Health Coverage | Other Coverage | Insurance # | Medicaid Eligibility | Medicaid # | Doctor/Medical Home

Medicaid Eligibility
☐ Not Eligible ☐ On Medicaid ☐ Potentially

Dental Coverage | Dental Coverage # | Dentist/Dental Home

Primary Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED
☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's

Employment Status
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed
☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled

Child's Relationship
☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Secondary or Other Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID

Race
☐ Asian ☐ American Indian/Alaska Native
☐ Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Multi-Racial
☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language

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☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed
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Child's Relationship
☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family
☐ Provides Financial Support
☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Name:____________________ DOB:______________

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ____________			☐ Proficient		☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race		Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian	☐ American Indian/Alaska Native	☐ Yes	☐ Little		☐ Little
☐ Black	☐ Hawaiian/Pacific Islander	☐ No	☐ Moderate		☐ Moderate
☐ White	☐ Multi-Racial		☐ None		☐ None
☐ Other: ____________			☐ Proficient		☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Living Address

Started Living At Date	Living Address	Address Line 2	ZIP	City	State	County

Family Mailing Address

Same as living?	Started Using Date	Mailing Address	Address Line 2	ZIP	City	State
☐ Yes ☐ No						

Phone Number(s)	Type (*check one*)	Note (extension or best time to call)	Opt In for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Family Income

Income Verified by	Verification Date	TANF Status	SSI
		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ No

Family Member	*Amount*	*Per (for example: week, month, year)*	*Annual Amount*	*Description (for example: SSI, Job, Child Support)*	*Verification (for example: W2, check stub)*	*Note*
	$		$			
	$		$			
	$		$			

Income Notes

Emergency Contacts

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 2

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Contact 3

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

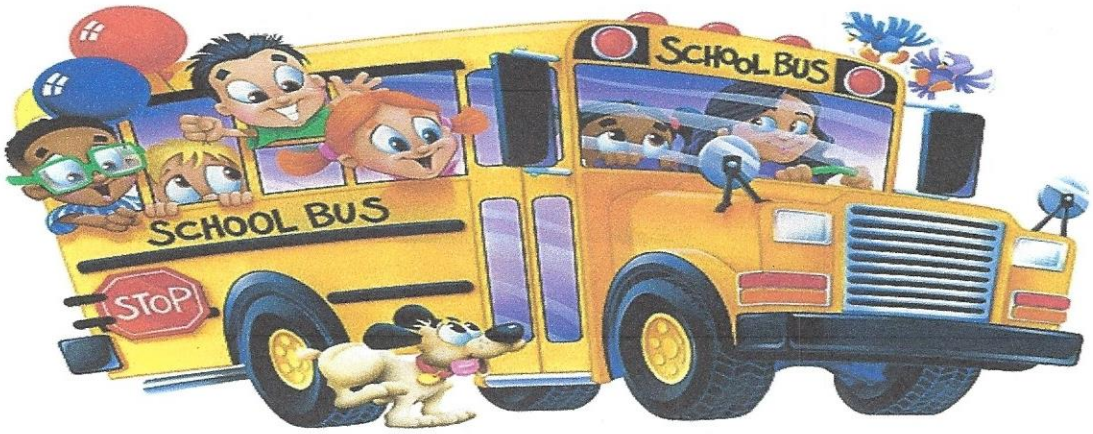
Address	ZIP	City	State

Phone Number 1	Phone Number 2	Phone Number 3
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature_____ Date _____

YANKTON SIOUX TRIBE HEAD START



Accident/Bus Emergency
Information

The bus operator has permission to authorize the physician of his/her choice to provide emergency care in the event that I cannot be contacted immediately.

Date:_____

Parent Signature:_____

Bus Operator Signature:_____

YANKTON SIOUX TRIBE HEAD START

CERTIFICATION OF NO INCOME

I_____, hereby certify that:

I **do not** individually receive income from any of the following Sources:

- Wages from employment
- Income from operation of a business
- Rental income from real or personal property
- Interest or dividends from assets
- Social Security payments
- Payment from annuities, insurance policies, retirement funds, pensions, or death benefits
- Unemployment or disability payments
- Public assistance payments (other than food stamps)
- Periodic allowances from alimony or child support
- Gifts received from persons not comprising of the household
- Sales from self-employed resources (Avon, Mary Kay, Pampered Chef, etc.)
- Any other source not named above; **AND**

I currently **do not** have income of any kind and there is no imminent change expected in my financial or employment status during the next 12 months; **AND**

I will be using the following sources of funds to pay for rent, utilities, and/or other necessities:

_____

_____

_____

APPLICANT CERTIFICATION

I certify, to the best of my knowledge, that the information presented in this **certification** is true and accurate.

_____ _____ _____

Parent/Guardian Printed Name Signature Date

YANKTON SIOUX TRIBE HEAD START

PARENT CONSENT FORM

Child's Name:_____

Please check each of the following:

I hereby give the YST Head Start Program personnel the authorization to:

1. Release my name, telephone number and/or address to the other parents for the purpose of communicating about specific program activities.
   Yes____ No____

2. Include information about my child/family in the program newsletter. I understand the newsletter is distributed to program staff and enrolled families. The information may include, but is not limited to child/family name, photographs, achievements, successes, birthdays and participation in program activities.
   Yes____ No____

3. Include my child on local field trips (fire department, post office, library, elementary schools, day care, Halloween activities, buffalo field trip, pumpkin patch field trip, and year end field trip). The parent or guardian, or other responsible adult must supervise children during home visits, field trips and socialization activities.
   Yes____ No____

4. Transport my child for all program purposes. Head Start staff will ensure that children are safely secured in their seats and assist them with buckling seat belts.
5. Take photographs/videos of my child for program use.
   Yes____ No____

6. Photographs or film of my family and me. I understand the photographs and footage may be for the purpose of publicity, illustration, and advertising a product or service directly related to the Head Start.
   Yes____ No____

7. Provide first aid and emergency care to my child as needed.
   Yes____ No____

8. Conduct a developmental screening on my child. I understand the screening is a tool used to determine my child's current level of performance in the areas of concepts, language, and development.
   Yes____ No____

9. Conduct a health screening on my child enrolled in the Head Start. I understand this screening may include height, weight, vision, hemoglobin, and blood pressure for my child.
   Yes____ No____

10. Have a qualified health care professional conduct a physical and/or dental exam on my child, in accordance with federal mandated health requirements for the Head Start program, in the event that those services are available.
    Yes____ No____

PARENT CONSENT FORM (continued)

11. Transfer all required records for kindergarten transition, including the child's behavior plan as appropriate.
    Yes____ No____

12. Observe my child in the classroom in relation to behavior or developmental concerns, and when needed have and affiliated professional conduct observations.
    Yes____ No_____

13. Will your child be attending Head Start Monday thru Thursday?
    Yes____ No____

14. Will your child be attending Head Start 9:00 A.M. to 2:00 P.M.?
    Yes____ No____

15. Will Your child be eating breakfast provided by the head Start between 9:15 A.M. to 9:45 A.M.?
    Yes____ No____

16. Will you child be eating lunch provided by the head Start between 11:45 A.M. and 12:30 P.M.?
    Yes____ No____

17. Consent to refer my child for follow-up on identified concerns resulting from screenings provided by the Head Start program.
    Yes____ No____

18. I give consent for my child's screening and special education records from the South Central Educational Cooperative to be released to the Yankton Sioux Tribe Head Start.
    Yes____ No____

19. Conduct ongoing assessments at the beginning, middle, and the end of the school year to determine my child's progress.
    Yes____ No____

Non-Discrimination Clause:
It is the policy of the Yankton Sioux Tribe Head Start to not discriminate on the basis of race, sex, age, color, national origin, or disabilities in the provision of services or employment.

Confidentiality Statement:
Information shared with the YST Head Start will be kept strictly confidential unless release is authorized in writing. These forms will be maintained in locked files.

I hereby release the Yankton Sioux Tribe from all legal responsibilities or liabilities that may arise from acts I have authorized above.

I would like a copy of this consent form Yes____ No____

Signature of Parent /Guardian Date

YANKTON SIOUX TRIBE HEAD START

RELEASE OF INFORMATION

I hereby authorize the Yankton Sioux Tribe Head Start to receive/send the following information:

____ Income verification

____ Copy of Medicaid care

____ Copy of child's birth verification

____ Copy of health Records

- ☐ Physical
- ☐ Dental
- ☐ Lead Screening Results
- ☐ Immunizations

____ Other:_____

_____
Employee Signature

Authorization given this ____ Day of _____ 20_____

_____ _____ _____
Signature of Parent/Guardian Child's Name DOB

Send Information to: **Yankton Sioux Tribe Head Start**
P.O. Box 1153
Wagner, S.D. 57380

CHILD HEALTH RECORD — FORM 2A, HEALTH HISTORY

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

PERSON INTERVIEWED: _____ DATE: _____ RELATIONSHIP: _____

NAME OF INTERVIEWER: _____ TITLE: _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?			
2. DID MOTHER VISIT PHYSICIAN FEWER THAN TWO TIMES DURING PREGNANCY?			
3. WAS CHILD BORN OUTSIDE OF A HOSPITAL?			
4. WAS CHILD BORN MORE THAN 3 WEEKS EARLY OR LATE?			
5. WHAT WAS CHILD'S BIRTH WEIGHT?			_____ lbs., _____ oz.
6. WAS ANYTHING WRONG WITH CHILD AT BIRTH?			
7. WAS ANYTHING WRONG WITH CHILD IN THE NURSERY?			
8. DID CHILD OR MOTHER STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
9. IS MOTHER PREGNANT NOW?			*(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements.)*
HOSPITALIZATIONS AND ILLNESSES	**YES**	**NO**	**EXPLAIN "YES" ANSWERS**
10. HAS CHILD EVER BEEN HOSPITALIZED OR OPERATED ON?			
11. HAS CHILD EVER HAD A SERIOUS ACCIDENT *(broken bones, head injuries, falls, burns, poisoning)*?			
12. HAS CHILD EVER HAD A SERIOUS ILLNESS?			
HEALTH PROBLEMS	**YES**	**NO**	**EXPLAIN *(Use additional sheets if needed)***
13. DOES CHILD HAVE FREQUENT ____ SORE THROAT; ____ COUGH; ____ URINARY INFECTIONS OR TROUBLE URINATING; ____ STOMACH PAIN, VOMITING, DIARRHEA?			
14. DOES CHILD HAVE DIFFICULTY SEEING *(Squint, cross eyes, look closely at books)*?	*		
15. IS CHILD WEARING *(or supposed to wear)* GLASSES?			*(If "yes")* WAS LAST CHECKUP MORE THAN ONE YEAR AGO? _____
16. DOES CHILD HAVE PROBLEMS WITH EARS/HEARING *(Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)*?	*		
17. HAVE YOU EVER NOTICED CHILD SCRATCHING HIS/HER BEHIND *(Rear end, anus, butt)* WHILE ASLEEP?			
18. HAS CHILD EVER HAD A CONVULSION OR SEIZURE? IS CHILD TAKING MEDICINE FOR SEIZURES?	*		*If "yes" ask:* WHEN DID IT LAST HAPPEN? _____ WHAT MEDICINE? _____
19. IS CHILD TAKING ANY OTHER MEDICINE NOW? *(Special consent form must be signed for Head Start to administer any medication).*			WHAT MEDICINE? _____ *(If "yes")* WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? ____ HOW OFTEN? ____
20. IS CHILD NOW BEING TREATED BY A PHYSICIAN OR A DENTIST?			(PHYSICIAN'S NAME: _____)
21. HAS CHILD HAD: ___ BOILS, ___ CHICKENPOX, ___ ECZEMA, ___ GERMAN MEASLES, ___ MEASLES, ___ MUMPS, ___ SCARLET FEVER, ___ WHOOPING COUGH?			
22. HAS CHILD HAD: ___ HIVES, ___ POLIO?	*		
23. HAS CHILD HAD: ___ ASTHMA, ___ BLEEDING TENDENCIES, ___ DIABETES, ___ EPILEPSY, ___ HEART/BLOOD VESSEL DISEASE, ___ LIVER DISEASE, ___ RHEUMATIC FEVER, ___ SICKLE CELL DISEASE?	*		*If "yes", transfer information to Forms 1 and 5.*
24. DOES CHILD HAVE ANY ALLERGY PROBLEMS *(Rash, itching, swelling, difficulty breathing, sneezing)*? a WHEN EATING ANY FOODS? _____ b WHEN TAKING ANY MEDICATION? _____ c WHEN NEAR ANIMALS, FURS, INSECTS, DUST, ETC.? _____	*		*If "yes", transfer information to Forms 1 and 5.* WHAT FOODS? WHAT MEDICINE? WHAT THINGS? HOW DOES CHILD REACT?
25. *(If any "yes" answers to questions 14, 16, 18, 22, 23, or 24 ask:)* DO ANY OF THE CONDITIONS WE'VE TALKED ABOUT SO FAR GET IN THE WAY OF THE CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAS THIS PROBLEM?			DESCRIBE HOW: WHEN?
26. ARE THERE ANY CONDITIONS WE HAVEN'T TALKED ABOUT THAT GET IN THE WAY OF THE CHILD'S EVERY-DAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU THE CHILD HAD THIS PROBLEM?			DESCRIBE: WHEN?

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

INTERVIEWER: GO TO FORM 4

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW. HEAD START CENTER: _____

CHILD HEALTH RECORD — FORM 2 — HEALTH HISTORY (Continued)

PERSON INTERVIEWED:_____ DATE:_____ RELATIONSHIP:_____

NAME OF INTERVIEWER:_____ TITLE:_____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT

THESE QUESTIONS WILL HELP US UNDERSTAND YOUR CHILD BETTER AND KNOW WHAT IS USUAL FOR HIM/HER AND WHAT MIGHT NOT BE USUAL THAT WE SHOULD BE CONCERNED ABOUT:

27. CAN YOU TELL ME ONE OR TWO THINGS YOUR CHILD IS INTERESTED IN OR DOES ESPECIALLY WELL?

28. DOES YOUR CHILD TAKE A NAP? _____NO, _____YES. IF "YES" DESCRIBE WHEN AND HOW LONG.

29. DOES YOUR CHILD SLEEP LESS THAN 8 HOURS A DAY OR HAVE TROUBLE SLEEPING (SUCH AS BEING FRETFUL, HAVING NIGHTMARES, WANTING TO STAY UP LATE)? _____NO, _____YES. IF "YES" DESCRIBE ARRANGEMENTS (OWN ROOM, OWN BED, AND SO FORTH)._____

30. HOW DOES YOUR CHILD TELL YOU HE/SHE HAS TO GO TO THE TOILET?_____

31. DOES YOUR CHILD NEED HELP IN GOING TO THE TOILET DURING THE DAY OR NIGHT, OR DOES YOUR CHILD WET HIS/HER PANTS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE._____

32. HOW DOES YOUR CHILD ACT WITH ADULTS THAT HE/SHE DOESN'T KNOW?

33. HOW DOES YOUR CHILD ACT WITH A FEW CHILDREN HIS/HER OWN AGE?

34. HOW DOES YOUR CHILD ACT WHEN PLAYING WITH A GROUP OF OTHER CHILDREN?

35. DOES YOUR CHILD WORRY A LOT, OR IS HE/SHE VERY AFRAID OF ANYTHING? _____NO, _____YES. IF "YES", WHAT THINGS SEEM TO CAUSE HIM OR HER TO WORRY OR TO BE AFRAID?

36. CHILDREN LEARN TO DO THINGS AT DIFFERENT AGES. WE NEED TO KNOW WHAT EACH CHILD ALREADY CAN DO OR IS LEARNING TO DO EASILY, AND WHERE THEY MIGHT BE SLOW OR NEED HELP SO WE CAN FIT OUR PROGRAM TO EACH CHILD. I'M GOING TO LIST SOME THINGS CHILDREN LEARN TO DO AT DIFFERENT AGES AND ASK WHEN YOUR CHILD STARTED TO DO THEM, AS BEST YOU CAN REMEMBER. *(INTERVIEWER: Read question for each item listed below, and check off the parent's answer in the appropriate space).*

a. WOULD YOU SAY YOUR CHILD BEGAN TO _____EARLIER THAN YOU EXPECTED, ABOUT WHEN YOU EXPECTED, OR LATER THAN YOU EXPECTED?

b. WHEN DID HE/SHE BEGIN TO _____?

	EARLIER	WHEN EXPECTED	LATER	AGE
(a) SIT UP WITHOUT HELP				
(b) CRAWL				
(c) WALK				
(d) TALK				
(e) FEED AND DRESS SELF				
(f) LEARN TO USE THE TOILET				
(g) RESPOND TO DIRECTIONS				
(h) PLAY WITH TOYS				
(i) USE CRAYONS				
(j) UNDERSTAND WHAT IS SAID TO HIM/HER				

37. DOES YOUR CHILD HAVE ANY DIFFICULTIES SAYING WHAT HE/SHE WANTS TO DO OR DO YOU HAVE ANY TROUBLE UNDERSTANDING YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

38. CHILDREN SOMETIMES GET CRANKY OR CRY WHEN THEY'RE TIRED, HUNGRY, SICK, AND SO FORTH. DOES YOUR CHILD OFTEN GET CRANKY OR CRY AT OTHER TIMES, WHEN YOU CAN'T FIGURE OUT WHY? _____NO, _____YES. IF "YES" CAN YOU TELL ME ABOUT THAT?

WHEN THIS HAPPENS, WHAT DO YOU DO ABOUT IT TO HELP THE CHILD FEEL BETTER?

39. HAVE THERE BEEN ANY BIG CHANGES IN YOUR CHILD'S LIFE IN THE LAST SIX MONTHS? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

40. ARE YOU OR YOUR FAMILY HAVING ANY PROBLEMS NOW THAT MIGHT AFFECT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE.

41. IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____NO, _____YES. IF "YES" PLEASE DESCRIBE?

TO BE COMPLETED BY HEAD START STAFF WITH PARENT GUARDIAN EARLY IN PROGRAM YEAR AFTER CHILD IS ENROLLED.

CHILD HEALTH RECOR

FORM 6, NUTRITION

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

PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE?_____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES?

	Yes	No
3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS?		
(a) If "yes", what kind are they? _____		
(b) Do they contain iron?		
(c) Do they contain fluoride?		
(d) Were they prescribed?		
4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR MEDICAL, RELIGIOUS, OR PERSONAL REASONS?	*	
5. IS YOUR CHILD ON A SPECIAL DIET?	*	
(a) What kind? _____		
6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH?	*	
7. DOES YOUR CHILD TAKE A BOTTLE?	*	
8. DOES YOUR CHILD EAT OR CHEW THINGS THAT AREN'T FOOD?	*	
9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING?	*	
10. DOES YOUR CHILD OFTEN HAVE:		
(a) Diarrhea?	*	
(b) Constipation?	*	
11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS?	*	

12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?

Approximate Number of Times a Week *(circle the number(s) nearest to parent's answer)*

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

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

PART II. TO BE COMPLETED BY HEAD START STAFF, HEALTH CARE PROVIDER, OR NUTRITIONIST

13. GROWTH

DATE	AGE	HEIGHT *(no shoes, to nearest 1/8 in.)*	WEIGHT *(light clothing, to nearest 1/4 lb.)*
	____yrs.____mo.		
	____yrs.____mo.		
	____yrs.____mo.		

14. ANEMIA SCREEN

	DATE	HEMOGLOBIN*	OR HEMATOCRIT *
SCREENING			
RESCREENING			

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

15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION

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

- ☐ Suspect dietary problem or inadequate food intake *(from Questions 2 to 12)*
- ☐ Hgb. less than 11 gm. or Hct. less than 34% *(from Question 14)*
- ☐ Underweight *(weight less than typical, from Growth Chart 1 or 4)*
- ☐ Overweight *(weight greater than typical, from Growth Chart 1 or 4)*
- ☐ Short for Age *(height less than typical, from Growth Chart 2 or 5)*
- ☐ Wt. for Ht. *(greater or less than typical, from Growth Chart 3 or 6)*

COMMENTS *(use additional page if needed)*

Signature_____ Title_____ Date_____