ENROLLING YOUR CHILD
2018 - 2019

Included in this packet:

☐ Applicant & Family Member Information
☐ Release of Confidential Information Forms (MH and NMPH)
☐ Consent for Health & Education Services
☐ Child Health History Form
☐ Nutrition Assessment Form
☐ Physical Examination Form (if needed)
☐ USDA Child Enrollment Form
☐ Verification of Annual Household Income Form
☐ Head Start Bus Route Form (ages 3-5 only)

In addition, the following items will be needed to complete your application:

☐ Birth Certificate or Verification of Age (can use other records)
☐ Current Immunization Record
☐ Up-to-Date Health Physical / Well-Child Exam (not more than a year old)
☐ Income Verification (W-2 or Income Tax Return)
☐ Tribal Enrollment / CIB (if applicable)

PLEASE NOTE:

All applications must include verification of age and income to be considered for enrollment. MH has forty-five (45) days to obtain required health information but we prefer to have it at the time of enrollment. Please ensure your provider is listed on the release forms for us to be able to obtain the information we need.

If you have any questions or would like to make an appointment to sit down and complete the application with Family Services Staff, please contact us at 208-843-7330.
### Applicant & Family Member Information

#### Applicant

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<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Suffix</th>
<th>Nickname</th>
<th>Birthday</th>
<th>Gender</th>
<th>SSN</th>
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</table>

**English Proficiency**
- □ Little
- □ Moderate
- □ None
- □ Proficient

**Other Language**
- □ Spanish
- □ Nmilpuutilmt

**Other Language Proficiency**
- □ Little
- □ Moderate
- □ None
- □ Proficient

**Does your child have an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP)?**
- □ Yes
- □ No
- □ Not Applicable

**Primary Health Coverage**
- □ Medicaid
- □ Private Insurance
- □ CHIP
- □ No Insurance

**Medicaid Eligibility**
- □ On Medicaid
- □ Not Eligible
- □ Potentially

**Insurance #**

**Dental Coverage**
- □ Medicaid
- □ Private Insurance
- □ CHIP
- □ No Insurance

**Dental Coverage #**

**Doctor/Medical/Home**
- □ NMPH
- □ VMC
- □ Palouse Pediatrics
- □ Medicaid
- □ Private Insurance
- □ Tri-State
- □ BMC
- □ CHAS

### Primary Adult

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<tr>
<th>First</th>
<th>Middle</th>
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<th>Suffix</th>
<th>Nickname</th>
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</table>

**Race**
- □ Asian
- □ Black
- □ White
- □ Other:

**Hispanic**
- □ Yes
- □ No

**English Proficiency**
- □ Yes
- □ Little
- □ Moderate
- □ None
- □ Proficient

**Other Language**
- □ Spanish
- □ Nmilpuutilmt

**Other Language Proficiency**
- □ Little
- □ Moderate
- □ None
- □ Proficient

**Highest Grade Completed**
- □ Associate's
- □ Bachelor's
- □ Col/Grad Train
- □ Col or Adv Train
- □ GED

**Employment Status**
- □ Full Time
- □ Part Time
- □ Seasonal
- □ Unemployed
- □ HS Graduate • Master's
- □ Training or School

**Child's Relationship**
- □ Biological/Adopted/Step
- □ Grandchild
- □ Other Relative
- □ Foster
- □ Other:

**Custody**
- □ Biological/Adopted/Step
- □ Grandchild
- □ Other Relative
- □ Foster
- □ Other:

**Receive emails from MH:**
- □ Yes
- □ No

### Secondary or Other Adult

<table>
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<tr>
<th>First</th>
<th>Middle</th>
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<th>Suffix</th>
<th>Nickname</th>
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**Race**
- □ Asian
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- □ Other:

**Hispanic**
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**English Proficiency**
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- □ Grandchild
- □ Other Relative
- □ Foster
- □ Other:

**Custody**
- □ Biological/Adopted/Step
- □ Grandchild
- □ Other Relative
- □ Foster
- □ Other:

**Receive emails from MH:**
- □ Yes
- □ No

### Additional Child (Non-Applicant) *

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Suffix</th>
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**Race**
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**Other Language Proficiency**
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- □ Moderate
- □ None
- □ Proficient

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*If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*
# Family Information, Income & Contacts

## Family Information

### Living Address
- **Length of time at this address:**
  - [ ] > 6 months
  - [ ] 1-2 years
  - [ ] 6-12 months
  - [ ] 2+ years
- **Living Address:**
  - **ZIP:**
  - **City:**
  - **State:**
  - **County:**

### Mailing Address
- **Same as living?**
  - [ ] Yes  [ ] No
- **Mailing Address:**
  - **ZIP:**
  - **City:**
  - **State:**

### Phone Number(s)
- **Type (check one):**
  - [ ] Cell  [ ] Home  [ ] Work  [ ] Other
  - **Note (Whose #, ext., or best time to call):**
  - **Opt In for Text Messages:**
    - [ ] Yes  [ ] No

### Parental Status
- **Status (check one):**
  - [ ] One  [ ] Two
  - **Primary Language at Home:**
    - [ ] English
    - [ ] Other:

### Homelessness
- **Family:**
  - [ ] Yes  [ ] No
- **Military:**
  - [ ] Yes  [ ] No

### SNAP
- **Welfare Agency:**
  - [ ] Yes  [ ] No
- **SNAP:**
  - [ ] Yes  [ ] No

### WIC
- **SNAP:**
  - [ ] Yes  [ ] No

### TANF Status
- **SSI:**
  - [ ] Yes  [ ] No
  - **Housing:**
    - [ ] Yes  [ ] No
    - **Interested in Volunteering:**
      - [ ] Yes  [ ] No
  - **Field Trip Permission:**
    - [ ] Yes  [ ] No

### Child’s Race
- **Identified Ethnicity:**
  - [ ] American Indian/Alaska Native
  - [ ] Hawaiian/Pacific Islander
  - [ ] Multi-Racial
  - [ ] Asian
  - [ ] White
  - **Other:**
  - [ ] Black
  - [ ] Other:
  - [ ] Descendent:
    - [ ] Yes, Tribe
    - [ ] No

### Emergency Contacts

#### Contact 1
- **Name:**
- **Relationship to child:**
  - [ ] Parent  [ ] Aunt  [ ] Uncle
  - [ ] Friend  [ ] Grandparent  [ ] Other
- **Address:**
  - **ZIP:**
  - **City:**
  - **State:**
- **Phone Number 1:**
  - [ ] Cell  [ ] Home  [ ] Work

#### Contact 2
- **Name:**
- **Relationship to child:**
  - [ ] Parent  [ ] Aunt  [ ] Uncle
  - [ ] Friend  [ ] Grandparent  [ ] Other
- **Address:**
  - **ZIP:**
  - **City:**
  - **State:**
- **Phone Number 1:**
  - [ ] Cell  [ ] Home  [ ] Work

#### Contact 3
- **Name:**
- **Relationship to child:**
  - [ ] Parent  [ ] Aunt  [ ] Uncle
  - [ ] Friend  [ ] Grandparent  [ ] Other
- **Address:**
  - **ZIP:**
  - **City:**
  - **State:**
- **Phone Number 1:**
  - [ ] 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:**
Nez Perce Tribe
Mamá'y'asnim Hitéemenwees
Release of Confidential Information

I, ____________________________________________, give the Mamá'y'asnim Hitéemenwees consent to obtain from or give to the following agencies and/or persons pertinent information about my child, ____________________________________________, for whom I am legally responsible. In granting such permission, I understand that information will remain confidential and that the information will be used for the benefit of the child named above. This consent is valid for the current school year as dated unless I revoke consent prior to.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>ADDRESS</th>
<th>PARENT INITIAL</th>
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Confidential Information:

The Nez Perce Tribe Personnel Policies and Procedures (4.12): Tribal programs performing certain assistance and/or treatment services to tribal members and/or clients may not disclose confidential information specified by that particular program's legislation and/or rules. "Unauthorized disclosers that can be documented may be grounds for disciplinary action including termination or legal action."

Head Start Performance Standards (1302.22 (a)(1-4)): These procedures give assurance that in cases parents will be told the nature of the data to be collected and the uses to which the data will be put, and that the uses will be restricted to the stated purposes. The records will be kept in a place that is inaccessible to unauthorized persons. Only authorized persons should be permitted to view the records. Parents and staff should jointly decide if such records are forwarded to the school districts after Head Start, in which case an Education consent form will need signed. Parents have a right to revoke this consent at any time.

Parent / Guardian Signature: __________________________________________ Date: ________________

........................................................................................................

STAFF USE:

I have explained to __________________________________________ the purpose of this release and the disclosure which may be reasonably anticipated.

Staff Signature: __________________________________________ Date: ________________
NIMIIPUU HEALTH
Authorization to Disclose Healthcare Information

PATIENT IDENTIFICATION:

Chart Number: __________________________
Name of Patient: _________________________
Date of Birth: ___________________________

I AUTHORIZE MEDICAL INFORMATION TO BE RELEASED:

FROM:

Nimipuu Health Clinic
Medical Records
PO Drawer 367
Lapwai, ID 83540

TO:


THE PURPOSE OF THIS REQUEST IS:

______Attorney  ________History & Physical  ________Lab Test Reports  ________Personal Use
______Continued Care  ________Immunization Record  ________Medical Health Summary  ________Radiology Reports
______Dental Notes  ________Insurance Purposes  ________Medical Progress Notes  ________Social Security Disability
______BKG’s
Other: ___________________________

Please specify below, the time period for information you are requesting above.

Only Information from: ______________ to ______________
(Month/Year) (Month/Year)

I understand that I have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire six (6) months from the date of my signature. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may be protected by federal privacy laws and regulations. I further understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Signature of Patient, Guardian or Legal Representative __________________________ Date __________________________
Nez Perce Tribe Mamáy’asnim Hitéemenwees
Consent for Health & Education Services

I, _______________________________ hereby give my consent to the Nez Perce Tribe Mamáy’asnim Hitéemenwees to provide the following screening tests and exams initialed below for my child while attending MH. If I do not initial below, it is indicated I do not want the service. If I choose not to participate in any of the listed screenings/exams, it will be my responsibility to ensure my child receives each required screening test and exam and I will be required to provide screening results to MH within my child’s first 45 days of school.

Initial below:

Developmental Screening  __________  Dental/Fluoride Screen  __________
Hearing Test  __________  Vision Test  __________
Nutrition Assessment  __________  Height & Weight  __________
Hematocrit/Hemoglobin***  __________  Lead Screening***  __________

***requires a blood sample to be obtained by a “finger poke” or venipuncture if necessary.

If my child should require further medical care after an abnormal screening test/exam, I will provide medical documentation to MH regarding medical care. I also understand if I need help obtaining medical services, I will contact my Family Service Representative or the Health & Safety Specialist.

I also understand that it is my responsibility to provide MH with an up-to-date immunization record and a record of physical and dental examinations performed in the past year. I am also responsible for providing medical documentation for medical care provided to my child during the school year, such as, well-child visits and updated immunizations. 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_____________________________

Parent/Guardian Signature_________________________________________________________________

Relationship to child_____________________________  Date_____________________________
# Child Health History Form

**Child’s Name:** __________________________  **DOB:** ________________  **Gender:** M or F

## Child’s Primary Care Information

**Child’s Primary Care Provider:** __________________________

**Primary Care Provider Phone Number:** __________________________

**Does the Child receive W.I.C.?**  Yes ☐  No ☐

**Does the child have access to regular medical care:** Yes ☐  No ☐

*If “Yes,” where __________________________

**Does the child have access to regular dental care:** Yes ☐  No ☐

*If “Yes,” where __________________________

## Child’s Past Medical History

“X” Mark appropriate column and provide additional information in comment section below.

<table>
<thead>
<tr>
<th>Illness/Condition</th>
<th>Yes</th>
<th>No</th>
<th>Illness/Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
<td>Lead Poisoning</td>
<td></td>
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<tr>
<td>Anemia</td>
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<td></td>
<td>Measles</td>
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<td>Asthma</td>
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<td>Meningitis</td>
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<tr>
<td>Cancer/Leukemia</td>
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<td></td>
<td>Mumps</td>
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<tr>
<td>Chicken Pox</td>
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<td>Orthopedic Problems</td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Pneumonia</td>
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<tr>
<td>Frequent Colds</td>
<td></td>
<td></td>
<td>Rheumatic Fever</td>
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<tr>
<td>Frequent Ear Infections</td>
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<td></td>
<td>Rubella</td>
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<td>Frequent Sore Throats</td>
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<td>Seizures/Convulsions</td>
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<tr>
<td>Gastroesophageal Reflux</td>
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<td></td>
<td>Sickle Cell</td>
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<td>Hearing Problems</td>
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<td>Speech Problems</td>
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<td>Heart Disease</td>
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<td></td>
<td>Surgeries</td>
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<td>Hepatitis</td>
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<td>Tuberculosis</td>
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<tr>
<td>Hospitalizations</td>
<td></td>
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<td>Visual Problems</td>
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<tr>
<td>Kidney Disease</td>
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<td></td>
<td>Whooping Cough</td>
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</tbody>
</table>

**COMMENTS** for each “YES” answer. *(If your child needs accommodation for any illness/condition, additional forms may be needed)*
Date of Last Physical Exam

Date of Last Dental Exam

Name of Health Care Provider who completed exam

Name of Dental Provider who completed the exam

**Birth History**

Did mother experience any difficulties during pregnancy or delivery:  Yes ☐ No ☐

Please Explain if "Yes"

________________________________________________________________________

**Current Medical History**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Comments/Additional Information</th>
</tr>
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<tbody>
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</table>

Is the child presently being treated for any medical, mental, or disabling condition?

Does the child currently require any medications and/or medical procedures?

**Developmental / Mental Health Information**

Is your child potty-trained:  Yes ☐ No ☐

Have there been any significant changes (positive or negative) in your child’s life within the past 12 months that may affect your child’s emotional well-being? Yes ☐ No ☐

If “Yes,” please explain

________________________________________________________________________

***Infants Only***

Name of child’s infant formula

How Much _____________________________ How Often ____________________________

In accordance with Federal law and the U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

Parent/Guardian Signature: ___________________________ Date: ___________________________
# Mamáy'asnim Hitéemenwees Nutrition Assessment

**Child Name:**

**Circle the foods your child eats or drinks (Section 1)**

<table>
<thead>
<tr>
<th>Food Item</th>
<th>Circle the best answer (Section 2)</th>
</tr>
</thead>
</table>
| **1. MILK (any kind)** | 1. My child eats from this food group:  
   a) less than 3 times a day  
   b) 3 to 4 times a day  
   c) 5 or more times a day |
| **CHEESE (except cream or cottage cheese)** |  
| **YOGURT** |  
| **MEAT & POULTRY (any kind)** | 2. My child eats from this food group:  
   a) less than 2 times a day  
   b) 2 or more times a day |
| **EGGS** |  
| **COTTAGE CHEESE** |  
| **BEANS (not green)** |  
| **PEANUT BUTTER** |  
| **RICE** | 3. My child eats from this food group:  
   a) less than 3 times a day  
   b) 3 to 4 times a day |
| **CRACKERS** |  
| **BREAD (any kind)** |  
| **NOODLES, SPAGHETTI** |  
| **TORTILLA** |  
| **GRAPEFRUIT (or juice)** | 4. My child eats from this food group:  
   a) less than once a day  
   b) 1 or more times a day |
| **ORANGE (or juice)** |  
| **TOMATO (or juice)** |  
| **BROCCOLI** |  
| **CARROTS** | 5. My child eats from this food group:  
   a) less than 3 times a week  
   b) 3 or more times a week |
| **APRICOTS** |  
| **YAMS (or sweet potatoes)** |  
| **SQUASH (dark yellow)** |  
| **DARK, LEAFY GREENS (spinach, romaine lettuce, mustard greens, etc.)** | 6. My child eats from this food group:  
   a) less than 2 times a day  
   b) 2 or more times a day |
| **PEACHES** |  
| **POTATOES (white)** |  
| **LETTUCE (iceberg)** |  
| **APPS** |  
| **PARES** |  
| **GREEN BEANS** |  
| **SQUASH (zucchini)** |  
| **BANANAS** |  
| **PEAS** |  
| **CORN** |  
| **SODA POP** | 7. My child eats from this food group:  
   a) 3 or more times a day  
   b) less than 3 times a day |
| **CANDY** |  
| **DOUGHNUTS, CAKES, PIE, COOKIES** |  
| **TANG, HI-C, KOOLAID** |  
| **POPSICLES** |  
| **JELLO** |  
| **SUGARY CEREALS** |  

**Check (Section 3)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Is child allergic to any foods?</td>
<td></td>
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<tr>
<td>Does child drink caffeinated drinks?</td>
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</tbody>
</table>

**Circle the food programs in which your family participates (Section 4)**

<table>
<thead>
<tr>
<th>Program</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Food Stamps</td>
<td></td>
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<tr>
<td>WIC</td>
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</tbody>
</table>
Infants (Section 5)
How many times does your infant eat each day? ______ What formula? _______ Milk %? _______ Breast Milk? _______
How many ounces? ______ First feeding method: Bottle fed____ Nursed_____

Healthy Active Living (Section 6)

1. How many hours of sleep does your child get per day?

2. My child gets “screen time” (TV, video games, computer, phone, etc.)
   a. Less than one (<1) hour per day.
   b. More than one (1) hour per day.
   c. More than two (2+) hours per day.

3. How much physical activity does your child get per day?
   a. Less than one (<1) hour per day.
   b. More than (1) hour per day.
   c. More than two (2+) hours per day.

Follow-up to nutrition assessment

If nutrition assessment finds inadequate diet (e.g., too little, too much, or unhealthy foods), growth problems (e.g., failure to thrive or overweight), or anemia, the child should be referred to a health care provider for evaluation and treatment.

Treatment may include:

- Referral to a nutritionist
- Counseling for parents and Head Start staff on the types and amounts of food the child should eat and recommended amount of physical activity
- Iron supplements or iron-enriched vitamins
- Treatment of medical conditions causing nutritional and growth problems

How a child eats can affect how she grows, develops, looks, and feels. Nutrition assessment and counseling can promote healthy growth and development. If you have questions or concerns about your child’s nutrition please contact the Health & Safety Specialist or your local WIC Office.
**Mamay'asnim Hteemenwees Child Health Record**  
**Screenings/Physical Examination/Assessment**

<table>
<thead>
<tr>
<th>Parent:</th>
<th>Address:</th>
<th>Phone:</th>
</tr>
</thead>
</table>
| **Growth**  
Date: | **Anemia Screen**  
Date: | **Lead Screen**  
Date: |
| **HT:** | **HCT:** | **In range:**  
□ Pending |
| **WT:** | **% HGB** | **Out of range:**  
□ Pending |
| **Head Circumference:** | **Follow-up needed?**  
YES NO | **Follow-up needed?**  
YES NO |
| **Follow-up Needed?**  
YES NO | **Follow-up needed?**  
YES NO | **Follow-up needed?**  
YES NO |

<table>
<thead>
<tr>
<th>Hearing</th>
<th>Vision</th>
<th>Strabismus</th>
</tr>
</thead>
</table>
| **Date:**  
1000 2000 | **Date:**  
| **4000Hz:** | **Date:**  
| **R:** | **R Eye:**  
| **L:** | **L Eye:**  
□ Unable to perform |
| **Presented at 25 DB**  
| **Follow-up Needed?**  
YES NO | **Follow-up Needed?**  
YES NO | **Follow-up Needed?**  
YES NO |
| **Follow-up Needed?**  
YES NO | **Follow-up Needed?**  
YES NO | **Follow-up Needed?**  
YES NO |

| Normal | Abnormal | Refer for Eval | Not Examined | Immunizations given at this exam: | Is child up-to-date on immunizations?  
YES NO |
|--------|----------|----------------|-------------|----------------------------------|-------------------------------------|
| General Appearance | | | | | Is child at risk for TB?  
YES NO |
| Posture, Gait | | | | | Was Fluoride prescribed?  
YES NO |
| Speech | | | | | Any Allergies/Restrictions?  
YES NO |
| Head | | | | | Anticipatory guidance offered: |
| Skin | | | | | Does family have a medical/dental "home?"  
YES NO |
| Eyes: 1-External Aspects | | | | | Dr.'s name: |
| 2-Optic Funduscopy | | | | | Dentist's name: |
| 3-Cover Test | | | | | Do you consider this child to be up-to-date on a schedule of age appropriate Preventative and Primary Health Care?  
YES NO |
| Ears: 1-External & Canals | | | | | Follow-up Needed?  
YES NO |
| 2-Tympanic Membranes | | | | | Please comment here on any special plan needed for this child in class, any follow-up we can assist family with or how we can support this child/family in maintaining good health. |
| Nose, Mouth, Pharynx | | | | | |
| Teeth | | | | | |
| Heart | | | | | |
| Lungs | | | | | |
| Abdomen (include hernia) | | | | | |
| Genitalia | | | | | |
| Bones, Joints, Muscles | | | | | |
| Gross Motor | | | | | |
| Fine Motor | | | | | |
| Communication Skills | | | | | |
| Cognitive | | | | | |
| Self-Help Skills | | | | | |
| Social Skills | | | | | |
| Glands | | | | | |
| Muscular Coordination | | | | | |
| Behavior During Exam | | | | | |

Examiner's Signature/Date:  
Revised 5/29/18 skk
CHILD ENROLLMENT FORM

Nez Perce Tribe Mamáy’asnim Hitéemenwees (Children’s School)
Child Care Center or Provider Name

<table>
<thead>
<tr>
<th>NAME OF CHILD</th>
<th>BIRTH DATE</th>
<th>NORMAL HOURS IN CARE</th>
<th>NORMAL MEALS WHILE IN CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last, First</td>
<td>(Mo/Day/Yr)</td>
<td>From am/pm</td>
<td></td>
</tr>
<tr>
<td>NAME PRINTED</td>
<td></td>
<td>To am/pm</td>
<td>X</td>
</tr>
</tbody>
</table>


I understand my child/children will receive meals at no extra charge to me when they are in care during any of the scheduled meal services.

Parent Signature: __________________________ Date: __________________

Parent(s) Name(s): ________________________________________________

Parent Address: _________________________________________________

Home Phone Number: ( ) __________ Work Phone Numbers: ( ) __________

Race/Ethnic Identity: You are not required to answer these questions. (Please circle all that apply)

<table>
<thead>
<tr>
<th>Hispanic or Latino</th>
<th>Non Hispanic or Latino</th>
<th>American Indian or Alaskan Native</th>
<th>Asian</th>
<th>Black or African American</th>
<th>Native Hawaiian or other Pacific Islander</th>
<th>White</th>
</tr>
</thead>
</table>

This institution is an equal opportunity provider.
Nez Perce Tribe
Mamay’asnim Hiteemenwees
Verification of Annual Household Income

STUDENT NAME: ___________________________ DATE OF BIRTH: __________________
SCHOOL YEAR: __________________

HEAD OF HOUSEHOLD: ___________________________ Social Security Number: __________
Name: ___________________________ Employer/School: ___________________________
Address: ___________________________ Address: ___________________________

Phone Number: ___________________________ Phone Number: ___________________________

Employed: □ Full-time □ Part-time □ Seasonal □ Temporary Student: □ Full-time □ Part-time

SPOUSE/SIGNIFICANT OTHER: ___________________________ Social Security Number: __________
Name: ___________________________ Employer/School: ___________________________
Address: ___________________________ Address: ___________________________

Phone Number: ___________________________ Phone Number: ___________________________

Employed: □ Full-time □ Part-time □ Seasonal □ Temporary Student: □ Full-time □ Part-time

CERTIFICATE OF VERIFICATION (must be submitted with application):
□ Wages (pay stub) □ Income Tax Form (1040) (copy)
□ TANF (check stub or award letter) □ Social Security Income (official document)
□ Unemployment Compensation (check stub) □ Foster Parent / Kinship Care (court order)
□ Other ___________________________ (i.e. child support) □ Zero Income (must be attached)

TOTAL NUMBER IN FAMILY: _____ TOTAL HOUSEHOLD INCOME: ________________

HOUSEHOLD MEMBERS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Annual Income</th>
<th>Source (ex: job, SSI, child support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<tr>
<td>8</td>
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</tr>
</tbody>
</table>

To the best of my knowledge this information is true and correct. I understand that if any of this information changes, I will notify the program; and, if this information is found to be incorrect, I will be contacted by the program for verification. The information submitted is confidential and will be treated in accordance with Federal Law and Nez Perce Tribe policies. I understand that providing false information may result in denial of services.

Parent/Guardian Signature: ___________________________ Date: __________

Staff Signature: ___________________________ Date: __________

* This copy is to be placed in the CONFIDENTIAL Income Binder with Family Services Specialist

5/29/18 skk
Head Start Bus Route Form

Transportation services will be provided for Head Start students. A pick-up and drop-off location must be established. Please make sure somebody from your approved pick up list will meet your child at the bus. If an approved adult does not greet the child, or if no one is home, your child will be transported back to the center. If your child does not utilize the bus route on a regular basis, you will be contacted to identify if transportation services are needed.

NOTE: THERE ARE NO TEMPORARY BUS CHANGES, YOUR CHILD MUST RIDE BOTH IN THE A.M. AND P.M. Also, if your child is a participant in the Wrap-Around Program, they are not eligible for bus services.

Student Name: ____________________________________________________________

Parent / Guardian Name(s): _______________________________________________

Parent / Guardian Signature: ______________________________________________

Home Phone: ___________________________ Cell Phone: _______________________

Emergency Numbers: ______________________________________________________

PICK-UP AND DROP-OFF LOCATIONS:

Location: ________________________________________________________________

Directions: ______________________________________________________________

Phone Number of Location: ________________________________________________

Staff Signature / Date: ___________________________________________________

A.) Transportation Committee  
B.) Bus Driver

For transportation questions, please call: (208) 843-7330 (Lapwai) or (208) 935-2888 (Kamiah)