What is Head Start/Early Head Start?

Head Start and Early Head Start are comprehensive child development programs which serve children from prenatal to age 5, pregnant women, and their families. They are child-focused programs, and have the overall goal of increasing the social competence of young children in either low-income and homeless families or both.

What is Standing Rock 0-5 Head Start Program?

Our goal is to provide a full range of services to meet the needs of children and families on Standing Rock. The comprehensive care provided from cognitive, emotional, physical, nutritional, mental health and Lakota language and cultural development of the children on Standing Rock.

How to apply for Head Start/Early Head Start?

Please read this eligibility application carefully and fill it out completely.

What Happens Next?

When we receive your enrollment application, it will be reviewed and you will be contacted if we need more information. You will receive additional documents to fill out to complete the registration process when our family service worker contacts you to set up an appointment.

CHECKLIST (Children with a disability or children in foster care will have priority)

These documents are required for enrollment:

- Completed Enrollment Application (required for determining eligibility)
- Birth Certificate
- Immunization Record
- Income Verification
- Certified Degree of Indian Blood (if applicable)

Additional points if on any of these services with proof of verification:

- WIC Verification
___ Energy Assistants Verification
___ Medicaid/CHIPS Verification
___ TANF/General Assistance Verification
___ SSI Verification
___ Child Support
___ Active Duty Military
___ Foster Care
___ SNAP (food Stamps)/Commodities
___ Copy of CDIB/Tribal Enrollment
<table>
<thead>
<tr>
<th>Date</th>
<th>Completed</th>
<th>Staff Signature</th>
<th>Forms</th>
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<td>Birth or Baptismal Certificate</td>
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<td>Immunization Record</td>
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<td>Nutrition Form</td>
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<td>CACFP/USDA Form</td>
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<td></td>
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<td></td>
<td>Johnson O'Malley Form</td>
</tr>
</tbody>
</table>
Standing Rock 0-5 Head Start
Enrollment Application
PO Box 768
Fort Yates ND 58538
(PH) 701-854-7250
(FAX) 701-854-7257

Please complete application thoroughly. Information provided helps to determine placement.

Child Information:

First Name: ________________________ Middle Name: ________________________ Last Name: ________________________

Date of Birth: ____________ Gender: ☐ Male ☐ Female

Address where child resides:

Street: ________________________ Street/PO Box: ________________________

Town/City: ________________________ State: ____________ Zip Code: ____________

Town/City: ________________________ State: ____________ Zip Code: ____________

County: ________________________ School District: ________________________

Child lives with: (Check all that apply)
☐ Mother ☐ Father ☐ Step Father ☐ Foster Parent ☐ Legal Guardian
☐ Grandparent(s) ☐ Other, specify: ________________________

Parent’s Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Parent/ Guardian’s relationship: ________________________

Parent/ Guardian 1: ☐ yes ☐ no
Parent/ Guardian 2: ☐ yes ☐ no

Parent Health Insurance:
Do you have health care insurance? ☐ yes ☐ no

Language(s) spoken in the child’s home?
Child’s Primary: ____________________________________________________________

Secondary: _______________________________________________________________

How well does the child speak English? ________________________

Parent 1 Primary: ________________________

Preferred Language: ______________________________________________________

Parent 2 Primary: ________________________

Is this child currently enrolled in SRST Head Start?
☐ yes ☐ no

☐ Early Head Start ☐ Head Start

Is another member of your family currently enrolled in SRST Head Start?
☐ yes ☐ no

☐ Early Head Start ☐ Head Start

Household Composition: List the primary caregivers.

Parent/Guardian 1:

First Name: ________________________ Middle Name: ________________________ Last Name: ________________________

Date of Birth: ____________ Relationship to child: ________________________

Telephone Number Information:
Home: ________________________ Work: ________________________

Cell phone: ________________________ Message: ________________________

E-mail: ________________________

Address if different than above: ________________________

Parent/Guardian 2:

First Name: ________________________ Middle Name: ________________________ Last Name: ________________________

Date of Birth: ____________ Relationship to child: ________________________

Telephone Number Information:
Home: ________________________ Work: ________________________

Cell phone: ________________________ Message: ________________________

E-mail: ________________________

Address if different than above: ________________________

Other Household Member Information: Please list all other persons living within the home not listed above.

First Name: ________________________ Last Name: ________________________ Date of Birth: ________________________ Relationship to child: ________________________

Are you employed:
☐ Part time ☐ Full time ☐ Seasonally ☐ Retired ☐ Disabled
☐ Unemployed ☐ Self-employed ☐ Start Date: ____________

Employer Name: ________________________

Highest level of education completed:
☐ 9th grade or less ☐ 10th grade ☐ 11th grade
☐ High School Graduate ☐ GED ☐ Training Certificate
☐ Associates ☐ Bachelor ☐ Master’s
☐ Advanced/Doctorate ☐ Other

Are you attending school/job training? ☐ Yes ☐ No

If yes, where? ________________________

Are you in the United States military? ☐ Yes ☐ No ☐ Previously ☐ No

Are you employed:
☐ Part time ☐ Full time ☐ Seasonally ☐ Retired ☐ Disabled
☐ Unemployed ☐ Self-employed ☐ Start Date: ____________

Are you attending school/job training? ☐ Yes ☐ No

If yes, where? ________________________

Are you in the United States military? ☐ Yes ☐ No ☐ Previously ☐ No

If an adult, does this person provide support for the child? (i.e., money, shelter, clothing, etc.)

☐ Yes ☐ No

If yes, how? ________________________
Child's name:

**Family Resource Information:**
- Does your family receive any of the following types of services or financial assistance? (please indicate all that apply)
- TANF
- Supplemental Security Income (SSI)
- Unemployment Insurance
- Child support payments/alimony
- Energy Assistance
- Financial Aid Award Letter (Grants and/or Scholarships)
- Adoption subsidy
- SNAP/Food Stamps
- WIC
- County
- **Please provide documentation**

What is your current living arrangement/situation?:
- Own
- Rent
- Motel
- Shelter/Mission
- Receive Subsidized Housing
- Live with others due to loss of housing, economic hardship or similar reason
- Live with Relatives/Friends by choice
- Other, Specify

How long have you lived at this address?

Does your family currently have reliable means of transportation?:
- Yes
- No
- Number of vehicles
- Private vehicle
- Friend's or relative's vehicle
- Public transportation
- Other

Are there any family situations, concerns or other crisis that we should be aware of to help meet the child's needs (such as recent divorce, parental health, counseling, recent moves, parent absent because they are in the military, incarcerated, etc.)?
- Yes
- No

If yes, please explain:

Is there any family or household member who has a serious health or mental health concern (i.e. substance abuse, depression, etc.) that affects/stresses the child?
- Yes
- No

If yes, please explain:

**Custodial Information:**
- Does not apply in my situation
- Sole Custody
- Joint Custody—both biological parents
- Joint Custody—other; explain:
- Physical Custody; explain who has custody
- Foster Care/Custody of State of SD or ND

Caseworker:
- Agency:
- Phone:

**Additional Information:**
- Number of hours per day child care is needed:
  - Relative
  - Not yet arranged
  - Child Care Center
  - In home child care
  - Other; Please specify:

**Child Care Provider Information:**
- Is there a protection or restraining order regarding the child?
  - Yes
  - No

(Please explain and provide a copy upon acceptance)

Are there special visitation orders?
- Yes

(Please explain and provide a copy upon acceptance)

Is there anyone in your household currently pregnant?
- Yes
- No

Due Date:
- information for the Standing Rock Head Start services for expectant families?

If you are pregnant, would you like an application?
- Yes
- No

**For Office Use Only**

Verification

<table>
<thead>
<tr>
<th>Witness</th>
<th>1.</th>
<th>Position</th>
<th>Family Size</th>
<th>Family Income</th>
<th>Date</th>
</tr>
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Re-verification

<table>
<thead>
<tr>
<th>Witness</th>
<th>1.</th>
<th>Position</th>
<th>Family Size</th>
<th>Family Income</th>
<th>Date</th>
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</table>
Child's name: 

Health, Nutrition & Developmental Information

Child's Physician/Health Care Provider Name: ____________________________ Address: ____________________________ Date of Last Exam: ____________________________

Health Care Coverage Information: □ CHIP/Medicaid □ Indian Health Service □ Private Health Insurance □ Medicaid □ No Health Care Coverage

Child's Dentist/Dental Care Provider Name: ____________________________ Address: ____________________________ Date of Last Exam: ____________________________

Dental Care Coverage Information: □ No Coverage □ CHIP/Medicaid □ Dental Insurance

Does the child have any health related concerns or conditions? For example: asthma/reactive airway disease, diabetes, failure to thrive, high lead levels, anemia, disabling conditions, pre-mature birth, mental health issues, seizures/seizure disorder, or other chronic health conditions. □ Yes □ No

Are they diagnosed by a health care professional? □ Yes □ No

If yes, please explain:

Does the child have any allergies?

For example: foods, medications, environmental, seasonal, insect bites. □ Yes □ No

Are they diagnosed by a health care professional? □ Yes □ No

Is there an emergency protocol in place? □ Yes □ No

If yes to any of the allergy questions, please explain:

Does the child have any current special dietary needs or nutrition concerns? □ Yes □ No

If yes, please explain:

Do you have any concerns about your child's development? □ Yes □ No If yes, please explain:

Has the child been diagnosed with a disability? □ Yes □ No If yes, please explain:

Is the child receiving any special services or currently on an IEP (Individual Education Program/Plan) or IFSP (Individual Family Service Plan)? (i.e., medical, speech therapy, physical therapy, occupational therapy, early childhood special education, counseling, etc.) □ Yes □ No

If yes, please provide name and address of service provider

Provider: ____________________________ Phone: ____________________________ Address: ____________________________

Release of Information (please write your initials in the yes or no box)

I give consent for the program to obtain my Income Verification from local agencies such as Social Services and Employer. For enrollment criteria

I give consent for my child's first name, last name, gender, date of birth, race/ethnicity, start and end date of Head Start services to be entered into the Child plus.net information system upon enrollment.

I give consent for the child's name and date of birth to be released to the school districts, education cooperatives, preschool and daycare providers that are in a partnership with the SRST Head Start program. Authorized consent to the 3 questions above are valid as long as this application remains active.

Referred By:

☐ Health Care Provider/Dentist □ Tribal Program

☐ WIC Office/County Health ○ Other Head Start Program

☐ School, Early Childhood or Newspaper

☐ Birth – Three Program ○ Church

☐ Friend or Relative ○ Poster/Sign

☐ Department of Social Services

☐ Other

Specify: ____________________________

☐ Head Start Staff

☐ Program Brochure

☐ Head Start Mailing

☐ Other

The statements and information on this application are true and accurate to the best of my knowledge.

**To process your application we need proof of age and a form of income verification.** To verify income please include last year's income tax return, W-2 Form, Student Financial Aid Award Letter, TANF Documentation, SSI Documentation, Child Support Documentation, or pay stubs. Please include a copy of the child's immunization record and birth certificate if available.

Parent Signature: ____________________________ Date: ____________________________

Parent Signature: ____________________________ Date: ____________________________
# Family Information, Income & Contacts

## Family Information

<table>
<thead>
<tr>
<th>Family Living Address</th>
<th>Address Line 2</th>
<th>ZIP</th>
<th>City</th>
<th>State</th>
<th>County</th>
</tr>
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<tbody>
<tr>
<td>Started Living At Date</td>
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<tr>
<td>Living Address</td>
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<th>Family Mailing Address</th>
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<th>ZIP</th>
<th>City</th>
<th>State</th>
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<th>Notes</th>
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<tr>
<td>Started Using Date</td>
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<tr>
<td>Mailing Address</td>
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<thead>
<tr>
<th>Phone Number(s)</th>
<th>Type (check one)</th>
<th>Note (extension or best time to call)</th>
<th>Opt In for Text Messages</th>
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<tr>
<th>Parental Status (check one)</th>
<th>Primary Language at Home</th>
<th>Homeless Family</th>
<th>Active Duty Military</th>
<th>Referred by Child Welfare Agency</th>
<th>Receiving SNAP</th>
<th>WIC</th>
<th>WIC ID (if applicable)</th>
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<td>Two</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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## Family Income

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<tr>
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<th>TANF Status</th>
<th>SSI</th>
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<td>Yes</td>
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<tr>
<th>Family Member</th>
<th>Amount</th>
<th>Per (for example: week, month, year)</th>
<th>Annual Amount</th>
<th>Description (for example: SSI, Job, Child Support)</th>
<th>Verification (for example: W2, check stub)</th>
<th>Note</th>
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Income Notes

## Emergency Contacts

### Contact 1

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<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>ZIP</th>
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<tbody>
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### Contact 2

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<tr>
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<th>Relationship</th>
<th>Address</th>
<th>ZIP</th>
<th>Phone Number 1</th>
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<th>Emergency Contact</th>
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### Contact 3

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<tr>
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<th>Relationship</th>
<th>Address</th>
<th>ZIP</th>
<th>Phone Number 1</th>
<th>Phone Number 2</th>
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<tr>
<th>Emergency Contact</th>
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<th>Phone Number 3</th>
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## 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
Standing Rock 0-5 Head Start
Eligibility Verification

(For Staff use only)

1. Child’s name: ________________________________

2. Child’s date of birth: ________________________________

3. This child’s is eligible to participate in the program __ Yes __ No

4. Check the applicable category of eligibility for this child:
   ___ Income (check mark that applies):
   ___ Below federal poverty guidelines
   ___ Between 100-130% of federal poverty guidelines
     (no more than 35% of enrolled children may fall into this category)
   ___ Over-income
     ___ Counted as part of 10% maximum for non-AI/AN programs
     ___ Counted as part of the 49% maximum for AI/AN programs
   ___ Public assistance
   ___ SSI
   ___ Homeless
   ___ Foster Care

5. What documentation was used to determine eligibility?
   ___ Income Tax Form 1040
   ___ W-2
   ___ TANF documentation
   ___ Pay stub or pay envelopes
   ___ Unemployment
   ___ Written statements from employers
   ___ Foster care reimbursement
   ___ SSI documentation
   ___ Other
          If other, please explain: __________________________

Application date: __/__/____
Start date: __/__/____

6. Staff signature: ________________________________
   verification: ______

7. Staff name: ________________________________
   Title: ________________________________
STANDING ROCK ZERO TO FIVE HEAD START
PERMIT AND RELEASE OF INFORMATION

1. That my child, ________________________________ may participate in the following health activities.  
(I understand that I may accompany my child to any of these activities.)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Vision Screening</td>
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<tr>
<td>Dental Screening</td>
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<tr>
<td>Hearing Screening</td>
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<tr>
<td>Physical Exam</td>
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<td>Lead Screening</td>
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<tr>
<td>Developmental Screening</td>
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<tr>
<td>Mental Health Screening</td>
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</tbody>
</table>

2. Center staff may secure needed emergency care in case of emergency when I cannot be contacted.  
   ____ Yes  ____ No

3. To provide required proof of birth and immunization records.  
   ____ Yes  ____ No

4. Allow staff to make home visits during  
   ____ Yes  ____ No

5. That my child will be in attendance in the program every day that he/she is able from _____ AM to _____ PM.  
   ____ Yes  ____ No

6. My child may go on all field trips after I have received information about the specific trip, date,  
destination and time of departure and return prior to trip. I understand that children will be  
accompanied by Teacher, Aides and Volunteers and that I may choose to attend also.  
   ____ Yes  ____ No

7. That the program has the absolute right and permission to copyright and/or publish the  
photograph portraits or pictures of my child  
   ____ Yes  ____ No

8. That necessary information concerning my child will be released to and from SR Birth to Five  
Head Start and to the following agencies:  
   AGENCIES
   I.H.S.  Public School  Social Services & Offices
   Disabilities Coordinator  Child Protection Team  Early Childhood Tracking
   Early Head Start  Grant Schools  Project Launch
   W.I.C.  BIA Schools

9. I would like to volunteer in the program.  
   ____ Yes  ____ No

10. I will try to attend and participate in parent meetings and activities.  
    ____ Yes  ____ No

11. Exceptions/Explanation (to any above items or to other considerations, i.e., religious or ethnic  
holidays, etc.)

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW RECORDS MAINTAINED ON MY FAMILY AND TO  
DISPUTE OR CORRECT ANY INFORMATION I FEEL TO BE INCORRECT. I UNDERSTAND THAT THE  
INFORMATION PROVIDED ABOVE WILL REMAIN CONFIDENTIAL.

_________________________  ____________________________
Signature                  Date

Revised 7/22/15
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, [Name of Patient], hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by: And is to be provided to:

NAME OF FACILITY

NAME OF PERSON/ORGANIZATION/FACILITY

ADDRESS

ADDRESS

CITY/STATE

CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other (Specify)

☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (HIE/Other)

IV. The information to be disclosed from my health record: (check appropriate box(es))

☐ Only information related to [specify]

☐ Only the period of events from [date] to [date]

☐ Other (specify) (CHS, Billing, etc.)

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

[Signature of Patient or Personal Representative (State relationship to patient)]

[Date]

[Signature of Witness (If signature of patient is a thumbprint or mark)]

[Date]

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a)(2)).

PATIENT IDENTIFICATION

NAME (Last, First, M)

RECORD NUMBER

ADDRESS

CITY/STATE

DATE OF BIRTH
Instructions for Completing IHS Form 810 --
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.

2. Section I, print your name or the name of patient whose information is to be released.

3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.

4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE.

5. Section IV, check the appropriate box as applicable.
   a. Only information related to -- specify diagnosis, injury, operations, special therapies, etc.
   c. Other (specify) -- e.g., Purchased Referred Care (PRC), Billing, Employee Health.
   d. Entire Record -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
   e. IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.

   f. Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.

   IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   g. When you opt-in to share information through the HIE, an expiration date must be entered.

6. Section V, if a different expiration date is desired, specify a new date. For HIE, a date 5 years in the future is recommended in order to provide health information for continuity of care.

7. Section V, Please sign (or mark) and date.

8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT
Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, Office of Management Services, Division of Regulatory Affairs, Mail Stop 09E70, 5600 Fishers Lane, Rockville, MD 20857, RE: OMB No. 0917-0030. Please DO NOT SEND this form to this address.
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Indian Health Service  
DENTAL PATIENT MEDICAL HISTORY

Please complete these two pages so that we can better provide care for your oral health problems. If you are unsure of how to answer any of the questions, please ask the dental staff for help.

Your name: 

Date of Birth: 

What is the purpose of your visit to our office today?

Do you have a toothache now?  □ Yes  □ No  If yes, for how long?

On a scale of 1-10, with 10 being the most painful, what is your pain level today (write a number): 

Do you have or have you had any of the following conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, Please Describe (include dates, if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Circulatory System</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any congenital heart disease, defect, or heart murmur?</td>
<td></td>
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<tr>
<td>Do you have, or have you ever had, heart disease or congestive heart failure?</td>
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<tr>
<td>Have you ever had a heart attack?</td>
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<tr>
<td>Do you have high blood pressure (hypertension)?</td>
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<tr>
<td>Have you ever had bacterial endocarditis?</td>
<td></td>
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<tr>
<td>Do you, or have you ever had, chest pain or angina?</td>
<td></td>
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<tr>
<td>Have you had anemia or abnormal bruising or bleeding?</td>
<td></td>
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<tr>
<td>Are you taking any blood thinners (Plavix, baby aspirin, etc.)? If so, which one?</td>
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<tr>
<td>Do you have a pacemaker, defibrillator, or other artificial heart device?</td>
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<tr>
<td><strong>Immune System</strong></td>
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<tr>
<td>Have you ever had an organ transplant?</td>
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<tr>
<td>Have you had your spleen removed?</td>
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<tr>
<td>Are you on steroids (prednisone) or biological drugs (Humira) now?</td>
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<tr>
<td>Do you have HIV or AIDS, or do you believe you have been exposed?</td>
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<tr>
<td>Do you have lupus, rheumatoid arthritis, or any immune condition?</td>
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<tr>
<td>Have you ever had cancer or tumors?</td>
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<tr>
<td>Have you ever received, or are you now receiving, chemotherapy or radiation?</td>
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<tr>
<td><strong>Excretory System</strong></td>
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<tr>
<td>Have you ever had any kidney problems, including dialysis?</td>
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<tr>
<td>Have you ever had hepatitis? If so, what type and is it currently active?</td>
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<tr>
<td>Do you have any type of liver disease?</td>
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<tr>
<td><strong>Endocrine System</strong></td>
<td></td>
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<tr>
<td>Do you have diabetes, and if so, what type?</td>
<td></td>
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<tr>
<td>Have you had thyroid problems of any kind? If so, was it high or low thyroid?</td>
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<tr>
<td><strong>Nervous System</strong></td>
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<tr>
<td>Have you ever had a stroke?</td>
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<tr>
<td>Have you ever had epilepsy, seizures, or a nervous system disorder?</td>
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<tr>
<td>Over the past 2 weeks, have you had little interest or pleasure in doing things?</td>
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<tr>
<td>Over the past 2 weeks, have you felt down, depressed, or hopeless?</td>
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<tr>
<td><strong>Musculoskeletal System</strong></td>
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<tr>
<td>Do you have osteoporosis or taken medicine for osteoporosis?</td>
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<tr>
<td>Have you ever had a joint replaced (hip, knee, ankle, shoulder)?</td>
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<tr>
<td><strong>Respiratory System</strong></td>
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<tr>
<td>Do you have asthma or any lung disease?</td>
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<tr>
<td>Have you ever had tuberculosis?</td>
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</tbody>
</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Indian Health Service  
**DENTAL PATIENT MEDICAL HISTORY**

<table>
<thead>
<tr>
<th>Reproductive System</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, Please Describe (Include dates, if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a sexually transmitted disease (STD)?</td>
<td></td>
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<tr>
<td>WOMEN ONLY: Are you currently pregnant? If yes, how many weeks?</td>
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<tr>
<td>WOMEN ONLY: Are you currently nursing?</td>
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<tr>
<td>WOMEN ONLY: Are you taking birth control?</td>
<td></td>
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</tbody>
</table>

**General Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any physical or mental disability that requires special consideration?</td>
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<tr>
<td>Have you ever experienced vertigo, dizziness, or fainting?</td>
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<tr>
<td>Do you have any allergies to latex, iodine, red dye, food, medications? If so, list:</td>
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<tr>
<td>Do you smoke or chew tobacco?</td>
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<tr>
<td>Have you ever had any type of operation or surgery? If so, please list.</td>
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<tr>
<td>Have you ever been hospitalized? If yes, describe when and why.</td>
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<tr>
<td>Are you allergic to any medications, or do any make you sick? If so, please list.</td>
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<tr>
<td>Do you have any disease, condition, or problem not listed? If yes, please list.</td>
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</tbody>
</table>

**When was your last medical appointment? (please list date):**

**Day**

**Month**

**Year**

**What was the purpose of that appointment?**

**Who is your primary care physician/provider?**

**Please list all medications you currently take (including over-the-counter drugs and herbal supplements):**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>What is it for?</th>
<th>How often do you take it?</th>
<th>What dosage (mg, etc.)?</th>
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<tbody>
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Please carefully read and sign the statement below.

The answers I have given above are true to the best of my knowledge. I am indicating my consent for routine diagnostic tests and procedures such as x-rays, cleaning, blood pressure, and fluoride by signing below on behalf of myself or the above named minor in my guardianship.

**Patient Signature:** ___________________________  **Provider Signature:** ___________________________  **Date:** ___________________________  **Date:** ___________________________

**Provider Name:** ___________________________  **Patient Health Record Number:** ___________________________

**Notes:**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
0-5 Head Start
Dental Consent Form

**Fluoride Varnish:** is a protective coating that is placed on the teeth. Over a period of time the varnish releases fluoride which strengthens teeth and prevents tooth decay. Fluoride varnish is **safe** and can be used on babies from the time they have their first teeth. Only a small amount of fluoride is used. It works best if it is placed on teeth 3 to 4 times a year.

**Oral Health Screening:** A dental hygienist will perform a toothbrush cleaning and screening to determine if your child has cavities or other oral health concerns. A letter will be sent home with the results included with a toothbrush and toothpaste. Fluoride varnish will then be placed after.

Please sign for the above the treatments you would like your child to receive. With your signature below you authorize your consent for IHS dental to perform the above marked treatments if able and warranted, as well as placing fluoride varnish on child’s teeth at least 3-4 times a year.

<table>
<thead>
<tr>
<th>Child’s name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

Head Start Location
Silver Diamine Fluoride (SDF):

Is an antibiotic solution that is placed on the cavity and kills the bacteria associated with tooth decay. One drop can treat up to ten teeth. Similar to fluoride varnish, it is safe and works best if placed on teeth 3-4 times a year.

- SDF is a great preventative measure to kill cavity-causing bacteria on teeth and prevent cavities like fluoride varnish. Silver Diamine Fluoride will turn any cavity dark, that is how you know it works. Once the child is older, we can perform restorative work to replace the dark area with a tooth colored filling. The following pages provide a detailed description and FAQ for SDF. Please read it.

The following consent form allows either our hygienist or children’s dentist to place the SDF on your child’s teeth at his/her head start location. Additional restorative work can be completed in our office.

Please sign the second page of our “CONSENT FOR TOOTH CAVITY-CONTROL PROTOCOL” And return with your enrollment packet.

Thank you,

Standing Rock Service Unit Dental Program
Standing Rock Service Unit Dental Program

Consent for Tooth Cavity-Control Protocol

Your dentist at Standing Rock Service Unit Dental Clinic has examined your child, ___________________________ and found him or her to have tooth cavities (also called tooth decay or dental caries). If untreated, these cavities are likely to progress and cause your child pain and disability. We now recommend treatment with a product called Silver Diamine Fluoride (SDF) which may stop the active tooth decay. It is our expert opinion that it is the best treatment option for your child, but you have the option of choosing that your child receive the conventional therapy used in the past instead of the SDF.

What is silver diamine fluoride? SDF is an antimicrobial solution that can kill the germs that cause cavities. It is similar to silver nitrate, which has been used in medicine for over 100 years to prevent infection and treat wounds. The SDF solution our clinic uses is produced in the U.S. and is available by prescription.

How is it applied? Your child’s tooth will be dried and surrounded by soft cotton. A very small brush about the size of a pencil tip will be used to paint the SDF onto the cavity. After letting it dry for a moment, fluoride varnish (the sticky paint-on fluoride we have used for decades in IHS) will be painted over the cavity and remainder of the teeth. The SDF will need to be painted on three times, with a few weeks between painting to allow it to work. Your child should not eat or drink for one hour or brush his or her teeth for 24 hours after treatment.

What is the benefit of using SDF on your child’s teeth? SDF can slow or stop decay on baby teeth without any pain, shots, or drilling. This is a really great option for treating kids who are too young to understand what is going on during a dental appointment, or for kids who are very afraid. For some kids, it means their cavities can be treated in the dental chair instead of having to go to the operating room for conventional treatment.

How long does it last? If the tooth is kept clean with good brushing, and your child avoids high sugar foods and drinks like Kool-Aid, pop, Gatorade, and so forth, the decay may never have to be treated again until the tooth is naturally lost.

What are the downsides to SDF? Any cavity treated by SDF turns dark or even black almost immediately – not the healthy tooth, just the cavity. THIS IS GOOD – that means it is working. Because some families don’t like that color, we can place a white sealant or filling over the dark area after the last application to make it look better. If you change your mind about the SDF, we can always repair the cavity using a regular filling or stainless steel crown (which may require numbing shots or a trip to the operating room).

Are there any side effects? If your child wiggles a lot during the painting process, some of the SDF might get on the skin or gums, leaving a painless brown or black spot that will go away without treatment within 2-3 weeks. In some cases, a dark spot might show up on a nearby tooth where a new cavity is forming. SDF that gets on clothing will stain permanently.

Are there any teeth that shouldn’t be treated with silver nitrate? We will not use it on teeth that are hurting, really broken down, or close to getting infected. Those teeth will need to be treated with the conventional approach, including the possibility of treatment under general anesthesia.

Contraindications: Silver allergy (very rare)

Stopping the active tooth decay with SDF does not always stop the cavity from growing or eliminate the need for fillings in your child’s teeth later. Your dentist may decide later to treat the tooth with conventional therapy or cover the tooth cavity with a material that has a more natural tooth appearance if you wish, but often it is not required. If this filling is done later, often it is not necessary to use local anesthetic (shots) when placing the filling.
The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of SRSU Dental. Alternate procedures or methods of treatment have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.

I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.

Risks and Complications: Although their occurrence is not frequent, some risks that are known to be associated with dental treatment including temporary staining of the skin or oral tissue or permanent staining of clothes have been explained.

I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my child's dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

If you would like for us to use silver diamine fluoride for your child through the SRSU Dental Program in the clinic or at the school sites, please sign below.

____ YES, I want my child to receive the silver diamine fluoride application. The risks and benefits have been explained and I have been given a handout about silver diamine fluoride.

____ NO, I do not want my child to receive silver diamine fluoride applications.

SRSU will treat all patient information as protected health information (PHI) under HIPAA regulations, exchanging the PHI only with personnel employed by SRSU Dental Clinic, facility/school officials who are responsible for medical/dental treatment and/or record review and their dental or medical providers.

By signing this consent form, I authorize and direct the dentists at SRSU Dental Clinic assisted by the dental staff of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained herein.

Patient's Name: _____________________________ Date of Birth: _____________________________

Printed Name of person completing form _____________________________

Signature of person completing form _____________________________

Today's date: _____________________________ Time: _____________________________
**CACFP Enrollment Form**

Please complete and/or update and sign this form and return it to _______ no later than _______. Our agency participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement for the meals served to your child(ren). The Federal regulations for the CACFP require us to collect and update this information on an annual basis for all of our enrolled children. This information is used to confirm your child(ren)'s current enrollment in the center and thus in the CACFP. All information is confidential and will be shared with appropriate personnel and state/federal staff as needed. Note: The indication of racial and ethnic background is optional and will not affect eligibility for the Program. This information is used for reporting purposes only. By providing this information you will assist us in assuring that this program is administered in a nondiscriminatory manner. If racial/ethnic background is not reported, a visual identification of the child’s race and ethnicity will be made.

<table>
<thead>
<tr>
<th>Full Name(s) of Enrolled Child(ren)</th>
<th>* Race/ Ethnicity</th>
<th>Date of Birth</th>
<th>Normal Hours In Care</th>
<th>Normal Days of Care</th>
<th>Meals Normally Eaten While at the Facility **</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>B AM L PM Su Ev</td>
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<tr>
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<td>M T W F S S B AM L PM Su Ev</td>
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<td></td>
<td>M T W F S S B AM L PM Su Ev</td>
</tr>
</tbody>
</table>

*Race: Hispanic or Latino  Ethnicity: American Indian or Alaskan Native/ Asian / Black or African American / Native Hawaiian or other Pacific Islander / White

** B = Breakfast  AM = AM Snack  L = Lunch  PM = PM Snack  Su = Supper  Ev = Evening Snack

List any holidays that may require care:

Special needs or instructions (i.e. allergies):

Parent/Guardian's Name: __________________________ Phone Number: __________________________
Home Address: __________________________ City: __________________________ State: ______ Zip: _______
Mother's Employer: __________________________ Phone Number: __________________________
Father's Employer: __________________________ Phone Number: __________________________
Family Doctor: __________________________ In Emergency Call: __________________________
Parent Signature: __________________________ Date: __________________________

**Annual Updates** (to be completed on an annual basis after initial enrollment):

1st Annual Update
I have reviewed the enrollment information for my child(ren) and (check one):
- [ ] found it to be accurate at the present time
- [ ] made changes as needed

Parent Signature: __________________________ Date: __________________________

2nd Annual Update
I have reviewed the enrollment information for my child(ren) and (check one):
- [ ] found it to be accurate at the present time
- [ ] made changes as needed

Parent Signature: __________________________ Date: __________________________

3rd Annual Update
I have reviewed the enrollment information for my child(ren) and (check one):
- [ ] found it to be accurate at the present time
- [ ] made changes as needed

Parent Signature: __________________________ Date: __________________________

"In accordance with Federal law and 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 of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410, or call toll free (866) 632-9992 (voice). Individuals who are hearing impaired 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."
JOHNSON O’MALLEY FORM
(VERIFICATION OF INDIAN BLOOD)

This information is requested for the purpose to obtain funds for the SRST Head Start Program from the BIA Enrollment Office of the tribe where the parent/guardian are enrolled. This form must be turned in with the application.

Child’s Name: ___________________________ Date of Birth: ________________
Is the child enrolled in a federally recognized Tribe? YES ___ NO ___ PENDING ___
If yes, what Tribe: ___________________________
Degree of Indian Blood: __________________ Enrollment Number: ______________

Father’s Name: ___________________________ Date of Birth: ________________
Is the father enrolled in a federally recognized Tribe? YES ___ NO ___ PENDING ___
If yes, what tribe: ___________________________
Degree of Indian Blood: __________________ Enrollment Number: ______________

Mother’s Name: ___________________________ Date of Birth: ________________
Is the mother enrolled in a federally recognized Tribe? YES ___ NO ___ PENDING ___
If yes, what tribe: ___________________________
Degree of Indian Blood: __________________ Enrollment Number: ______________

I/We give the SRST Head Start Program authorization to release the above information to the school system where my child will be attending kindergarten. I/We give permission for the use of the information in the annual JOM count and also give the SRST Head Start Program authorization to obtain the Certificate Degree of Indian Blood if one is not attached to my child’s file for the purpose of the JOM count. This is only for the Standing Rock Sioux Tribe. If my child or one or both parents are enrolled with another tribe, I/We understand it will be my responsibility to obtain the Certificate Degree of Indian Blood and turn it in with the application.

Parent/Guardian Signature: ___________________________ Date: ________________
SRST 0-5 HEAD START CHILD PHYSICAL EXAMINATION FORM

Child's Name:  
Gender:  
DOB:  

1. Health problems and Allergies noted by parent/guardian:  

2. SCREENING TESTS: Starred items (*) are required by Head Start and recommended by the AAP for children 3-5 years. Check the box "N", "A", or "NE" for Normal, Abnormal, Not Examined respectively.

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3. PHYSICAL EXAM/ASSESSMENT

a. General Appearance
b. Posture, Gait
c. Speech
d. Head
e. Skin
f. Eyes: Optic Fundus
g. Ears: External & Canals
   Tympanic Membranes
h. Nose, Mouth, Pharynx
i. Teeth
j. Heart
k. Lungs
l. Abdomen
m. Genitalia
n. Bones, Joints, Muscles
o. Neurological
   1. Gross Motor
   2. Fine Motor
   3. Communication Skills
   4. Cognitive
   5. Self-Help Skills
   6. Social Skills
p. Glands
q. Muscular Coordination
r. Behavior during exam
s. Other
t. General statement on child's physical status

Describe fully any abnormal findings

4. Findings, Treatments, Plans, and Referrals

Healthcare Provider Name- Clinic Site  
Phone

Healthcare Provider Signature  
Date

Parent Name  
Date
Standing Rock 0-5 Head Start
Family Partnership Agreement

Child’s Name: ________________________________ Date: ____________________

Parent or Guardian Name: ______________________ Phone #: ____________________

Family Information

1. Does child live with biological parent(s)? ___ YES ___ NO If NO, with whom does child live with? ________________________________

2. If applicable, what is the custody status of your child(ren)? ___ SOLE ___ JOINT

3. What do you feel are your strengths(s) as a parent? ________________________________

4. What do you as parents wish to gain from the Head Start Program? ________________________________

5. Do you currently have any preexisting family plans with another organization(s)? (TANF, IFSP, IEP, etc.) ___ YES ___ NO
   If YES, please answer the following questions:
   a. With which agency/organization? ________________________________
   b. How can we assist you with your preexisting plan? ________________________________
   c. Which of the following would you prefer?
      ___ Use preexisting plan ___ Referral with Head Start

Finance/Employment

1. Would like information on any vacant position with the SRST? ___ YES ___ NO
2. Would you like information on heating assistance program? ___ YES ___ NO
3. Do you need assistance finding employment? ___ YES ___ NO

Transportation

1. Do you have a vehicle/source of transportation? ___ YES ___ NO
2. Do you have a car/booster seats for your child(ren)? ___ YES ___ NO
3. Do you have a valid driver’s license and insurance? ___ YES ___ NO
4. Will you need transportation to Parent Meeting/Workshops? ___ YES ___ NO

Continuing Education/Development

1. Is either parent currently taking GED classes, college, vocational education or job training? ___ YES ___ NO If YES, whom? ________________________________ In what field or vocation? ________________________________

2. Would you like assistance with continuing your education, job skills or developing a resume? (circle those interested in) ___ YES ___ NO
Child Care
1. Do you have a need for child care? YES NO
2. Do you need assistance to pay for child care? YES NO
   If YES, have you applied for child care assistance? YES NO
   (i.e. Child Care Program)

Health/Dental Care
1. Do you have health insurance? YES NO
2. Do you children have health insurance? YES NO
3. Would you like more information on well child exams? YES NO
4. How can Head Start staff assist or support you in providing your family with regular medical and dental care? (i.e., transportation, locating a physician, etc.)

Mental Health
1. Are you aware of mental health support programs available in the community? YES NO
2. Would like parent training or information on any mental health issues?
   If so what types?

Safety
1. Do you and your family feel safe in your current environment? YES NO
2. Do you talk to your children about the following safety issues?
   Strangers YES NO
   Seat Belts YES NO
   Fire YES NO
   Helmets YES NO

Parent Volunteer
1. What days can you volunteer in the classroom, kitchen, or other areas of the program?

2. If you cannot volunteer during the school day, in what other ways could you assist our program?

3. Would you like a volunteer packet?
Parenting/Advocating

1. Is there any information/training we can offer you, which will support you in role as a parent(s)? (Examples: Parenting, nutrition, marriage, medical, dental, advocating for your child, etc.). ___YES ___NO List topics:

2. In what ways would you like to participate in your child’s education?
   At home __________________ At school __________________

3. Do you currently sit on any boards/committees or assist programs in the community? ___YES ___NO. If YES, which ones: ____________________________

Parent Committee & Policy Council

1. Do you know what the Parent committee is? ___YES ___NO
2. Do you know that the Policy Council is ___YES ___NO
3. Do you know what the Health Advisory Committee is? ___YES ___NO
4. What can we do to ensure you will come to the monthly parent meetings? (i.e. provide food, child care, transportation, incentives, etc.) __________________________

Family Goals

After completing all the above information, what goals do you have for your family? Please list and prioritize your goals in order of importance.

Goal # ___:

1. Date goal established:
2. List the person(s) who can help in attaining this goal:
3. Action steps required to attain goal:
4. What resources will you require in attaining this goal?
5. When do you hope to attain this goal by?

 Attach additional sheets as necessary.
All information provided in this agreement will be kept in strict confidence. All confidentiality policies will be adhered to. If you need more space please use the back of page

Parent Signature ___________________________________________ Staff Signature ___________________________________________