Keep this sheet for your records!

****PLEASE READ THIS BEFORE YOU TURN IN YOUR APPLICATION!***

Thank you for taking the time to consider the Grand Traverse Band Early Head Start/Head Start/GSRP Programs for your child. There are a few things you need to know…

- If your child was born between September 1, 2014 and September 1, 2015 your child is age eligible for Head Start/GSRP.
- If your child was born AFTER September 1, 2015 your child is age eligible for Early Head Start.

After completing and returning this application for your child, a Selection Criteria form will be filled out, and your child will be assigned "points" based on their eligibility for the program. Children will be accepted based on these points. Eligibility factors include (but are not limited to): Income Eligibility (the Federally established Poverty Guidelines are used to make this determination), Special Needs of Child, Age of Child, Need for Services, Parental Status, and other factors. While GTB Members are given priority when income eligibility factors are met, these programs are open to all individuals regardless of Tribal Affiliation. Applications that are not completely filled out will not be considered.

All applications are due on Friday, June 29th and selection for enrollment into the Early Head Start/Head Start/GSRP Programs will take place on FRIDAY, July 6th. All of the required information MUST be submitted BEFORE this date, or we will not be able to consider your child for acceptance into the program.

When all openings are filled, a waiting list will be established for those children not accepted. The children on the waiting list will be chosen to fill vacancies based on the points they receive from the Selection Criteria, regardless of when the application was turned in. **It is not possible to tell families where their child is placed on the waiting list, due to the changing nature of applications received.**

If your child is accepted into the Early Head Start/Head Start/GSRP Programs, you will be required to meet with your child's teacher. You will also be required to attend a Parent Orientation session prior to your child attending classes at the Center.

Please be sure to submit your Income Verification WITH THIS APPLICATION. Applications without income verification CANNOT be considered for acceptance. Please submit your 1040 tax return form or W-2 for 2017. If you did not file taxes, please submit income verification for the past 12 months which could include: Wages/Salary, Unemployment Compensation, Per Capita Payments, Other Trust Money Payments, Child Support Payments, SSI Payments.

Your child will also be required to have a current Physical and Dental exam **within the first 90 days** of your child's attendance. These forms are attached. Please make your appointments **NOW** in order to guarantee that your child will remain in the program.

If you need assistance completing this application, or have questions, please contact Trista at (231) 534-7994 or Leona at (231) 534-7929.

If your child is accepted for enrollment, you will be required to submit the following information:

- Your Child's Birth Certificate
- Your Child's Insurance information
- Your Child's Tribal ID (if applicable)
- Immunization Record
- Current Physical & Dental Exam (after first tooth erupts)

Grand Traverse Band
Early Head Start, Head Start & GSRP
Enrollment Application
2018-2019

2605 NW Bay Shore Drive
Peshawbestown, MI 49682
Phone: (231)534-7650 FAX (231)534-7583

Please indicate which program you are applying for: ☐Head Start/GSRP ☐Center-Based Early Head Start ☐Home-Based Early Head Start

Applicant Information: (Child or Expectant Woman)

First Name	Middle Name	Last Name	Date of Birth:	Gender: ☐Male ☐Female

Address where applicant/child resides:	**Mailing Address:**
Street:	Street/PO Box:
City: State: Zip Code:	City: State: Zip Code:
County:	School District:

What is the Applicant's Race:
☐American Indian/Alaskan Native
☐White
☐Black/African American
☐Bi-racial/multi-racial
☐Asian
☐Native Hawaiian or other Pacific Islander
☐Other:_____

What is the Applicant's Ethnicity:
☐Hispanic or Latino origin
☐Non-Hispanic or Non-Latino Origin

Is Applicant a:
☐GTB Member
☐Member of another Tribe: _____
☐Not Affiliated with any Tribe

Language(s) spoken in the child's home?
Primary:_____
Secondary:_____

Is Applicant Currently:
☐Enrolled in Head Start
☐Enrolled in Early Head Start
☐Home Based
☐Not Previously Enrolled in Head Start or Early Head Start

Applicant's Custodial Information:

☐Does not apply in my situation
☐Sole Custody
☐Joint Custody—both biological parents
☐Joint Custody—other; Explain:_____
☐Physical Custody: Explain who has legal custody:_____
☐Foster Care (Please explain and provide a copy with your application)
Caseworker:_____
Phone:_____

Is there a protection or restraining order regarding the child?
☐No ☐Yes (Please explain and provide a copy with your application)

Are there special visitation orders we should be aware of?
☐No ☐Yes (Please explain and provide a copy with your application)

Household Composition: List the Primary Caregivers

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Other:_____

Primary Adult **Lives with Child: ☐Yes ☐No**

First Name: Last Name:
Date of Birth: Relationship To Child:
Is Parent/Guardian a: ☐GTB Member ☐Member of Another Tribe_____
Telephone Number/Contact Information:
Home:_____ Work:_____
Cell Phone:_____ Message:_____
E-Mail Address:_____

Are you employed:
☐Part time ☐Full Time ☐Seasonally ☐US Military-Active Duty
☐Retired ☐Unemployed ☐Self Employed ☐Disabled
Employer Name:_____
Are you attending school/job training:
☐Yes ☐No
Highest level of education completed:
☐9th grade or less ☐10th grade ☐11th grade
☐High School Graduate ☐GED ☐Training Certificate
☐Vocational ☐Associates ☐Bachelor ☐Master's
☐Advanced ☐Other:_____

Primary Adult **Lives with Child: ☐Yes ☐No**

First Name: Last Name:
Date of Birth: Relationship To Child:
Is Parent/Guardian a: ☐GTB Member ☐Member of Another Tribe_____
Telephone Number/Contact Information:
Home:_____ Work:_____
Cell Phone:_____ Message:_____
E-Mail Address:_____

Are you employed:
☐Part time ☐Full Time ☐Seasonally ☐US Military-Active Duty
☐Retired ☐Unemployed ☐Self Employed ☐Disabled
Employer Name:_____
Are you attending school/job training:
☐Yes ☐No
Highest level of education completed:
☐9th grade or less ☐10th grade ☐11th grade
☐High School Graduate ☐GED ☐Training Certificate
☐Vocational ☐Associates ☐Bachelor ☐Master's
☐Advanced ☐Other:_____

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

Additional Information

Is there anyone in your household currently pregnant? ☐No ☐Yes Due Date:_____

Child Care Provider Information:

Will this child be cared for by someone other than you, in addition to participating in this program? ☐Yes ☐No
If yes, please complete the following information:

☐Child Care Center ☐Relative's Home or at Child's home by Relative
☐Family Child Care Home ☐Other:_____
☐Need assistance finding child care

_____ Number of hours per day child care is needed

Family Resource Information:

Does your family receive any of the following types of services or financial assistance? (Check all that apply)

☐Medicaid/Medicare
☐WIC - County_____
☐Supplemental Security Income (SSI)
☐Refugee Assistance Program
☐SNAP/Bridge Card
☐Child Support
☐State Disability Assistance (for yourself or someone in your care)
☐Cash Assistance (from DHS)
☐Child Care Assistance (from DHS) (Tribal)
☐State Emergency Relief Programs
☐Other:_____

What is your current living arrangement/situation: ☐Own ☐Rent ☐Motel ☐Receive Subsidized Housing
☐Shelter ☐Homeless—live with others because I have no alternative ☐Live with relatives/friends by choice
How long have you lived at this address:_____ ☐Other, Specify_____

In order to best meet the needs of your family, please indicate if your family receives or is in need of any of the following services:
Please write an "N" in the box by those services that you need or would like additional information, and write an "R" in the box by those services that you are currently receiving.

☐Crisis Assistance
☐Food
☐Housing
☐Clothing
☐Transportation
☐Parenting Education
☐Employment
☐Mental Health
☐Literacy
☐English as a Second Language
☐Adult Education
☐Relationship/Marriage Education
☐Legal Assistance
☐Job Training
☐Substance Abuse Prevention
☐Substance Abuse Treatment
☐Child Abuse/Neglect Services
☐Prenatal Education
☐Budgeting Information
☐Domestic Violence Services
☐Child Support Assistance
☐Health Education
☐Assistance to families of Incarcerated Individuals
☐Other:_____

Health, Nutrition & Developmental Information:

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

Health Care Coverage Information:
☐Medicaid ID #_____ ☐Contract Health ☐No Health Care Coverage
☐Private Health Insurance Policy #_____

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

Dental Coverage Information: ☐No Coverage ☐Medicaid ☐Private Insurance (please list):

Does the applicant have any health conditions such as: Allergies (to foods, medications, insect bites, seasonal, etc.), Diabetes, Asthma, Seizures, or any other conditions? ☐Yes ☐No (If yes, medical documentation is needed)
If yes, please list and explain if there is a protocol for emergency intervention:_____

Does the applicant have any special dietary needs? ☐Yes ☐No Are they diagnosed by a health care professional? ☐Yes ☐No
If yes, please explain:_____

Do you have any concerns about your child's development? ☐Yes ☐No
If yes, please describe:_____

Child's Birth Weight: _____lb _____oz

Was child born more than 3 weeks early or late? ☐Yes ☐No
If yes, please explain:

Did the child's mother visit the doctor LESS than 2 times during pregnancy?
☐Yes ☐No

Did the child's mother have any health problems during pregnancy or delivery of this child?
☐Yes ☐No
If yes, please explain:_____

Has your child been diagnosed with a disability? ☐Yes ☐No
If yes, please list:_____

Is the applicant receiving any special services or currently on an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? (i.e., medical, speech therapy, physical therapy, occupational therapy, early childhood special education, etc.)
☐Yes ☐No
If yes, please describe and list name of provider:_____

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. I understand that this is an application only and does not guarantee enrollment into the Early Head Start/Head Start/GSRP Programs.

Parent/Guardian Signature: **Date:**

FOR OFFICE USE ONLY

Interview completed in person ☐ By phone ☐

Applicant interviewed by: Date: Birth Verified ☐Yes ☐No Income Verified ☐Yes ☐No

Return this completed form to: (GTB Benodjenh EHS/HS/GSRP, 2600 N. Strongheart Way, Peshawbestown, MI 49682; 231-534-7650)

Participant Enrollment Form

Instructions:

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

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

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

Adult/Parent/Guardian's Address

Adult/Parent/Guardian's Phone Number

Signature of Adult/Parent/Guardian

Date Signed

MICHIGAN Education

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

S: CACFP/Participant Enrollment Form 6-2017

GTB Benodjenh Early Head Start/Head Start/GSRP

LETTER OF UNDERSTANDING

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

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

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

The Early Head Start/Head Start/GSRP programs cost me nothing, they are free of charge yet will provide my child and family with over $10,000 worth of services.

Along with the privilege of being a part of these preschool programs comes my responsibility to adhere to the following requirements of the Early Head Start/Head Start/GSRP Programs:

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

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

*** In the event of illness, it is my responsibility to keep my child at home when they are sick and/or have any of the symptoms listed on page 20 & 43-45 in the Parent Handbook.**

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

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

Parent/Guardian Signature_____Date_____

GTB EARLY HEAD START, HEAD START & GSRP revised 3/2018
2600 N. Strongheart Way
Suttons Bay, MI 49682
(231)534-7650 / FAX (231)534-7583

CONSENT FOR PARTICIPATION

Child's Name:_____
I, the undersigned, hereby give permission to the Grand Traverse Band Early Head Start/Head Start/GSRP Programs to:

PLEASE INITIAL:

_____ Release and Obtain **ALL** Health Records of my child including to and from my child's primary care physician, dental care provider, ophthalmologist, and/or any other pertinent health provider's information.

_____ Obtain and share information regarding my child with DHS.

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

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

_____ Obtain and share information regarding my child with AFS.

_____ Obtain and share information regarding my child with Pine Rest/Mental Health Therapist/Consultant_____.

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

*Immunization Clinic	*Dental Examination
*Physical Examination	*Speech Evaluation/Therapy/OT/PT
*Early Intervention Staff	*TBAISD/Early-On
*Hearing and Vision Testing	*Height & Weight Measurements
*Developmental Screening/s	*Tooth brushing daily with Fluoridated Toothpaste
* Hemoglobin & Blood Pressure Screening	*Referrals to other agencies for Disability Services
*Child observations and/or staff consultations regarding my child with Mental Health Consultant, Nutrition/Dietician Consultant, and/or Nursing Consultant if needed.	

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

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

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

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

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

_____ _____
Signature of Parent/Guardian Date

CHILD INFORMATION CARD

GTB Early Head Start, Head Start & GSRP

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

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

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

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

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

Name	Name
Name	Name

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

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

___Severe Asthma ___Diabetes ___Allergic to Insect Bites ___Allergic to Medications ___Seizures

Other:

Signature of parent or guardian Date

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

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

Signature of parent or guardian Date

GTB Benodjenh Early Head Start/Head Start/GSRP

2600 N. Strongheart Way
Peshawbestown, MI 49682
Phone: (231) 534-7650 Fax: (231) 534-7583

Transportation Information

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

Child's Name: _____

Address: _____

_____

Phone Number: _____

Child will get to the program by:

- ☐ Bus (Child MUST be at least 20 lbs. AND 1 year old) Bussing for Early Head Start is only available to children living on or near the reservation. The T.C. bus run is only available to Head Start/GSRP children ages 3-5 years old.

- ☐ Parent will transport

If child will ride the bus, please complete the following:

Day Of The Week	Morning Pick-Up Address	Afternoon Drop-Off Address
Monday		
Tuesday		
Wednesday		
Thursday		

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

_____

_____

_____

_____

If there are any changes in the above schedule, please contact the Benodjenh Center staff as soon as possible at (231) 534-7650. If there is no one at your home or drop off site, your child will be brought back to the Benodjenh Center and will be signed into the Child Care Program until you come in to pick them up. **You will then be charged for Child Care costs starting from the time that Early Head Start/Head Start/GSRP ends until the time you sign your child out of Child Care.** If you have any further questions or concerns, please feel free to contact any of the Benodjenh Center Staff.

Rev. 3/2018

MICHIGAN Department of Education

Michigan Department of Education
Child and Adult Care Food Program

Formula/Food Sign-Off Statement

Dear Parent,

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

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

_____.
(Insert Name of Formula)

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

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

Please Check Your Preferences:

Formula or Breast Milk: (check up to two)

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

Solid Food: (check one)

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

Infant's Name:_____ Birth date: _____

Parent/Guardian Signature:_____ Date:_____

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

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

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

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

Current Oral Health Status

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

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

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

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

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

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

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

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____ /_____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

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

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

Oral Health Provider's Contact Information and Signature

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

Practice name _____ Address _____

Provider signature _____ Date of service _____

This document was prepared under grant #90HC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Early Childhood Health and Wellness.

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

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

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

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

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*

Topical Fluoride Application?	No_____	Unknown_____	Yes_____
Fluoridated water?	No_____	Unknown_____	Yes_____
Fluoride Supplement diet? (tablets_____, liquid_____)	No_____	Unknown_____	Yes_____

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

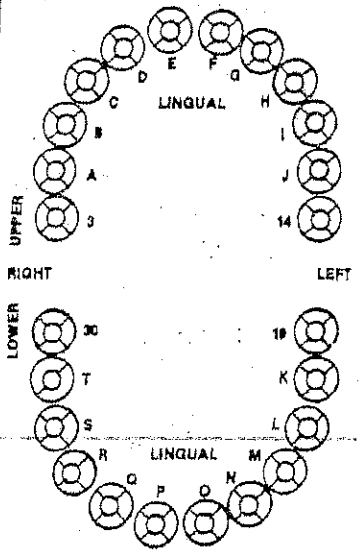
PART I. TO BE COMPLETED BY HEAD START STAFF

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

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

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

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (▨), or filled (■); Indicate restorations you perform in Item 10.*



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

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

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

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

   Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (____is, ____is not) complete. If not, explain here, as well as items checked.

   _____

   _____

   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

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

   Signature_____ Date_____

INTERVIEWER: GO TO FORM 6

Early Head Start/Head Start/GSRP

EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT

AGE 1 MONTH THROUGH 5 YEARS

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

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

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

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

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

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

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

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

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

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

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

4. FINDINGS, TREATMENTS AND RECOMMENDATIONS

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

PHYSICIAN NAME AND ADDRESS (PLEASE PRINT):

PHONE:

FAX:

Signature

Date

GTB Benodjenh Early Head Start/Head Start/GSRP Center

2600 N. Strongheart Way, Suttons Bay, MI 49682
Phone: (231) 534-7650 Fax: (231) 534-7583

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

Referral is determined by what insurance coverage is in effect:

1. The following Clinics below accept Medicaid:

Dental Clinics North
2600 LaFranier Rd., Suite B
Traverse City, MI 49686
(231) 932-7316

Mancelona Clinic
205 Grove Street
Mancelona, MI 49659

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

East Jordan Clinic
601 Bridge Street
East Jordan, MI 49727

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

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

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

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

3. GTB Contract Health Funding:

This funding is only available to GTB Tribal members. Any dental appointments must be pre-approved by the GTB Contract Health Office prior to scheduling. Please contact MaryJo McSauby at (231) 534-7884, Stella Chippewa at (231) 534-7931, or Monica Anderson at (231) 534-7210 for additional information.