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/ren. There are a few things you need to know…

- If your child was born between September 1, 2020 and September 1, 2021 your child is age eligible for Head Start/GSRP.
- If your child was born AFTER September 1, 2021 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, July 12th and selection for enrollment into the Early Head Start/ Head Start/GSRP Programs will take place on FRIDAY, July 26th. 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 2023 for ALL household members that provide support for your child. 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, or 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.
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

Grand Traverse Band
Early Head Start, Head Start & GSRP
Enrollment Application
2024-2025

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/GSRP
☐Enrolled in Early Head Start
☐Home Based Early Head Start
☐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 ☐Experiencing homelessness—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

CHILD INFORMATION CARD

GTB Early Head Start, Head Start & GSRP

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

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

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

Name	Relationship to Child	Phone number **(REQUIRED)**	
Address Number and Street	City	State **MI**	Zip Code
Name	Relationship to Child	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 efforts have been made to locate me, I have been found unavailable.

Please indicate if your child has 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

Revised 4/2024

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 4/2024

2600 N. Strongheart Way
Peshawbestown, 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 Early Head Start/Head Start/GSRP 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

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 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).

☐ 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. 4/2024

Return this completed form to: (*The Grand Traverse Band Benodjenh Center 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

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.

MICHIGAN Education

MICHIGAN 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.

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.

Early Childhood National Centers
NATIONAL CENTER ON
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.

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe): _____
☐	☐		Does your child take any medication(s) regularly?
Reason for Medication			

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications: ⇨

_____ / / _____
Parent/Guardian Signature Date

Was the health history reviewed by a health professional?
☐ Yes ☐ No ***Examiner's Initials:*** _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION	Visual Acuity			
			Muscle Imbalance			
		Date: / /	Other:			
☐	☐	HEARING	Audiometer			
			Other:			
		Date: / /				
☐	☐	URINALYSIS	Sugar			
			Albumin			
		Date: / /	Microscopic			
☐	☐	BLOOD LEAD LEVEL	Level _____ ug/dl ⇨			
		Date: / /				

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN	Type: _____			
		Date: / /	Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (HepA)	1	2
Influenza (IIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	2	
	Type of Vaccine(s)	Date of Vaccine(s)
OTHER Vaccines Specify Date & Type	1	
	2	
	3	

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ _____ ___/___/___

Health Professional's Signature | Title | Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____

child's name

_____ ___/___/___

Dentist's Signature | Date

PHYSICIAN'S SIGNATURE

_____ ___/___/___ _____ _____

Examiner's Signature | Date | *Examiner's Name (Print or Type)* | Degree or License

_____ _____ MI _____ (_____)_____

Number & Street | City | ZIP Code | Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

GTB Benodjenh Early Head Start/Head Start/GSRP Center

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

Treatment: Upon acceptance into the program, a dental exam and any follow-up 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
(231) 587-5068

Petoskey Clinic
3434 M-119 Suite G
Harbor Springs, MI 49740
(231) 348-3970

East Jordan Clinic
603 Bridge Street
East Jordan, MI 49727
(231) 536-3000

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

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

GTB Health Clinic (231)
534-7200 & Dental Clinic
(231) 534-7211
2300 N. Stallman Rd.
Peshawbestown, MI 49682

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

4. 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 Stella Chippewa at (231) 534-7931 or Monica Anderson at (231) 534-7210 for additional information.

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