Red Lake Nation Head Start

P.O. Box 53, Red Lake, MN 56671
Ph. 218-679-3396 / 218-679-2923 Fax
karen.martin@redlakenation.org
dbarrett@redlakenation.org

Ponemah Site

P.O. Box 262, Ponemah, MN 56666
Ph. 218-554-7331 / 218-554-7386 Fax

Application

Head Start requires the following information with your child's application:

- ☐ Child must turn age 3 by September 1st
- ☐ Proof of Income
- ☐ Birth Certificate
- ☐ Guardianship Documents
- ☐ Immunization Records
- ☐ Head Start Physical - call **679-3355** to schedule a Head Start Physical & include with application
- ☐ Dental Exam - call **679-0119** to schedule a Head Start Exam & include with application
- ☐ Pre-School Screening - Call **679-3396 ext. 1412** to schedule an appointment

Please answer **all** questions. **Sign and Date** where necessary and if you have questions regarding the application, please feel free to call anytime and a staff member will be happy to assist you.

Thank You,

Red Lake Nation Head Start Staff

Please return applications to:

Dawn Barrett or Cheryl Holthusen, Red Lake
218-679-3396 Ext. 1404
Shirley Rosebear, Ponemah
218-554-7331

Red Lake Nation Head Start Application

Child's Legal Name: _____ **Birthdate:** _____ Male / Female

Child is: (Circle all that apply) Asian Black White Native American Native Alaskan Native Hawaiian Hispanic/Latino Bi-Racial Multi-Racial Unspecified Other _____

Is Child an Enrolled Tribal Member? Yes / No If yes, Where _____

Child's Primary Language is _____ **Child's English Fluency:** Some Good Well Very Well

Child Lives With: (Circle One) Mom Dad Both Parents Grandparent(s) Foster Other _____

Name of Legal Guardian: _____

Physical Address: _____ **City:** _____ **Zip:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Mother's Home # _____ Work # _____ Cell # _____

Father's Home # _____ Work # _____ Cell # _____

Guardian's Home # _____ Work # _____ Cell # _____

Does your child go to Day Care? Yes / No Where _____ Phone # _____

Do you have other children attending Head Start? Yes / No If yes, who _____

Head Start Requires Two (2) Emergency Contacts (NOT a Parent or Guardian)

Name: _____ **Name:** _____

Home # _____ **Work #** _____ **Home #** _____ **Work #** _____

Cell # _____ **City** _____ **Cell #** _____ **City** _____

Relationship to Child _____ **Relationship to Child** _____

Bus Route Information

Child Pick Up _____ **Child Drop Off** _____

Directions to Home: _____

_____

_____

For Office Use Only

Date Received / Received By

Circle all that Apply

Mother/Guardian Full Name: _____ **Birthdate:** _____

Ethnicity/Race: Asian Black White Native American Native Alaskan Native Hawaiian Hispanic/Latino Bi-Racial Multi-Racial Unspecified Other _____

Marital Status: Single Married Divorced Separated Widowed Significant Other

Education Status: Some H.S. H.S. Grad. GED Some College Vocational School A.A. Degree B.A./B.S. Degree Post Grad. Degree Earned _____ On the Job Training and/or Currently Attending _____

Employment Status: Part-time Full-time Unemployed Self-Employed Seasonal Retired Disabled Employer: _____ Address: _____

Father/Guardian Full Name: _____ **Birthdate:** _____

Ethnicity/Race: Asian Black White Native American Native Alaskan Native Hawaiian Hispanic/Latino Bi-Racial Multi-Racial Unspecified Other _____

Marital Status: Single Married Divorced Separated Widowed Significant Other

Education Status: Some H.S. H.S. Grad. GED Some College Vocational School A.A. Degree B.A./B.S. Degree Post Grad. Degree Earned _____ On the Job Training and/or Currently Attending _____

Employment Status: Part-time Full-time Unemployed Self-Employed Seasonal Retired Disabled Employer: _____ Address: _____

All others living in the Household that is NOT listed above: (Use back side if needed) **Household Total:** _____

Name: _____ M / F Birthdate: _____ Grade: ___ Relationship to Child: _____

Name: _____ M / F Birthdate: _____ Grade: ___ Relationship to Child: _____

Name: _____ M / F Birthdate: _____ Grade: ___ Relationship to Child: _____

Name: _____ M / F Birthdate: _____ Grade: ___ Relationship to Child: _____

Name: _____ M / F Birthdate: _____ Grade: ___ Relationship to Child: _____

Name: _____ M / F Birthdate: _____ Grade: ___ Relationship to Child: _____

Do You: (Circle One) Own Home Rent Homeless (McKinney-Vento Act / Share Housing) Other _____

Are any family members in the Military? Yes / No Are any family members a Military Veteran? Yes / No

Does anyone in the Household Smoke? Yes / No Circle if on: City Water or Own Well

Types of Services or Financial Assistance Received:

____ Child Care Subsidies	____ Child Support/Alimony	____ Energy Program Assist.
____ EPSDT	____ Foster Care/Adoption Subsidy	____ General Assistance (GA)
____ Medical Assistance	____ Public Assistance – TANF/MFIP	____ Public Housing
____ Retirement/Pension	____ SNAP – Food Stamps	____ SSI
____ Unemployment Insurance	____ Veterans Administration (VA)	____ WIC
____ Other _____		

INCOME:

One or more of the following is needed to VERIFY income: This application **CANNOT BE ACCEPTED** without proper Income Documentation.

____ Pay Stub	____ W-2	____ Income Tax Form (1040)	____ TANF/MFIP
____ GA	____ VA	____ Unemployment Letter	____ Foster Care Document
____ SSI	____ Alimony	____ Retirement/Pension	____ Unemployment Letter
____ Child Support	____ None	____ Other _____	

Has your Income changed drastically in the last three (3) months? Yes / No If yes, please explain: _____

_____

I certify that the information on this application is true and correct and will be used in determining eligibility for enrollment at the Red Lake Nation Head Start. I understand that this application does **NOT** automatically **"Enroll"** my child in the Head Start Program.

_____

Parent/Guardian Signature Date

CACFP - Child and Adult Care Food Program
Child Enrollment Form
Name of Facility: Red Lake Nation Head Start

Print Parent/Guardian Name: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ Home # _____ Work # _____ Cell # _____

This facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) and receives federal cash assistance to serve healthy meals to your child at no cost to you. In order to participate and receive reimbursement for meals, this facility has agreed to follow the USDA guidelines. The USDA's CACFP needs verification of enrollment **annually** for each participant in this facility. Meals served here must meet nutrition requirements established by the USDA's CACFP. Good nutrition today means a stronger tomorrow.

Child's name: _____ **Date of Birth:** _____ **M / F**

Check the days your child normally attends: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Write the hours your child normally attends: Start time: _____ End time: _____

Check the meals your child normally receives: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper

State Contact Information
Minnesota Department of Education - Food and Nutrition Service
1500 Highway 36 West, Roseville, MN 55113
1-651-582-8526 or 1-800-366-8922 mde.fns@state.mn.us

Civil Rights Information

Provision of this information is voluntary and has no effect on benefits received by you or the facility. This information will be used to determine whether the facility is complying with civil rights laws. If you do not provide this information, a representative of the facility is required to identify the ethnic and racial categories of your child in care at this facility.

Child Ethnicity: (Check One) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Child Race: (Check one or more) ☐ Native American or Alaskan ☐ Native Hawaiin or Other Pacific Islander

☐ Black or African American ☐ Asian ☐ White ☐ Other: please list _____

Please mark an option: ☐ Identified by an adult household member ☐ Identified by a child care representative

In accordance with Federal 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, Contact: USDA Director, Office of Civil Rights, 1400 Independence Avenue SW., Washington, DC 20250-9410 or call toll free 1-866-653-9992 (voice). Individuals who are hearing impaired or have speech difficulties may contact through the Federal Relay Service at 1-800-8339 or 1-800-845-6136 (spanish). USDA is an equal opportunity provider and employer.

Parent/Guardian Signature: _____ **Date**

This institution is an equal opportunity provider and employer

Red Lake Nation Head Start

P.O. Box 53, Red Lake, MN 56671
Ph. 218-679-3396 / 218-679-2923 Fax

Permission to Obtain, Exchange and Release Information about this child:

Name of Child: _____ Date of Birth: _____

Medical/Dental:

Parent/Guardian initial here

From: (Please check all that apply)

_____ Red Lake IHS Hospital, Red Lake, MN
_____ Sanford Health/Medical Records, Bemidji, MN
_____ Cass Lake IHS Hospital, Cass Lake, MN
_____ Mental Health Consultation
_____ Dental: _____
_____ Other Facility: _____

_____

For: Physical/Health Record
Immunization Record
Hematocrit, Hemoglobin & Lead Tests
Dental Record
Mental Health Record
Referral Follow-up

Human Services:

Parent/Guardian initial here

From: (Please check all that apply)

_____ Oshkiimaajaatada, New Beginnings, Redby, MN
_____ Family & Children Services, Red Lake, MN
_____ Beltrami County, Bemidji, MN
_____ Cass County, Cass Lake, MN
_____ Hennepin County, Minneapolis, MN
_____ Other Facility: _____

_____

For: Verification of Public Assistance
Verification of Health Care
Guardianship Documents
Birth Certificates
Referral Follow-up
Other Documents as needed

School Records:

Parent/Guardian initial here

From: (Please check all that apply)

_____ Red Lake ISD, Red Lake, MN
_____ Bemidji ISD, Bemidji, MN
_____ Clearbrook/Gonvick ISD, Clearbrook, MN
_____ Kelliher ISD, Kelliher, MN
_____ Blackduck ISD, Blackduck, MN
_____ Other School: _____

_____

For: Official Student Record
Individualized Education Plan (IEP)
Pre-School Screening
Psychological Evaluations
Other School Documents as needed

Pre-School Screening:

Parent/Guardian initial here

Hearing, Vision, Speech, Heights, Weights
DIAL - Motor Concepts
ASQSE - Social & Emotional Behavior
Child Health & Development - Health, Nutrition, Dental
Daily Routines, Home Safety & Learning

Other Consents:

Emergency Medical/Dental/X-ray Treatment
Transportation/Bus Service
School Field Trips/Activities

Use of Photograph/Video for the HeadStart Facebook Page, Brochures, School Bulletin Boards, etc.

I, (print name), _____, authorize the Red Lake Nation Head Start to obtain, exchange or release information with the above named agencies, only as needed for the direct benefit of my child, whose name and date of birth is written above. I understand this information will NOT be re-released without my consent. This permission is valid three years from the date of my signature.

Parent/Guardian Signature **Date**

Your Privacy Rights

The purpose of the information we collect from you is listed below. Details about the purposes of the information we collect from you are often listed on the forms you are asked to complete. The data we collect may be used for the following purposes:

- Determine your eligibility for services provided by this agency.
- Provide effective care and treatment of medical, social, psychological problems.
- Enable us to collect federal, state, and local funds for services.
- Determine your ability to pay for medical treatment or other aids and services provided to you or to other persons for whom you are responsible.
- Prepare statistical reports and evaluations.
- Conduct program and financial audits.
- Collect reimbursement from other agencies or individuals for services or assistance we give you.

LEGAL REQUIREMENTS

In most cases, you are not legally required to provide the information requested. If you are legally required to supply the information requested, you will be informed of the law which requires it.

If you do not provide the information requested, we may not be able to determine your eligibility for the services you request. In some cases, giving you the services will be delayed or hindered if you refuse to provide the information.

SHARING INFORMATION

The information you provide will be shared with other employees or agents of the statewide welfare system ONLY when programs require access.

The information you provide will be shared under the following circumstances:

- To individuals, persons, agencies, institutions or organizations **you** authorize sharing via a valid consent for release of information.
- To court via a court order.
- To administer federal funds or programs.
- To appropriate law enforcement personnel who are acting in an investigation, prosecution, criminal or civil proceeding relating to administration of a program.
- To appropriate parties in an emergency.

We may share this information with: state and local welfare agencies; community based organizations; local and state public and private human service agencies; the Minnesota Department of Economic Security; the United States Department of Labor; and the United State Department of Health and Human Services; and state and local Educational Programs, as allowed by law.

Details about how the information will be shared may be provided on the forms you will be asked to complete. Additional information is also available from the staff person assisting you.

You have the right to know and have access to information maintained about you. You also have the right to have it explained to you.

I have read this explanation of my privacy rights and understand the purposes of giving the information and who is authorized to use it.

Parent/Guardian Signature **Date**

Red Lake Nation Head Start

P.O. Box 53, Red Lake, MN 56671
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Health, Attendance, Parent Responsibility Policies & Parent Volunteer Survey

Name of Child: _____ Date of Birth: _____

Health Policy

Parent/Guardian initial here

Enrolled Students MUST HAVE age appropriate preventative and primary health care, which includes; Medical, Dental and Mental Health Care.

Federal Rules and Regulations require your child to have the following information in his/her file:

* Birth Certificate
* Child's Head Start Physical, which includes;
  - Hemoglobin
  - Hematocrit
  - Lead
* Child's Immunization Record
  - Diptheria
  - Tetanus
  - Pertussis (Whooping Cough)
  - Polio (Oral & IPV)
  - Mumps, Rubella, Rubeola
  - Hepatitis A & B
  - HIB/Peduax
  - Varicella
* Child's Dental Examination

Attendance Policy

Parent/Guardian initial here

ATTENDANCE IS VERY IMPORTANT FOR YOUR CHILD!!!

Your child **MUST** be signed in/out when he/she is dropped off or picked up. Signatures, dates & times need to be recorded for each day!

If your child will be absent; Please Notify the school **As Soon As Possible** by calling ahead of time. We are responsible for documenting absences in the attendance record and need an explanation why your child has not been in school. If your child is absent three consecutive days, we will call to make an appointment for a home visit. Chronic Absenteeism may result in your child to be dropped from our program.

Child Protective Services will be called if your child is not picked up by 4:00 pm and you have not contacted us about an emergency or an unavoidable situation.

Excused Absences: Illness or serious injury, death in the family; medical, dental or therapy appointments that could not be scheduled outside of class. Foster Care transitions.

Parent/Guardian Responsibility

Parent/Guardian initial here

Children will **NOT** be accepted into the classroom before 7:45 am. Children are **NOT** allowed to be dropped off outside the school and are **Required** to be signed in at the front office.

Please call the school before 8:15 am if your child will be absent and before 12:30 pm if your child gets off the bus at a different location.

Parent/Guardian **Must** show some visible sign for the bus staff to know that someone **IS HOME.** Please teach your child to "Wait until the Bus has come to a complete stop before getting on and off the bus."

Parent Volunteer Survey

Parent/Guardian initial here

All Parents/Guardians are considered Members of the "Head Start Parent Committee" if your child is enrolled.

Our Head Start depends on shared decision making with parents/guardians, therefore, we need volunteers to serve on the "Parent Policy Council". One parent/guardian is **voted** to the Policy Council from each classroom and will meet as often as possible. Policy Council members are reimbursed.

I am willing to volunteer to serve on the "Parent Policy Council"

Yes or No

By signing this document, I have read and understand the information requested and given.

Parent/Guardian Signature **Date**

Red Lake Nation Head Start

Child Medical & Dental Health Questionnaire

*** This document is **CONFIDENTIAL** and is kept in a locked file cabinet ***

Child's Name: _____ **Birthdate:** _____

Parent/Guardian: _____ **Phone #** _____

Child's Medical Coverage is: Medicaid/MA Private and/or Employer Military None Other _____

Child's Physician is: _____ Child's Dentist is: _____

Medications your child is currently taking: _____

Does your child: (circle) wear glasses use hearing aid use wheelchair Other _____ None

Does your child have an IEP? Yes / No Has your child completed the Pre-School Screening? Yes / No

Does your child have any Allergies or Food Allergies? Yes / No Please list _____

Is there any Child Abuse or Neglect in the home? Yes / No Is there any Substance Abuse in the home? Yes / No

Are any of these documented? Yes / No Where? Police Dept. Hospital Courts FCS Other _____

Is there any Mental Health concerns in the home? Yes /No Please Explain _____

When was your child's last dental visit? _____ Has your child completed the Dental Screening? Yes / No

What are your child's Dental concerns?

☐ Bleeding Gums	☐ Crooked Teeth	☐ Missing Teeth	☐ Bad Breath
☐ Toothache	☐ Loose Teeth	☐ Teeth Spacing	☐ Food Trapping
☐ Other, please list _____			

Does your child have, or ever had, any of the following:

	Yes	No	Not Sure		Yes	No	Not Sure		Yes	No	Not Sure
Eye Trouble				Arthritis, rheumatism				Anemia/Blood Disorder			
Ear Trouble				Severe Headaches				Painful Urination			
Nose Trouble				Rheumatic or Hay Fever				Stroke			
Throat Trouble				Sinusitis				Jaundice			
Hearing Trouble				Asthma				Glaucoma			
Foot Trouble				Chronic Cough or Colds				Tuberculosis			
Heart Trouble				Bronchitis				Cleft Lip or Palate			
Sleeping Trouble				Emphysema				Abnormal Chest X-Ray			
Thyroid Trouble				Shortness of Breath				Abnormal EKG			
Kidney Trouble				Dizzy or Fainting Spells				Growths or Cysts			
Bladder Trouble				Amnesia or Memory Loss				Cancer or Tumors			
Stomach Trouble				Chest Pain				Hepatitus			
Liver Trouble				Head Injury				Blood Transfusion			
Intestinal Trouble				Depression				Epilepsy			
Gall Bladder Trouble				High or Low Blood Pressure				Seizures			
Broken Bones				Recent Weight Gain or Loss				Paralysis			
Bone, Joint or other Deformity				Car Sickness				Steriod Therapy			
Swollen or Painful Joints				Eczema				Diabetes			

Does the Child and/or family member have a history of HAE (Hereditary Angio Edema)? Yes / No

I, the undersigned, certify that all the above medical and dental information is true and correct to the best of my knowledge and that I have not omitted any pertinent information.

_____

Parent/Guardian Signature **Date**

Red Lake Nation Head Start

Family Partnership Agreement

*****This Document is CONFIDENTIAL*****

Child's Name: _____ Date of Birth: _____

Where will this Child attend kindergarten? _____

This Agreement is a personalized, family-driven document, which focuses on the strengths of your family, and to assist in creating short-term and long-term goals. Setting goals gives you clarity on what you ultimately want for yourself and your family. They are a representation of your inner desires.

The Family Community Partnership Coordinator will provide assistance to develop your goals, outline who is responsible for realizing your goals, build strategies for reaching your goals and create timelines to track your goals. Setting SMART goals are a way to improve the quality of your goal setting and increase the likeliness of achieving those goals.

SMART = S=Specific M=Measurable A=Attainable R=Realisitic T=Time Based
BROAD = B=Bold R=Responsive O=Organizational A=Aspirational D=Dynamic

What is a **Short-Term GOAL** that you and/or your family would like to accomplish while attending Red Lake Nation Head Start?

Who will be responsible for realizing this GOAL? Example: Mom, Everyone, Dad

List some strategies for reaching this GOAL?

How long will it take to complete this GOAL?

What is a **Long-Term GOAL** that you and/or your family would like to accomplish while attending Red Lake Nation Head Start?

Who will be responsible for realizing this GOAL? Example: Mom, Everyone, Dad

List some strategies for reaching this GOAL?

How long will it take to complete this GOAL?

(please use back side if needed)

Family Services: Please check all that apply:	Am Interested	We Receive
Emergency/Crisis Intervention such as meeting immediate needs for food, clothing, or shelter		
Housing Assistance such as subsidies, utilities, repairs, etc..		
Mental Health Services		
English as a Second Language (ESL) Training		
Adult Education such as GED programs and college selection		
Job Training		
Substance Abuse Prevention		
Substance Abuse Treatment		
Child Abuse and Neglect Services		
Domestic Violence Services		
Child Support Assistance		
Health Education		
Assistance to families of incarcerated individuals		
Parenting Education		
Relationship/Marriage Education		
Asset Building Services such as financial education, open a savings and/or checking account, debt counseling, etc...		

Family Interest Survey: Please check all that apply:

Children, Parenting, Family Life

_____ Helping children feel good about themselves
_____ What my child is learning in the program
_____ Helping my child learn to love books and read
_____ Helping children move from one activity to the next in school (transitioning)
_____ Keeping children safe from abuse & neglect
_____ Child development-how my child grows, learns
_____ Parenting classes
_____ Toilet training
_____ Importance of a child's sleep schedule
_____ Importance of a child's routines in learning
_____ Positive disciplining
_____ Age appropriate tv & movie viewing
_____ Single parenting
_____ Co-parenting after divorce/separation
_____ Step-parenting and blended families
_____ Immigration Information
_____ Promoting mental health in the family
_____ Father/Male involvement in child development
_____ Other, Please list:

Life Skills, Health-Well being, Self-Improvement

_____ Fun, physical activities you can do as a family
_____ Budgeting and Money management
_____ Legal Assistance
_____ Obtaining health/dental insurance
_____ Family planning/birth control
_____ Childhood disease or illness
_____ Car seat safety and seat belt laws
_____ Stress management/relaxation techniques
_____ Anger management techniques
_____ Stop smoking/secondhand smoking effects
_____ Healthy meals on a budget
_____ Healthy feeding of infants
_____ First AID - CPR Training
_____ How to lose weight
_____ Diabetes education
_____ Time manangement
_____ Staying organized
_____ Computer use
_____ Learning a craft: beading, sewing, scrapbooking
_____ Other, please list:

Parent/Guardian Signature **Date**

Red Lake Nation Head Start Community Needs Assessment

This form is confidential information and will be used strictly for Head Start purposes

The Red Lake Nation Head Start must ensure parents are involved in the decision making process and that services are provided to meet their unmet needs. What types of services would you participate in if offered at the Red Lake Nation Head Start?

____ Member of the Parent Policy Council	____ Fatherhood Support Activities	____ Stress Reduction
____ Volunteer in the classroom	____ Child Care Training Classes	____ Nutrition
____ Parent Pow-wow Committee	____ Culture Awareness Activities	____ Other (list on back)

1 What hours would you like Head Start to have school for the children?

____ 9:00 - 1:30 ____ 9:30 - 2:00 ____ 8:00 - 3:00 ____ 9:00 - 4:00 Other_____

2 How many days a week would you like Head Start to have school?

____ 3 days ____ 4 days ____ 5 days

3 A Center-Based Program is where children attend school without their parents. A Home-Based Program is where the teachers come into your home and work with the families 2 to 3 times per week. Which option would you prefer?

____ Center-Based ____ Home-Based

4 Do you think classes should be held during the summer months? _____ Yes ____ NO

5 What do you expect your child to learn while at Head Start?

____ ABC's	____ Numbers/Counting	____ Social Skills (playing with other children)
____ Shapes	____ Manners	____ Name Writing or Recognition
____ Colors	____ Sharing	____ Other (use back side to list)

6 How often do you expect to be in contact with your child's Head Start Teacher?

____ Everyday ____ Once a week ____ Twice a week ____ Once a month

7 Would you like a teacher to come to your home for Home Visits? _____ Yes ____ No

8 Is the Head Start in the best location for your family? ____ Yes _____ No

9 What is the coldest temperature you would consider sending your child to school?

____ 0 degree ____ - 10 degrees ____ - 15 degrees ____ - 20 degrees ____ -25 degrees

10 Can you bring your child to school if the buses are running late? _____ Yes ____ No

11 Are you satisfied with the amount of time your child rides the bus? ____ Yes ____ No

if No, what would you recommend? _____

12 What community do you live in?

____ Red Lake ____ Redby ____ LittleRock ____ Ponemah ____ Off Reservation

13 What do you feel are the greatest challenges the children and families face in your community?

____ Housing ____ Child Care ____ Teen Pregnancy ____ Education
____ Violence ____ Transporation ____ Teenage Gangs ____ Limited Job Skills
____ Unemployment ____ Behavioral Health ____ School Drop-Outs ____ Drug or Alcohol Abuse

14 What prevention programs would you like to see in the community?

____ Drugs/Alcohol ____ Violence ____ Gangs ____ Fire ____ Other (please list any on back)

15 Is full year, full day child care needed for your Head Start Children? ____ Yes ____ No

16 Do you receive Child Care Services through:

Beltrami County ____ Yes ____ No Red Lake New Beginnings Program ____ Yes ____ No

17 What type of Child Care do you use?

____ Care provided by a relative/no cost to you ____ Public Day Care
____ Care provided by a relative/at cost to you ____ At home with another adult or relative
____ At a babysitters home ____ I do not pay for Child Care

18 How many children do you have in the following age groups?

____ 0 - 3 years old (Early Head Start) ____ 11 - 13 Years Old (6th - 8th Grade)
____ 3 - 4 years old (Head Start) ____ 14 - 18 Years Old (9th - 12th Grade)
____ 5 - 10 years old (K - 5th Grade)

19 Do you have a child with a disability? ____ Yes ____ No

If Yes, is your child under 3 years of age? ____ Yes ____ No

If Yes, what is your child's disability? _____

20 Did you graduate from High School? ____ Yes ____ No ____ GED

If No, what was the last grade you completed? ____ 8th ____ 9th ____ 10th ____ 11th

21 Have you ever attended college or vocational school? ____ Yes ____ No

22 Have you graduated from college or vocational school? ____ Yes ____ No

If Yes, what type of degree? ____ 2 year ____ 4 year ____ Master ____ Doctorate

Name of Degree _____

Thank You for completing this Community Needs Assessment!!! Chii-Miigwetch!!!

PLEASE REVIEW AND SIGN BOTH SIDES OF THIS FORM

RED LAKE NATION
COMPREHENSIVE HEALTH SERVICES
SCHOOL DENTAL SEALANT/FLUORIDE VARNISH PREVENTION PROGRAM

DEAR PARENT:

YOUR CHILD'S SCHOOL HAS CHOSEN TO PARTICIPATE IN THE RED LAKE NATION SCHOOL DENTAL PREVENTION PROJECT. AS YOU KNOW, A HEALTHY MOUTH IS PART OF TOTAL HEALTH AND WELLNESS, AND MAKES A CHILD MORE READY TO LEARN.

THE DENTAL TEAM, WHICH CONSISTS OF A LICENSED DENTAL HYGIENIST AND DENTAL ASSISTANT EMPLOYED BY RED LAKE COMPREHENSIVE HEALTH SERVICES AND SUPERVISED BY THE RED LAKE HOSPITAL DENTAL CLINIC DENTISTS, WILL SCREEN YOUR CHILD'S TEETH TO CHECK FOR TOOTH DECAY AND OTHER DENTAL PROBLEMS. YOUR CHILD WILL RECEIVE A TOOTHBRUSH AND ORAL HYGIENE INSTRUCTIONS. YOU WILL RECEIVE A REPORT ON THE HEALTH OF YOUR CHILD'S TEETH AND RECOMMENTATIONS FOR FURTHER CARE BY A DENTIST. **THIS SCREENING DOES NOT TAKE THE PLACE OF REGULAR DENTAL EXAMS BY A LICENSED DENTIST.**

WHEN YOU SIGN THE CONSENT FORM BELOW GIVING PERMISSION FOR YOUR CHILD TO PARTICIPATE IN THIS PROGRAM, YOUR CHILD WILL BE ABLE TO HAVE THEIR TEETH CLEANED, FLUORIDE APPLICATIONS, DENTAL SEALANTS APPLIED TO UNDECAYED TEETH AND TEMPORARY SEDATIVE MATERIAL PLACED FOR RELIEF OF PAIN. THESE PREVENTATIVE AND PALLIATIVE SERVICES HELP REDUCE THE RISK OF DENTAL DISEASE.

YOUR CHILD WILL NOT BE NAMED IN ANY REPORTS BUT WE DO ASK FOR CONSENT TO USE PHOTOS OF YOUR CHILD PARTICIPATING IN THE DENTAL PROJECT WHICH WE OCCASIONALLY PLACE IN THE LOCAL NEWSPAPER AND AT OTHER HEALTH EVENTS.

AS WE HAVE A VERY LIMITED AMOUT OF TIME TO DELIVER THIS CARE IN ALL 5 SCHOOLS ON THE RESERVATION, SOME GRADES MAY NOT RECEIVE ALL SERVICES ANNUALLY. ***IN ORDER FOR YOUR CHILD TO RECEIVE THESE SERVICES WHEN WE ARE AT THEIR SCHOOL, THIS FORM GIVING US PERMISSION MUST BE SIGNED BY YOU AND RETURNED TO YOUR CHILD'S TEACHER.***

PLEASE CALL RED LAKE SCHOOL DENTAL PROJECT HYGIENIST AT **218-679-0395** IF YOU HAVE ANY QUESTIONS.

THE PRIVACY RULES OF THE HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT OF 1996 WILL BE STRICTLEY ADHERED TO. TO EXERCISE YOUR RIGHTS UNDER HIPPA, TO REQUEST ADDITIONAL INFORMATION, OR TO REPORT A PROBLEM, PLEASE CONTACT THE HIPPA COORDINATOR AT RED LAKE PHS HOSPITAL 218-679-3912.

WE WILL ACCESS ELECTRONIC HEALTH INFORMATION ABOUT YOUR CHILD FOR THE FOLLOWING PURPOSES:

- **TREATMENT**
- **PAYMENT**
- **CARE OPERATIONS**

_____YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE AND TO ACCESS THEIR ELECTRONIC HEALTH RECORD AS NEEDED FOR DENTAL CARE. PLEASE COMPLETE THE DENTAL HEALTH HISTORY FORM.

_____NO, I DO NOT GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS PROGRAM

CHILD'S NAME _____ **DATE OF BIRTH** _____

GUARDIAN SIGNATURE _____ **DATE** _____

PLEASE REVIEW AND SIGN BOTH SIDES OF THIS FORM

Red Lake Comprehensive Health Services
School Dental Prevention Program
24760 Hospital Drive
Red Lake, MN 56671
218-679-3316 ext 4395

Consent for Headstart Classroom Fluoride Supplement Prescription

Dear Parents:

Your child's HeadStart class is participating in a dental health program. The children in the program will:

1. Learn how to prevent cavities and gum disease
2. Brush their teeth in the classroom
3. Take a daily fluoride tablet given by the classroom teacher

Using fluoride is a safe, easy way to make teeth stronger. There is no cost to you, but you must sign this permission form for your child to participate with the rest of the class.

IMPORTANT: Fluoride tablets should not be given to a child both at home and in school on the same days. Therefore, if your child is receiving fluoride tablets at home, he or she should not participate in the tablet portion of this program. Or, you may wish to stop using tablets at home on school days and let your child participate in the program at school.

Cavities can be reduced significantly by this program. However, it does not take the place of regular dental care given by your dentist.

IF YOU HAVE ANY QUESTIONS REGARDING THIS PROGRAM, PLEASE CALL THE SCHOOL HYGIENIST AT 218-679-0395. PLEASE HAVE YOUR CHILD RETURN THE BOTTOM PORTION OF THIS FORM TO HIS/HER TEACHER.

Please check appropriate box, sign and return school:

[ ] **YES** - I want my child to receive prescription fluoride supplements during their Headstart school day.
[ ] **NO** -My child may **NOT** receive fluoride tablets at school.

Child's name _____ Date of Birth _____

Child's address _____

School _____

Signature of Parent or Guardian _____ Date _____

Daytime phone where you can be reached _____

PLEASE REVIEW AND SIGN BOTH SIDES OF THIS FORM

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Child's name _____ Date of Birth _____

Child's address _____

School _____

Signature of Parent or Guardian _____ Date _____

Daytime phone where you can be reached _____

PLEASE REVIEW AND SIGN BOTH SIDES OF THIS FORM

RED LAKE NATION
COMPREHENSIVE HEALTH SERVICES

SCHOOL DENTAL SEALANT/FLUORIDE VARNISH PREVENTION PROGRAM

DEAR PARENT:

YOUR CHILD'S SCHOOL HAS CHOSEN TO PARTICIPATE IN THE RED LAKE NATION SCHOOL DENTAL PREVENTION PROJECT. AS YOU KNOW, A HEALTHY MOUTH IS PART OF TOTAL HEALTH AND WELLNESS, AND MAKES A CHILD MORE READY TO LEARN.

THE DENTAL TEAM, WHICH CONSISTS OF A LICENSED DENTAL HYGIENIST AND DENTAL ASSISTANT EMPLOYED BY RED LAKE COMPREHENSIVE HEALTH SERVICES AND SUPERVISED BY THE RED LAKE HOSPITAL DENTAL CLINIC DENTISTS, WILL SCREEN YOUR CHILD'S TEETH TO CHECK FOR TOOTH DECAY AND OTHER DENTAL PROBLEMS. YOUR CHILD WILL RECEIVE A TOOTHBRUSH AND ORAL HYGIENE INSTRUCTIONS. YOU WILL RECEIVE A REPORT ON THE HEALTH OF YOUR CHILD'S TEETH AND RECOMMENTATIONS FOR FURTHER CARE BY A DENTIST. **THIS SCREENING DOES NOT TAKE THE PLACE OF REGULAR DENTAL EXAMS BY A LICENSED DENTIST.**

WHEN YOU SIGN THE CONSENT FORM BELOW GIVING PERMISSION FOR YOUR CHILD TO PARTICIPATE IN THIS PROGRAM, YOUR CHILD WILL BE ABLE TO HAVE THEIR TEETH CLEANED, FLUORIDE APPLICATIONS, DENTAL SEALANTS APPLIED TO UNDECAYED TEETH AND TEMPORARY SEDATIVE MATERIAL PLACED FOR RELIEF OF PAIN. THESE PREVENTATIVE AND PALLIATIVE SERVICES HELP REDUCE THE RISK OF DENTAL DISEASE.

YOUR CHILD WILL NOT BE NAMED IN ANY REPORTS BUT WE DO ASK FOR CONSENT TO USE PHOTOS OF YOUR CHILD PARTICIPATING IN THE DENTAL PROJECT WHICH WE OCCASIONALLY PLACE IN THE LOCAL NEWSPAPER AND AT OTHER HEALTH EVENTS.

AS WE HAVE A VERY LIMITED AMOUT OF TIME TO DELIVER THIS CARE IN ALL 5 SCHOOLS ON THE RESERVATION, SOME GRADES MAY NOT RECEIVE ALL SERVICES ANNUALLY. ***IN ORDER FOR YOUR CHILD TO RECEIVE THESE SERVICES WHEN WE ARE AT THEIR SCHOOL, THIS FORM GIVING US PERMISSION MUST BE SIGNED BY YOU AND RETURNED TO YOUR CHILD'S TEACHER.***

PLEASE CALL RED LAKE SCHOOL DENTAL PROJECT HYGIENIST AT **218-679-0395** IF YOU HAVE ANY QUESTIONS.

THE PRIVACY RULES OF THE HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT OF 1996 WILL BE STRICTLEY ADHERED TO. TO EXERCISE YOUR RIGHTS UNDER HIPPA, TO REQUEST ADDITIONAL INFORMATION, OR TO REPORT A PROBLEM, PLEASE CONTACT THE HIPPA COORDINATOR AT RED LAKE PHS HOSPITAL 218-679-3912.

WE WILL ACCESS ELECTRONIC HEALTH INFORMATION ABOUT YOUR CHILD FOR THE FOLLOWING PURPOSES:

- **TREATMENT**
- **PAYMENT**
- **CARE OPERATIONS**

_____YES, I GIVE PERMISSION FOR MY CHILD TO PARTICIPATE AND TO ACCESS THEIR ELECTRONIC HEALTH RECORD AS NEEDED FOR DENTAL CARE. PLEASE COMPLETE THE DENTAL HEALTH HISTORY FORM.

_____NO, I DO NOT GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS PROGRAM

CHILD'S NAME _____ **DATE OF BIRTH** _____

GUARDIAN SIGNATURE _____ **DATE** _____