Mandan, Hidatsa, Arikara Nation
Head Start

509 9th Street North
New Town, ND 58763
(701) 627-4820 Fax (701) 627-4401

Enrollment Application 2020-2021

Completed Application requirements:

1. *Application*
2. *Birth Record - Birth Certificate, Crib Card,*
3. *Tribal Enrollment (extra 50pts)*
4. *Income Documentation - Copy of pay stub, W-2, Employer statement*
5. *Physicals - Required before school starts.*
6. *Immunizations*

Returning students:

1. *Application*
2. *Income Documentation (**UPDATED DOCUMENTS REQUIRED**)*
3. *Physicals -Returning students **REQUIRE** updated physicals before returning to school.*
4. *Updated Immunizations*

*Due to Covid 19, Head start is accepting the following information **(Birth Certificate, Enrollment and Income)** documents sent through e-mail or text. We would appreciate it if you are sending information through either of the two methods please include your name as guardian and the child's name. Documents can be e-mailed to wajones@mhanation.com or texted as a picture to 701-421-6651.*
*(**If printing/scanning documents please keep them one sided**)*

Applicant & Family Member Information

School Year 2020-2021

Applicant

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Tribal ID

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Primary Health Coverage	Other Coverage	Insurance #	Medicaid Eligibility	Medicaid #	Doctor/Medical Home
			☐ Not Eligible ☐ On Medicaid ☐ Potentially		

Dental Coverage	Dental Coverage #	Dentist/Dental Home

Primary Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED	☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent If teen parent, subsidized? ☐ Yes ☐ No

Email Address:

Secondary or Other Adult

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN	Alt ID

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED	☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent If teen parent, subsidized? ☐ Yes ☐ No

Email Address:

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Suffix	Nickname	Birthday	Gender	SSN

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ Little ☐ Moderate ☐ None ☐ Proficient		☐ Little ☐ Moderate ☐ None ☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Living Address

Started Living At Date	Living Address	Address Line 2	ZIP	City	State	County

Family Mailing Address

Same as living?	Started Using Date	Mailing Address/P.O. Box	Address Line 2	ZIP	City	State
☐ Yes ☐ No						

Phone Number(s)	Type (*check one*)	Note (extension or best time to call)	Opt In for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	Veteran
☐ One ☐ Two		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Family Income

Income Verified by Staff Member	Verification Date	TANF Status	SSI Disability
		☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ No

Family Member	*Amount*	*Per (for example: week, month, year)*	*Annual Amount*	*Description (for example: SSI, Job, Child Support)*	*Verification (for example: W2, check stub)*	*Note*
	$		$			
	$		$			
	$		$			

Income Notes

Emergency Contacts (Other than Parent/Guardian)

Contact 1

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Physical Address/No P.O. Boxes	ZIP	City	State

Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐		☐ Cell ☐ Home ☐ Work

Contact 2

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Physical Address/No P.O. Boxes	ZIP	City	State

Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work

Contact 3

Name	Relationship	Emergency Contact	Release To
		☐ Yes ☐ No	☐ Yes ☐ No

Physical Address/No P.O. Boxes	ZIP	City	State

Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Emergency Contacts (Other than Parent/Guardian)

Contact 4

Name		Relationship		Emergency Contact	Release To
				☐ Yes ☐ No	☐ Yes ☐ No
Physical Address/No P.O. Boxes		ZIP		City	State
Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work

Contact 5

Name		Relationship		Emergency Contact	Release To
				☐ Yes ☐ No	☐ Yes ☐ No
Physical Address/No P.O. Boxes		ZIP		City	State
Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work

Contact 6

Name		Relationship		Emergency Contact	Release To
				☐ Yes ☐ No	☐ Yes ☐ No
Physical Address/No P.O. Boxes		ZIP		City	State
Phone Number 1		Phone Number 2		Phone Number 3	
	☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work		☐ Cell ☐ Home ☐ Work

Certification: *I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.*

Parent/Guardian Signature _____ Date _____

Interviewer_____Date_____

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Three Affiliated Tribes Head Start
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No Income Statement

To whom it may concern,

I_____verify that I have no income at this time.
(Parent/Guardian's Name)

_____ _____
(Signature of Parent/Guardian) **(Date)**

Medical Screenings Consent

Child's Name: _____ Check One : **Returning Student**
New Student

Medical Insurance: ☐ **Yes** **Specify:** _____
☐ **No**

By signing below you are granting permission for your child (As named above) to participate in the screening done for that specified medical area:

- **A1C**
- **Blood Pressure**
- **Brigance**
- **Dental**
- **Hearing**
- **Height/Weight**
- **Hemoglobin**
- **Head Circumference**
- **Lead**
- **Vision**

_____ _____

(Parent/Guardian Signature) **(Date)**

****The Three Affiliated Tribes Head Start Program partners and shares information with Elbowoods Memorial Health Center and the TAT Infant & Toddler Program.**

Medical Emergency Transportation Consent

In case of an emergency that occurs while in the care of Head Start. I give permission for the Head Start Center Staff to transport my child, _____, to the nearest medical facility.

_____

Parent Signature Date

Photography and Videography Consent

I give permission for my child, _____, to be included in photographs and/or videos taken while at Head Start.

_____

Parent Signature Date

Child Demographics

The following question are being asked so that we may better serve our Head Start children and their families as well as to comply with Head Start regulations.

Head Start regulation 45CFR 1305.6(c) states that a least 10% of enrollment opportunities must be made available to children with disabilities.

1. Indicate if your child has been identified as having or is suspected as having any of the following so that we may meet the needs of the child. Please fill in all appropriate information.

☐ Parent report and records indicate no disabilities

	Suspected	Identified	Date	Evaluated by
Autism				
Emotional/Behavioral Disorder				
Health Impairment				
Learning Disability				
Mental Retardation				
Orthopedic Impairment				
Speech or language impairment				
Traumatic Brain Injury				
Visual Impairment including Blindness				
Other				

Family Circumstances

2. Please indicate any issues which have occurred to your child's immediate family.

Within the Last 2 Years

☐ Child abuse or neglect
☐ Death in the family
☐ Divorce
☐ Domestic Violence
☐ Drug and Alcohol Abuse
☐ Military Deployment
☐ Incarceration of parent/guardian
☐ Homelessness (includes families living temporarily in shelter, hotels, or vehicles; moving frequently between homes of relatives and friends)

Currently

☐ Child is in foster care
☐ Child is not in foster care, but is not living with a biological or adoptive paren
☐ Only one adult lives in the home
☐ Parent/Guardian is receiving disability payments
☐ Other: _____

3. Why would you like your child to be considered for Head Start?

Child Plus Nutritional Assessment

Note: To Be Completed By Parent

Date Completed: 05/29/2020

Child's Name: _____ **Date of Birth**_____

Parent Signature: _____

Eating Frequency (times per day): |___|___|

****

Dietary Habits:

Favorite Foods:

_____

Least Favorite Foods:

_____

	Yes
Child takes vitamin/ mineral supplements?	☐
Supplements contain iron?	☐
Supplements contain fluoride?	☐
Supplements were prescribed?	☐
Foods not eaten for medical, religious or personal reasons?	☐
Child on a special diet?	☐
Change in child's appetite in the past month?	☐
Child takes a bottle?	☐
Child eats or chews things that aren't food?	☐
Child has trouble chewing or swallowing?	☐
Child often has:	
Diarrhea	☐
Constipation	☐
Concerns about what the child eats?	☐

Comments:

Usual Food Group Eating Frequency:

	Approximate Number of Times Each Week								
	0	1	2	3	4	5	6	7	7+
A. Milk, cheese, yogurt	☐	☐	☐	☐	☐	☐	☐	☐	☐
B. Meat, poultry, fish, eggs; or dried beans/peas, peanut butter	☐	☐	☐	☐	☐	☐	☐	☐	☐
C. Rice, grits, bread, cereal, tortillas	☐	☐	☐	☐	☐	☐	☐	☐	☐
D. Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes	☐	☐	☐	☐	☐	☐	☐	☐	☐
E. Oranges, grapefruit, tomatoes (fruit/juice)	☐	☐	☐	☐	☐	☐	☐	☐	☐
F. Other fruits and vegetables	☐	☐	☐	☐	☐	☐	☐	☐	☐
G. Oil, butter, margarine, lard	☐	☐	☐	☐	☐	☐	☐	☐	☐
H. Cakes, cookies, sodas, fruit drinks, candies	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Head Lice Policy

1. **POLICY:** Head Start has a "**NO INFESTATION**" policy that prevents children from returning to the center until their hair and scalp reveal "**NO NITS.**"

2. **PROCEDURE:** Every Thursday morning the center staff will conduct a head check for lice or nits. When a child is absent, he or she will be checked for lice or nits upon returning to the center. When a child in the Head Start Program is found to have head lice or nits, the center staff will maintain confidentiality and the following steps will be taken:
   1. The child with head lice/nits will be taken home but may return as soon as the teacher determines the child to be nit free.
   2. When a child, who has been sent home with Head Lice, returns to the center, the center staff will recheck to determine if the child is lice free. A maximum of two days will be allowed for the child to be lice free and back in school.
   3. An incident report will be written by the teacher and signed by both the parent and teacher with proof of nits/bugs taped to the incident report.
   4. Center staff will give parents written information on head lice prevention and treatment as well as Lice Treatment Kits at no cost.
   5. Center staff will conduct head checks on the children, each day for the remainder of the week. This will be documented on the head check form and sent to the Head Start office with the monthly reports.
   6. When a child is sent home for the 2nd. Time with head lice/nits, the Health/Disabilities and Family Partnership Managers will be notified and will contact the parent to arrange a home visit. The purpose of the home visit will be to reinforce the information the center staff has given to the parent. Information is offered relating to the treatment of head lice, nit removal, treatment of the environment and the need to reinspect head and scalp following the treatment. An incident form will be written by the staff and signed by both the parents and the staff that are in attendance.
   7. When a child is sent home for the 3rd. time with head lice/nits, the Health Manger will make a referral to the Community Health Representatives (CHR) to assist them in cleaning their environment. An incident report form will be written by the Health Manager and signed by both the parents and staff. Upon return to school, the Health Manager will clear the child as nit free. In the absence of the Health Manager, other management staff can clear a child for readmission.
   8. Should a child continue to have head lice, a 960 (child neglect) will be filed with the Child Welfare Program.

_____ _____

Parent/Guardian Acknowledgement Date

Parent Report—Self-help and Social-Emotional Scales

Child's Name _____ Child's Date of Birth _____ Today's Date _____

Parent's/Caregiver's Name _____ Teacher's Name _____

Directions: Read each item and circle the response or description that best reflects your child's behavior or skill level.

SELF-HELP SKILLS

A. Eating Skills

1. Does your child use a spoon?
If yes, does your child place the spoon in his/her mouth without turning the spoon upside down, with little or no spilling of food?

Rarely/No	Sometimes	Most of the time

2. Does your child use the side of the fork for cutting soft food, such as a piece of baked potato or a piece of cake?

Rarely/No	Sometimes	Most of the time

3. Does your child hold a fork in his/her fingers, not in his/her fist?

Rarely/No	Sometimes	Most of the time

B. Dressing Skills

4. Does your child put on his/her shoes?
Criteria: Buckling, tying, or Velcro® fastening is not required for credit.

No	Yes (sometimes on wrong feet)	Yes (each shoe on correct foot 90% of the time)

5. Does your child dress himself/herself unsupervised?

Rarely/No	Sometimes	Most of the time, except for help with difficult fasteners

Yes (completely dresses himself/herself, putting all clothes on correctly and fastening all fasteners)	Yes (completely dresses himself/herself, including tying shoelaces and fastening all fasteners)

6. Does your child put on his/her socks?

Rarely/No	Sometimes	Most of the time

C. Toileting Skills

7. Does your child get on the toilet or potty by himself/herself (even if he/she needs help with clothing)?

Rarely/No	Sometimes	Most of the time

8. Does your child have bowel movements ("poop") in the toilet or potty (no more than one accident a week)?

Rarely/No	Sometimes	Most of the time

9. Does your child urinate ("pee") in the toilet or potty (no more than one accident a week)?

Rarely/No	Sometimes	Most of the time

10. Does your child attempt to wipe himself/herself after toileting?

Rarely/No	Sometimes	Most of the time

OR

Does your child wipe himself/herself independently after toileting?

Rarely/No	Sometimes	Most of the time

11. Does your child take care of his/her toileting needs?

Rarely/No	Sometimes	Yes (flushing the toilet most of the time after using it)	Yes (flushing the toilet and washing and drying his/her hands most of the time)

12. Does your child go to the bathroom on his/her own without being asked or reminded?

Rarely/No	Sometimes	Most of the time

Parent Report—Self-help and Social-Emotional Scales *(continued)*

SOCIAL AND EMOTIONAL SKILLS

D. Relationships with Adults

13. Does your child respond with feelings of pride and enthusiasm when he/she earns positive feedback?

Rarely/No	Sometimes	Most of the time

14. Does your child look forward to sharing his/her feelings with you when he/she is happy?

Rarely/No	Sometimes	Most of the time

15. Does your child enjoy sharing information with you about himself/herself, such as things he/she likes, names of his/her family members or pets, or what he/she did over the weekend?

Rarely/No	Sometimes	Most of the time

16. Does your child share his/her thoughts and ideas with you?

Rarely/No	Sometimes	Most of the time

E. Play and Relationships with Peers

17. Does your child have several friends but one who is a special or best friend?

No	Yes

18. Does your child have a best friend with whom he/she is close and who reciprocates by coming over for play dates or extending an invitation to a party?

No	Yes

19. Does your child play cooperatively in a large-group game, such as duck-duck-goose, tag, or kickball?

Rarely/No	Sometimes	Most of the time

20. Does your child give verbal directions or incorporate verbal directions into play activities?

Rarely/No	Sometimes	Most of the time

F. Motivation and Self-Confidence

21. Does your child maintain interest when engaged in a small-group activity or project?

Rarely/No	Sometimes	Most of the time

22. Does your child show that he/she likes to finish what he/she starts, perhaps by dawdling less than at an earlier age?

Rarely/No	Sometimes	Most of the time

23. Does your child approach new tasks with confidence and a "can-do" attitude?

Rarely/No	Sometimes	Most of the time

24. Does your child remain focused on what he/she has been asked to do even when there are minor distractions, such as a car making noise outside or someone tapping a pencil?

Rarely/No	Sometimes	Most of the time

G. Prosocial Skills and Behaviors

25. If supervised by an adult, does your child take turns without undue objection?

Rarely/No	Sometimes	Most of the time

26. Does your child understand or accept the need to share and take turns, perhaps willingly taking turns even if he/she isn't asked to?

Rarely/No	Sometimes	Most of the time

27. Does your child ask an adult for permission before using things that belong to others or before engaging in an activity that may be restricted, such as going to the bathroom or leaving the classroom?

Rarely/No	Sometimes	Most of the time

28. Does your child react to a disappointment or failure in an acceptable manner by being a good sport and refraining from shouting or getting upset?

Rarely/No	Sometimes	Most of the time

CHILD ENROLLMENT FORM - CACFP

NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
CHILD NUTRITION AND FOOD DISTRIBUTION PROGRAMS
(Rev. 3/2018) G/Tools/CACFP/Child Enrollment form-CACFP

To be completed by parent or guardian only

Center Name:

In the chart below, please indicate the normal days and hours your child(ren) is in care, and the meals received while in care.

Children's Names	Date of Birth	Age	Child is usually at Day Care Center on:	Normal hours in child care	Please check (√) meals your child normally receives while in care				
			☐ Full-time Basis ☐ Part-time Basis	8:30am- 3:30pm	Breakfast ☐	AM Snack ☐	Lunch ☐	PM Snack ☐	Supper ☐
			☐ Full-time Basis ☐ Part-time Basis		Breakfast ☐	AM Snack ☐	Lunch ☐	PM Snack ☐	Supper ☐
			☐ Full-time Basis ☐ Part-time Basis		Breakfast ☐	AM Snack ☐	Lunch ☐	PM Snack ☐	Supper ☐
			☐ Full-time Basis ☐ Part-time Basis		Breakfast ☐	AM Snack ☐	Lunch ☐	PM Snack ☐	Supper ☐

Parent's Name	Parent's Signature
Address	
Telephone Number	Date

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) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, 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.

Child Physical Exam – Three Affiliated Tribes Head Start

Note: To Be Filled Out and Signed by Medical Physician

Date Completed: ___/___/____

Child's Name: _____ **Date of Birth:** ___/___/____

Parent/Guardian Name: _____

Provider Setting: ☐ Doctor/Clinic ☐ School/Center ☐ Other: Specify_____

Medical Insurance: ☐ No Yes Specify: _____

Does your child experience any of the following (check all that apply):

☐ Asthma ☐ Allergic Reactions ☐ Physical/Learning Disability ☐ None

Allergies: _____

Medications: _____

For Medical Provider:

Ht:_____ Wt:_____ BP:_____ Head Circumference: _____

Blood Glucose _____ HGB:_____A1c:_____

Lead Screening:

☐ N/A ☐ Blood Draw Result:_____

Vision Screening:

Right Eye _____Left Eye _____Both _____

Hearing Screening:

Right Ear (circle one): PASS or FAIL Left Ear (circle one): PASS or FAIL

Dental Screening:

Dental Caries: _____

Food Allergy: _____

Please turn page over.

Child Physical Exam – Three Affiliated Tribes Head Start

Physical Exam/Assessment:

Physical Examination	**Normal**	**Abnormal**	**Needs Y/N**		**Normal**	**Abnormal**	**Needs Y/N**
General Appearance				Heart			
Posture, Gait				Lungs			
Head				Abdomen (include hernia)			
Skin				Genitalia			
Eyes External Aspects				Bones, Joint, Muscles			
Ears External Canal				Muscular Coordination			
Nose, Mouth, Pharynx				Gross Motor			
Glands (Lymphatic/Thyroid)				Fine Motor			
Communication Skills				Cognitive			
Speech				Self-Help Skills			

Comments: _____

_____

_____

Determined to be up-to-date on a schedule of age appropriate preventive and primary health care which includes medical, dental and mental health as per ND EPSDT guidelines. ☐Yes ☐ No HSPS 1304.20(a)(ii)

Provider Signature: _____ **Date:** ____/____/____

Print Provider Name: _____