Cheyenne River Head Start Program

Application for SY 2023-2024

To be **COMPLETE**, the following must be submitted:

- ☐ **Birth Certificate:** If child was born in South Dakota see Family Services to obtain a free one
- ☐ **Income Documentation (Food Stamp letter can be submitted)**
- ☐ **Physical Examination:** This **MUST** be turned in **BEFORE** your child can begin school.

CRST Field Health: 964-0772
- Cherry Creek Clinic: 538-4251
- Red Scaffold Clinic: 538-4403
- Swiftbird Clinic: 733-2174
- White Horse Clinic: 733-2133

Timber Lake
- West Dakota Health 865-3258
- Community Health/WIC 865-3587

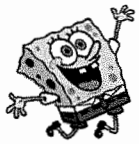
Eagle Butte:
- Indian Health Service: 964-7724
- Horizon Health Center: 964-8000
- Upell Clinic 964-7700

Faith Community Clinic 967-2644

Isabel Clinic 466-2120

- ☐ **Lead Testing & Hematocrit/Hemoglobin is Required:**.
- ☐ **Updated Immunization:** Please check with your medical provider on your child's immunization
- ☐ **Degree of Indian Blood:** If child is not enrolled, please submit parent's DIB:
  - ♦ CRST Enrollment Office 964-6612
- ☐ **Custody Papers (if applicable)**
- ☐ **Medicaid/CHIP Numbers:** Please write number on application
- ☐ **IEP** (Individual Education Plan) **or IFSP** (Individual Family Service Plan)
- ☐ **If your child has a food and/or milk allergy or a special diet prescription please have you medical provider complete the form and it MUST BE signed by a Medical Doctor (MD).**

ALL documents MUST be submitted to the Family Services before the 1st day of School.



Call 964-8713 for information:
Rita Kym Louis, Family Services Manager

If you DO NOT want your child to be taken for vision or hearing screenings by Head Start, it will be the parents/guardians responsibility to submit results of these screenings within 45 days of the child's first day of school.

Mnicoujou Itazipco
CHEYENNE RIVER SIOUX TRIBE
Sihasapa Oohenumpa

Cheyenne River Head Start Program
CHILD APPLICATION
P. O. Box 590, Eagle Butte, SD 57625
Phone: 605-964-8713 Fax: 605-964-8705

Office Use Only:
Date Received_____
Center: _____

TEACHER REQUEST (EB ONLY): _____

What center is application for?: _____ **Is Child:_ New:** ☐ **Returning:** ☐

Please COMPLETE all areas of this application. **Chronological Age:**_____

Applicant Information:			**Date of Birth:**	**Gender:**
First Name:	MI	Last Name:		Male: ☐ Female: ☐

Parents/Guardians E-MAIL:	
Mother: _____	**Father:** _____
Guardian:_____	

Living Address:	**Mailing Address of Primary Adult (physical custody)**
Street/House No.: _____	Street/P.O. Box: _____
Town/City: _____	Town/City: _____

Child lives with: (Check all that applies)

○ Mother ○ Father ○ Step-Father ○ Step-Mother ○ Foster Parent(s) ○ Legal Guardians
○ Grandparent(s) ○ Other Relative Other (specify): _____

Ethnicity of Child:

○ American Indian/Alaska Native ○ Asian ○ African American or Black
○ BiRacial/Multi-Racial ○ ○ Native Hawaiian or Pacific Islander ○ White

Household Composition/Ethnicity: **AI/AN:** American Indian/Alaska Native **Asian** **AA:** African American or Black
MR/BR: Multiracial or Biracial **NH/PI**: Native Hawaiian or Pacific Islander **W**: White

First Name:	Last Name:	Date of Birth	Relationship to Child:	Ethnicity:

Child and/or Family Information:

Is family on SNAP: Yes: ☐ No ☐ Is child on WIC: Yes: ☐ No ☐ Is family on SSI? Yes: ☐ No: ☐
Is family on TANF Yes: ☐ No: ☐ Formerly on TANF: Yes: ☐ No: ☐
Is family homeless: Yes: ☐ No: ☐ Is child toilet trained: Yes: ☐ No: ☐
Does child have food and/or milk allergy: Yes: ☐ No: ☐ (Form signed by Dr. must be submitted)
Is child on IEP (Individual Education Plan)? Yes: ☐ No: ☐
Primary language of child: _____ 2nd Language of child: _____

Medical Information for Child:

Is child currently on: ○ Medicaid Only ○ CHIP Only ○ Combined Medicaid/CHIP ○ Private Insurance ○ Military Insurance ○ No Insurance

Medicaid/CHIP number: _____

Do you utilize Indian Health Service: ○ Yes ○ No

Medical Home (name of hospital/clinic): _____

Address: _____ Phone Number: _____

Does child have access to regular dental care: ○ Yes ○ No Utilize I.H.S._____

Dental Home (name of dentist/dental clinic):_____

Address: _____ Phone Number: _____

Primary Adult:	**Secondary Adult:**
First Name: MI Last Name	First Name: MI Last Name:
Date of Birth: Relationship to Child:	Date of Birth: Relationship to Child:
Telephone Number Information:	**Telephone Number Information:**
Home: _____ Work: _____	Home: _____ Work: _____
Cell: _____ Message: _____	Cell : _____ Message: _____

Primary Adult Employment & Education	**Secondary Adult Employment & Education**
Employment:	**Employment:**
○ Full Time ○ Part-Time ○ Seasonal ○ Unemployed ○ Self-Employed	○ Full-Time ○ Part-Time ○ Seasonal ○ Unemployed ○ Self-Employed
Employer name:_____	Employer Name: _____
Are you attending school/job training? ○ Yes ○ No	Are you attending school/job training? ○ Yes ○ No
If Yes, where: _____	If Yes, where: _____
Are you active in any branch of the United States Military? ○ Yes ○ No	Are you active in any branch of the United States Military? ○ Yes ○ No
Are you a **Veteran** of the United States Military? ○ Yes ○ No	Are you a **Veteran** of the United States Military? ○ Yes ○ No
Highest level of education completed:	**Highest level of education completed**:
○ 9th or less ○ 10th ○ 11th ○ 12th (didn't finish)	○ 9th or less ○ 10th ○ 11th ○ 12th (didn't finish)
○ High School graduate ○ GED ○ Some college	○ High School graduate ○ GED ○ Some college
○ Associate's Degree ○ BS/BA ○ MA/MS	○ Associate's Degree ○ BS/BA ○ MA/MS
○ Vocational ○ Doctorate ○ Other: _____	○ Vocational ○ Doctorate ○ Other: _____
Ethnicity: ○ American Indian/Alaska Native ○ Asian ○ African American or Black ○ Bi-Racial/Multi-Racial ○ Native Hawaiian or Pacific Islander ○ White	**Ethnicity**: ○ American Indian/Alaska Native ○ Asian ○ African American or Black ○ Bi-Racial/Multi-Racial ○ Native Hawaiian or Pacific Islander ○ White

Transportation/Emergency Contact:

Pick-Up: Will bring in: _____
House Number: _____
Street/Housing Area: _____

Drop-Off: Will pick up: _____
House Number: _____
Street/Housing Area: _____

Emergency contact: Please **DO NOT** list yourself; this person will be contacted when the parent/guardian cannot be reached:
Name of Person: _____ Relationship to Child: _____
House Number: _____ Street/Housing Area: _____
Phone Numbers: Home: _____ Work: _____ Cell: _____

Release: Please list the people who you authorize to pick up your child from the center/classroom:
_____
_____

Volunteer:

Mother:	Father:	Guardian	Activity:
			Read stories to children in classroom
			Help in kitchen (cooking, washing dishes, etc.)
			Assist teaching staff with prep time
			Assist with Week of the Young Child activities

☐ **NO,** I cannot volunteer at this time.

Parent Consent:

While my child is participating in the CRST Head Start Program, I agree to the following:

☐ Yes ☐ No 1. I give consent for my child to be transported for an emergency or to services to and from the center for educational field trips, neighborhood walks

☐ Yes ☐ No 2. I give consent that, in case of an emergency and if the parent/guardian cannot be contacted, qualified Head Start personnel may provide first aid or obtain emergency medical care, if needed.

☐ Yes ☐ No 3. I give consent that, my child may receive all necessary health (vision, dental, hearing) and developmental (DIAL-4) screenings, assessments

☐ Yes ☐ No 4. Mental Health professional will be making routine mental health observations at Cheyenne River Head Start centers. I hereby give my permission for the mental health professionals to review my child's records, if needed.

☐ Yes ☐ No 5. I give authorization for my child's file to be transferred to the parent/school, if requested by either parent or school.

All children's records are kept in locked filing cabinets with an access form. Statistical data will be used for the annual Program Information Report (PIR).

I certify that the information provided on this application is correct and to the best of my knowledge. If any information changes during the school year, I understand that it will be my responsibility to inform the staff.

Parent/Guardian Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION

Child's Name: _____

Date of Birth: _____

Physical Address: _____

Mailing Address: _____

Parent/Guardian (Mom) _____ (C) _____ (H) _____ (W) _____

Parent/Guardian (Dad): _____ (C) _____ (H) _____ (W) _____

Alternate Emergency Contact Person:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Medical Information (any allergies to medications, food or other substances):

Authorized People to Pick up Student:

Child's Primary Care Provider: _____ Phone #: _____

Does your child have Asthma?: ○Y /○N Does child have a Asthma Action Plan? ○Y /○N

Is your child on an IEP? ○Y /○N

I agree that the teacher/teacher aide may authorize the physician of his/her choice to provide emergency medical care in the event that neither Parent/Guardian, alternate contact(s) can be located immediately.

Parent/Guardian Signature: _____ Date: _____

Cheyenne River Head Start Program
One Call

Parents/Guardians:

The Cheyenne River Head Start Program has implemented the One Call System. By implementing this system, the program will be able to send out notifications to the parents in a timely manner.

The notifications could exist of

- No school
- Early school dismissal
- Parent/Teacher Conferences
- Parent Activity Nights
- Weather related school cancellations
- Cancellation of Bus services due to road conditions
- Other mass notifications that will be sent to the concerned parties

Please Fill Out This Form

Name of Parent/Guardian:_____

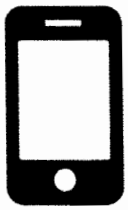
Name of Child:_____

Center:

◯ Cherry Creek ◯ Dupree ◯ Eagle Butte ◯ Swift Bird
◯ Red Scaffold ◯ Timber Lake ◯ White Horse

Classroom:_____

Contact Information:



Home Phone:_____

Cell Phone:_____

Email:_____

CRST Head Start Program

Nutrition Form

Child's Name: _____ DOB: _____

Gender: ☐ Female ☐ Male

Dietary Habits:

1. What foods does your child especially like? _____
2. Are there any foods your child dislikes? _____

		Yes	No
3.	Does your child take vitamins and mineral supplements? If "Yes", they would have to be taken at home.	☐	☐
	(a) Were they prescribed?	☐	☐
4.	Is there any food your child should not eat for medical, religious or personal reasons? _____	* ☐	☐
5.	Is your child on a special diet? If "Yes", the doctor MUST fill out & sign the medical diet prescription form and special diet request forms that are in the enrollment packet.	* ☐	☐
6.	Has there been a big change in your child's appetite in the last month	* ☐	☐
7.	Does your child take a bottle?	* ☐	☐
8.	Does your child eat or chew things that aren't food?	* ☐	☐
9.	Does your child have trouble chewing or swallowing?	* ☐	☐
10.	Does your child often have: (a) Diarrhea?	* ☐	☐
	(b) Constipation?	* ☐	☐
11.	Do you have any concerns about what your child eats? If so, you are welcome to visit your child's classroom.	* ☐	☐

* Starred answers may require follow-up. Please explain details or give additional comments here:

_____

_____

12. About how often does your child eat a food from each of the following groups?

Approximate number of times a week (circle the numbers for each answer.)

Recommendations from the Food Pyramid:

1. **Meat Group** (Includes milk, meat) (2 servings daily) — 0* *1 2 3 4 5 6 7 7+
2. **Vegetable Group** (3 servings daily) — 0* *1 2 3 4 5 6 7 7+
3. **Fruit Group** (Includes juice – 2 servings daily) — 0* *1 2 3 4 5 6 7 7+
4. **Grain Group** (1 serving daily) — 0* *1 2 3

* Starred answers may require follow-up. Please explain details or give additional comments here:

_____

_____

CHILD HEALTH RECORD *HEALTH HISTORY*

Child's Name: _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS:
Did mother have any health problems during this pregnancy or during delivery?	☐	☐	
Was child born 3 weeks early or late?	☐	☐	
What was child's birth weight?	☐	☐	_____lbs. _____oz.
Did child have any problems at birth?	☐	☐	

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN "YES" ANSWERS:
Has child ever been hospitalized or operated on?	☐	☐	
Has child ever had a serious illness?	☐	☐	
Has child ever had a serious accident? (broken bones, head injuries, falls, burns, poisoning?)	☐	☐	

HEALTH PROBLEMS	YES	NO	EXPLAIN "YES" ANSWERS:
Does child have frequent: ☐ sore throat ☐ cough ☐ diarrhea ☐ trouble urinating ☐ stomach pain ☐ vomiting ☐ Other: _____	☐	☐	
Has child ever had a convulsion or seizure?	☐	☐	
Is child taking medicine for seizures?	☐	☐	What medicine?_____
Is child taking any other medicine now? (Special consent form must be signed for Head Start staff to administer any medication.) Will medicine need to be given to child at Head Start?	☐	☐	What medicine?_____ How often?_____
Has child had: ☐ Measles ☐ Chicken Pox ☐ Mumps ☐ Whooping Cough ☐ RSV ☐ Shigella	☐	☐	
Does child have: ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Heart problems ☐ Frequent ear infections ☐ Other _____	☐	☐	
Does child have any allergy problems (rash, itching, swelling, difficulty in breathing)	☐	☐	
a. When eating foods?			What foods?
b. When taking medication?	☐	☐	What medicine?
c. When near animals, fur, insects, etc.?	☐	☐	How does child react?
Does child use an Epi Pen?	☐	☐	
Does child squint or rub his/her eyes?	☐	☐	

Child's Name: _____

DISABILITIES	YES	NO	EXPLAIN "YES" ANSWERS:
Does your child have a diagnosed disability?	☐	☐	
Are services being provided:	☐	☐	By whom?_____
Is child on an IEP or IFSP? (IEP: Individual Education Plan) (ISFP: Individual Family Service Plan	☐	☐	IEP_____ IFSP_____

If you have a concern with your child's development, you can contact the Developmental Clinic at 964-3900

PHYSICAL/PSYCHOLOGICAL/SOCIAL	YES	NO	EXPLAIN "YES" ANSWERS:
Does child take a daily nap?	☐	☐	How long?
Does child need assistance going to the bathroom?	☐	☐	
Does child have any fears?	☐	☐	
Does child have temper tantrums?	☐	☐	What do you do?
Does your child interact with other children?	☐	☐	Please describe:
Do you discipline your child at home?	☐	☐	What do you do?
Have there been any changes in your child's life in the last six months?	☐	☐	
Is family having any problems that may affect the child?	☐	☐	
Is there anything you want us to know about your child?	☐	☐	

How do you comfort your child?

SPEECH/LANGUAGE	YES	NO	EXPLAIN "YES" ANSWERS:
Do you have difficulty understanding your child?	☐	☐	
Does your child have any difficulty saying what he/she wants?	☐	☐	

FAMILY HEALTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS:
Do the parents/guardians have a disability?	☐	☐	

Indian Health Service

OPTOMETRY CLINIC

Eagle Butte, South Dakota 57625

Child Vision History

(Please complete this form for your child; **REQUIRED SCREENING)**

Child's Name: _____ DOB: _____

Address: _____ Home Phone: _____

_____ Cell #: _____

Insurance/Medicaid/Medicare #: _____

Is this child's first eye exam? Yes: ☐ No: ☐

When was child's last eye exam? _____

Has child worn glasses before: Yes: ☐ No: ☐ Contacts? Yes: ☐ No: ☐

Does child wear glasses now? Yes: ☐ No: ☐ Contacts? Yes: ☐ No: ☐

Has the child had any: *If Yes, please explain:*

Head injuries	Yes☐ No☐	_____
Eye injuries	Yes☐ No☐	_____
Eye diseases	Yes☐ No☐	_____
Eye surgeries	Yes☐ No☐	_____

Is child taking any medications? Yes☐ No☐

If Yes, please list medications: _____

Does child have:		***Does anyone in the family have:***	
Diabetes	Yes☐ No☐	Diabetes	Yes☐ No☐
Hypertension	Yes☐ No☐	Hypertension	Yes☐ No☐
Heart trouble	Yes☐ No☐	Heart trouble	Yes☐ No☐
Thyroid trouble	Yes☐ No☐	Thyroid trouble	Yes☐ No☐
Asthma	Yes☐ No☐	Asthma	Yes☐ No☐
Allergies	Yes☐ No☐	Glaucoma	Yes☐ No☐
Sinus problems	Yes☐ No☐	Cataracts	Yes☐ No☐
Arthritis	Yes☐ No☐	Amblyopia (Lazy Eye)	Yes☐ No☐
Other: _____		Eye turns	Yes☐ No☐

Has child complained about any of the following problems?

Blur at a distance	Yes☐ No☐	Blur at near objects	Yes☐ No☐
Double vision	Yes☐ No☐	Eye pain	Yes☐ No☐
Headaches	Yes☐ No☐	Eye strain	Yes☐ No☐
Difficulty reading	Yes☐ No☐	Flashes of light	Yes☐ No☐
Itching eyes	Yes☐ No☐	Tearing	Yes☐ No☐

Does your child sit very close to the television and/or computer? Yes☐No☐

Does your child receive optometry services elsewhere? Yes☐No☐

If Yes, please provide name of doctor: _____ and location of services: _____.

I hereby give my consent/permission to Head Start to transport my child to the IHS Optometry Clinic for a complete eye exam.

_____ _____

(Signature of Parent/Guardian) (Date)

CHILD DENTAL FORM

(A Dental Exam is REQUIRED before child attends school)

Is child on Medicaid/CHIP? Yes ☐ No ☐ Please list number: _____

Child's Name: _____ Health Record No. _____

Date of Birth: _____ Community where you live: _____

Phone No. (Home) _____ Work: _____ Cell: _____

Mailing Address: _____

_____

PLEASE CHECK:	YES	NO
1. Does child have a toothache now?	☐	☐
2. Has child received medical care in the last 2 years?	☐	☐
3. Have child ever been hospitalized?	☐	☐
4. Has child taken medication in the the last 2 months?	☐	☐
5. Is child allergic to or made sick by any medication such as penicillin, aspirin or codeine?	☐	☐
6. Has child ever had a bleeding problem that needed medical treatment?	☐	☐
7. Does child have chest pains?	☐	☐
8. Do you have reason to believe that the child has been exposed to AIDS or HIV?	☐	☐
9. Does child or anyone in the family have diabetes?	☐	☐

Has child ever had any of the following?	Yes	No
10. Hepatitis	☐	☐
11. Heart murmur	☐	☐
12. Heart attack	☐	☐
13. High blood pressure	☐	☐
14. Rheumatic fever	☐	☐
15. Heart valve or pacemaker	☐	☐
16. Artificial joint	☐	☐
17. Anemia	☐	☐
18. Ulcers	☐	☐
19. TB or lung disease	☐	☐
20. Asthma	☐	☐
21. Sinus trouble	☐	☐
22. Cancer or tumors	☐	☐
23. Epilepsy or seizures	☐	☐
24. Arthritis/rheumatism	☐	☐
25. Blood transfusions	☐	☐
26. Kidney problems	☐	☐
27. Liver problems	☐	☐
28. Nervous or mental disorders	☐	☐

Does child have any disease, condition or problem not listed? Yes ☐ No ☐
(If Yes, please list): _____

Do you have any concerns about child receiving dental services? Yes ☐ No ☐
(If Yes, please list): _____

IMPORTANT

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns and local anesthesia by signing below. I give authorization for the Head Start staff to take my child to the tribal dental office for such procedures if I am unable to do so.

_____ _____
Signature of Patient or Parental Consent) Date

_____ _____
Signature of Dentist Date

Child Adult & Nutrition Services (CANS) – CRST Head Start

Child Food or Milk Allergy Form

Special Diet Prescription for Meals _____Not Applicable

PART I – TO BE FILLED OUT BY PARENT/GUARDIAN OR LOCAL AGENCY

Child's Name: _____ Birth Date: _____

Attendance Center (school, child care, etc.): _____

Parent/Guardian Name: _____

Parent/Guardian contact number(s): _____

PART I – TO BE FILLED OUT BY PHYSICIAN:

Diagnosis: _____

_____

_____

Describe the patient's disability and the major life activity affected by the disability:

_____

_____

Does the disability restrict the individual's diet? Yes☐ No☐ If Yes, list food(s) to be omitted from the diet and food(s) that may be substituted (Diet Plan):

Foods to Omit:	**Foods to Substitute:**
_____	_____
_____	_____

I certify that the above named child needs special meals prepared as described because of the child's disability or chronic medical condition.

Physician signature: _____ Date: _____

Clinic/Hospital: _____

Office Phone Number: _____

☐ Original: Child's File
☐ Copy: Kitchen
☐ Copy: Dietitian/Food Service Director

LIONS KIDSIGHT SOUTH DAKOTA

Vision Screening Consent Form

Your local Lions Club and KIDSIGHT South Dakota is offering a free vision screening to your child. The screening is approximately 85-90% effective in detecting potential vision problems. No physical contact is made with your child and no eye drops are required. For more information go to www.kidsightsd.org.

Child's Name:	Date of Birth:	◯ Male ◯ Female
Ethnicity: ◯ Hispanic ◯ White ◯ Black ◯ Native American ◯ Asian ◯ Other		

Parent/ Guardian Name:	Phone:
Address:	Email:

For Multiple Children Being Screened:

Child's Name:	Date of Birth:	◯ Male ◯ Female
Ethnicity: ◯ Hispanic ◯ White ◯ Black ◯ Native American ◯ Asian ◯ Other		

Child's Name:	Date of Birth:	◯ Male ◯ Female
Ethnicity: ◯ Hispanic ◯ White ◯ Black ◯ Native American ◯ Asian ◯ Other		

1. The information obtained from this vision screening is preliminary only, and does not constitute a complete exam or diagnosis of vision problems.
2. The Data obtained from this vision screening may be shared with entities participating in the vision screening i.e. school nurse, Head Start, daycare provider, SD Lions Foundation, etc. Results will be kept private and on file by the SD Lions Foundation including your child's name and date of birth.
3. I will receive the results of the screening through the Lions "KIDSIGHT" Preschool Vision Screening Program only if my child is being recommended for a full eye exam.
4. I understand I am responsible for arranging a complete eye exam if my child has been referred as a result of the screening.
5. I may receive communication by telephone or email if my child does not pass the vision screening for the purpose of evaluating the success of the program.
6. I will not hold the SD Lions Foundation accountable for any errors of commission, omission or another misdiagnosis.

_____ _____

Parent or Guardian Signature Date

Cheyenne River Head Start Program
Family Assessment 2022-2023

PLEASE LIST ALL HOUSEHOLD MEMBERS: (Please pring all information in black or blue pen only)

Relation	Name	DOB	Gender	Ethnicity	Race	Please answer Y or N					Highest	Parenting
See Legend				See Legend	See Legend	Health	Veteran	Disabled	Currently	Currently	Grade	Classes
Below				Below	Below	Insurance			in School	employed	Completed	Yes or No
						This section is for the adults in the home: (18 & up)						

LEGEND:

Relation to Applicant:

SP	Spouse
CH	Child
PA	Parent
GP	Grandparent
GC	Grandchild
NR	Not Related
SI	Sibling
BF	Boyfriend
GF	Girlfriend
UN	Unknown

Ethnicity:

H	Hispanic of Latino
N	Non-Hispanic or Latino

Race:

AI	American Indian or Alaska Native
BL	Black
AS	Asian
HA	Hawaiian or Pacific Islander
WH	White
B/M	Bi-Racial or Multi-Racial

Cheyenne River Head Start Program
Family Assessment 2022-2023
Contact Information:

Home Address: _____
City/Town: _____ State: SD Zip: _____

Mailing Address: _____
City/Town: _____ State: SD Zip: _____

Phone Number:
Home Phone: _____
Cell Phone: _____
Work Phone: _____

HOUSEHOLD CHARACTERISTICS: (check one in each category):

Marital Status

- ☐ Married and Living with Spouse
- ☐ Married and Not Living with Spouse
- ☐ Single
- ☐ Divorced
- ☐ Living Together
- ☐ Widowed
- ☐ Other: _____

Family Type:

- ☐ Two Parent Household
- ☐ Single Parent (Female)
- ☐ Single Parent (Male)
- ☐ Grandparents
- ☐ One Grandparent (Female)
- ☐ One Grandparent (Male)
- ☐ Foster Parents
- ☐ Guardians

Housing Status:

- ☐ Homeless
- ☐ Unstable; at risk of losing home
- ☐ Live with Relatives/Other
- ☐ Own Home
- ☐ Rent Home/Mobile Home
- ☐ Rent Apartment

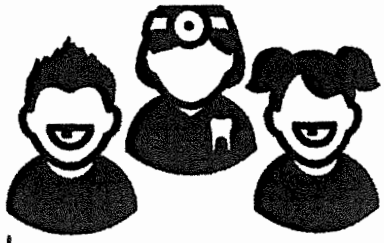
Housing Type:

- ☐ House
- ☐ Mobile Home
- ☐ Shelter
- ☐ Multi-Family Home
- ☐ Other: _____

1. Is your family experiencing any crisis/need now? Yes: ☐ No: ☐
   If Yes, what kind: _____
2. Does your Head Start child need a winter coat/jacket? Yes ☐ No ☐
   If Yes, what size: _____
3. Would you like information on Lakota culture/history? Yes: ☐ No ☐
4. What type of training or information would you like:

If Yes, what type of topics would you like	Training	Information
Child Abuse and Neglect	_____	_____
Budgeting and Finance	_____	_____
Parenting	_____	_____
Health Topics: _____	_____	_____
Nutrition Topics: _____	_____	_____
Suicide Awareness:	_____	_____
Substance Abuse: _____	_____	_____
Other: _____	_____	_____

DELTA DENTAL



Parent Information

The Delta Dental Mobile Program is coming to your child's school!

Our Mobile Program team will visit your child's school this year to provide preventive dental care.

A dental hygienist will provide:

- **teeth cleaning;**
- **sealant and fluoride treatments to prevent cavities;**
- **instruction to care for teeth at home; and**
- **a free toothbrush.**

This care is provided at NO COST to the child or family. Sign up today!

To have your child receive this dental care, you must COMPLETE & SIGN the attached Patient Information and Permission Form.

Your child will not receive care unless the ENTIRE form is completed and includes your signature.

Healthy teeth are important!

A toothache can make it hard for a child to eat, sleep, and pay attention. That's why a child with good oral health will do better in school.

Cavities are almost 100% preventable. Let us help keep your child's smile healthy and happy.

Note: if your child already has a dental home and regular office visits (at least one a year), a visit with our team may not be necessary.

Delta Dental of South Dakota deltadentalsd.com Toll Free: (877) 841-1478 Fax: (605) 494-2578

DELTA DENTAL

MOBILE PROGRAM

Patient Information and Permission Form

General information

Patient information

Legal name

Age _____ Birth date (mm/dd/yyyy) ____/____/____

Sex ◯ Male ◯ Female

School attending _____ Grade _____

Race
- ◯ White
- ◯ Asian
- ◯ Other
- ◯ Black or African American
- ◯ American Indian or Alaska Native
- ◯ Hawaiian or Other Pacific Islander
- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino

Parent/guardian information

Name

Relation to patient

Home (mailing) address

City _____ Zip _____

Home phone (____)____-____

Work phone (____)____-____

Cell phone (____)____-____

☐ Check here if you do not want to receive text messages.

Emergency contact information

Name

Relation to patient

Phone (____)____-____

Dental history

Dental visits should start at first tooth

◯ Yes ◯ No Is this the patient's first dental visit?
If no, how long has it been?
◯ Less than 2 years ◯ More than 2 years

Past or current dentist's name

◯ Yes ◯ No Is the patient experiencing toothache/ mouth pain/face swelling?

◯ Yes ◯ No Has the patient visited the ER/hospital for dental pain in the last year?

◯ Yes ◯ No Has dental pain caused you or your child to miss school and/or work in the last year?
◯ School ◯ Work ◯ Both

Medical history

Patient's current physician

Date of last medical exam (mm/yy) ____/____

◯ Yes ◯ No Is the patient taking any medications?
If yes, please list _____

◯ Yes ◯ No Does the patient have any allergies?
If yes, please list _____

◯ Yes ◯ No Does the patient have any special needs that would require special arrangements for dental care? e.g. autism
If yes, please explain _____

◯ Yes ◯ No Is the patient pregnant?

Does the patient have, or have they had, a history of the following:

- ◯ ADHD
- ◯ AIDS / HIV
- ◯ Anemia
- ◯ Anxiety
- ◯ Asthma
- ◯ Birth defects
- ◯ Cancer
- ◯ Cerebral Palsy
- ◯ Diabetes
- ◯ Epilepsy/seizures
- ◯ Excessing bleeding
- ◯ Fainting
- ◯ Heart problems
- ◯ Hepatitis
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Mono
- ◯ Rheumatic fever
- ◯ Tuberculosis
- ◯ Other _____

Please explain your answers:

Continue on back ➡

DELTA DENTAL

MOBILE PROGRAM

Patient Information and Permission Form

Patient behavior

Yes No Does the patient brush daily?

Yes No Does the patient drink soda pop or other sugar-sweetened drinks (Kool-Aid, fruit drink, sports drink) daily?

Yes No Is the patient using tobacco or vaping products?

Yes No Does anyone in the household use tobacco or vaping products?

Household information

Annual household income

Less than $10,000 $10,000-20,000

$20,000-30,000 More than $30,000

How many children age 21 or younger live in your household?

_____

Insurance

Please check any that apply.

No dental insurance

Medicaid

Medicaid number _____

Private DENTAL insurance (please provide copy of card)

_____

Dental insurance name

_____

Policy number

_____

Group number

_____

Dental insurance address

Insurance phone (_____) _____ - _____

_____

Employer name

IMPORTANT - Permission to provide treatment

We cannot treat your patient if form is not signed.

I, _____, as a legally responsible guardian of _____

Print parent/legal guardian name — Print child's name

give my permission for the dental services I have authorized below. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular exams by a dentist. I have been offered and/or have read Delta Dental's HIPAA Notice of Privacy Practices available at southdakota.deltadental.com/privacy-and-policies/notice-of-privacy-practices/.

Each item needs to be answered in order to receive dental care.

☐ Yes ☐ No Preventive services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.

☐ Yes ☐ No Dentist exam (including dental x-rays)

☐ Yes ☐ No Restorative services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.

☐ Yes ☐ No Silver diamine fluoride (decayed area of the tooth will be stained black permanently – please see attached for more information about this treatment)

☐ Yes ☐ No Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.

☐ Yes ☐ No The use of nitrous oxide (laughing gas) may be used as deemed necessary.

X _____ X ____/____/____

Parent/legal guardian signature — Date

CRST HEAD START RELEASE OF INFORMATION FORM

Purpose: To provide direct services to families in meeting basic family needs/concerns.

☐ ***YES*** **I give the CRST Head Start Program permission to release/obtain information with the understanding that the information will be used to assist my family in receiving services. I also understand that I will be an active partner in the process.**

☐ ***NO*** **I do not give permission for the CRST Head Start Program to assist my family in obtaining any services. My family's needs are being met at this time or I am able to obtain services on my own.**

Disabilities & Education:

Preschools (Dupree, Timber Lake, Other: _____)
Child Developmental Clinic (Services to infants and young children with special needs, referrals & screenings)
Title I (Jump Start Program)

Family Services:

BIA Social Services (includes GA)
Child Support Enforcement (SD Office of Child Support Enforcement, CRST Child Support Enforcement)
Domestic Violence (Sacred Heart Center & Family Violence Prevention)
Employment (CRST Personnel, Employment & Training, BIA Personnel, TERO, etc.)
Energy Assistance (LIHEAP, Weatherization/HIP, Moreau-Grand, etc.)
Four Bands Healing Center (Substance Abuse, Al-Anon, Ala-Teen, Co-Dependency, etc.)
Housing (CRST Housing Authority,, Oti Kaga, Inc., Wheatridge/Prairie/Evergreen)
Legal Services (Dakota Plains, Public Defenders, Children's Court, Civil/Criminal)
Nutrition Services (Food Pantry, WIC, Food Distribution, etc.)
Sacred Heart Center (Domestic/Family Violence, clothing assistance, counseling, etc.)
Support Services (Emergency Assistance)
The Main (Heating Assistance, Direct Services-clothing, diapers, etc., After School Activities)

Health & Mental Health:

Counseling Services (Professional Consultation Services, CRST Counseling, etc.)
Dental Program (dental work, etc.)
Diabetes (, Youth Diabetes Prevention, Diabetes Program)
Eagle Butte Family Horizon Health Center (Physicals/Immunizations)
Faith Clinic (physicals, immunizations)
Indian Health Service (Pediatrics, Field Health, Medical Records – Physicals and Immunizations)
Isabel Clinic (Physicals/Immunizations)
Optometry (Appointments for vision, glasses, contacts, exam results.)
West Dakota Health Center (Physicals/Immunizations)
State Department of Health (Immunizations)

Transition:

☐ **I DO** ☐ **I DO NOT** give permission for the CRST Head Start program to transfer my child's records to: (name of school): _____ where my child will be attending Kindergarten for the SY 2024-2025

Publicity:

☐ **I DO** ☐ **I DO NOT** give my consent for the Head Start Program to use my child's photograph in the Head Start newsletter and the local media (*West River Eagle, and Timber Lake Topic);* and not on the internet.

If you have more than one child in Head Start, please list both children:

Child: _____ **DOB:** _____
Child: _____ **DOB:** _____

I understand that this form will be valid for one year from the date of my signature.

X _____ **X** _____
Signature of Parent/Guardian Date 010223

Cheyenne River Head Start Program

JOHNSON O'MALLEY FORM

(Verification of Indian Blood)

This information is requested to help the CRST Head Start Program obtain funds from Johnson O'Malley. The degree of Indian blood can be obtained from the Tribal Enrollment Office or the BIA Realty Office of the tribe where the child and/or parents are enrolled. **The form and DIB must be turned in with the application.**

NOT APPLICABLE: _____

CHILD'S NAME: _____ DOB: _____
Is the child enrolled with a federally recognized tribe? Yes: ☐ No: ☐ Pending: ☐
If Yes, what tribe: _____
Degree of Indian blood: _____ Enrollment Number: _____

FATHER'S NAME: _____ DOB: _____
Is father enrolled with a federally recognized tribe? Yes: ☐ No: ☐ Pending: ☐
If Yes, what tribe: _____
Degree of Indian blood: _____ Enrollment Number: _____

MOTHER'S NAME: _____ DOB: _____
Maiden Name: _____
Is mother enrolled with a federally recognized tribe? Yes: ☐ No: ☐ Pending: ☐
If Yes, what tribe: _____
Degree of Indian blood: _____ Enrollment Number: _____

Release of Information

I/We hereby give the CRST Head Start Program authorization to release the above information to the school system where my child will be attending Kindergarten. I/We give permission for the use of the information in the annual JOM Count and also give the CRST Head Start Program staff authorization to obtain the Degree of Indian Blood (DIB) if one is not attached to my child's file. ***The authorization to obtain a Degree of Indian blood is for the Cheyenne River Sioux Tribe ONLY; if my child or one or both parents are enrolled with another tribe, I/We understand that it will be my responsibility to obtain the degree of Indian blood and submit with the application.***

X_____ **X**_____
Signature of Parent/Guardian Date

031212

CHEYENNE RIVER HEAD START PROGRAM
PHYSICAL EXAMINATION FORM
(Parents fill out top part of form)

Child's Name:_____ Sex:_____ Date of Birth:_____
Home Address:_____Home Ph#:_____ Cell: _____

The following screening tests are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N" for normal, "S" for suspect or "A" for Atypical/Abnormal, respectively.

REQUIRED	DATE	RESULTS	OPTIONAL	DATE	RESULTS
Present Age		____Yrs____Mos.	TB Test		
Height			Urinalysis		
Weight		***BMI is:**	Ova & Parasites		
Blood Pressure			Sickle Cell		
***Hematocrit/Hemoglobin**					
***Lead**					
Hearing		Type of Test:_____ Right:_____ Left:_____ Comments:			
Vision		Type of Test:_____ Right:_____ Left:_____ Comments:			

Physical Examination/Assessment	**Normal**	**Abnormal**	**Comments:**
General Appearance			
Posture/Gait			
Speech			
Head			
Skin			
Eyes			
1. External Aspect			
2. Optic Fundoscopic			
3. Cover Test			
Ears			
1. External & Canals			
2. Tympanic Membranes			
Nose, Mouth, Pharynx			
Teeth			
Heart			
Lungs			
Abdomen			
Genitalia			
Bones, Joints, Muscles			
Neurological/Social			
1. Gross Motor			**What immunizations were given, if any?**
2. Fine Motor			
3. Communication Skills			
4. Cognitive			
5. Self Help Skills			**Does child have Mongolian Spots? Yes☐ No☐**
6. Social Skills			**If Yes, describe where on body:**
Glands (lymphatic/thyroid)			_____
Muscular Coordination			

Child up to date on immunizations/EPSDT? Yes☐ No☐

General Statement on Child's Physical Status:

Findings, Treatments, and Recommendations:

Physician/Health Professional Signature:_____ Date:_____
Physician/Health Professional Printed Name:_____ Facility: _____