INCA HEAD START APPLICATION

Inca is an equal opportunity emplyer and server provider.

Dear Parent/Guardian,

We are happy that you want to complete an application for the INCA Head Start Program

We must have a copy of the following documents in order to process your application:

- ☐ Proof of income (Tax 1040 forms, W-2 forms, pay stubs, written statement from employers or documentation showing current status as recipient of public Assistance)
- ☐ Birth Certificate
- ☐ Current Immunization Record
- ☐ Insurance Coverage (Can be Private Insurance Card, Sooner Care Cared, or CDIB

Family previously enrolled in the Head Start Program? Yes_____ No_____

For more information please contact:

INCA Community Services Head Start

Applicant & Family Member Information

Applicant (child applying for services)_____ School District _____

Name: First	Middle	Last	Nickname

Address:	Birthdate:

Race	Hispanic	English Proficiency	Other Language Proficiency
___Asian ___Multi-Racial ___Black ___ White ___Hawaiian/Pacific Islander ___American Indian/Alaska Native ___ Other_____	__Yes __No	__Poor __Little __Moderate __Proficient	__Poor __Little __Moderate __Proficient

Primary Heath Coverage	Insurance Number	Other Health Coverage	Insurance Number

Medicaid (Sooner Care)	Medicaid Number	Eligibility	___CDIB
_____ Yes _____ No	_____	___On Medicaid ___Not Eligible ___Potentially Eligible	Card number _____

Doctor	Address	City	State	Zip	Phone Number

Dentist	Address	City	State	Zip	Phone Number

Adult 1 (Primary)

Name: First	Middle	Last	Nickname

Birthday:	____ Male ____ Female	Social Security Number:

Race	Hispanic	English Proficiency	Other Language Proficiency
___Asian ___Multi-Racial ___Black ___ White ___Hawaiian/Pacific Islander ___American Indian/Alaska Native ___ Other_____	__Yes __No	__Poor __Little __Moderate __Proficient	__Poor __Little __Moderate __Proficient

Education Level	Employment	Child's Relationship	Custody	Check all that apply (adult 1)
__GED	__Full Time	__Natural / Adopted / Step	__Yes	__Lives with Family
__College	__Part Time	__Grandchild	__No	__Provides Financial Support
__Degree Associate	__Seasonal	__Niece /Nephew		__Teen Parent (Currently)
__High School	__Unemployed	__Other		__If teen parent, subsidized?
__8th__9th__10th__11th	__Retired			__Yes __No

Adult 2

Name: First	Middle	Last	Nickname

Birthday:	____ Male ____ Female	Social Security Number:

Race	Hispanic	English Proficiency	Other Language Proficiency
___Asian ___Multi-Racial ___Black ___ White ___Hawaiian/Pacific Islander ___American Indian/Alaska Native ___ Other_____	__Yes __No	__Poor __Little __Moderate __Proficient	__Poor __Little __Moderate __Proficient

Education Level	Employment	Child's Relationship	Custody	Check all that apply (adult 1)
__GED	__Full Time	__Natural / Adopted / Step	__Yes	__Lives with Family
__College	__Part Time	__Grandchild	__No	__Provides Financial Support
__Degree Associate	__Seasonal	__Niece /Nephew		__Teen Parent (Currently)
__High School	__Unemployed	__Other		__If teen parent, subsidized?
__8th__9th__10th__11th	__Retired			__Yes __No

ALL Family Members in Household

	Last Name	First Name	Birthday	Gender	
Child	_____	_____	____/____/____	___M	___F
Child	_____	_____	____/____/____	___M	___F
Child	_____	_____	____/____/____	___M	___F
Child	_____	_____	____/____/____	___M	___F
Child	_____	_____	____/____/____	___M	___F
Adult	_____	_____	____/____/____	___M	___F
Adult	_____	_____	____/____/____	___M	___F
Adult	_____	_____	____/____/____	___M	___F
Adult	_____	_____	____/____/____	___M	___F

Total Number of Adults____ and Children____ in household, regardless of whether they are considered part of the family income eligibilty purposes.

How will your child get to school?_____

Parental Status	Military Family	Referred by DHS	Receiving SNAP (Food Stamps)	WIC?
___ One Parent	___ Yes	___ Yes	___ Yes	___ Yes
___ Two Parent	___ No	___ No	___ No	___ No

Transportation Agreement

Child's Name _____

All applicants must understand and agree to the transportation agreement on this page. Transportation services may be arranged for children who cannot attend school without this assistance.

Please discuss your transportation needs with the Family Advocate

I agree:

- To escort my child to the bus at the appropriate time. I understand that the bus is on a schedule and will wait one (1) minute for my child before continuing on the route.
- To meet my child at the bus at the appropriate drop-off time, or the person I have designated in writing will come to the bus.
- Not to allow my child to board the bus with any food, toys, sharp or breakable objects, or weapons (including toy type) of any kind.
- To inform the driver, monitor, teacher, family advocate, or transportation manager in advance when I know my child will not require transportation.
- To immediately inform the driver, monitor, teacher, family advocate, or transportation manager of any name, phone number, address or legal custodial changes.

INCA Head Start Agrees:

- To arrive at the scheduled pick-up and drop-off in a timely manner.
- To inform you of any changes in the bus route that will affect scheduled pick-up or drop-off times.
- To transport your child in a safe, pleasant manner.
- To treat all children and families with respect

I UNDERSTAND THAT INCA HEADSTART RESERVES THE RIGHT TO TERMINATE TRANSPORTATION SERVICES:

- If my child misses three (3) consecutive days of riding the bus and no contact has been made with driver, monitor, teacher, family advocate, or transportation manager.
- If my child repeatedly unbuckles child safety sytems, or my child's behavior is continuously disruptive, uncontrollable, or inappropriate.
- If I or any family member makes threats of violence against the driver or monitor.

I FURTHER UNDERSTAND THAT:

If an authorized adult is not present at the time my child is delivered home, the driver/monitor will try to contact the parent/guardian by phone. If an authorized adult is not present, the driver/monitor will continue the route then return my child to his/her teacher at the end of the route. INCA, driver/monitor, nor the teacher will release you child to anyone that is not authorized by you, in writing. Please list ALL adults that you authorize INCA to release your child to. Be sure to notify your child's teacher and bus staff of any changes or additions. Changes must be in writing, not by phones

I will attend Parent Orientation regarding my child's bus service, and Pedestrian/Bus Safety Training as required by Head Start transportation Regulations 45 CFR 1310.21. Agenda and sign-in sheet will be on file in the transportation manager's office. I understand that my signature permits INCA Head Start to provide daily transportation for my child to and from their assigned center, and/or on any field trip (with my permission).

Parent/Guardian Signature _____ Date_____

Family Information and Contacts

Living Address:

_____ _____ _____ _____ _____
Address Zip City State County

Mailing Address (if different):

_____ _____ _____ _____ _____
Address Zip City State County

Phone Numbers:

( )_____ ___Cell ___Home ___Work ___Other _____
( )_____ ___Cell ___Home ___Work ___Other _____
( )_____ ___Cell ___Home ___Work ___Other _____

Emergency Contacts/Consenting Adults

INCA is authorized to release my child to:

Contact 1

_____ _____ ___Yes ___No ___Yes ___No
Name Relationship Emergency Contact? Release to pick up?

_____ _____ _____ _____ _____
Address Zip City State County

( )_____ ( )_____ ( )_____
Phone #1 (Cell) Phone #2 (Home) Phone #3 (Work)

Contact 2

_____ _____ ___Yes ___No ___Yes ___No
Name Relationship Emergency Contact? Release to pick up?

_____ _____ _____ _____ _____
Address Zip City State County

( )_____ ( )_____ ( )_____
Phone #1 (Cell) Phone #2 (Home) Phone #3 (Work)

Contact 3

_____ _____ ___Yes ___No ___Yes ___No
Name Relationship Emergency Contact? Release to pick up?

_____ _____ _____ _____ _____
Address Zip City State County

( )_____ ( )_____ ( )_____
Phone #1 (Cell) Phone #2 (Home) Phone #3 (Work)

Restricted Persons:

Is there anyone restricted from picking up or seeing your child? ___Yes ___No

Name:_____ Relationship:_____

I give my consent for my child to be transported on the bus for field tipes and in case of an emergency.

Parent/Guardian Signature _____ **Date**_____

INCA Head Start

Eligibility Verification

1. Wages: _____Amount	2. Wages: _____Amount
☐ Monthly	☐ Monthly
☐ Twice per Month	☐ Twice per Month
☐ Weekly	☐ Weekly
☐ Bi-Weekly	☐ Bi-Weekly

Child Support/Alimony:_____Amount	Foster Care/Adoption Subsidy:_____Amount
☐ Monthly	☐ Monthly
☐ Twice per Month	☐ Twice per Month
☐ Weekly	☐ Weekly
☐ Bi-Weekly	☐ Bi-Weekly

Social Security/Pension:_____ *(Monthly Amount)*

Public Assistance/TANF:_____ *(Monthly Amount)*

SSI:_____ *(Monthly Amount)*

Other:_____ *(Specific Type)*

Annual Income Conversion: Weekly x52 Bi-Weekly x26 Twice Monthly x24 Monthly x12

» Caculate income using above conversions only or homeless verification.

Total Annual Income: _____

Poverty Level_____% (Caculated by child plus)	Number in Household _____

Interview Verification:

I confirm that this information gathering process was conducted in strict confidence during a:

☐ Personal Interview ☐ Private Phone Conversation

Justification for phone discussion:_____

Name of person interviewed by phone:_____

☐ Permission is granted for third party contact of:_____
(name, title, and/or affiliation)

Parent/Guardian Signature _____ Date_____

INCA Staff Intial:_____ Date_____

Head Start Eligibility Verification

1. Child's Name:_____

2. Child's Date of Birth:_____

3. This child is eligible to participate in the program: ☐ Yes ☐ No

4. Type of eligibilty interview conducted: ☐ In-Person ☐ Telephone
(If a telephone interview was conducted, please attach an explanation why the interview was not in-person)

5. Check the applicable category of eligibility for this child:

☐ SSI ☐ Public Assistance
☐ Homeless ☐ Income Eligible
☐ Foster Care ☐Between 100-130% of federal poverty guidelines
(no more than 35% of enrolled children may fall into this category)

6. Check the applicable determination for **over-income** children:

☐ *Counted as part of 10% maximum for non-AL/AN programs*
☐ *Counted as part of 49% maximum for non-AL/AN programs*

&. What documentation was used to determine eligibility?

☐ Income Tax From 1040 ☐ Written Statements from Employers
☐ W-2 ☐ Foster Care Reimbursement
☐ TANF Documentation ☐ SSI Documentation
☐ Pay Stub or Pay Envelopes ☐ Other
☐ Unemployment If other, please explain:_____

Documentation of no income:_____

8. Staff Signature:_____ Date of eligibility verification:_____

9. Staff Name:_____ Title:_____

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)
ENROLLMENT FORM

CHILD'S INFORMATION

1. Child's Name:_____ Date of Birth:_____

2. Normal Days in Attendance:

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

3. Head Start Facilities Only (Indicate Session):

☐ A.M. ☐ P.M. ☐ All Day

4. Special Dietary Needs? ☐ Yes ☐ No

5. Nomal Hours of Attendace: _____ to _____
A.M./P.M A.M./P.M

6. Normal Meals Eaten:

☐ Breakfast ☐ Lunch ☐ Supper

☐ A.M. Snack ☐ P.M. Snack ☐ Late P.M. Snack

7.Parent/Guardian Signature:_____ Date:_____

*Attach Signed Medical Statement

PARENT'S INFORMATION

Name of Parent/Guardian:_____

Address: _____ City: _____ Zip: _____

Home Telephone Number: _____

RENEWAL UPDATES

If there are no changes to the above information sign and date.
If there are changes, a new enrollment form must be completed, signed, and dated.

Parent/Guardian Signature: **Date:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

INCA HEAD START
Nutrition Assesment

CACFP (Child and Adult Care Food Program Requirements)

Child's Name:_____ Date of Birth:_____

Normal Days in Attendance:

Mon	Tues	Wed	Thurs	Fri

A.M.	P.M.	ALL DAY

Normal Meals Eaten: (check all that apply) *this is based for a typical day, to help staff understand child's eating patterns

Breakfast	Lunch	Supper	A.M. Snack	P.M. Snack	Late P.M. Snack

Please answer the following questions regarding your child:	YES	NO	NOTES
1. Does your child have any food allergies or intolerance?(we need documentation)			What foods?
2. Is your child on a speical diet? Medical/Ethnic			What diet?
3. Is your child participating in any nutrition programs			Check all that apply: ☐WIC ☐Food Stamps ☐Other
4. Does your child feed themselves?			
5. Does your child have trouble swallowing?			
6. Has your child had a dramatic weight change in the the past year?			
7. Do you think your child is too: ☐ Thin ☐Heavy ☐Small			
8. Does your child eat or chew anything that is not food?			Specify:
9. Does your child have persitent/current: ☐Naseau☐Vomiting☐Diarreah☐Constipation			
10. Does your child use a feeding tube or other special feeding methods?			Please explain:
11. Do you have any other nutritional concerns?			Specify:

12 What does your child eat for:

Breakfast: _____

Lunch: _____

Snack: _____

Dinner: _____

13. List foods your child-

Likes:

Dislikes:

On a WEEKLY basis, how often does your child eat an item from the following groups:

(A) Milk, Cheese, Yogurt	0* 1* 2* 3 4 5 6 7 7+
(B) Meat, Poultry, Fish, Eggs, Dried Beans, Peanut Butter	0* 1* 2* 3 4 5 6 7 7+
(C) Rice, Grits, Bread, Cereal, Tortillas	0* 1* 2* 3 4 5 6 7 7+
(D) Greens, Carrots, Broccoli, Winter Squash, Pumpkin, Sweet Potatoes	0* 1* 2* 3 4 5 6 7 7+
(E) Oranges, Grapefruit, Tomatoes (Fruit or Juice)	0* 1* 2* 3 4 5 6 7 7+
(F) Others Fruits and Vegetables	0* 1* 2* 3 4 5 6 7 7+
(G) Oil, Butter, Lard, Margarine	0* 1* 2* 3 4 5 6 7 7+
(H) Cakes, Cookies, Soda/Pop, Fruit Drinks (Kool-Aid), Candy	0* 1* 2* 3 4 5 6 7 7+

*Information gathered from this assesment, your child's heath record, growth screenings, and daily observations may indicate a need for follow-up or referrals. INCA has a contract with a registered/licensed dietitian, and staff will keep you informed of any concerns they may have about your child's eating habits, growth, or nutritional needs.

INCA HEAD START CHILD HEALTH INFORMATION

Child's Name_____ Center_____

Birthday_____

Please provide the date of your child's most recent:

Physical _____

Dental Exam _____

Lead Screening _____

Are Immunizations up to date at Enrollment? ___ Yes ___ No

MEDICATION INFORMATION

Is your child currently taking daily medication? ___ Yes ___ No

What is the name of the medication? _____

What is the dosage? _____

HEALTH INFORMATION

Has your child ever had or received treatment for any of the following conditions:

___ Allergies	___Chicken Pox	___ High Blood Pressure	___ Surgery
___ Anemia	___ Diabetes	___ Immune System Disease	___ Tonsils Removed
___ Asthma	___ Eczema	___ Overweight	___ Tubes in Ears
___ Autism	___ Fever	___ Pneumonia	___ Vision Problems
___ ADD/ADHD	___ Frequent Infections	___ Seizures	___ Underweight
___ Boils	___ Frequent Sore Throat	___ Scarlet Fever	___ Other
___ Broken Bones	___ Heart Conditions	___ Sickle Cell Disease	

If you have answered yes to any of the above questions please provide details below.

_____

_____

_____

DENTAL INFORMATION

Has this child been diagnosed as needing dental treatment (resoration, pulp therapy, extraction, etc)

___ Yes ___No ___ No Exam Completed

Has this child received or are they currently receiving dental treatment? ___ Yes ___ No

DISABILITY/MENTAL HEALTH INFORMATION

Has your child ever received special education or related services (Speech, Conseling, PT, OT, etc)

___ Yes ___ No

Has your child been diagnosed with the following primary disability:

___ Autism	___ Heath Impairment
___ Developmental Delay/Non-Categorical	___ Multiple Disability
___ Emotional/Behavior Disorder	___ Orthopedic Impairment
___ Hearing Impairment Including Deafness	___ Speech/Language Impairments
___ Visual Impairment Including Blindness	

Authorizations and Notifcations

I give my consent for my child to receive the screenings and examinations listed below (Please Initial):

_____ Devlopment Screening / Development Assessment / Hearing Test / Visual Test / Strabismus Test

_____ Speech - Language Evaluation / Complete Physical Exam / Dental Exam / Height, Weight, and Blood Pressure Exam

_____ Measurements / Behavorial Screenings / Mental Heath Observations / Screenings

I understand that these services are deemed necessary by Head Start, and I will be informed of all results.
I understand that my child must be fully immunized, and I am responsible for having my child immunized.
I authorize INCA Head Start to consent to emergency medical/dental treatment for my child
INCA Head Start has my permssion to use my child's photograph in newspaper, newsletters, posters, agency website, or other Head Start material.

___ Yes ___No

Parent/Guardian's Signature_____ Date_____

INCA Head Start Child Abuse and Prevention Policy:

Child abuse is everyone's problem. Individuals who work daily with young children have a unique opportunity to make a positive difference in the life of a child. Along with the opportunity, comes a serious responsibility.

The Child Abuse Prevention and Treatment Act was signed into law on January 31, 1974. The act established the National Center on Child Abuse and Neglect in the HEW Children's Bureau, which funds demonstration projects related to prevention, identification, and treatment of child abuse and neglect. Through federal policy instructions, all Head Start agencies are required to report suspected cases of child abuse and neglect.

Types of child abuse defined by the Child Abuse Prevention and Treatment Act include: (1) Non-accidental physical injuries which may include severe shaking or beating, burnes, strangulation, human bites, broken bones, or serious internal injuries, (2) Neglect which includes the witholding of or failure to provide a child with the basic necessities of lie such as food, clothing, shelter, medical care, attention to hygience, protection, or supervision, (3) Sexual Abuse in general terms, includes any sexual activity between and adult and a child, and (4) Physiological Maltreatment/Emotion Abuse which is a pattern of behavior that attacks a child's emotional development and sense of self worth (examples: Constant criticism, belittling, insulting, rejecting and/or failure to provide the understanding, warmth, attention, and supervision necessary for a child's healthy physiological growth.

As state previously, Head Start must report any suspected child abuse or neglect to the Department of Human Services. Should you need nay additional information on this subject, please contact your Family Advocate.

I have been informed of INCA's policy regarding child abuse and negect and fully understand. I also verify that the information I have provided in this application is true and correct.

Parent/Guardian's Signature_____ Date_____

Head Start Parent's Work Schedule

INCA Head Start strived to meet the needs of the parents. Head Start provides full day services to those children and families with special needs ot to those children whose parents are employed, in job training or college, or with no caregiver present in the home. We realize the stress and expense of taking children to daycare these days, and we would like to help keep from doing so. If, at any time, you need to make changes, please contact your child's teacher.

Father's Name: _____

Place of Employment: _____

Work Schedule:

Monday	Tuesday	Wednesday	Thursday	Friday

Where father attends school:_____

College or Vocational School Schedule (If Applicable):

Monday	Tuesday	Wednesday	Thursday	Friday

Mother's Name: _____

Place of Employment: _____

Work Schedule:

Monday	Tuesday	Wednesday	Thursday	Friday

Where mother attends school:_____

College or Vocational School Schedule (If Applicable):

Monday	Tuesday	Wednesday	Thursday	Friday

Parent's Signature: _____ Date: _____

INCA Head Start Parent Interest Survey

Please review the following topics of interest and choos up to ten that most interest your family.
Information/Training will be available periodically throughout your child's Head Start Year.

Nutrition
☐ Child/Family Nutrition
☐ Meals on a Budget
☐ Mealtimes
☐ Nutritious Snacks
☐ Infant/Breast Feeding
☐ Other_____

Employment/Literacy
☐ Literacy and Your Child
☐ Using the Public Library
☐ Adult Education Resources
☐ Student Loan/Financial Aid
☐ Job Skills
☐ English as a Second Language
☐ Other_____

Mental Health
☐ Positive Self-Esteem
☐ Stress Management
☐ Time Management
☐ Mental Resources
☐ Transitions for Children
☐ Children's Emotions
☐ Child Abuse and Neglect
☐ Domestic Violence
☐ Substance Abuse
☐ Other_____

Health
☐ Medical Home/Medical Records
☐ Dental Care for Ages 0-5
☐ Immunizations
☐ Too Sick to Go to School
☐ First Aid and CPR Resources
☐ Sexually Transmitted Diseases
☐ Family Planning Resources
☐ Other_____

Accident Prevention
☐ Child Proofing Your Home
☐ Home Fires Safety
☐ Automobile Safety
☐ Stranger Danger
☐ Family Disaster Plans
☐ Weapons and Firearms Safety
☐ Poison Control
☐ Other_____

Disabilities
☐ IEP/IFSP
☐ Positive Behavior Plans
☐ IDEA
☐ Transition EHS
☐ Other_____

Parenting/Child Development
☐ Ages and Stages of Children
☐ Positive Child Guidance
☐ Play Child's Work
☐ Parent/Child Learning
☐ Language Development
☐ Reading With Your Child
☐ Quality Child Care
☐ Fatherhood
☐ Effective Parenting Skills
☐ Potty Training
☐ Other_____

Community Issues
☐ Housing and Homelessness
☐ Community Needs
☐ Crime Watch Programs
☐ Community Organizations
☐ Other_____

Other
☐ Gardening
☐ Sewing
☐ Arts and Crafts
☐ Hunting and Fishing
☐ Hairstyling/Make-up
☐ Helpful Household Tips
☐ Car Maintenance
☐ Financial Management
☐ Income Tax Preparation
☐ Credit Counseling
☐ Other_____

Father/Father Figure

Father's Name_____ **Relationship (biological, step, foster, etc)**_____

Volunteer Interest Area (CHECK ALL THAT APPLY):

☐ Classroom Education	☐ Office Work	☐ Support to Other Families
☐ Meeting Preparation	☐ Transportation	☐ Maintenance/Construction
☐ Recruitment	☐ Fundraising	☐ Legal Services
☐Food Service	☐ Material Preparation	☐ Policy Council
☐ Field Trips	☐ Heath Services	☐ Other_____

Mother/Mother Figure

Mother's Name_____ **Relationship (biological, step, foster, etc)**_____

Volunteer Interest Area (CHECK ALL THAT APPLY):

☐ Classroom Education	☐ Office Work	☐ Support to Other Families
☐ Meeting Preparation	☐ Transportation	☐ Maintenance/Construction
☐ Recruitment	☐ Fundraising	☐ Legal Services
☐Food Service	☐ Material Preparation	☐ Policy Council
☐ Field Trips	☐ Heath Services	☐ Other_____

Parent Observations

This information helps teaches learn about your child's interests and experiences in order to plan individual activities to build their skills. Place a plus sign (+) in the column if your child can do the task and a minus (-) if he/she cannot. Use the comment section to provide any other information such as if the child needs help to do the task.

Child's Name_____ Date of Birth_____

Classroom_____

LAP-D Item	Does your child . . .	+	-	Comments
PS6	refer to self by name.			
PS8	interact with familiar adults.			
PS14	initiate interactions with familiar adults.			
PS17	share toys.			
PS20	separate from parent easily.			
PS29	name 2 emotions.			
PS31	express own feelings verbally.			
PS40	go on errands out of the room parent is in.			
SH6	asks for food, drink, or toilet when needed.			
SH16	brush teeth with assistance.			
SH18	undress completely with assistance ((+) if child undresses self other than with difficult fastenings).			
SH20	pour from pitcher.			
SH22	untie and remove shoes.			
SH26	go to toilet alone ((+) if child goes to toilet and manages most clothing without difficulty).			
SH35	dress completely without assistance.			
SH40	insert belt in loops.			
SH41	zip separating front zipper ((+) if child places zipper foot in catch and zips zipper without assistance).			
SH42	spread food with table knife ((+) if child covers at least 75% of bread with peanut butter or jelly).			

Parent Signature_____ Date_____

Authorization to Release Confidential Information

Medical /Health Authorization

Parent's Name_____ Date of Birth_____

I the undersigned, do hereby authorize_____
(Releasing Agency, Medical Provider, or Individual)

Address_____

to release_____
(Describe or name records to be released)

from my child's records to the following:

INCA Head Start
Attention: Jane Allen, INCA Health Services Manager
PO Box 68
Tishomingo, OK 73460 Fax 580-371-0277

NOTICE
(63 O.S. 1992, 1-502.2.B)

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. YOU MAY STOP FURTHUR RELEASE OF THIS INFORMATION BY REVOKING THIS AUTHORIZATION BY WRITTEN NOTICE TO THE OFFICE AUTHORIZED ABOVE TO MAKE THIS RELEASE.

Information may be released to the above named persons until one year from the date of parent/guardian's signature.

_____ _____
Date (Signature of Patient)

_____ _____
Date (Signature of Guardian or Authorized Individual)

_____
(Relationship to Patient)

Witness (1)_____

Witness (2)_____
(signature by mark must have 2 witnesses)

NOTICE TO THE ABOVE NAMED RECIPIENTS
Certain statutes, State and Federal, may prohibit further disclosures of release of the above information without specific written consent from the person about whom it pertains. This "Authorization to Release Confidential Information" is not intended to authorize further release or disclosure, or to constitute a waiver of such othere statutes. However, information released by this Authorization may be subject to re-disclosure by the recipient and will no longer be protected.

Child Oral Health Examination Report

· INCA Community Services Head Start · PO BOX 68 · Tishomingo, OK 73460 · 1(580)-371-2352 ·

Child Name:_____ Date:_____

Parent(s) Name:_____ Head Start Center:_____

Insurance (Sooner Care, CDIB, or Private Insurance):_____

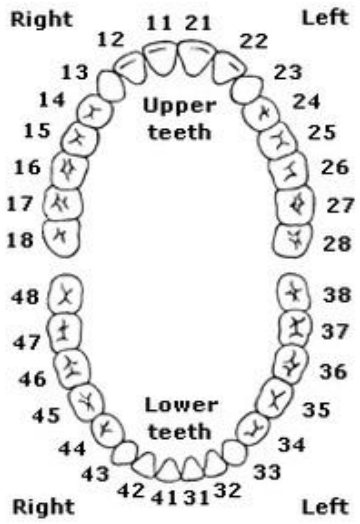
Current Status:

Number of Cavities:_____

Gum Condition: ___Normal ___Swollen ___Bleeds Easily ___Infected

Recommendation:

___No further treatment needed at this time ___Additional Dental Treatment Required



Tooth Number	Description of Dental Services Required

Next Appointment Date _____ /_____ /_____

_____ _____ _____

Dentist Name (please print) Signature Date

_____ _____

Address, City, State, & Zip Phone Number

INCA Head Start Physical Examination Form

Please return exam result to:

· INCA Community Services Head Start · PO BOX 68 · Tishomingo, OK 73460 · 1(580)-371-2352 ·

Parents:

Head Start required a physical exam. Please return or fax this form when completed.

(Head Start require un examen fisico. Por favor regrese esta forma a Head Start cuando e doctor la complete.)

Child's Name:_____ Date of Birth:_____

Classroom:_____

Physician:

Please complete the following three sections:

1. Mandatory Screenings:

*Lead Test Results_____ *HCT/HGB_____

Blood Pressure: _____ /_____ Height:_____ Weight:_____

2. General Exam:

Evaluation:	Normal	Abnormal	Evaluation:	Normal	Abnormal
Skin			Abodoment/Groin		
Posture			Genitalia/Urniary		
Speech/Communication			Bones/Joints		
Head			Neurological		
Eyes/Vision			Gross/Fine Motor		
Ears/Hearing			Muscles		
Nose			Cognitive		
Mouth/Teeth			Self-Help		
Heart/Circulatory			Social Skills		
Chest/Lungs			Glands/Thyroid/Lymph Nodes		
Allergies			Nutrition		

3. Findings and Follow-Up:

☐ Normal

☐ Following Conditions Discovered:

_____

_____

_____

_____

☐ Recommended Follow-Up:_____

Provider Signature:_____ **Exam Date:**_____

Clinic Name and Address:_____

Office Use Only

Date Entered on Child Plus _____ / _____ / _____

Date Received by Heath Manager _____ / _____ / _____

Authorization to Release Confidential Information

Patient's Name_____

Address_____City_____State_____Zip_____

I the undersigned, do hereby authoize the _____Oklahoma State Department of Health_____

to release _Blood Lead Testing Results_information from my _child's_record(s) to the following:

_____INCA Community Services_____

(Name of person, agency, or firm authorized to receive information)

_____PO Box 68. Tishomingo, OK. 73460._____

NOTICE

(63 O.S. 1992, 1-502.2.B.)

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR NONCOMMUNICABLE DIESASE. YOU MAY STOP ANY FURTHER RELEASE OF THIS INFORMATION BY REVOKING THIS AUTHORIZATION BY WRITTEN NOTICE TO THE OFFICE AUTHORIZED ABOVE TO MAKE THIS RELEASE.

Information may be released to the above persons until _one year from the date of parent/guardian's signature_

_____ _____

Date (Signature of patient)

_____ _____

Date (Signature of patient)

_____

(Relationship to Patient)

Witness (1)_____

Witness (2)_____

(signature by mark must have 2 witnesses)

THE CLIENT MUST RECEIVE A COPY OF THIS SIGNED AND/OR DATED DOCUMENT

NOTICE TO THE ABOVE NAMED RECIPIENTS

Certain statutes, State and Federal, may prohibit further disclosures of release of the above information without specific written consent from the person about whom it pertains. This "Authorization to Release Confidential Information" is not intended to authorize further release or disclosure, or to constitute a waiver of such othere statutes. However, information released by this Authorization may be subject to re-disclosure by the recipient and will no longer be protected.

For County Health Department Use:

Specific Information Released:	To Whom Information was Released:	By:	Date: