

Keep this sheet for your records!******PLEASE READ THIS BEFORE YOU TURN IN YOUR APPLICATION!******

Thank you for taking the time to consider the Grand Traverse Band Early Head Start/Head Start/GSRP Programs for your child. There are a few things you need to know...

- If your child was born between September 1, 2017 and September 1, 2018 your child is age eligible for Head Start/GSRP.
- If your child was born AFTER September 1, 2018 your child is age eligible for Early Head Start.

After completing and returning this application for your child, a Selection Criteria form will be filled out, and your child will be assigned "points" based on their eligibility for the program. Children will be accepted based on these points. Eligibility factors include (but are not limited to): Income Eligibility (the Federally established Poverty Guidelines are used to make this determination), Special Needs of Child, Age of Child, Need for Services, Parental Status, and other factors. While GTB Members are given priority when income eligibility factors are met, these programs are open to all individuals regardless of Tribal Affiliation. Applications that are not completely filled out will not be considered.

All applications are due on Friday, July 16th and selection for enrollment into the Early Head Start/Head Start/GSRP Programs will take place on FRIDAY, July 30th. All of the required information MUST be submitted BEFORE this date, or we will not be able to consider your child for acceptance into the program.

When all openings are filled, a waiting list will be established for those children not accepted. The children on the waiting list will be chosen to fill vacancies based on the points they receive from the Selection Criteria, regardless of when the application was turned in. **It is not possible to tell families where their child is placed on the waiting list, due to the changing nature of applications received.**

If your child is accepted into the Early Head Start/Head Start/GSRP Programs, you will be required to meet with your child's teacher. You will also be required to attend a Parent Orientation session prior to your child attending classes at the Center.

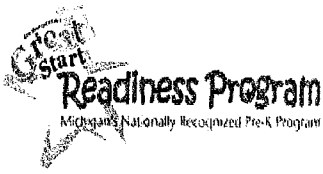
Please be sure to submit your Income Verification WITH THIS APPLICATION. Applications without income verification CANNOT be considered for acceptance. Please submit your 1040 tax return form or W-2 for 2020 for ALL household members that provide support for your child. If you did not file taxes, please submit income verification for the past 12 months which could include: Wages/Salary, Unemployment Compensation, Per Capita Payments, Other Trust Money Payments, Child Support Payments, SSI Payments.

Your child will also be required to have a current Physical and Dental exam **within the first 90 days** of your child's attendance. These forms are attached. Please make your appointments **NOW** in order to guarantee that your child will remain in the program.

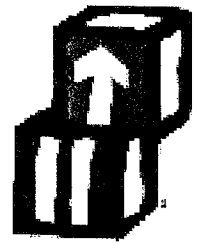
If you need assistance completing this application, or have questions, please contact Trista at (231) 534-7994 or Leona at (231) 534-7929.

If your child is accepted for enrollment, you will be required to submit the following information:

- Your Child's Birth Certificate
- Your Child's Insurance information
- Your Child's Tribal ID (if applicable)
- Immunization Record
- Current Physical & Dental Exam (after first tooth erupts)



Grand Traverse Band Early Head Start, Head Start & GSRP Enrollment Application 2021-2022



2605 NW Bay Shore Drive
Peshawbestown, MI 49682
Phone: (231)534-7650 FAX (231)534-7583

Please indicate which program you are applying for: Head Start/GSRP Center-Based Early Head Start Home-Based Early Head Start

Applicant Information: (Child or Expectant Woman)			
First Name		Middle Name	Last Name
Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address where applicant/child resides:		Mailing Address:	
Street:		Street/PO Box:	
City:	State:	Zip Code:	City:
State:	Zip Code:	School District:	
County:			
What is the Applicant's Race:	What is the Applicant's Ethnicity:	Is Applicant a:	Is Applicant Currently:
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Bi-racial/multi-racial <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> Hispanic or Latino origin <input type="checkbox"/> Non-Hispanic or Non-Latino Origin	<input type="checkbox"/> GTB Member <input type="checkbox"/> Member of another Tribe: _____ <input type="checkbox"/> Not Affiliated with any Tribe Language(s) spoken in the child's home? Primary: _____ Secondary: _____	<input type="checkbox"/> Enrolled in Head Start <input type="checkbox"/> Enrolled in Early Head Start <input type="checkbox"/> Home Based <input type="checkbox"/> Not Previously Enrolled in Head Start or Early Head Start
Applicant's Custodial Information:			
<input type="checkbox"/> Does not apply in my situation	<input type="checkbox"/> Foster Care (Please explain and provide a copy with your application)		
<input type="checkbox"/> Sole Custody	Caseworker: _____		
<input type="checkbox"/> Joint Custody—both biological parents	Phone: _____		
<input type="checkbox"/> Joint Custody—other; Explain: _____			
<input type="checkbox"/> Physical Custody: Explain who has legal custody: _____			
Is there a protection or restraining order regarding the child?		Are there special visitation orders we should be aware of?	
<input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain and provide a copy with your application)	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain and provide a copy with your application)		
Household Composition: List the Primary Caregivers			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____			
Primary Adult	Lives with Child: <input type="checkbox"/> Yes <input type="checkbox"/> No		
First Name:	Last Name:		
Date of Birth:	Relationship To Child:		
Is Parent/Guardian a: <input type="checkbox"/> GTB Member	<input type="checkbox"/> Member of Another Tribe		
Telephone Number/Contact Information:	Are you employed:		
Home: _____ Work: _____	<input type="checkbox"/> Part time <input type="checkbox"/> Full Time <input type="checkbox"/> Seasonally <input type="checkbox"/> US Military-Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Disabled Employer Name: _____		
Cell Phone: _____ Message: _____	Are you attending school/job training:		
E-Mail Address: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Highest level of education completed:		
	<input type="checkbox"/> 9 th grade or less <input type="checkbox"/> 10 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Training Certificate <input type="checkbox"/> Vocational <input type="checkbox"/> Associates <input type="checkbox"/> Bachelor <input type="checkbox"/> Master's <input type="checkbox"/> Advanced <input type="checkbox"/> Other: _____		
Primary Adult	Lives with Child: <input type="checkbox"/> Yes <input type="checkbox"/> No		
First Name:	Last Name:		
Date of Birth:	Relationship To Child:		
Is Parent/Guardian a: <input type="checkbox"/> GTB Member	<input type="checkbox"/> Member of Another Tribe		
Telephone Number/Contact Information:	Are you employed:		
Home: _____ Work: _____	<input type="checkbox"/> Part time <input type="checkbox"/> Full Time <input type="checkbox"/> Seasonally <input type="checkbox"/> US Military-Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Disabled Employer Name: _____		
Cell Phone: _____ Message: _____	Are you attending school/job training:		
E-Mail Address: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Highest level of education completed:		
	<input type="checkbox"/> 9 th grade or less <input type="checkbox"/> 10 th grade <input type="checkbox"/> 11 th grade <input type="checkbox"/> High School Graduate <input type="checkbox"/> GED <input type="checkbox"/> Training Certificate <input type="checkbox"/> Vocational <input type="checkbox"/> Associates <input type="checkbox"/> Bachelor <input type="checkbox"/> Master's <input type="checkbox"/> Advanced <input type="checkbox"/> Other: _____		
Other Household Member Information: Please list all other persons living within the home not listed above			
First Name	Last Name	Date of Birth	Relationship to Child

Additional Information:			
Is there anyone in your household currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Due Date: _____			
Child Care Provider Information:			
Will this child be cared for by someone other than you, in addition to participating in this program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete the following information:			
<input type="checkbox"/> Child Care Center	<input type="checkbox"/> Relative's Home or at Child's home by Relative	Number of hours per day child care is needed _____	
<input type="checkbox"/> Family Child Care Home	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Need assistance finding child care			
Family Resource Information:			
Does your family receive any of the following types of services or financial assistance? (Check all that apply)			
<input type="checkbox"/> Medicaid/Medicare	<input type="checkbox"/> SNAP/Bridge Card	<input type="checkbox"/> Cash Assistance (from DHS)	
<input type="checkbox"/> WIC - County _____	<input type="checkbox"/> Child Support	<input type="checkbox"/> Child Care Assistance (from DHS) (Tribal)	
<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> State Disability Assistance (for yourself or someone in your care)	<input type="checkbox"/> State Emergency Relief Programs	
<input type="checkbox"/> Refugee Assistance Program		<input type="checkbox"/> Other: _____	
What is your current living arrangement/situation: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Motel <input type="checkbox"/> Receive Subsidized Housing			
<input type="checkbox"/> Shelter <input type="checkbox"/> Experiencing homelessness—live with others because I have no alternative <input type="checkbox"/> Live with relatives/friends by choice			
How long have you lived at this address: _____ <input type="checkbox"/> Other, Specify _____			
In order to best meet the needs of your family, please indicate if your family receives or is in need of any of the following services: Please write an "N" in the box by those services that you need or would like additional information, and write an "R" in the box by those services that you are currently receiving.			
<input type="checkbox"/> Crisis Assistance	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Job Training	<input type="checkbox"/> Budgeting Information
<input type="checkbox"/> Food	<input type="checkbox"/> Literacy	<input type="checkbox"/> Substance Abuse Prevention	<input type="checkbox"/> Domestic Violence Services
<input type="checkbox"/> Housing	<input type="checkbox"/> English as a Second Language	<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Child Support Assistance
<input type="checkbox"/> Clothing	<input type="checkbox"/> Adult Education	<input type="checkbox"/> Child Abuse/Neglect Services	<input type="checkbox"/> Health Education
<input type="checkbox"/> Transportation	<input type="checkbox"/> Relationship/Marriage Education	<input type="checkbox"/> Prenatal Education	<input type="checkbox"/> Assistance to families of Incarcerated Individuals
<input type="checkbox"/> Parenting Education	<input type="checkbox"/> Legal Assistance		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Employment			
Health, Nutrition & Developmental Information:			
Applicant's Physician/Health Care Provider Name: _____		Address: _____	Date of Last Exam: _____
Health Care Coverage Information:			
<input type="checkbox"/> Medicaid ID # _____		<input type="checkbox"/> Contract Health	<input type="checkbox"/> No Health Care Coverage
<input type="checkbox"/> Private Health Insurance Policy # _____			
Applicant's Dentist/Dental Care Provider Name: _____		Address: _____	Date of Last Exam: _____
Dental Coverage Information: <input type="checkbox"/> No Coverage <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance (please list): _____			
Does the applicant have any health conditions such as: Allergies (to foods, medications, insect bites, seasonal, etc.), Diabetes, Asthma, Seizures, or any other conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, medical documentation is needed)			
If yes, please list and explain if there is a protocol for emergency intervention: _____			
Does the applicant have any special dietary needs? <input type="checkbox"/> Yes <input type="checkbox"/> No Are they diagnosed by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain: _____			
Do you have any concerns about your child's development? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe: _____			
Child's Birth Weight: _____ lb _____ oz	Was child born more than 3 weeks early or late? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please explain: _____		
Did the child's mother visit the doctor LESS than 2 times during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the child's mother have any health problems during pregnancy or delivery of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If yes, please explain: _____		
Has your child been diagnosed with a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list: _____			
Is the applicant receiving any special services or currently on an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? (i.e., medical, speech therapy, physical therapy, occupational therapy, early childhood special education, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe and list name of provider: _____			
Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours. I understand that this is an application only and does not guarantee enrollment into the Early Head Start/Head Start/GSRP Programs.			
Parent/Guardian Signature: _____		Date: _____	
FOR OFFICE USE ONLY			
Interview completed in person <input type="checkbox"/> By phone <input type="checkbox"/>			
Applicant interviewed by: _____		Date: _____ Birth Verified <input type="checkbox"/> Yes <input type="checkbox"/> No Income Verified <input type="checkbox"/> Yes <input type="checkbox"/> No	

CHILD INFORMATION CARD

GTB Early Head Start, Head Start & GSRP

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

Name of Child (last, first, middle int.)		Name of Parents			
Allergies, if any		Address, number and street			
Date of birth	Home phone number	City	State MI	Zip Code	
1. Parents Location when child is in care		Hours of Employment		Phone Number	
Address Number and Street		City	State MI	Zip Code	
2. Parents Location when child is in care		Hours of Employment		Phone Number	
Address number and street		City	State MI	Zip Code	
Persons other than the parent who are located within 30 minutes of the Benodjenh Center and can be notified in an emergency situation when the parent is not available.					
Name		Relationship to Child		Phone number (REQUIRED)	
Address Number and Street		City		State MI	Zip Code
Name		Relationship to Child		Phone number (REQUIRED)	
Address Number and Street		City		State MI	Zip Code
Names of persons other than parent to whom child may be released.					
Name			Name		
Name			Name		
<p>I Hereby give permission to the GTB Benodjenh Center to secure emergency medical and/or emergency surgical treatment for the above named minor child in care. Non-emergency medical or elective surgical treatment is not included in this authorization. This includes care by a physician or dentist and transportation to and from the source of emergency treatment. This does not include the right to perform surgical operations without my further consent, except in the case of emergency and when after an effort has been made to locate me I have been found unavailable.</p> <p>Please indicate if your child has any of the following conditions which could be important in an emergency: <input type="checkbox"/> Severe Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Allergic to Insect Bites <input type="checkbox"/> Allergic to Medications <input type="checkbox"/> Seizures Other: _____</p>					
Signature of parent or guardian			Date		
Date of child's most recent DTP (tetanus) shot:			Name of Child's Dentist:		
Name of child's Physician or health clinic			Office Hours	Phone Number	
Address number and street		City	State	Zip Code	
Hospital Preferred for medical treatment		Health insurance policy and number			
I hereby give permission to the GTB Benodjenh Center for my child to be transported in a vehicle and/or participate in field trips.					
Signature of parent or guardian			Date		

GTB Benodjenh Early Head Start/Head Start/GSRP

LETTER OF UNDERSTANDING

Regarding _____ attendance, illness, and emergency contact information
(Child's Name)

I, _____ understand the following:
(Parent/Guardian Name)

Early Head Start/Head Start/GSRP serves less than half of the eligible population. For every enrolled child, there is at least one eligible child who will not be served due to limited space.

The Early Head Start/Head Start/GSRP programs cost me nothing, they are free of charge yet will provide my child and family with over \$10,000 worth of services.

Along with the privilege of being a part of these preschool programs comes my responsibility to adhere to the following requirements of the Early Head Start/Head Start/GSRP Programs:

- * If my child must miss, I will notify program personnel as instructed in the parent handbook. I understand that Head Start requires an average daily attendance rate of 85%.**
- * My child will be replaced by a child from the waiting list for excessive absences.**
- * In the event of illness, it is my responsibility to keep my child at home when they are sick and/or have any of the symptoms listed on page 20 & 43-45 in the Parent Handbook.**
- * If my child becomes ill while at school, it is my responsibility to pick up my child or make arrangements to have another person pick my child up from Early Head Start/Head Start/GSRP within 30 MINUTES of being contacted.**
- * It is also my responsibility to keep my child's emergency contact information up to date and to provide phone numbers of at least two people who live in close proximity of the Benodjenh Center who can be contacted to pick my child up in the event of an illness/emergency when I cannot be reached.**

Parent/Guardian Signature _____ Date _____

GTB EARLY HEAD START, HEAD START & GSRP

revised 4/2021

2600 N. Strongheart Way
Suttons Bay, MI 49682
(231)534-7650 / FAX (231)534-7583

CONSENT FOR PARTICIPATION

Child's Name: _____

I, the undersigned, hereby give permission to the Grand Traverse Band Early Head Start/Head Start/GSRP Programs to:

PLEASE INITIAL:

_____ Release and Obtain ALL Health Records of my child including to and from my child's primary care physician, dental care provider, ophthalmologist, and/or any other pertinent health provider's information.

_____ Obtain and share information regarding my child with DHS.

_____ Obtain and share information regarding my child with Health Department/WIC.

_____ Obtain and share information regarding my child with GTB Behavioral Health Services.

_____ Obtain and share information regarding my child with AFS.

_____ Obtain and share information regarding my child with Pine Rest/Mental Health Therapist/Consultant _____.

_____ Allow my child to participate in Head Start's Free Health Care Program which could include all or some of the following:

*Immunization Clinic	*Dental Examination
*Physical Examination	*Speech Evaluation/Therapy/OT/PT
*Early Intervention Staff	*TBAISD/Early-On
*Hearing and Vision Testing	*Height & Weight Measurements
*Developmental Screening/s	*Tooth brushing daily with Fluoridated Toothpaste
* Hemoglobin & Blood Pressure Screening	*Referrals to other agencies for Disability Services
*Child observations and/or staff consultations regarding my child with Mental Health Consultant, Nutrition/Dietician Consultant, and/or Nursing Consultant if needed.	

_____ Release my name, phone number, and the name, birth date, address, and pertinent Head Start file contents of my child to the school of my choice: _____
This will be done when my child is age eligible for Kindergarten Round-Up activities.

_____ To take photographs and/or videos of my child/family which may be used in displays, recruitment, or other types of news/educational publications. Occasionally local news media may take photographs or video of the children.

_____ Release my child's name on a class list which will be distributed to all parents/guardians. Allow my child's name to appear in class, program or promotional material.

_____ Allow Head Start/Early Head Start staff to apply sunscreen (SPF 45) to my child before going outside in spring/summer months.

**This consent is valid for one year after the date signed. In signing this document, I am fully aware of the items listed and concur that the above consent is in the best interest of my child.

Signature of Parent/Guardian

Date

GTB Benodjenh Early Head Start/Head Start/GSRP

2600 N. Strongheart Way

Peshawbestown, MI 49682

Phone: (231) 534-7650 Fax: (231) 534-7583

Transportation Information

To ensure that your child is picked up and dropped off at the proper place, please fill in the correct following information:

Child's Name: _____

Address: _____

Phone Number: _____

Child will get to the program by:

Bus (Child MUST be at least 20 lbs. AND 1 year old) Bussing for Early Head Start is only available to children living on or near the reservation. The T.C. bus run is only available to Head Start/GSRP children ages 3-5 years old.

Parent will transport

If child will ride the bus, please complete the following:

<u>Day Of The Week</u>	<u>Morning Pick-Up Address</u>	<u>Afternoon Drop-Off Address</u>
------------------------	--------------------------------	-----------------------------------

Monday	_____	_____
--------	-------	-------

Tuesday	_____	_____
---------	-------	-------

Wednesday	_____	_____
-----------	-------	-------

Thursday	_____	_____
----------	-------	-------

Please give directions to the location(s) your child will be picked up and/or dropped off:

If there are any changes in the above schedule, please contact the Benodjenh Center staff as soon as possible at (231) 534-7650. If there is no one at your home or drop off site, your child will be brought back to the Benodjenh Center and will be signed into the Child Care Program until you come in to pick them up. **You will then be charged for Child Care costs starting from the time that Early Head Start/Head Start/GSRP ends until the time you sign your child out of Child Care.** If you have any further questions or concerns, please feel free to contact any of the Benodjenh Center Staff.

Return this completed form to: (insert institution's name, address & telephone number)

Participant Enrollment Form

Instructions:

1. List full name of participant enrolled in care
2. Circle the typical days each participant is in care
3. List times each participant is in care
4. Circle the meals and snacks each participant typically receives while in care
5. Select the ethnicity of each participant using the following codes: H = Hispanic or Latino, N = Not Hispanic or Latino*
6. Select one or more racial designations of each participant using the following codes: A/I = American Indian or Alaskan Native, A = Asian, B = Black or African American, H/PI = Native Hawaiian or Pacific Islander, W = White*
7. Sign and date the form and return to your care center

Participant's First and Last Name	Typical Days in Care (circle all that apply)	List Times in Care	Meals/Snacks Received (circle all that apply)	Ethnicity	Race
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		
	Mon Tues Wed Thu Fri Sat Sun		Breakfast AM Snack Lunch PM Snack Supper Evening Snack		

* This information is voluntary. This will assist us in assuring the Child and Adult Care Food Program is administered in a nondiscriminatory manner.

Adult/Parent/Guardian's Address

Adult/Parent/Guardian's Phone Number

Signature of Adult/Parent/Guardian

Date Signed

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the *USDA Program Discrimination Complaint Form*, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: 202-690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.





Michigan Department of Education
Child and Adult Care Food Program

Formula/Food Sign-Off Statement

Dear Parent,

Your childcare center participates in the Child and Adult Care Food Program (CACFP). The CACFP is a child nutrition program of the United States Department of Agriculture (USDA). Childcare centers are reimbursed a meal rate to help with the cost of serving nutritious meals to enrolled children. The meals must meet CACFP meal pattern requirements for children and infants.

To meet CACFP requirements, this child care center offers formula and other required infant food to all enrolled infants. The iron-fortified infant formula(s) provided for infants until they turn one year of age is:

(Insert Name of Formula)

As the parent or guardian, you may decline the formula offered by the center and supply the infant's formula yourself. However, when your infant turns one year of age, the center will begin to provide milk and the other required food items to meet the meal pattern requirements for toddler-age children.

To assist us in your infant formula and food preferences, please complete the questions below by checking one item each in the formula and solid food sections.

Please Check Your Preferences:

Formula or Breast Milk: (check up to two)

- I want the center to provide formula for my infant.
I will bring iron-fortified infant formula for my infant.
I will bring expressed breast milk for my infant.
I will come to the center to breast feed my infant.

Solid Food: (check one)

- I want the center to provide solid food for my infant when s/he is developmentally ready for it.
I will bring solid food for my infant when s/he is developmentally ready for it.

Infant's Name: Birth date:

Parent/Guardian Signature: Date:

Non-Discrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) (http://www.ascr.usda.gov/complaint_filing_cust.html) online, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.



Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: Yes No

Current Oral Health Status

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? Yes No

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: Yes No

X-rays: Yes No

Risk assessment: Yes No

Cleaning: Yes No

Fluoride varnish: Yes No

Dental sealants: Yes No

Counseling/Anticipatory Guidance

Yes No

Referral to Specialty Care

Yes No

(Please specify specialist)

Restorative/Emergency Care

Fillings: Yes No

Crowns: Yes No

Extractions: Yes No

Emergency care: Yes No

Other: _____

(Please specify)

Future Oral Health Care Services

All treatment completed: Yes No

Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? Yes No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name (please print) _____

Phone number _____

Fax number _____

Practice name _____

Address _____

Provider signature _____

Date of service _____

HEALTH APPRAISAL

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

PERSONAL

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

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?	Birth History:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	If yes, please describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam / /	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child take any medication(s) regularly?	If yes, list medications:
Reason for Medication				
Parent/Guardian Signature _____ Date / /				Was the health history reviewed by a health professional?
				<input type="checkbox"/> Yes <input type="checkbox"/> No Examiner's Initials: _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
		Date: / /	Muscle Imbalance				<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	Weight			
			Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT	Other			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____			
		Date: / /	Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	Date: / /	Neg.: <input type="checkbox"/> Pos.: <input type="checkbox"/> _____ mm			
		Date: / /	Albumin				NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.						
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	Microscopic										
<input type="checkbox"/>	<input type="checkbox"/>	Date: / /	Level _____ ug/dl										

Examinations and/or Inspections

Essential Findings Deviating from Normal:
Exam Date: / /

SECTION III - IMMUNIZATIONS					
Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*					
VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2				
DTaP/DTP/DT/Td	1	4	Influenza (IV/LAIV)	1	3
	2	5		2	4
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus influenzae type b (HIB)	1	3		2	
Polio (IPV/OPV)	1	3	OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	2	4		1	
Pneumococcal Conjugate (PCV7/PCV13)	1	3		2	
	2	4	3		
Rotavirus (RV1/RV5)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	2		*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____ Health Professional's Signature				_____ Title	
				_____/_____/_____ Date	

		SECTION IV - RECOMMENDATIONS (Required for Child Care and Head Start/Early Head Start)
No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other _____
Other Recommendations _____ _____		

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)
I have examined _____ child's name _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ _____
_____ Dentist's Signature
_____/_____/_____ Date

PHYSICIAN'S SIGNATURE			
_____ Examiner's Signature	_____/_____/_____ Date	_____ Examiner's Name (Print or Type)	_____ Degree or License
_____ Number & Street	_____ City	_____ MI	_____ ZIP Code (_____) _____ Telephone

Information required for:

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

Child Care Licensing - Physical Exam, Restrictions, Immunizations

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

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

GTB Benodjenh Early Head Start/Head Start/GSRP Center

2600 N. Strongheart Way, Suttons Bay, MI 49682

Phone: (231) 534-7650 Fax: (231) 534-7583

Treatment: Upon acceptance into the program, a dental exam and any follow-up treatment is mandatory and not optional.

Referral is determined by what insurance coverage is in effect:

1. The following Clinics below accept Medicaid:

Dental Clinics North
2600 LaFranier Rd., Suite B
Traverse City, MI 49686
(231) 932-7316

Mancelona Clinic
205 Grove Street
Mancelona, MI 49659
(231) 587-5068

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

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

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

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

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

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

4. GTB Contract Health Funding:

This funding is only available to GTB Tribal members. Any dental appointments must be pre-approved by the GTB Contract Health Office prior to scheduling. Please contact MaryJo McSauby at (231) 534-7884, Stella Chippewa at (231) 534-7931, or Monica Anderson at (231) 534-7210 for additional information.