

Osage Nation Head Start

This is a **RECRUITMENT** application only. **This does not guarantee your child's acceptance.** The children are accepted by guidelines established by our Parent Policy Council and by the Office of Head Start Federally Mandated Guidelines.

I have read and understand the above statement.

Child's Name: _____

Parent's Signature

Date

Ages of other children in the home: _____

Detach and give bottom portion to parent.

The following information checked is needed before your child's application will be considered for acceptance.

_____ **Income Verification** (*Pay Stub, W- 2, Income Tax, Letter from Employer, TANF, Unemployment, SSI, Foster Care Reimbursement, Doc. of No Income*)

_____ **Immunization Record**

The following information checked is needed to complete your child's file:

_____ Child or Parent's Proof of Indian (if applicable)

_____ Birth Certificate

_____ IHS Clinic _____

Chart # (if applicable) _____

_____ Social Security Numbers

If your child is accepted into the program, it is mandatory that they have a physical and dental exam

This information needs to be provided as soon as possible to be considered for enrollment. You may contact your local center for more information or call the main office located in Pawhuska, 1-800-287-6647 or 287-5460.

Center's Phone Number: _____

Skiatook 918-699-5471

Fairfax 918-642-5505

Hominy 918-699-5648

**Recruitment Application Only

OSAGE NATION HEAD START

P.O. BOX 1389

PAWHUSKA, OK. 74056

1-800-287-6647 FAX: 1-918-287-3416

McCord/ Shidler 580-762-0412

Pawhuska 918-287-5464

Barnsdall 918-699-5561

Center: _____

Date of Application: _____

Mother's SSN _____ - _____ - _____

Father's SSN _____ - _____ - _____

Child's SSN _____ - _____ - _____

Child's Last Name _____ First Name _____ Middle _____ Date of Birth _____

Street Address (Use Pencil) _____ City _____ State _____ Zip Code _____

Mailing Address (Use Pencil) _____ City _____ State _____ Zip Code _____

() _____ () _____ () _____ () _____ Child's Sex _____ Male _____ Female
Home Phone (Pencil) Message Phone (Pencil) Cell Phone (Pencil) Work Phone (Pencil)

Fathers Name _____ Ethnic Code(Circle all that apply) Primary Language _____
B= Black H= Hispanic E= English
A= Asian W= White S= Spanish
N= Native American O= Other
Tribe: _____ Degree of Blood: _____

Mothers Name _____ # of Adults in Family _____ # of Children in Family _____

Guardians Name _____

Family Type: (Circle One) Two Parent Single Parent Relative Foster Homeless Other

TANF Case # _____ Sooner Care # _____ Private Insurance Name and # _____

Medication: _____ Bites: _____ Allergies Food: (Need a Dr's statement) _____

Has your child been diagnosed for special need services? _____ Yes _____ No ***If yes, please provide documentation
Please Specify: _____ By Whom: _____

Has your child previously been enrolled in another Head Start Program or Child Development Program? _____ yes
_____ no If so, where: _____

A copy of the following information must be attached before the application will be considered complete and screened: Income Verification; Immunization Record; Certificate of Degree of Indian Blood Card (CDIB) on child and/ or parent; Child's Social Security Card; Child's Birth Certificate.

Upon acceptance for enrollment, your child will need a completed physical, dental, and updated immunization record.

I certify that the attached information is true and accurate to the best of my knowledge. I also understand that all information is kept confidential.

Applicant Signature/ Date _____

Receiving Staff Signature/ Date _____

**** OFFICE USE ONLY ****

Age: 3 yr. 4yr. Under Age Number in Family CNP:

Sex: Female Male Under Income: Over Income:

Ethnic Code : Disability: Yes No

Homeless: TANF: Foster Child:

Complete Application: Incomplete Application: (specify:)

Replacement for Drop: Yes No Date of Acceptance:

Greener: Date:

Head Start Criteria of Needs

Child's Name: _____

Date: _____

Total: _____

- _____ 1. Immediate family member with documented diagnosed disability.
 - _____ 2. Court ordered enrollment or referred from another agency.
 - _____ 3. Substance abuse or domestic violence in the home.
 - _____ 4. Single-parent family
 - _____ 5. Crisis in the family during the past 12 months, includes, but is not limited to; fire, death, incarceration, life-threatening illness, etc.
 - _____ 6. Child was enrolled and participated in a Head Start program last year including home base, and/or Early Head Start or other agency.
 - _____ 7. Family is receiving TANF benefits.
 - _____ 8. Non-English speaking and/or literacy needs within the family.
 - _____ 9. Child being raised by persons other than parent/s, includes foster situations.
 - _____ 10. Child suspected of or diagnosed as having a disability.
 - _____ 11. Child has had little or no opportunity to interact with children close to his or her own age.
 - _____ 12. Pregnant woman.
 - _____ 13. Parent is under the age of 18.
 - _____ 14. Child's parent/s are working or are full time students.
 - _____ 15. Family is residing in the home of other family members or friends.
 - _____ 16 OTHER (Describe)
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CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

PART I TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
 HEAD START CENTER: _____ PHONE: _____
 ADDRESS: _____

1. RELEVANT INFORMATION (from Health History, Parent/Teacher Observations):

2. SCREENING TESTS. *Starred items (*) 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", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.*

| TEST | DATE | RESULTS | TEST | DATE | RESULTS |
|--|------|----------------------|-------------------------------|------|---------|
| a. PRESENT AGE* | | ____ Yrs., ____ Mos. | g. VISION (Type of Test)* | | |
| b. HEIGHT (no shoes, to nearest 1/8 in.)* | | | ACUITY, R/L | | |
| c. WEIGHT (light clothing to nearest 1/4 lb.)* | | | RESCREENING | | |
| d. BLOOD PRESSURE | | | STRABISMUS | | |
| e. HEMATOOCRIT or HEMOGLOBIN* | | | COMMENTS | | |
| f. HEARING (Type of Test)* | | | h. OTHER TESTS (if indicated) | | |
| RESULTS, R/L | | | (1) TB | | |
| RESCREENING | | | (2) Sickle Cell | | |
| COMMENTS | | | (3) Lead | | |
| | | | (4) Ova. & Parasites | | |
| | | | (5) Urinalysis | | |
| | | | (6) Other | | |

3. PHYSICAL EXAMINATION/ASSESSMENT. *Complete and return top three copies to Head Start.*

| | NORMAL FOR AGE | ABNOR- MAL | NOT EVAL | COMMENTS (Use Additional sheet if necessary) |
|---|----------------|------------|----------|--|
| a. GENERAL APPEARANCE | | | | |
| b. POSTURE, GAIT | | | | |
| c. SPEECH | | | | |
| d. HEAD | | | | |
| e. SKIN | | | | |
| f. EYES: (1) External Aspects (2) Oculo Funduscopia (3) Cover Test | | | | |
| g. EARS: (1) External & Canals (2) Tympanic Membranes | | | | |
| h. NOSE, MOUTH, PHARYNX | | | | |
| i. TEETH | | | | |
| j. HEART | | | | |
| k. LUNGS | | | | |
| l. ABDOMEN (include hernia) | | | | |
| m. GENITALIA | | | | |
| n. BONES, JOINTS, MUSCLES | | | | |
| o. NEUROLOGICAL/SOCIAL (1) Gross Motor (2) Fine Motor (3) Communication Skills (4) Cognitive (5) Self-Help Skills (6) Social Skills | | | | |
| p. GLANDS (Lymphatic/Thyroid) | | | | |
| q. MUSCULAR COORDINATION | | | | |
| r. OTHER | | | | |

Please print doctor's name.

6. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Signature: _____ Date: _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

| ABNORMAL FINDINGS/DIAGNOSIS | TREATMENT PLAN | RECOMMENDED FOLLOW-UP OR RESULTS <i>(Initial when complete)</i> | DATE |
|-----------------------------|----------------|--|------|
| | | | |
| | | | |

PART II TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

