

**NORTON SOUND HEALTH CORPORATION
AUTHORIZATION TO RELEASE
HEALTH CARE INFORMATION**

Patient Name: _____

Date of Birth: _____ Patient ID Number or
Social Security Number: _____

I, _____, hereby
authorize

(Patient Name)

Norton Sound Health Corporation, to release my health care information and records as

Described below to the person or organization listed below.

Health Care Information is to be Released to:

Name of Person or Organization: Kawerak Head Start

Address: P.O. Box 948

City, State: Nome, AK

Phone: 1-800-443-5294 Fax: 1-907-443-5570

Release the Following Health Care Information:

*(You must check at least one box in this section and
Supply the necessary information on the lines or NO
Health care information can be released).*

- My Health Care Information and Records concerning the following
treatment of condition:

(describe treatment or condition)

- My Health Care Information and Records concerning treatment I
Received during the following dates:

From: _____ To: _____

All of my Health Care Information and Records.

Other: _____

Termination of Authorization:

(Check only one box in this section and supply additional information if necessary. If no box is checked, this Authorization will automatically end 90 days after the Date this Authorization was signed).

This Authorization ends: In ____ days from the date this Authorization was signed; **or**

On _____: **or**
(Specify Date)

When the following occurs:

_____ End of Head Start School Year _____

I acknowledge and understand that I may cancel or otherwise end this Authorization at any time using any of the following actions:

1) Sign and date a "Revocation of Authorization" form. This form is available from Norton Sound Health Corporation:

2) Write, sign, and date a letter to Norton Sound Health Corporation, Attn: Privacy Officer, P.O. Box 966, Nome, Alaska 99762, that states that I want to cancel this Authorization; **or**

3) Sign, date, and write "CANCEL" on this original Authorization form.



KAWERAK, INC.
-Head Start Program-
Child Health History



Child's Name: _____ Sex: M F D.O.B. _____

Pregnancy/Birth History	Yes	No	Explain "Yes" Answers	
1. Did the mother have any health problems during pregnancy or during delivery of this child?				
2. Did the mother visit a physician fewer than two times during the pregnancy?				
3. Was the child born outside of a hospital?				
4. Was the child born more than three weeks early or late?				
5. What was the child's birth weight?	-----	-----	lbs.	oz.
6. Was anything wrong with the child at birth?				
7. Was anything wrong with the child in the nursery?				
8. Did the child or mother stay in the hospital for medical reasons longer than usual?				
9. Is the mother pregnant now?				

Hospitalizations and Illness	Yes	No	Explain "Yes" Answers	
10. Has the child ever been hospitalized or operated on?				
11. Has the child ever had a serious injury (broken bones, head injury, fall, burn, poisoning)?				
12. Has the child ever had a serious illness?				

Health Problems	Yes	No	Explain "Yes" Answers	
13. Does the child have frequent: ___ Sore Throat ___ Cough ___ Urinary infections/trouble urinating ___ Stomach pains, vomiting, diarrhea				
14. Does Child have difficulty seeing (squints, crosses eyes, looks closely at books)?				
15. Is child wearing (or supposed to wear) glasses?				



KAWERAK, INC.
-Head Start Program-
Child Health History



Health Problems (cont.)	Yes	No	Explain "Yes" Answers
16. Does the child have problems with their ears/hearing (pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?			
17. Have you ever noticed the child scratching their behind (rear end, buttocks, anus) while sleeping?			
18. Has the child ever had convulsions or a seizure? Is the child taking medicine for seizures?			When did it last happen? What medicine?
19. Is the child taking any other medicine now? Will medicine need to be give to the child while at Head Start?			What medicine?
20. Is the child being treated by a physician or a dentist?			Physician's Name: Dentist's Name:
21. Has the child had: <input type="checkbox"/> Boils <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Mumps <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Hives <input type="checkbox"/> Polio <input type="checkbox"/> Eczema <input type="checkbox"/> German Measles <input type="checkbox"/> Measles <input type="checkbox"/> Scarlet Fever			
22. Does the child have: <input type="checkbox"/> Diabetes <input type="checkbox"/> Epliepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Tendencies <input type="checkbox"/> Liver disease <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Sickle cell disease			
23. Does child have any allergy problems? (rash, itching, swelling, difficulty breathing) <input type="checkbox"/> When eating foods? <input type="checkbox"/> When taking medication? <input type="checkbox"/> When near animals, fur, insects, dust?			
24. Do any of the conditions we've talked about get in the way of the child's everyday activities? (such as questions 14,16, 18, 21, 22, 23) Did a doctor or a health professional tell you that the child has this problem?			Describe how: When?
25. Are there any conditions we haven't talked about that get in the way of the child's everyday activities? Did a doctor or health professional tell you that the child has this problem?			



KAWERAK, INC.
-Head Start Program-
Child Health History



Physical, Psychological, and Social Development

These questions will help us understand your child better and know what is usual for them and what may be unusual that we should be concerned about.

26. Can you tell me one or two things that your child is interested in or does especially well?

27. Does your child take a nap? ___yes ___no If yes, when and for how long?

28. Does your child sleep less than 8 hours a day or have trouble sleeping (such as being fretful, having nightmares, wanting to stay up late)? ___yes ___no If yes, describe sleeping arrangements?

29. How does your child tell you that they need to go to the toilet?

30. Does your child need help going to the toilet during the day or night? ___yes ___no

31. Does your child wet their pants? ___yes ___no

32. How does your child act with adults that they do not know?

33. How does your child act with children their own age?

34. How does your child act when playing with a group of other children?

35. Does your child worry a lot or are they afraid of anything? ___yes ___no If yes, what things seem to cause them to worry or be afraid?

36. Children learn to do things at different ages. I'm going to list some things children learn at different times, and ask you to answer them the best that you can recall and how age appropriate you think it was. This will assist us in fitting our program to your child.

	Age	Earlier than Expected	When expected	Later than expected
(a) Sit up without help				
(b) Crawl				
(c) Walk				
(d) Talk				
(e) Feed and dress self				
(f) Learn to use toilet				
(g) Respond to directions				
(h) Play with toys				
(i) Use crayons				
(j) Understand what is said to them				



KAWERAK, INC.
-Head Start Program-
Child Health History



37. Does your child have any difficulties saying what he/she wants to do or do you have any problems understanding your child? ___yes ___no If yes, please describe.
38. Does your child often get cranky or cry when they are not tired, hungry, or sick and you can't figure out why? ___yes ___no If yes, can you elaborate on it?
39. Have there been any big changes in your child's life in the last six months? ___yes ___no If yes, please explain.
40. Are you or your family having any problems that may affect your child? ___yes ___no If yes, please explain.
41. Is there anything else that you would like us to know about your child?

Health Services Provider

42. Who is your child's health care provider?

Name: _____ Phone: _____
 Address: _____ City: _____ State: _____

43. How long has this agency or physician provided services to your child?
44. How do you transport your child to this health care provider?
45. Where does your child get dental care?
46. How long has your child been receiving services from this dentist?

Person Interviewed: _____ Date: _____
 Relationship to child: _____
 Name of Interviewer: _____ Date: _____
 Title: _____



KAWERAK, INC.
-Head Start Program-
Child Nutrition History



Family Name: _____ Site: _____

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

Nutrition History

(please circle the correct answer)

1. Is your child allergic to any foods? Yes No If yes, which foods? _____
2. Has a doctor, nurse, or nutritionist suggested any special diet for your child? Yes No If yes explain:
3. Does your child take vitamin or mineral supplements at home? Yes No If yes explain:
4. Are there any foods your child does not or will not eat? Yes No If yes explain:
5. Does your child have trouble chewing or swallowing? Yes No If yes explain:
6. Have there been any changes in the child's appetite during the last three months? Yes No If yes explain:
7. How often do you serve the following foods?

Food Type	Daily	Weekly	Sometimes
Milk, Cheese, Yogurt			
Meat, Fish, Chicken			
Eggs, Dried Beans, Peas, Peanut Butter			
Bread, Rice, Cereals			
Fruit or Fruit Juice			
Vegitables			
Cake, Cookies, Candy, Pop			
Butter, Oil, Fats			
Traditional foods (list some of them)			

Comments:

 Signature of Parent/ Guardian

 Date

 Signature of Head Start Staff

 Date



KAWERAK, INC.
-Head Start Program-
Volunteer Bill of Rights



Volunteering is a rewarding experience when those participating in the relationship have a mutual respect and desire to cooperate in meeting designated needs.

- 1. The right to be treated as a Co-worker**
Accepted with the same respect as staff, not treated as free help. Trusted with confidential information that will help carry out the assignment.
- 2. The right to be given a suitable assignment**
With consideration for personal preference, temperament, life experience, education and employment background.
- 3. The right to know as much about the Kawerak Head Start program as possible**
Learn about its policies, people, and programs.
- 4. The right to receive training for the job**
All training pertaining to the job will be given, thoughtfully planned, and effectively presented.
- 5. The right to continuing education**
On the job, as a follow-up to the training. It should include information about new developments and offer training for greater responsibility. The volunteer should also attend meetings and read agency newsletter.
- 6. The right to receive sound guidance and direction**
From experienced, well-informed, patient and thoughtful staff, who have time to invest in giving guidance.
- 7. The right to work**
This should be in an orderly designed area, conducive to work and worthy of the job to be done.
- 8. The right to a promotion and a variety of experiences**
This can be achieved through advancement to assignments with more responsibility, through transfer from one activity to another, and through special assignment.
- 9. The right to be heard**
To have a part in planning, to feel free to make suggestions, to receive respect for an honest opinion.
- 10. The right to recognition**
Given in the form of promotion and awards, through day-to-day expression of appreciation, and by being treated as a genuine co-worker.



KAWERAK, INC.
-Head Start Program-
Parent Volunteer Agreement



Head Start expects all parents to contribute to their child's participation in the Program by volunteering as much as possible. One of the most important ways to volunteer is in your child's center. Please complete the following form so that we can know your availability and work with you to schedule your volunteer time. **NOTE: Parents who volunteer in the classroom for 3 or more days must have a TB skin test completed to ensure the safety of all of the children. Kawerak Head Start will provide this.**

Name: _____ Child's Name: _____

Address: _____

Telephone Number: _____

I pledge to volunteer at least:

____ 10 hours this year

____ 100 hours this year

____ 40 hours this year

____ 160 hours this year

____ 80 hours this year

____ hours this year

I would like to:

____ Work in the classroom

____ Do yard work

____ Help with field trips

____ Help clean the Center

____ Help outside on the playground

____ Help as a bus aide

____ Help do bulletin boards

____ Help in the kitchen

____ Help wash the bus

____ Help paint

____ Plant some flowers

____ Wax, mop, buff floors

____ Help in the office

____ Other

Please tell us what you would like to do: _____

I would like to volunteer on:

____ Monday

____ Tuesday

____ Wednesday

____ Thursday

____ Friday

Volunteer's Signature: _____

Date: _____

Head Start Staff Signature: _____

Date: _____



KAWERAK, INC.
-Head Start Program-
 Arrival/Departure & Daily Attendance Policy



Arrival/ Departure & Attendance Policy

Establishing consistent daily routines gives your child security and helps to build a relationship between the classroom and home. Children who have irregular attendance or who are consistently late miss meals and activities provided by Head Start. For these reasons, children are expected to be at school on time and attend the full class session.

Arrival/Departure

Your child(ren) must arrive at school no earlier than their designated arrival time and must leave no later than their designated departure time. If your child rides the bus, you or your authorized adult must be at the drop-off address at the time assigned to you. (a bus schedule will be provided by the driver). Parents who transport their children or walk them to school will need to drop off and pick-up children based on the classroom schedule.

If you have not picked up your child within 45 minutes or if your child is returned to the Center because you were not at the bus stop, we will call all the numbers you have given us for emergency purposes. If the Center staff is unable to reach you or a representative designated by you within a 45 minute time frame (starting once the child has returned to the center), they will contact the Family Service Coordinator and apprise him/her of the situation. The Family Service Coordinator or Teacher/Teacher Aide will then contact the Office of Children Services as OCS considers the child abandoned.

Attendance

Regular attendance is necessary so that your child gets the most from his/ her Head Start experience. If you fail to call in when your child is absent, Head Start Staff will contact you in regards to the absence. If absences become excessive or routine, a conference will be scheduled to discuss services, options and/or withdrawal. You must respond within 5 days of written staff contact or your child will be considered withdrawn from the program. If your family needs extended leave, you must submit a request in writing.

I will inform a site staff member immediately at (907) _____ if the following emergencies occur:

- * **I or my authorized adult cannot be at the center by the scheduled arrival or departure time,**
- * **I or my authorized adult cannot be at the designated drop-off address at the scheduled time, or if,**
- * **My child is going to be absent from classes.**

Drop-off Time: _____ **Pick-up Time:** _____

I have read the Arrival/Departure & Attendance Policy and it has been explained to me. I understand that my child's participation in the Head Start Program depends on following this policy. Failure to follow it may result in my child being withdrawn from the program.

I further certify that I have received a copy of this policy.

Signature of Parent/ Guardian

Date

Signature of Head Start Staff

Date



KAWERAK, INC.
-Head Start Program-
Statement of Confidentiality



Dear Parent (s):

To preserve the confidentiality of personal and private information collected, such as the results of medical and developmental screenings, ALL records will be kept in a locked file cabinet with limited personnel access.

We will utilize the health and family needs information collected to ensure that your child has a quality Head Start experience. As a parent you have the right to review any information regarding yourself and your family.

Sincerely,

Name/ Title of Head Start Staff

Date



KAWERAK, INC.
-Head Start Program-
Child Abuse Reporting Policy



Kawerak Inc. Head Start staff are obligated by law to report *any suspicion* of child abuse or neglect to the proper authorities.

Definition of Child Abuse and Neglect:

Any mistreatment of children including:

1. **battering** (physical: *hitting, pinching, pulling hair, slapping, excessive corporal punishment*, mental or emotional maltreatment: *name calling, putdowns*)
2. **sexual abuse** or **incest** (inappropriate touching, fondling, and/or penetration, incest is sexual abuse perpetrated by a blood relative)
3. **verbal abuse** (yelling, screaming)
4. **deprivation** (failure to provide necessities)
5. **abandonment** (leaving a child under the age of 12 alone without adult supervision)
6. **exploitation** (using a child for personal or monetary gain, e.g. child pornography)
7. **failure to provide proper supervision** (placing a child at risk)

Reporting Procedures:

1. To further confirm any suspicions, ***talk to the child*** about what has happened to gain as much information as possible.
2. If there are ***any*** suspicions of child abuse or neglect call ***OCS*** (Office of Children Services, formerly the Department of Family and Youth Services) in Nome at **443-5247**.
3. If there is no answer, try ***Kawerak Inc. Social Services*** at **443-5231**.
4. ***Explain the situation***. Ask questions. Ask what will be done. Be assertive and make your concerns known. Remember, the safety of the child is the number one priority.
5. If the person making the report cannot reasonably contact OCS and immediate action is necessary for the well being of the child, ***the person shall make the report to the local peace officer***.
6. If a person making a report is not sure if the situation constitutes child abuse or neglect, they should contact ***OCS*** for advice on the situation. They will let you know if action should be taken.
7. ***Write a formal report to document the incident*** and ***send a copy to*** the Head Start Family Community Partnership Specialist (P.O. Box 948, Nome, AK 99762). The file will ***remain confidential*** as mandated by law. Keep the original in a separate reporting file.
8. If there are any concerns about what action is taking place, a ***follow-up call*** to OCS ***may be warranted***.

I have read and understand the about policies and procedures concerning child abuse and neglect according to Kawerak, Inc. Head Start.

Parent/Guardian's Signature: _____

Date: _____

Head Start Staff Signature: _____

Date: _____



KAWERAK, INC.
-Head Start Program-



Child Development Permission/Agreement Form

I AGREE/UNDERSTAND: (Please Initial)

_____ It is okay for my child(ren) to come and go on the Head Start Bus.

_____ That I am expected to attend one (1) parent orientation session in my child's classroom on the first day of school.

_____ That I am expected to participate in the Parent Committee Meetings and in the classroom.

_____ That I have read and received a copy of the Volunteer Bill of Rights and the Volunteer Guide Handbook. I will comply with the policies of the Kawerak Head Start program concerning volunteers.

_____ That my child, _____, will be in attendance in the classroom every school day on time. I have received a copy of the Daily Attendance and Pick-up Policy

_____ To allow Head Start staff to make 2 home visits during the school year at my convenience (One Home Visit MUST be scheduled within thirty (30) days after the child has been enrolled).

_____ To attend 2 Parent/Teacher Conferences during the school year. The teacher will attempt to schedule a convenient time for you.

_____ That at the end of the school day, and during the school day, my child may be released ONLY to the person(s) signing this form or listed on the Child Plus Application. In the case of an emergency and I cannot be reached, the person to notify is listed on the Child Plus Application and on the Emergency Contact Card. I have received a copy of the child pick-up policy.

_____ That my child may go on all field trips taken by the program, provided I have received information prior to each trip concerning the trips' specific date, destination, time of departure and return. I understand that my child(ren) will be accompanied by the teacher, aides and volunteers, and that I may also choose to attend.

_____ That Kawerak Head Start has the right and permission to copyright and/or publish the photographic portraits, pictures or videos of my child and family. I agree that any such visuals become the exclusive property of Head Start, and I waive all rights thereto. I waive all rights to inspect and/or approve copy that may be used in conjunction with the visuals and the use to which it may be applied. The visual presentation, whole, in part, or composite, may be used as Head Start sees fit in publications of educational materials, and the advertising thereof, and for an other lawful purpose.

_____ That I have the right to review records maintained on my family and to dispute or correct any information I feel to be incorrect. I understand that the Health and Social Services information provided will remain strictly confidential and I have received a copy of the confidentiality policy.

_____ That if a parent, parent substitute, or other authorized person, is not at home or at the bus stop when the child is delivered, he/she will be taken back to the Center. Attempts will be made to contact the parent. If the parent, or other authorized person cannot be reached, OCS Protective Services Unit will be called.

_____ That I have read and received a copy of the Child Abuse policy and reporting requirements.

_____ That Kawerak Head Start has my permission for any screenings/tests/examinations that involve vision, hearing, dental, developmental, physicals, height and weight, mental health observations, and immunizations.

_____ To schedule and keep any appointments with the Public Health Nurse, Dentist, Eye Doctor, or Audiologist to have my child examined and will provide a copy of the exam results to Head Start Staff.



KAWERAK, INC.
-Head Start Program-
Parent Interest Questionnaire



Your answers to this questionnaire will help us present workshops during the year that are of interest to you. If there are other topics you would like to receive training on that we have not listed, please list them under "OTHER". Thank you for completing this questionnaire. **Please order topics in each section from 1 up to 16.**

EDUCATION:

- Early childhood education
- Ages and stages of development
- Building self-esteem
- Make & take learning activities
- Discipline/behavior management (school/home)
- Activities to do with children at home
- Other_____

HEALTH/MENTAL HEALTH:

- HIV/AIDS prevention
- Drugs and alcohol use
- Child abuse & neglect
- Adapting to change
- First Aid & CPR
- Stress management
- Children and medicines
- Home safety and injury prevention
- Childhood diseases
- Gun and weapon safety
- Domestic violence
- Fire prevention and safety
- Health promotion/wellness
- Grief training
- Survival skills (hypothermia etc)
- Other_____

CHILDREN WITH DISABILITIES:

- Head Start & the child with disabilities
- General Information for parents of children with disabilities
- Transition from Head Start to public school
- Teaching aids for parents to help children with disabilities
- Information on the ADA

SITE _____

CHILD'S NAME: _____

NUTRITION:

- Family budgeting/food stamps & low cost meals
- Homemaking skills
- Other_____
- Other_____
- Parent's role in decision-making
- Support services for Grandparent's raising grandchildren
- Other_____

SOCIAL SERVICES:

- Housing needs
- Child support payments
- Community resources
- Legal aid / voter registration
- Budgeting and money management
- Employment
- Other_____

CAREER DEVELOPMENT:

- Developing a resume'
- Completing a job application
- Setting goals
- Developing short range/long range plans
- Job interviewing techniques
- Conflict resolution

PARENT INVOLVEMENT

- Mini-courses on parenting
- Teacher-parent relationships
- Classroom volunteering
- Transportation Commercial Driver License

DATE: _____

PARENT SIGNATURE: _____



KAWERAK, INC.
-Head Start Program-
 Family Survey



Site _____

Program Year: 2004/2005

Child's Name: _____ Parent's Name(s) _____

Box # _____ Phone# _____ Work Phone#(s) _____

Food, Shelter and Clothing:

1. Kawerak has General Assistance for people who need assistance who are not on AFDC or Social Security. Would you like information on how to apply? ___yes ___no
2. Would you like an Energy Assistance application? ___yes ___no
3. Could you use help with winter clothing for your family? ___yes ___no
4. If you live in public housing, does your home need repairs? ___yes ___no
5. Please check if you would like assistance in applying for these services:
 ___AFDC or other public assistance _____
 ___Medicaid _____
 ___Food Stamps _____
6. Would you like information on Nome's Food Bank? ___yes ___no
7. Would you like information on Kawerak's Child Care assistance? ___yes ___no

Health of the Family:

1. Would someone in your family benefit from counseling? ___yes ___no
2. Would you like information on Alcoholism? ___yes ___no
3. Have any of your children had problems with Ear infections that have not been treated? ___yes ___no
4. Does your child have Hearing problems? ___yes ___no
5. Has your child had any other illnesses that have not been treated? ___yes ___no
 If you said yes, please explain the illness _____
6. Would you like information on any other health problems? ___yes ___no
 If you said yes, please list _____
7. Do you need help getting a BIA card that documents degree of blood? ___yes ___no

Prevention of Accident or Injury:

1. Would you like information on protecting child's teeth? ___yes ___no
2. Would you like help with a Family Plan in case of fire? ___yes ___no
3. Would you like help getting a Smoke alarm for your house? ___yes ___no
4. Would you like information on Poison's and Hazardous materials that should be out of children's reach? ___yes ___no



KAWERAK, INC.
-Head Start Program-
 Family Survey



Child Rearing: Head Start has a number of articles that deal with Family Life. Please check which of the following subjects you would like a copy of articles on:

Activities for children		Fears of Children	
Bed Wetting		Fighting among children	
Child Abuse		Single Parenting	
Child Development		Raising self-esteem	
Colic		School Management	
Coping with Death		Suicide	
Discipline		Swearing/Bad Language	
Divorce		Tantrums/Tears/Anger	
Eating Problems		Toilet training	
Fathers Role		Teaching Independence	

Please list any other subjects you would like information on: _____

Would you like us to refer your name to any of the following agencies?

- WIC Norton Sound Health Corp.
- Counseling Norton Sound Health Corp.
- Hearing/Vision Test Norton Sound Health Corp.
- Smoke Alarm Kawerak Head Start/IRA Council/Volunteer Fire Department
- Child Care Kawerak Child Care/IRA Tribal Coordinator
- House Repair Kawerak Housing Authority/Bering Straits Housing Authority

Please check if you would like information on:

Kawerak Adult Basic Education (ABE)

GED (High School Diploma) Drivers Education

Resume Writing

Kawerak Vocational Training

Adult Vocational Training (AVT) Work Experience (JTPA)

Kawerak Adult Higher Education

College Course Work

University of Alaska College Course Work

Northwest Campus (NOME) (Many of these courses can be done by phone)

Job Search Assistance (if you are on AFDC)

Signature _____ Date _____