Enrollment and Orientation Paperwork will be completed remotely due to COVID-19 Pandemic, signatures are waived during this time with the exception of the CACFP and the Emergency Contact/Pickup form.

Enrollment Packet/Acknowledgement

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Parent/Guardian Signature</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center Name/Number</td>
<td>Print Parent Name Consulted</td>
<td></td>
</tr>
<tr>
<td>Head Start Staff Completing</td>
<td>Date Completed with Parent</td>
<td></td>
</tr>
</tbody>
</table>

Child Enrollment Forms to be completed and reviewed by Parent and Staff:

- Scholarship Form (New 7/20)
- Attendance Agreement (Form #1d) ER002 – DOES NOT APPLY TO ABC
- Consent for Sensory, Developmental, Health & Mental Health Observations/Screenings (Rev.6/19)
- ASQSE - Ages and Stages Questionnaire (Social Emotional – give for appropriate age of child)** MH007
- New Enrollees Completed Now
- Returning students completed at Summer Home Visit #1

This section applies to Head Start/ABC only

- Screening Permission Form (O.U.R. Co-Op, Harrison Preschool, NCAESC only) Specifically:
  - Norfolk Center: NCAESC form for parents to complete
  - Harrison Center: (Including Alpena/VS if child lives in Harrison School District) Have parents to complete HSD Preschool Readiness Pre-Screener
- Health Data/Partnership Agreement HL015 (Rev.6/19)
- Health Requirements HL016 Form #1e (Rev.10/19)
- Handout forms and encourage parents to begin these
  - Child Health Record Form #3
  - Dental Exam Verification HL011
- Lead Screening Consent and Release HL020 (Rev.6/19) – DOES NOT APPLY TO ABC
- Consent to Exchange Confidential Health Information HL005 (Rev.6/19)
- Family Strength Assessment** ER010 (Rev.6/19)
- Hand out parent resources for each family according to the family's interests/needs
  - Were any resource information given out during this visit? Yes No (Circle One)
  - Staff Note: Remember to input this data into ChildPlus

OOI HS Form EP ER008

Revised 7-2020

**Direct: Services
If you are interested in accepting this Scholarship, please sign below:

- Follow all guidance in the Parent Handbook.
- Child attends school regularly (at least 85%).
- Completed Dental, Physical within the first 90 days of school.
- Up to date Immunizations are provided before the second week of school.
- 2 Home Visits per year.
- At least 2 family goals will be established and worked toward achieving.
- Each adult volunteer (either at home or in the classroom) at least 2 hours per month.
- At least one adult attends a monthly parent meeting and a monthly M.A.D. meeting.

Upon accepting this scholarship, the following things are expected of each family:

Your child will attend for free!

Has been awarded a tuition scholarship for the 2020/21 school year.

Tuition Scholarship
Ozark Opportunities, Inc.
Program (Circle One): Head Start Early Head Start

Attendance Agreement

Center Name: __________________________ Phone #: __________________________
Child’s Name: __________________________ Teacher Assistant: __________________________
Teacher: __________________________ Center Director: __________________________
Family Support Worker: __________________________

My child will be transported to the Center by (check one): Private vehicle □ Other: ________

Head Start Performance Standards 1302.16 requires that Head Start Programs:

• If the child is unexpectedly absent and the parent has not contacted the center within one hour of start time, staff must attempt to contact the parent to ensure the child’s well-being.

• Monthly average daily attendance of 85%
  o Each time a center’s average falls below 85% the cause must be evaluated.

• Head Start staff will provide appropriate family support for all children to promote regular attendance.

• Home visits or other direct contact with child’s parents will be completed if the child has multiple unexplained absences.

• Individual child attendance data will be reviewed to identify any patterns of absences that put them at risk of missing ten percent of the program year and goals/plans developed to help improve attendance.

I, __________________________ (Parent/Guardian Name) understand that in order for my child to receive the full benefit of the Head Start/Early Head Start Program it is important that my child attend every day the center is open, unless illness or unforeseen circumstances prevent my child from attending.

In the event that my child cannot attend class on any particular day, I will call, text and/or send a message within one hour of center start time or as soon as is reasonably possible to notify the Center Staff and to explain the reason(s) for the absence(s).

(If regular attendance cannot be established through classroom participation, another child on the waiting list must be given the opportunity to enroll in the program. Families will be given every opportunity to establish regular attendance and will be withdrawn from the program only when they are unwilling or unable to participate. Performance Standard 1302.16)

Comments and/or Special Circumstances: __________________________________________

Use the back of this form if additional space is required

New Agreements will be negotiated when circumstances change.

Parent/Legal Guardian’s Signature __________________________ Date __________

Staff Signature __________________________ Date __________

Two copies: One for Child’s file
One for Parent/Legal Guardian

EP ER002

OOI HS 6/2019
Ozark Opportunities, Inc.

Early Childhood Development

*Consent for Sensory, Developmental, Health & Mental Health Observations/Screenings*

- I consent to Federal and/or State guidelines requiring routine screenings for my child participating in the early childhood program. These screenings include: Speech, Developmental, Vision and Hearing performed by trained professionals/staff.

- I consent to Educational Cooperatives/School Districts/DHS/First Connections permission to release screening protocol to Ozark Opportunities, Inc., Early Childhood Program.

- I consent to give Ozark Opportunities, Inc., permission to share information with the child’s school district regarding the health care of my child. I give permission for the school district nursing staff to treat my child with medical issues such as the following but not limited to: accidents, medication administration, visible rashes, spots or sores.

- I consent to release relevant medical information necessary to Emergency Medical Staff in case of an emergency situation with my child.

- I consent for my child to be observed by a Behavioral Health Professional in the classroom setting within 90 days of enrollment. (Parent will be notified of the scheduled date).

- I consent for the Ages and Stages Social-Emotional Questionnaire to be completed on my child.

__________________________________________    __________________________
Parent/Guardian Signature                        Date
Insert ASQ SE for appropriate child age
What is H₂O? What is H₂SO₄? What is NH₄⁺?
Screening Permission Form
Confidential Preschool Screening Consent and Intake/Referral Form

*Legal Name of Child: (Print) ____________________________________________

*Child's Social Security Number: ___________________________ *Date of Birth: ________________

*Age: __________________ *Sex: __________________ *Race: __________________

*Home Address: ________________________________________________

*City: __________________________ *Zip: __________ *Phone: __________________

*County: ____________________ *School District of Residency: __________________

*Parent or Guardian: (Print) ______________________________________

I give Arch Ford Education Service Cooperative Early Childhood permission to screen my child.

*Signature: ______________________________________________ *Date: __________________

*Mark only the area(s) in which you have a concern:

__ Developmental   __ Hearing   __ Behavior, if indicated

__ Speech   __ Vision

*Child's Medicaid Number: ____________________________ (If Applicable)

*Child's Primary Care Physician if Medicaid: ____________________________

*Daycare child attends: ____________________________ (If Applicable)

*Daycare phone: ____________________________

*This information is REQUIRED before, the screening of a child by the Arch Ford Early Childhood.

**This form is to be used on an individual basis, NOT to be included in enrollment packets.**

Please fax or email this form to LeAnne Waddle at: 501-354-6947 fax / leanne.waddle@archford.org email, or you may call the Early Childhood Office at 501-208-5417.

~If this goes further than the Screening Process, copies of the following items are required: birth certificate, social security card and Medicaid or ArKids card (if applicable)
Screening Permission Form

As a service to preschool children, O.U.R. Educational Cooperative will provide screenings for vision, hearing, speech, and developmental (motor, communication, cognition, adaptive and self-help skills). Information about your child may be shared between O.U.R. and your child’s preschool program.

I, as parent/guardian of ________________________________ give my permission for participation in these procedures. I understand that I will be notified of the results and I also give O.U.R. permission to bill Medicaid for eligible services. I understand that no further action will be taken without written parental consent.

Please PRINT the following:

Child’s Name: ____________________________ Date of Birth: ______________

Circle: Male  Female  Race: _______  Nickname?: ______________________

Preschool Name: _________________________ Teacher: ___________________

Home Address

Street __________________________________ City __________________________
State _______ Zip Code _______

School District: (Circle)
Mountain Home  Cotter  Flippin  Yellville  Ozark Mountain  Valley Springs

Parent(s)/Guardian(s): ______________________

Home Phone # ________________ Work Phone # ______________________

Best Time to Call __________________________

Medicaid/AR Kids Insurance card? No ___ Yes ___ # ______________________

Child’s Social Security # ______________________

The Child’s Primary Care Physician: ______________________

Has this child ever received speech or developmental services: No ___ Yes ___?

If yes, Where? __________________________

_________________________ Relationship to Child: ______________________

Parent/Guardian Signature

Form #6.c
The staff of Harrison Early Childhood Educational Services will be visiting your child's preschool center to administer a series of screening measurements which include vision, hearing, speech, and developmental. These screenings will determine possible specialized instruction for your child to help prepare him/her for school.

All screenings are offered as a free service to children, ages 3-5 years (but not kindergarten eligible), residing in the Harrison School District. If you have any questions, please contact Tammie Bright or Becky Morse at Harrison Early Childhood Services at 741-2337.

Child's Name ___________________ Date of Birth ____________ Male ___ Female ___
Child primarily lives with: _____Mother _____Father _____Both _____Guardian(s)
Parent/Guardian Name ________________________________
Home Address (if PO Box, must include a physical address)

____________________________________________________

Home Phone _______________ Work ___________ Cell __________
Parent's Email Address: ________________________________
Does your child have a Medicaid Card? ____ No ____ Yes _______________________
(Medicaid Number Required if Applicable)
Does your child have ARKids Insurance? ____ No ____ Yes _________________________
(ARKids Number Required if Applicable)
Child's Social Security Number: ____________________________
(Required)
Child's Primary Physician: __________________ Phone: __________________________

Has this child ever received speech or developmental service before? YES  NO
If so, what services were received and where? ________________________________
Current Child Care Center or HIPPY Program: ________________________________
Child's Classroom Teacher or HIPPY Provider: ________________________________
Primary language spoken in the home: ___ English ___ Spanish ___ Other ________

I, as parent/guardian, give Harrison Early Childhood Services consent to screen my child.

_________________________________________ ________________________________
Parent/Guardian Signature                    Date
Parental Consent to Access Public Insurance and to Release Personally Identifiable Information

Name: ___________________________ ID: ___________________________ Date of Birth: ___________________________

Age: _______ Grade: _______ Local Education Agency: ___________________________

Medicaid Number: ________________

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid, and who receive those services that are identified in their individualized education program (IEP). In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to agencies not identified in the Act. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

By signing below, you are indicating the following:

- I understand and agree that I am giving the school district permission to access my or my child's public benefits or insurance.

- I understand that my child's education records and information about the services my child receives through an IEP may be released to the Department of Human Services, Division of Medical Services, Arkansas Medicaid, and the school district's Medicaid billing agent for the purpose of billing Medicaid.

- I understand that this may include sharing information with DHS, contracted billing agents, and/or a physician to obtain necessary documentation to receive reimbursement for services provided through an IEP.

- I understand that information to be released may include: student's name, date of birth, social security number, Medicaid ID, disability, IEP and evaluations, type of service(s), times and dates services were delivered, and progress notes.

- I understand that this consent will remain in effect at all times the district is responsible for providing IEP services to my child, unless revoked by me.

- I understand that I may revoke consent at any time by notifying the school district in writing.

- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.

Before giving my consent below, I was provided with a written notice further explaining my rights and protections under Part B of the Individuals with Disabilities Education Act (IDEA) regarding consent and the purpose of this form.

_____________________________  ___________________________
Parent or Guardian Signature  Date

_____________________________
ur child covered by private insurance? ☐ No ☐ Yes (If yes, please complete Third Party Liability Section)

Parental Consent to Access Public Insurance and to Release Personally Identifiable Information
Parental Consent to Release Personally Identifiable Information
Third Party Liability Section*

*This section should only be completed if the student is covered by private insurance.

Name: ___________________________ ID: ___________ Date of Birth: ___________

Age: _______ Grade: _______ Local Education Agency: _________________________

Medicaid Number: __________________

Information Related to Billing Third Party Insurance:
Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability, requires that all third party sources must be utilized before reimbursement can be made by Medicaid. Part B of the Individuals with Disabilities Education Act (IDEA) prohibits a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes. IDEA does not create exceptions to Title 42 CFR, Part 433, Subpart D. All Medicaid providers, including school districts, should attempt to exhaust third party liability prior to making claims to Medicaid.

Please check one of the following:

☐ I do NOT give permission to the school district to bill my private insurance for healthcare services delivered in the school.

☐ I give my permission to the school to bill my private insurance for healthcare services delivered in the school.

Private Insurance Information:
Insurance Company: ________________________________

Address: _______________________________________

Phone: _____________________________

Name of Policy Holder: ____________________________

Policy Holder Date of Birth: ___________________ Social Security Number: _____________

Policy Number: ___________________________ Group Number: ___________________

Parent or Guardian Signature ___________________________ Date ___________
HEALTH DATA SHEET & HEALTH PARTNERSHIP AGREEMENT

Head Start/Early Head Start Center __________________________ Room# ______________

Child’s Name __________________________________________ Birthdate ____ / ____ / ____

Child’s Physician __________________________ Child’s Dentist __________________________

Child’s Health Insurance: Medicaid □ Arkids □ Private Insurance □ None □ Other ______

1. Child has known or suspected health conditions: Yes□ No□
   Diabetes □ Asthma □ Seizures □ Anemia □ Food Allergies □ Hearing Impaired □
   Other __________________________

2. Documented by (Physician’s name) __________________________ City __________ Date __________

3. Does child take medication? Yes□ No□ Name of Medication __________________________
   For what condition __________________________

4. Will the child need medication during school hours? Yes□ No□

Health History Update:

5. Has your child had any hospitalization, operation, major illness or injury? Yes□ No□

6. Has your child had trouble with wheezing or coughing at night? Yes□ No□

7. Has your child experienced any excessive weight loss or gain recently? Yes□ No□

8. In the last 12 months, has your child had a physical and/or dental exam? Yes□ No□
   Date of last physical exam __________ Date of last dental exam __________

Explain any ‘yes’ answers ____________________________________________________________

List other necessary health or nutrition information/concerns ____________________________

________________________________________

HEALTH PARTNERSHIP AGREEMENT

Yes□ No□ I understand the Health requirements must be met as soon as possible or within 90 days.
Yes□ No□ I understand the importance of being involved in my child’s healthcare.
Yes□ No□ I understand the information on this form will be used to meet the health needs of my child.
Yes□ No□ I agree to keep my child on a schedule of well child care while enrolled in the program.
Yes□ No□ I hereby enter into this Health Partnership with OOE Head Start/Early Head Start.

________________________________________
Signature of Parent/Guardian

________________________________________
Date

EP

HL015

Revised 6/2019
Ozark Opportunities, Inc. Early Child Development
HEALTH REQUIREMENTS

Date: ____________________ Child’s Name: ____________________ Date of Birth: ____________________
Center: ____________________ Classroom: ____________________ Teacher: ____________________
Family Support Worker (FSW): ____________________ Phone: ____________________

Dear Parent,

Federal, State, and local regulations require that each child in the Early Child Development programs be up-to-date on a schedule of age appropriate preventative and primary health care, including medical and dental. Head Start Program Performance Standards (specifically) require that each child have:

- A well child checkup/physical exam **prior to or within 90 days of enrollment**
- A dental exam **prior to or within 90 days of enrollment**
- Blood Lead Testing **prior to or within 90 days of enrollment** (may be acquired through Head Start services or your primary care physical and typically done at 12 and 24 months) **Not Required for ABC students**
- Up-to-date, age appropriate immunizations **prior to or at enrollment**

If you have not done so, please contact your doctor or clinic as soon as possible to take care of these requirements within the mandated timeframe. Failure to do so may result in your child being placed back on the wait list until the requirements have been met and an opening is available in the classroom.

Your center’s Family Support Worker can assist you by scheduling appointments, providing transportation to and from those appointments for you and/or your child and in accessing a medical provider or obtaining medical insurance. Limited funds are also available in the event of extreme circumstances and/or a specific need.

Thank you,
Sharon D. Burnett
(Health & Nutrition Coordinator)

__________________________
By my signature, ____________________________, parent of ____________________________, I acknowledge that I am aware of the preventative health and oral care requirements of the Early Child Development Program, as set by federal, state, and local regulations. I also acknowledge that I understand that failure to meet the health and oral care requirements of these regulations within the allowed timeframe may result in my child being placed back on the wait list until those requirements are met and an opening is available in the classroom.

Parent Signature: ____________________________ Date: ____________________________
Witness Signature: ____________________________ Date: ____________________________
CHILD HEALTH RECORD

Form 3, Screenings, Physical Examination / Assessment

Part 1: To be completed by head start staff or health care provider before physical examination / assessment

Child's Name: ____________________________ Sex: ________ Birth Date: ____________________________

Head Start Center: ____________________________

1. RELEVANT INFORMATION (from health history, parent/teacher observations):

ANY CHANGES IN PATIENT HEALTH SINCE LAST VISIT? Yes ______ No ______

EXPLAIN: ____________________________

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.

<table>
<thead>
<tr>
<th>TEST</th>
<th>DATE</th>
<th>RESULTS</th>
<th>TEST</th>
<th>DATE</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. PRESENT AGE*</td>
<td><em>Yrs.</em> <em>Mos.</em></td>
<td>h. VISION (Type of Test)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. HEIGHT (no shoes, to nearest 1/8&quot;)*</td>
<td></td>
<td>Acuity, R/L</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. WEIGHT (light clothing to nearest 1/4 lb.)*</td>
<td></td>
<td>Re-screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. BLOOD PRESSURE</td>
<td></td>
<td>Strabismus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. HEMOGLOBIN or HEMATOCRIT*</td>
<td></td>
<td>Comments:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. HEARING (Type of Test)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results, R/L</td>
<td></td>
<td>(1) TB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-screening</td>
<td></td>
<td>(2) Sickle Cell</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
<td>(3) Lead</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. CHOLESTEROL</td>
<td></td>
<td>(4) Ova &amp; Parasites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. OTHER TESTS (if indicated)</td>
<td></td>
<td>(5) Urinalysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td></td>
<td>(6) Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td></td>
<td>(7) BMI%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3)</td>
<td></td>
<td>(8) Temp.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. PHYSICAL EXAMINATION / ASSESSMENT:

<table>
<thead>
<tr>
<th>Normal For Age</th>
<th>Abnormal</th>
<th>Not Eval.</th>
<th>Comments: (Use additional sheet if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. General Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Posture, Gait</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Speech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Eyes: (1) External Aspects (2) Optic Funduscopic (3) Cover Test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Ears: (1) External &amp; Canals (2) Tympanic Membranes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Nose, Mouth, Pharynx</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Teeth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Abdomen (include hernia)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m. Genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. Bones, Joints, Muscles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p. Glands (Lymphatic/Thyroid)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q. Muscular Coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. OTHER:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CLINIC INFORMATION (or stamp):

Name: ____________________________

Address: ____________________________

Phone: ____________________________

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS:

<table>
<thead>
<tr>
<th>Abnormal Findings/Diagnosis</th>
<th>Treatment Plan</th>
<th>Recommended Follow-Up or Results (initial when complete)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: ____________________________ M.D./D.O. Date: ____________________________

a. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Do you consider this child up-to-date on a schedule of well-child care according to the State EPSDT schedule? Yes ______ No ______

Do you see any reason this child cannot participate in Head Start program? Yes ______ Explain ______ No ______

EP
Ozark Opportunities, Inc. Head Start/Early Head Start Program
Dental Exam/Follow Up

Child’s Name: __________________________ Date of Birth: ____ / ____ / ________

Parent/Guardian Name: __________________________ Phone#: ______________________

Number of Caries: _______ Plaque: Light _______ Moderate _______ Heavy _______

Condition of Teeth: ____________________________________________________________

Gum Condition: Normal _______ Swollen _______ Bleeds Easily _______ Infected ______

<table>
<thead>
<tr>
<th>DATE</th>
<th>SERVICES PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESULTS/RECOMMENDATIONS</th>
<th>APPOINTMENT DATE (S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

____ Child needs extensive work
Will be done by this DDS

____ Child needs extensive work by Pedodontist
Referral to:

                                  __________________________

____ Child needs minimal work: can be completed
within five (5) visits

____ Child needs routine prevention services only

____ Child has areas that need to be watched, will
schedule to see in six (5) months

Remarks: ________________________________________________________________

Dentist’s Name (Please Print): __________________________ Date of Exam: ____ / ____ / ________

Address: __________________________ Phone#: ______________________

Signature of Dentist: __________________________
Lead Screening Consent and Release

Child's Name _______________________________ DOB ___/___/____

Last First MI

Has this child had a Lead Screening before? Yes (Date_____) No
Child's Physician ___________________________
Parent/Guardian ____________________________
Phone ____________________________ Phone ______________

Would you like to be present when the blood lead testing is done? Yes No

NOTE: If you indicate that you wish to be present during the testing, you must be present for your child to receive this FREE service.

Lead Poisoning occurs when a person swallows a lead object or inhales lead dust, some of the poison can stay in the body and cause serious health problems. A single high, toxic dose of lead can cause severe emergency symptoms. However, it is more common for lead poisoning to build up slowly over time. Children under 6 years of age are at the greatest risk. You may not notice any signs of lead poisoning. Some symptoms of lead poisoning are headaches, stomach aches, nausea, tiredness and irritability. Irreversible health effects of lead poisoning include:

- Reduced IQ
- Slowed body growth
- Hearing problems
- Learning or behavior problems
- Restlessness
- Brain, liver and kidney damage

Participation involves pricking your child’s finger to get a sample of blood to test for the presence of lead. Should your child’s results be high, you will be referred to your primary care physician to have your child tested again to confirm the results. There is little risk to your child. Benefits of the Screening include:

1) Individual results of your child’s blood lead level are known in minutes
2) Individual results supplied to you to take to your child’s physician
3) Testing is performed in a non-evasive manner

Arkansas Health Department will be supplied with results and other requested information.

Choose from one of the options listed below:

____ I consent to having OOI staff, along with a licensed health care professional, conduct a lead screening by finger stick, and hereby release OOI Head Start/Eary Head Start and the licensed health care professional from any liability.

____ I will take my child to his/her primary care physician to have a BLOOD LEAD LEVEL screening completed by the date of _____________. I understand any cost and/or payment arrangements will be my responsibility.

____ I understand this screening is required by Head Start/Eary Head Start and is for the health of my child, but choose to refuse this screening for the following reasons:

________________________________________

________________________________________

Parent/Guardian Signature

Date

Licensed Health Care Professional Signature

Date

OOI Health Services Coordinator Signature

Date

HL020 #8(f) Revised 06/2019
EP
Ozark Opportunities, Inc. Head Start/Early Head Start Program

CONSENT TO EXCHANGE CONFIDENTIAL HEALTH INFORMATION

Dear Health Care Provider: 

__________________________ __________________________

Child’s Name Date of Birth

is an enrollee in our Head Start/Early Head Start Program. His/her parents have indicated that you or your clinic serves as this child’s primary source of health/dental care.

All children enrolled in a Head Start/Early Head Start program are required to have a physical and dental exam according to the EPSDT schedule of Arkansas. Our information indicates the above-named child has received the age-appropriate exam within the past 12 months.

In order to maintain a complete health record for this child, we ask that you complete, sign and date the attached document: (Form #3 Physical Exam or Form #5 Dental Exam), indicating (1) the date of the child’s last well-child check up or dental exam, (2) any recommendations for follow-up, and (3) if you consider them up-to-date, based on the above-mentioned criteria.

Do you consider this child up-to-date on a schedule of well-child health care according to the State EPSDT schedule? _____Yes _____No

Comments

__________________________ __________________________

Signature Primary Care Provider (MD/DO or DDS) Date

__________________________ __________________________

Parent’s Signature (indicates permission to obtain information) Date

Thank you for your promptness in forwarding the requested information and for providing health/dental health services to the families in our community.

Return documentation to:

Family Support Worker _______________________________________

Head Start/Early Head Start Center _______________________________

Address _____________________________________________________

Phone # ______________________________ FAX# ___________________

HL005 EP #8(d) Revised 06/2019
Ozark Opportunities, Inc., 0-5 Early Childhood Education, HS, EHS & ABC

Family Strengths/Needs Self-Assessment

Child’s Name: ___________________________ Dates Completed: ___________________________

Parent/Guardian Name(s): ___________________________

Child’s Center: ___________________________ Teacher: ___________________________

Please answer the following questions. Your answers will help set goals to support your child’s education at home. Your answers will help identify your strengths and skills and help you reach your goals. The focus is on family well-being and parent connections to peers and community. The points will help us support you. All your answers are kept confidential. Thank you!

Section 1. Access to Community Resources

How satisfied are you with the resources that are available to you in your community? Check one box.

Resource Examples: Medical, Dental, Clothing, Food, Gas, Utilities, Housing, etc.

R1 R2 R3 R4
☐ ☐ ☐ ☐ 4 We have strong social networks through our friends, neighbors, place of worship, and town, and know where to get help from community agencies when we need it. This is an area of significant strength in my family.

☐ ☐ ☐ ☐ 3 We have strong social networks, but would like to learn more about the resources and services available to us in our community.
My family could benefit from some support in this area.
Area(s) of Need ___________________________

☐ ☐ ☐ ☐ 2 We don’t know the community very well, and have limited friends or family, or church members, to support us.
My family could benefit from significant support in this area.
Area(s) of Need ___________________________

☐ ☐ ☐ ☐ 1 We need help with basic needs for our family and don’t know what to do or where to go.
My family needs help in this area right now.
Area(s) of Need ___________________________

Section 2. Access to Health

A. Medical
Does your child have a medical home (doctor)?

R1 R2 R3 R4
☐ ☐ ☐ ☐ Yes Where: ___________________________ Date Release is Signed: ___________________________

☐ ☐ ☐ ☐ No (Complete a Goal Medical Home Worksheet to track progress).

1 | Page
EP

Revised 06/2019
ER010
Section 2. Access to Health (continued)

B. Dental
Does your child have a dental home (dentist)?

R1 R2 R3 R4
☐ ☐ ☐ ☐ Yes Where: __________________________ Date Release is Signed: ______________

☐ ☐ ☐ ☐ No (Complete a Goal Dental Home Worksheet to track progress).

☐ ☐ ☐ ☐ N/A for EHS 12 month or younger

Section 3. Self-Sufficiency

A. Housing/Community
How satisfied are you with your housing and community? Check one box.

R2 R3 R4
☐ ☐ ☐ 4 We own our home, or maintain a stable rental without any housing subsidy assistance.

This is a significant strength for my family.

☐ ☐ ☐ 3 We have stable subsidized housing that meets our basic needs, OR would like to find a nicer house or neighborhood.

My family could benefit from some support in this area.

☐ ☐ ☐ 2 We are living doubled up with friends or family or in an unsafe or poorly maintained house or apartment OR we are having trouble affording our current rent.

My family could benefit from significant support in this area.

☐ ☐ ☐ 1 We are about to get evicted or are in danger of being homeless.

My family needs help in this area right now.

B. Transportation
How satisfied are you with your current transportation situation? Check one box.

R2 R3 R4
☐ ☐ ☐ 4 We have a car or easy access to public transportation.

This is a significant strength for my family.

☐ ☐ ☐ 3 We have a car or access to public transportation, but sometimes I need help getting to appointments or getting the children to school.

My family could benefit from some support in this area.

☐ ☐ ☐ 2 We often have trouble getting to work, school, shopping or other appointments and need to rely on others.

My family could benefit from significant support in this area.

☐ ☐ ☐ 1 Our lack of transportation is making it impossible to get to school, work, shopping.

My family needs help in this area right now.
Section 3. Self-Sufficiency

C. Employment
How satisfied are you with your current job or employment situation? Check one box.
R2  R3  R4
☐ ☐ ☐ 4 My current job/income provides sufficient income to meet all of my family’s needs and wants.
This is an area of significant strength for my family.

☐ ☐ ☐ 3 I have a job, but would like a better one OR I'm not currently employed and would like to find a job.
My family could benefit from some support in this area.

☐ ☐ ☐ 2 We need help finding employment OR have been out of work for a long time.
My family could benefit from significant support in this area.

☐ ☐ ☐ 1 We need help finding work in order to support our children.
My family needs help in this area right now.

D. Education
How satisfied are you with your current educational situation? Check one box.
R2  R3  R4
☐ ☐ ☐ 4 I am completely satisfied with my current level of education. My educational level allows me to meet
my employment goals and dreams.
This is an area of significant strength for my family.

☐ ☐ ☐ 3 I have completed high school or have my GED, but would like to further my education OR have some
college/technical training and am interested in pursuing more.
My family could benefit from some support in this area.

☐ ☐ ☐ 2 I need more education to get a better job or to help my children succeed in school.
My family could benefit from significant support in this area.

☐ ☐ ☐ 1 I cannot read or write in English or my native language OR I cannot find a job because of my level of
education.
My family needs help in this area right now.

E. Child Care
How satisfied are you with your current child care situation? Check one box.
R2  R3  R4
☐ ☐ ☐ 4 All of our children have high quality and stable child care from a center, school program, or relatives.
This is an area of significant strength for my family.

☐ ☐ ☐ 3 My children have child care, but I would like to find higher quality or more consistent care for them.
My family could benefit from some support in this area.

☐ ☐ ☐ 2 My child care often falls through and is not reliable.
My family could benefit from significant support in this area.

☐ ☐ ☐ 1 My children do not have child care or have poor quality care, and I need child care to attend school or
go to work.
My family needs help in this area right now.
Section 4. Family Finances

Sometimes families have a hard time getting by on the money available. Please answer yes or no:

R2  R3  R4  I am able to pay my bills on time.
☐ ☐ ☐ Yes
☐ ☐ ☐ No

R2  R3  R4  I know how to create a family budget.
☐ ☐ ☐ Yes
☐ ☐ ☐ No

R2  R3  R4  It is sometimes difficult to meet basic needs for food, clothing or housing.
☐ ☐ ☐ Yes
☐ ☐ ☐ No

R2  R3  R4  My family has a lot of debt.
☐ ☐ ☐ Yes
☐ ☐ ☐ No

R2  R3  R4  My family is able to get credit.
☐ ☐ ☐ Yes
☐ ☐ ☐ No

R2  R3  R4  My family sometimes has to rely on others for financial assistance.
☐ ☐ ☐ Yes
☐ ☐ ☐ No

R2  R3  R4  My family has financial needs at this time.
☐ ☐ ☐ Yes  Please describe your current needs: ____________________________________________
☐ ☐ ☐ No