Welcome to NACT Head Start program. Our program is designed to provide you and your child with comprehensive education services. These services include developmentally appropriate educational experiences, health, and mental health services, and a safe and secure environment. We provide family support services by offering parent training workshops on various topics, resources and referral information and opportunities to be involved in the Head Start program.

Head Start services are provided to families that meet the income guidelines as well as families of children with disabilities.

EACH CHILD'S APPLICATION MUST HAVE THE FOLLOWING DOCUMENTS BEFORE IT CAN BE PROCESSED

- **Birth certificate**
- **Current immunization record**
- **Verification of income**
- **For Foster parents or Legal Guardians official documentation**

YOUR CHILD WILL ALSO NEED:

- **Current physical (to include lead screening and Hematocrit.) (form attached)**
- **Dental exam (form attached)**

✦ AN INCOMPLETE APPLICATION CANNOT BE PROCESSED

** If assistance is needed to obtain any of the items listed above please contact us at 918-446-7939

** NACT does not provide transportation; resources will be made available upon request.

Native American Coalition of Tulsa
Criteria List

This form must be completed at time of application to the program to be considered for enrollment. An X should be placed by any of the situations described below that apply to anyone in your immediate family.

This information will be use to prioritize your eligibility into the NACT Head Start Program.

1.____Homeless (this means children who lack a fixed, regular and adequate nighttime residence, or families who share the housing of others due loss of housing, economic hardship, living in motels, hotels camping grounds, or emergency or transitional shelters.

2.____Single Parent family

3.____Child raised by someone other than parent (grandparents, other family members)

4.____Foster child (provide documentation)

5.____Child was previous enrolled in Head Start (or Early Head Start)

6.____Family is receiving TANF, or SSI

7. ____Substance abuse, domestic violence in the home

8.____Court ordered or referral from another agency (provide proof of referral)

9.____ Family member has health issues, or disability

10.___Crisis in family during past year (incarceration, fire, death, etc.)

11. ___Child has a professionally diagnosed disability (provide documentation)

12.___ Child suspected of having a disability (what type?) _____

13. ___Current Physical (with HGB and Lead Screening)

14. ___Current Dental

13. ___Other, describe _____

Parent/ Guardian Signature _____

Please mark which site you are requesting:

____ West Campus **____ Mark Twain**

____ Highway 97 **____ Glenpool**

NACT HEAD START Enrollment Application

CHILD INFORMATION

Child's Legal Name First	Middle	Last
Date of Birth:	Child's Gender: Male Female	
Address:	City:	State : Zip:
Child's Race: Black/African American White Biracial/ Multiracial Asian American Indian/Alaska Native Other: _____	**Child's Ethnicity:** Hispanic/Latino Non- Hispanic **Insurance:** Medicaid #_____ Sooner Care # _____ Private Name & # _____	**Primary Language At Home:** English Spanish Other:_____ **Proficiency:** Poor Moderate Proficient **Secondary Language:** English Spanish Other_____

ADULT INFORMATION

Primary Adult: First Name	**Last name**	**Relationship to Applicant:**
Date of Birth:	**Gender:** Male Female	**Marital Status:** Single Married Divorced Other
Home Phone Number:	**Cell Phone Number:**	**Work Number:**
Housing: Rent Own Staying with family	**Adult Race:** Black/African American White Biracial/Multiracial Asian American Indian/Alaskan Native Other _____	
Language Spoken at Home English Spanish Other _____ **Secondary Language:**_____	**Employment Status:** Part time Full time Unemployed Retired/ Disabled **Are you attending School /Training?** If so where_____	
Education Level: Non graduate Diploma GED Some College AA BA		

Secondary Adult: First Name	**Last name:**	**Relationship to Applicant:**
Date of Birth:	**Gender:** Male Female	**Marital Status:** Single Married Divorced Other
Home Phone Number:	**Cell Phone Number:**	**Work Number:**
Housing: Rent Own Staying with family	**Adult Race:** Black/African American White Biracial/Multiracial Asian American Indian/Alaskan Native Other _____	
Language Spoken at Home: English Spanish Other _____ **Secondary Language**: _____	**Employment Status:** Part time Full time Unemployed Retired/ Disabled **Are you attending School /Training?** If so where_____	
Education Level: Non graduate Diploma GED Some College AA BA		

First and Last Name of Other people Living in household	Date of Birth	Gender	Relationship to Child	Adult or child
1.				
2.				
3.				
4.				
5.				

FAMILY INFORMATION

Parental Status: One parent Two Parent Foster Grandparent Non Parent Other

Total Household Size _____

Any member of your family In the US Military or a Veteran?

Does your family receive any of the following:

TANF SNAP SSI WIC

How did you hear about our program?

Flyer Staff Newspaper Word of Mouth Family/friend Referral Other

MEDICAL INFORMATION

Which of the following health concerns or problems relate to this child?

Behavior/Emotional Problems Developmental Delays Seizures/Convulsions Hyperactivity

Allergies Chronic Health problems : Severe Asthma Diabetes Obesity Arthritis

No Health Concerns Other_____

SPECIAL NEEDS INFORMATION

Does this child have a disability or special need? Yes No Suspected_____

If yes, what is diagnosis;_____

Receiving services? Yes No If yes, with who_____

Does child have an IEP or had an IFSP? Yes No

If no has child been referred for services related to suspected disability? Yes No

PARENT/GUARDIAN – PLEASE READ AND SIGN

I understand that this is an application for services offered and does not constitute enrollment into program. Applications must meet all eligibility guidelines and will be prioritized by greatest need.

I understand that if my child is selected to participate in the program, parent involvement will be critical to the success of my child.

I understand my child will need a physical and dental exam, along with lead and hematocrit results.

I agree to allow any and all documents pertaining to my child's enrollment of the program to be released to the public school district my child will be attending in kindergarten. I understand this consent is voluntary _____. (Parent initials)

I certify that the information given on this application is true and accurate and all income has been reported. I certify that I am the parent/guardian of the child for whom this application is being made.

_____ _____

Parent/Guardian Signature Date

Office Use Only

- ☐ In Person Interview
- ☐ Telephone Interview: Reason_____

_____ _____

Staff Signature Date

NACT HEAD START
Physical Examination

Child's Name: _____ DOB: _____ Date of Exam: _____

REQUIRED TESTS

B/P: ____ **Hemoglobin:** Date:_____ Results:_____ **Blood Lead Level**: Date_____ Results:_____

IMMUNIZATION RECORD (*MUST BE PROVIDED TO ATTEND HEAD START*) PLEASE PROVIDE THE MOST RECENT IMMUNIZATION RECORD. If child is not up-to-date with immunizations, the next scheduled appointment is:

_____

SCREENING RESULTS:

Height:	Weight:	Vision:	Hearing:

PHYSICAL EXAM RESULTS:

Head:	Eyes:	Ears:
Nose:	Oral:	Lymph nods:
Skin:	Chest:	Speech:
Abdomen:	Hernias:	Orthopedic:
Nervous System:	Muscular Coordination:	
Behavior/Development:	Heart/Lungs:	

Allergies/Chronic Conditions: (an Individual Health Plan will have to be signed)

_____

Physician Specific Concerns/Referrals: _____

_____

If any medication is to be given at Head Start, per law, we must have the Medication Administration form completed by the doctor and the parent to include medication name, dose, route, frequency, symptoms necessitating, side effects and actions to be taken if side effects occur. Form must be updated yearly.

Provider's Name (please print): _____

Provider's Address: _____

_____

Provider's Signature: _____ Date: _____

PLEASE RETURN THE COMPLETED PHYSICAL FORM, ALONG WITH IMMUNIZATION RECORD TO NACT HEAD START.

This form can be faxed to (918) 446-6003.

THE NATIONAL CENTER ON Health

Head Start Oral Health Form

Patient Information

Pregnant woman's/child's name _____ Pregnant woman's/child's date of birth _____

This practice is the pregnant woman's/child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the pregnant woman or child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

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

Does the pregnant woman have gum disease? ☐ 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 Pregnant Women, Parents, Head Start Staff, and Medical Providers

_____

_____

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

actice name _____ Address _____

Provider signature _____ Date _____

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