Nez Perce Tribe

Mamáy'asnim Hitéemenwees

ENROLLING YOUR CHILD

2020 - 2021

Included in this packet:

- ☐ Applicant & Family Member Information
- ☐ Release of Confidential Information Forms (MH and NMPH)
- ☐ Consent for Health & Education Services
- ☐ Child Health History Form
- ☐ Nutrition Assessment Form
- ☐ USDA Child Enrollment Form
- ☐ Verification of Annual Household Income Form
- ☐ Head Start Bus Route Form (ages 3-5 only)

In addition, the following items will be needed to complete your application:

- ☐ Birth Certificate or Verification of Age (can use other records)
- ☐ Current Immunization Record
- ☐ Up-to-Date Health Physical / Well-Child Exam (not more than a year old)
  ask for a physical form if needed
- ☐ Income Verification (W-2 or Income Tax Return
- ☐ Tribal Enrollment / CIB (if applicable)

PLEASE NOTE:

All applications must include verification of age and income to be considered for enrollment. Mamáy'asnim Hitéemenwees has forty-five (45) days to obtain required health information but we prefer to have it at the time of enrollment. Please ensure your provider is listed on the release forms for us to be able to obtain the information we need.

If you have any questions or would like to make an appointment to sit down and complete the application with Family Services Staff, please contact us at 208-843-7330.

Applicant & Family Member Information — Mamáy'asnim Hitéemenwees

Applicant

First | Middle | Last | Suffix | Nickname | Birthday | Gender ☐ Female ☐ Male | SSN

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language
☐ Spanish ☐ Nimiipuutimt

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Does your child have an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP)?
☐ Yes ☐ No ☐ Not Applicable

Primary Health Coverage
☐ Medicaid ☐ Private Insurance ☐ CHIP ☐ _____ ☐ No Insurance

Insurance #

Other Coverage

Medicaid Eligibility
☐ On Medicaid ☐ Not Eligible ☐ Potentially

Medicaid #

Doctor/Medical Home
☐ NMPH ☐ VMC ☐ Palouse Pediatrics ☐ Tri-State ☐ BMC ☐ CHAS ☐ _____

Dental Coverage
☐ Medicaid ☐ Private Insurance ☐ CHIP ☐ _____ ☐ No Insurance

Dental Coverage #

Dentist/Dental Home
☐ NMPH ☐ BMC ☐ CHAS ☐ _____

Primary Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender ☐ Female ☐ Male | SSN

Race
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language
☐ Spanish ☐ Nimiipuutimt

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's

Employment Status
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed ☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled

Employer: _____

Child's Relationship
☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other: _____

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Receive emails from MH:
☐ Yes ☐ No

Secondary or Other Adult

First | Middle | Last | Suffix | Nickname | Birthday | Gender ☐ Female ☐ Male | SSN

Race
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language
☐ Spanish ☐ Nimiipuutimt

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Highest Grade Completed
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED ☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's

Employment Status
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed ☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled

Employer: _____

Child's Relationship
☐ Biological/Adopted/Step ☐ Grandchild ☐ Other Relative ☐ Foster ☐ Other: _____

Custody
☐ Yes ☐ No

Check all that apply:
☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent

If teen parent, subsidized?
☐ Yes ☐ No

Email Address:

Receive emails from MH:
☐ Yes ☐ No

Additional Child (Non-Applicant) *

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language
☐ Spanish ☐ Nimiipuutimt

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Additional Child (Non-Applicant) *

First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN

Race
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____

Hispanic
☐ Yes ☐ No

English Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

Other Language
☐ Spanish ☐ Nimiipuutimt

Other Language Proficiency
☐ Little ☐ Moderate ☐ None ☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

This Section for Agency Use Only:

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

Family Information

Family Living Address

Length of time at this address
☐ > 6 months ☐ 1-2 years
☐ 6-12 months ☐ 2+ years

Living Address | **ZIP** | **City** | **State** | **County**

Family Mailing Address

Same as living?
☐ Yes ☐ No

Mailing Address | **ZIP** | **City** | **State**

Phone Number(s)	Type (*check one*)	Note (Whose #, ext., or best time to call)	Opt In for Text Messages
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No
	☐ Cell ☐ Home ☐ Work ☐ Other		☐ Yes ☐ No

Parental Status (*check one*)	Primary Language at Home	Homeless Family	Active Duty Military	Referred by Child Welfare Agency	Receiving SNAP	WIC	WIC ID (*if applicable*)
☐ One ☐ Two	☐ English ☐ Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

TANF Status	SSI	Current CCDF Participant	Housing	Interested in Volunteering	Field Trip Permission	Photograph Permission
☐ Yes ☐ No ☐ Formerly on TANF/Not now	☐ Yes ☐ No	☐ Yes ☐ No	☐ Rent ☐ Own ☐ Section 8 ☐ Live w/Relatives ☐ HUD	☐ Yes, best times:_____ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Child's Race

Identified Ethnicity
☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander
☐ Multi-Racial ☐ Asian ☐ White
☐ Black
☐ Other: _____

American Indian/Alaska Native
Tribe Enrolled: _____
Enrollment #: _____
Descendent: ☐ Yes, Tribe _____ ☐ No

Hispanic
☐ Yes
☐ No

Emergency Contacts

Contact 1

Name | Relationship to child: ☐ Parent ☐ Aunt ☐ Uncle ☐ Friend ☐ Grandparent ☐ Other | Emergency Contact: ☐ Yes ☐ No | Release To: ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 2

Name | Relationship to child: ☐ Parent ☐ Aunt ☐ Uncle ☐ Friend ☐ Grandparent ☐ Other | Emergency Contact: ☐ Yes ☐ No | Release To: ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

Contact 3

Name | Relationship to child: ☐ Parent ☐ Aunt ☐ Uncle ☐ Friend ☐ Grandparent ☐ Other | Emergency Contact: ☐ Yes ☐ No | Release To: ☐ Yes ☐ No

Address | ZIP | City | State

Phone Number 1 ☐ Cell ☐ Home ☐ Work | Phone Number 2 ☐ Cell ☐ Home ☐ Work | Phone Number 3 ☐ Cell ☐ Home ☐ Work

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.*

Parent/Guardian Signature _____ Date _____

Nez Perce Tribe

Mamáy'asnim Hitéemenwees

Release of Confidential Information

I, _____, give the Mamáy'asnim Hitéemenwees consent to obtain from or give to the following agencies and/or persons pertinent information about my child, _____, for whom I am legally responsible. In granting such permission, I understand that information will remain confidential and that the information will be used for the benefit of the child named above. This consent is valid for the current school year as dated unless I revoke consent prior to.

AGENCY	ADDRESS	PARENT INITIAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Confidential Information:

The Nez Perce Tribe Personnel Policies and Procedures (4.12): Tribal programs performing certain assistance and/or treatment services to tribal members and/or clients may not disclose confidential information specified by that particular program's legislation and/or rules. "Unauthorized disclosers that can be documented may be grounds for disciplinary action including termination or legal action."

Head Start Performance Standards (1302.22 (a)(1-4): These procedures give assurance that in cases parents will be told the nature of the data to be collected and the uses to which the data will be put, and that the uses will be restricted to the stated purposes. The records will be kept in a place that is inaccessible to unauthorized persons. Only authorized persons should be permitted to view the records. Parents and staff should jointly decide if such records are forwarded to the school districts after Head Start, in which case an Education consent form will need signed. Parents have a right to revoke this consent at any time.

Parent / Guardian Signature: _____ Date: _____

STAFF USE:

I have explained to _____ the purpose of this release and the disclosure which may be reasonably anticipated.

Staff Signature: _____ Date: _____

Nez Perce Tribe Mamáy'asnim Hitéemenwees

Child Health History Form

Child's Name: _____ **DOB:** _____ **Gender: M or F**

Child's Primary Care Information

Child's Primary Care Provider: _____

Primary Care Provider Phone Number: _____

Does the Child receive W.I.C.? Yes ☐ No☐

Does the child have access to regular medical care: Yes ☐ No ☐

*If "Yes, where*_____

Does the child have access to regular dental care: Yes ☐ No ☐

*If "Yes," where*_____

Child's Past Medical History

"X" Mark appropriate column and provide additional information in comment section below.

Illness/Condition	Yes	No	Illness/Condition	Yes	No
Allergies			Lead Poisoning		
Anemia			Measles		
Asthma			Meningitis		
Cancer/Leukemia			Mumps		
Chicken Pox			Orthopedic Problems		
Diabetes			Pneumonia		
Frequent Colds			Rheumatic Fever		
Frequent Ear Infections			Rubella		
Frequent Sore Throats			Seizures/Convulsions		
Gastroesophageal Reflux			Sickle Cell		
Hearing Problems			Speech Problems		
Heart Disease			Surgeries		
Hepatitis			Tuberculosis		
Hospitalizations			Visual Problems		
Kidney Disease			Whooping Cough		

COMMENTS for each "YES" answer. *(If your child needs accommodation for any illness/condition, additional forms may be needed)*

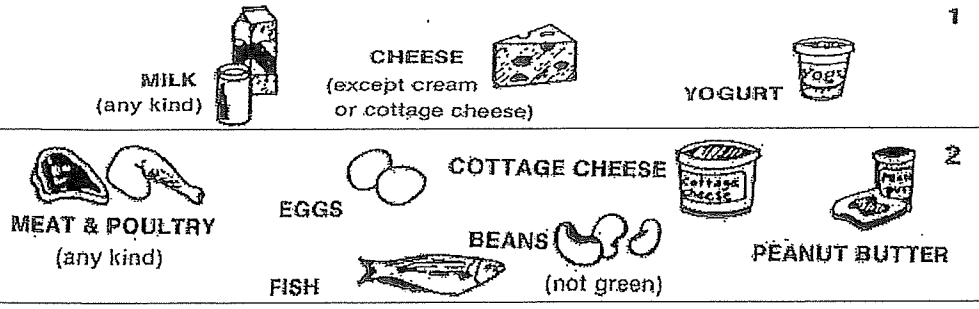
Complete other side

Nez Perce Tribe

Mamáy'asnim Hitéemenwees

Mamáy'asnim Hitéemenwees Nutrition Assessment

Child Name:	Date:
Circle the foods your child eats or drinks (Section 1)	**Circle the best answer (Section 2)**



1. My child eats from this food group:
   a) less than 3 times a day
   b) 3 to 4 times a day
   c) 5 or more times a day

2. My child eats from this food group:
   a) less than 2 times a day
   b) 2 or more times a day

3. My child eats from this food group:
   a) less than 3 times a day
   b) 3 to 4 times a day

4. My child eats from this food group:
   a) less than once a day
   b) 1 or more times a day

5. My child eats from this food group:
   a) less than 3 times a week
   b) 3 or more times a week

6. My child eats from this food group:
   a) less than 2 times a day
   b) 2 or more times a day

7. My child eats from this food group:
   a) 3 or more times a day
   b) less than 3 times a day

Check (Section 3)	Yes	No	Check	Yes	No	Circle the food programs in which your family participates (Section 4)
Is child allergic to any foods?			Does child live in a home that has running water and a stove and refrigerator which work?			Food Stamps
Does child drink caffeinated drinks?			Are you satisfied with what this child eats?			WIC

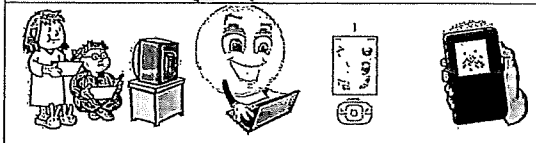
Does child ever eat dirt, clay, paint chips, ice?			Does child take vitamins? Or iron?			Commodities
Does child have diarrhea or constipation often?			Is child a vegetarian?			Other:
Do you ever run out of food to feed the child or family?			Is there foods child does not eat for religious reason?			
Does the child eat breakfast every day?						

Infants (Section 5)

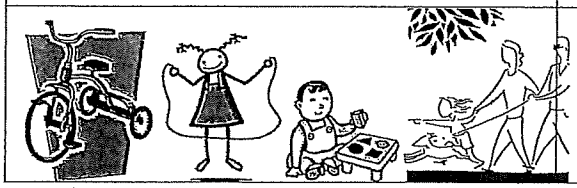
How many times does your infant eat each day?_____ What formula? _____ Milk %?_____ Breast Milk?_____
How many ounces?_____ First feeding method: Bottle fed____ Nursed_____

Healthy Active Living (Section 6)

1. How many hours of sleep does your child get per day?



2. My child gets "screen time" (TV, video games, computer, phone, etc.)
   a. Less than one (<1) hour per day.
   b. More than one (1) hour per day.
   c. More than two (2+) hours per day.



3. How much physical activity does your child get per day?
   a. Less than one (<1) hour per day.
   b. More than (1) hour per day.
   c. More than two (2+) hours per day.

Follow-up to nutrition assessment

If nutrition assessment finds inadequate diet (e.g., too little, too much, or unhealthy foods), growth problems (e.g., failure to thrive or overweight), or anemia, the child should be referred to a health care provider for evaluation and treatment.

Treatment may include:

- Referral to a nutritionist
- Counseling for parents and Head Start staff on the types and amounts of food the child should eat and recommended amount of physical activity
- Iron supplements or iron-enriched vitamins
- Treatment of medical conditions causing nutritional and growth problems

How a child eats can affect how she grows, develops, looks, and feels. Nutrition assessment and counseling can promote healthy growth and development. If you have questions or concerns about your child's nutrition please contact the Health & Safety Specialist or your local WIC Office.

NIMIIPUU HEALTH
Authorization to Disclose Healthcare Information

PATIENT IDENTIFICATION:

Chart Number: _____
Name of Patient: _____
Date of Birth: _____

I AUTHORIZE MEDICAL INFORMATION TO BE RELEASED:

FROM:	TO:
Nimiipuu Health Clinic	_____
Medical Records	_____
PO Drawer 367	_____
Lapwai, ID 83540	_____

THE PURPOSE OF THIS REQUEST IS:

_____Attorney	_____History & Physical	_____Lab Test Reports	_____Personal Use
_____Continued Care	_____Immunization Record	_____Medical Health Summary	_____Radiology Reports
_____Dental Notes	_____Insurance Purposes	_____Medical Progress Notes	_____Social Security Disability
_____EKG's			

Other: _____

Please specify below, the time period for information you are requesting above.

Only Information from: _____ (Month/Year) to _____ (Month/Year)

I understand that I have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire six (6) months from the date of my signature. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may be protected by federal privacy laws and regulations. I further understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient, Guardian or Legal Representative Date

Nez Perce Tribe Mamáy'asnim Hitéemenwees
Consent for Health & Education Services

I, _____ hereby give my consent to the Nez Perce Tribe Mamáy'asnim Hitéemenwees to provide the following screening tests and exams initialed below for my child while attending MH. If I do not initial below, it is indicated I do not want the service. If I choose not to participate in any of the listed screenings/exams, it will be my responsibility to ensure my child receives each required screening test and exam and I will be required to provide screening results to MH within my child's first 45 days of school.

Initial below:

Developmental Screening	_____	Dental/Fluoride Screen	_____
Hearing Test	_____	Vision Test	_____
Nutrition Assessment	_____	Height & Weight	_____
Hematocrit/Hemoglobin***	_____	Lead Screening***	_____

***requires a blood sample to be obtained by a "finger poke" or venipuncture if necessary.

If my child should require further medical care after an abnormal screening test/exam, I will provide medical documentation to MH regarding medical care. I also understand if I need help obtaining medical services, I will contact my Family Service Representative or the Health & Safety Specialist.

I also understand that it is my responsibility to provide MH with an up-to-date immunization record and a record of physical and dental examinations performed in the past year. I am also responsible for providing medical documentation for medical care provided to my child during the school year, such as, well-child visits and updated immunizations. This consent is valid for one year after the signed date. The purpose of this consent has been explained to me.

CHILD'S NAME_____ DATE OF BIRTH_____

Parent/Guardian Signature_____

Relationship to child_____ Date_____

MH PERMISSION FORM

RECREATIONAL ACTIVITIES PERMISSION

The Early Childhood Development Program believes in enhancing our students' educational experiences by routinely attending off-campus activities. Activities range from museums, libraries, and parks to nature hikes. All activities are designed to be educational. These events will be included on the monthly classroom calendars and will be sent home each month.

□ I hereby give my permission to MH to have my child participate in all supervised, recreational activities.

****

PHOTOGRAPHIC PERMISSION

In order to avoid undue disruption of your child as they are involved in learning, and to protect the privacy and individual rights of all persons, it is necessary that you agree to and provide permission for the photographs of your child for and on behalf of the Mamay'asnim Hiteemenwees. Photographs are not to be sold by or to anyone or used in any manner for commercial purposes. This includes, but is not limited to, the following: newspapers, contests, magazines, or television.

□ I hereby give my permission to MH to have my child photographed for classroom and other school related activities.

****

TEXTING AND EMAIL PERMISSION

If you would like to be contacted through text and/or email, and receive notifications, please provide mobile phone number and email address (SMS rates may apply).

□ I hereby give my permission to MH to contact me via text and/or email.

Phone Number: _____ Email: _____

****

_____ _____

Printed Parent / Guardian Name Signature of Parent / Guardian

_____

Date

* This Permission Form will remain valid until services are relinquished.

CHILD ENROLLMENT FORM

SCHOOL YEAR 2021-2022

This form must be updated annually

Nez Perce Tribe Mamáy'asnim Hitéemenwees (Children's School)

Child Care Center or Provider Name

NAME OF CHILD	BIRTH DATE	NORMAL HOURS IN CARE		NORMAL MEALS WHILE IN CARE					
Last, First PLEASE PRINT	(Mo/Day/Yr)	From	To	BKFST	AM SNACK	LUNCH	PM SNACK	SUPPER	LATE SNACK
	/ /	am/pm	am/pm	X		X	X		
	/ /	am/pm	am/pm	X		X	X		
	/ /	am/pm	am/pm	X		X	X		

Days in care on a normal week (circle): Sun. Mon. Tue. Wed. Thur. Fri. Sat.

I understand my child/children will receive meals at no extra charge to me when they are in care during any of the scheduled meal services.

Parent Signature: _____ Date: _____

Parent(s) Name(s): _____

Parent Address _____

Home Phone Number: (___) _____ Work Phone Numbers: (___) _____ (___) _____

Race/Ethnic Identity: You are not required to answer these questions. (Please circle all that apply)

Hispanic or Latino	Non Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or other Pacific Islander	White

This institution is an equal opportunity provider.

Nez Perce Tribe
Mamay'asnim Hiteemenwees
Verification of Annual Household Income

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STUDENT NAME: _____ **DATE OF BIRTH:** _____
SCHOOL YEAR: _____

HEAD OF HOUSEHOLD:
Name: _____
Address: _____
_____
Phone Number: _____

Social Security Number: _____
Employer/School: _____
Address: _____
_____
Phone Number: _____

Employed: □ Full-time □ Part-time □ Seasonal □ Temporary Student: □ Full-time □ Part-time

SPOUSE/SIGNIFICANT OTHER:
Name: _____
Address: _____
_____
Phone Number: _____

Social Security Number: _____
Employer/School: _____
Address: _____
_____
Phone Number: _____

Employed: □ Full-time □ Part-time □ Seasonal □ Temporary Student: □ Full-time □ Part-time

CERTIFICATE OF VERIFICATION ***(must be submitted with application)*** **:**

□ Wages (pay stub)
□ TANF (check stub or award letter)
□ Unemployment Compensation (check stub)
□ Other _____ (i.e. child support)
□ Income Tax Form (1040) (copy)
□ Social Security Income (official document)
□ Foster Parent / Kinship Care (court order)
□ Zero Income (must be attached)

TOTAL NUMBER IN FAMILY: _____ **TOTAL HOUSEHOLD INCOME:** _____

HOUSEHOLD MEMBERS:

Name:	Age	Annual Income	Source (ex: job, SSI, child support)
1			
2			
3			
4			
5			
6			
7			
8			

To the best of my knowledge this information is true and correct. I understand that if any of this information changes, I will notify the program; and, if this information is found to be incorrect, I will be contacted by the program for verification. The information submitted is confidential and will be treated in accordance with Federal Law and Nez Perce Tribe policies. I understand that providing false information may result in denial of services.

_____ _____
Parent/Guardian Signature Date

_____ _____
Staff Signature: Date:

* This copy is to be placed in the CONFIDENTIAL income binder with the Family Services Specialist

6/5/19 skk

Head Start Bus Route Form

Transportation services will be provided for Head Start students. Please note: Due to limited seating, priority will be given to those children with the highest need.

A pick-up and drop-off location must be established. Please make sure an adult from your approved pick up list will meet your child at the bus. If an approved adult does not greet the child, or if no one is home, your child will be transported back to the center. Your emergency numbers will be utilized.

If your child does not utilize the bus route on a regular basis, a referral will be provided to Family Services and you will be contacted to identify if transportation services are a need for your family.

Please review the bus rules with your child to ensure the safety of all children and staff: Keep hands/feet to self, remain buckled at all time, inside voices. **THERE ARE NO TEMPORARY BUS CHANGES.** If you would like a permanent change please notify the program at: 843-7330 Lapwai and 935-2888 Kamiah. If your child is a participant in the Wrap-Around Program, they are not eligible for bus services.

STUDENT NAME: _____

Parent / Guardian Name(s): _____

Parent / Guardian Signature: _____

Home Phone: _____ Cell Phone: _____

Emergency Numbers: _____

PICK-UP LOCATION:

Location: _____

Directions: _____

Phone Number of Location: _____

DROP-OFF LOCATION:

Location: _____

Directions: _____

Phone Number of Location: _____

Staff Signature / Date : _____