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 Hítéemenwees 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

**Mamá'yasnim Hítéemenwees**

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Suffix</th>
<th>Nickname</th>
<th>Birthday</th>
<th>Gender</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
</tbody>
</table>

**English Proficiency**

- [ ] Little
- [ ] Moderate
- [ ] None
- [ ] Proficient

**Other Language**

- [ ] Other Language Proficiency
  - [ ] Little
  - [ ] Moderate
  - [ ] None
  - [ ] Proficient

**Primary Health Coverage**

- [ ] Medicaid
- [ ] Private Insurance
- [ ] CHIP
- [ ] No Insurance

**Doctor/Medical Home**

- [ ] CHAS
- [ ] Tri-State
- [ ] Palouse Pediatrics
- [ ] NMPH
- [ ] VMCH

**Insurance #**

**Dental Coverage**

- [ ] Medicaid
- [ ] Private Insurance
- [ ] CHIP
- [ ] No Insurance

**Dental Coverage #**

**Primary Adult**

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Suffix</th>
<th>Nickname</th>
<th>Birthday</th>
<th>Gender</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
</tbody>
</table>

**Race**

- [ ] Asian
- [ ] American Indian/Alaska Native
- [ ] Black
- [ ] Hawaiian/Pacific Islander
- [ ] White
- [ ] Multi-Racial
- [ ] Other: ____________

**Highest Grade Completed**

- [ ] Associate's
- [ ] Bachelor's
- [ ] Col Deg/Train
- [ ] HS Graduate
- [ ] GED
- [ ] Col or Adv Train

**Employment Status**

- [ ] Full Time
- [ ] Part Time
- [ ] Seasonal
- [ ] Unemployed
- [ ] Retired or Disabled

**Child's Relationship**

- [ ] Biological/Adopted/Step
- [ ] Grandchild
- [ ] Other Relative
- [ ] Foster
- [ ] Other: ____________

**Custody**

- [ ] Lives with Family
- [ ] Provides Financial Support
- [ ] Teen Parent

**If teen parent, subsidized?**

- [ ] Yes
- [ ] No

**Secondary or Other Adult**

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Suffix</th>
<th>Nickname</th>
<th>Birthday</th>
<th>Gender</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
</tbody>
</table>

**Race**

- [ ] Asian
- [ ] American Indian/Alaska Native
- [ ] Black
- [ ] Hawaiian/Pacific Islander
- [ ] White
- [ ] Multi-Racial
- [ ] Other: ____________

**Highest Grade Completed**

- [ ] Associate's
- [ ] Bachelor's
- [ ] Col Deg/Train
- [ ] HS Graduate
- [ ] GED
- [ ] Col or Adv Train

**Employment Status**

- [ ] Full Time
- [ ] Part Time
- [ ] Seasonal
- [ ] Unemployed
- [ ] Retired or Disabled

**Child's Relationship**

- [ ] Biological/Adopted/Step
- [ ] Grandchild
- [ ] Other Relative
- [ ] Foster
- [ ] Other: ____________

**Custody**

- [ ] Lives with Family
- [ ] Provides Financial Support
- [ ] Teen Parent

**If teen parent, subsidized?**

- [ ] Yes
- [ ] No

---

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

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## Family Information, Income & Contacts

### Family Information

<table>
<thead>
<tr>
<th>Family Living Address</th>
<th>Living Address</th>
<th>ZIP</th>
<th>City</th>
<th>State</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of time at this address</td>
<td>□ 6 months □ 1-2 years □ 6-12 months □ 2+ years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Mailing Address</th>
<th>Mailing Address</th>
<th>ZIP</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same as living? □ Yes □ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number(s)</th>
<th>Type (check one)</th>
<th>Note (Whose #, ext., or best time to call)</th>
<th>Opt In for Text Messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Cell □ Home □ Work □ Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parental Status (check one)</th>
<th>Primary Language at Home</th>
<th>Homeless Family</th>
<th>Active Duty Military</th>
<th>Referred by Child Welfare Agency</th>
<th>Receiving SNAP</th>
<th>WIC</th>
<th>WIC ID (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ One □ Two</td>
<td>□ English</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>TANF Status</th>
<th>SSI</th>
<th>Current CCDF Participant</th>
<th>Housing</th>
<th>Interested in Volunteering</th>
<th>Field Trip Permission</th>
<th>Photograph Permission</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child's Race</th>
<th>Identified Ethnicity</th>
<th>American Indian/Alaska Native</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ American Indian/Alaska Native □ Hawaiian/Pacific Islander □ Multi-Racial □ Asian □ White □ Black □ Other:</td>
<td>Tribe Enrolled:</td>
<td>Enrollment #:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Descendant: □ Yes □ Tribe □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Contacts

<table>
<thead>
<tr>
<th>Contact 1</th>
<th>Relationship to child</th>
<th>Emergency Contact</th>
<th>Release To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number 1</td>
<td>□ Cell □ Home □ Work</td>
<td>Phone Number 2</td>
<td>□ Cell □ Home □ Work</td>
</tr>
<tr>
<td>Phone Number 2</td>
<td>□ Cell □ Home □ Work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact 2</th>
<th>Relationship to child</th>
<th>Emergency Contact</th>
<th>Release To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number 1</td>
<td>□ Cell □ Home □ Work</td>
<td>Phone Number 2</td>
<td>□ Cell □ Home □ Work</td>
</tr>
<tr>
<td>Phone Number 2</td>
<td>□ Cell □ Home □ Work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact 3</th>
<th>Relationship to child</th>
<th>Emergency Contact</th>
<th>Release To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number 1</td>
<td>□ Cell □ Home □ Work</td>
<td>Phone Number 2</td>
<td>□ Cell □ Home □ Work</td>
</tr>
<tr>
<td>Phone Number 2</td>
<td>□ Cell □ Home □ Work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ____________

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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.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>ADDRESS</th>
<th>PARENT INITIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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.

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

COMMENTS for each “YES” answer. (If your child needs accommodation for any illness/condition, additional forms may be needed)
Mamá'snim Hitéemenwees Nutrition Assessment

<table>
<thead>
<tr>
<th>Child Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circle the foods your child eats or drinks (Section 1)</td>
<td>Circle the best answer (Section 2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>My child eats from this food group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>less than 3 times a day</td>
</tr>
<tr>
<td>b</td>
<td>3 to 4 times a day</td>
</tr>
<tr>
<td>c</td>
<td>5 or more times a day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>My child eats from this food group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>less than 2 times a day</td>
</tr>
<tr>
<td>b</td>
<td>2 or more times a day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>My child eats from this food group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>less than 3 times a day</td>
</tr>
<tr>
<td>b</td>
<td>3 to 4 times a day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>My child eats from this food group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>less than once a day</td>
</tr>
<tr>
<td>b</td>
<td>1 or more times a day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>My child eats from this food group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>less than 3 times a week</td>
</tr>
<tr>
<td>b</td>
<td>3 or more times a week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6</th>
<th>My child eats from this food group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>less than 2 times a day</td>
</tr>
<tr>
<td>b</td>
<td>2 or more times a day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7</th>
<th>My child eats from this food group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>3 or more times a day</td>
</tr>
<tr>
<td>b</td>
<td>less than 3 times a day</td>
</tr>
</tbody>
</table>

Check (Section 3)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Check</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check the food programs in which your family participates (Section 4)

<table>
<thead>
<tr>
<th>Is child allergic to any foods?</th>
<th>Does child live in a home that has running water and a stove and refrigerator which work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Does child drink caffeinated drinks?</th>
<th>Are you satisfied with what this child eats?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
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:

Nimipuu Health Clinic
Medical Records
PO Drawer 367
Lapwai, ID 83540

TO:

_____________________________________
_____________________________________
_____________________________________
_____________________________________

THE PURPOSE OF THIS REQUEST IS:

__________________ Attorney
__________________ History & Physical
__________________ Immunization Record
__________________ Dental Notes
__________________ Insurance Purposes
__________________ Lab Test Reports
__________________ Medical Health Summary
__________________ Medical Progress Notes
__________________ Personal Use
__________________ Radiology Reports
__________________ Social Security Disability

Other: ___________________________________

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

Only Information from: ___________ to ___________
(Month/Year) (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.

******************************************************************************

PHOTOGRAHIC 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’snim 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

Nez Perce Tribe Mamáy’asnim Hitéeemenwees (Children’s School)

Child Care Center or Provider Name

<table>
<thead>
<tr>
<th>NAME OF CHILD</th>
<th>BIRTH DATE</th>
<th>NORMAL HOURS IN CARE</th>
<th>NORMAL MEALS WHILE IN CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Mo/Day/Yr)</td>
<td>From</td>
<td>To</td>
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<td>1/1</td>
<td>am/pm</td>
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</table>


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

STUDENT NAME: ___________________________ DATE OF BIRTH: __________
SCHOOL YEAR: ____________________________

HEAD OF HOUSEHOLD: ___________________________
Name: ___________________________ Employer/School: ___________________________
Address: ___________________________ Address: ___________________________
Phone Number: ___________________________ Phone Number: ___________________________

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

SPouse/SIGnIFICANT OTHER: ___________________________
Name: ___________________________ Employer/School: ___________________________
Address: ___________________________ Address: ___________________________
Phone Number: ___________________________ 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) □ Income Tax Form (1040) (copy)
□ TANF (check stub or award letter) □ Social Security Income (official document)
□ Unemployment Compensation (check stub) □ Foster Parent / Kinship Care (court order)
□ Other ___________________________ (i.e. child support) □ Zero Income (must be attached)

TOTAL NUMBER IN FAMILY: ________ TOTAL HOUSEHOLD INCOME: ________________

HOUSEHOLD MEMBERS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Annual Income</th>
<th>Source (ex: job, SSI, child support)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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 8/5/19 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: ______________________________________