

BBNA Head Start

PO Box 310 Dillingham, AK 99576

907-842-4059

ENROLLMENT FORMS CHECKLIST

Returning

New

CHILDS NAME: _____ BIRTH DATE: ____ / ____ / ____ COMMUNITY: _____

PARENT(S) NAME: _____

Complete Incomplete

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Consent/Comments Form |
| <input type="checkbox"/> | <input type="checkbox"/> | Supplemental Child Information |
| <input type="checkbox"/> | <input type="checkbox"/> | Health History (not applicable for returning students) |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutritional History (not applicable for returning students) |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>**Returning Student Health History and Nutrition Update</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | Parent Child Abuse & Neglect Policy |
| <input type="checkbox"/> | <input type="checkbox"/> | Confidentiality Policy for Parents and Volunteers |
| <input type="checkbox"/> | <input type="checkbox"/> | Release of Information forms:
Bristol Bay Area Health Corporation
State of Alaska Public Health Clinic
Dental Consent |
| <input type="checkbox"/> | <input type="checkbox"/> | Family Needs Assessment and Interest Survey |
| <input type="checkbox"/> | <input type="checkbox"/> | Education Home Visit |
| <input type="checkbox"/> | <input type="checkbox"/> | DECA (Parent Part) |
| <input type="checkbox"/> | <input type="checkbox"/> | Individualized Plan |

IMMUNIZATIONS

- | | | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Current Immunizations Due (if any) |
|--------------------------|--------------------------|------------------------------------|
- _____

REQUIRED WITHIN 45 DAYS FROM THE CHILD'S ENTRY INTO HEAD START

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Current Physical
Due: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Developmental Screening (Dial 3 or Denver II)
Due: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Screen
Due: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Screen
Due: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental Exam
Due: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | TB screening
Due: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Lead screening
Due: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemoglobin screening
Due: _____ |

Teacher's Signature: _____ Date: _____