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ORIENTATION

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*indicates that this form is available in Spanish
PARENT ORIENTATION CHECKLIST

Parent orientation must be completed by at least one parent/guardian of each child before a child can attend class. Every effort should be made to complete orientation with both parents/guardians. The parent orientation procedure will be slightly different for families in a school partnership program. All classes should follow the Parent Orientation Checklist as closely as possible and any variations should be discussed with an Area Manager.

Child’s Name_____________________________ Center/Classroom_____________________
FSW____________________________________ Orientation: Date_____________________

Orientation Packet Process:

☐ Parent Handbook/Calendar-review entire document with parent/guardian including Head Start Mission Statement
☐ Resource Book given to new family only
☐ School to Home Folder
☐ Parent Permission
☐ Change of Status (check address/phone from application for any changes)
☐ Authorization of Release of Information-if necessary
☐ Child Emergency Care and Consent
☐ Lead Screening Questionnaire for new families only
☐ Physical Form-(circle one)
  -Parent turned in
  -Gave new copy to parent
☐ Dental Form-(circle one)
  -Parent turned in
  -Gave new copy to parent
☐ Nutrition Questionnaire
☐ Food Recall for 24 Hours
☐ Review of Immunizations needed from Eligibility Information Sheet (page 3) of the application.
☐ Asthma Action Plan-if applicable
☐ Medical Action Plan-if applicable
☐ Medical Statement for Food Substitutions-if applicable
☐ WIC Release-if applicable
☐ Program Governance- the Policy Council Representative and the Health Advisory Representative Descriptions
☐ Family Development Plan (Write 1st goal)
☐ Parent/Community Grievance Procedure
☐ Tour/Parent Corner-including location of

Sex Offenders list & Sign In and Out Procedure
☐ Pedestrian Safety
  (Any child starting after first 30 days)

Optional during Orientation:

☐ Child height & weight
☐ Child/Family picture
☐ Monthly Packet-menu’s, calendar, book order, parent education
☐ Classroom Daily Schedule
☐ Explanation of Literacy program-lending library, monthly literacy challenge, fatherhood challenge, reading challenge

☐
☐
☐
☐

*FSWs and Education staff need to determine how they will complete the orientation process.
Parent Permission Form

Child’s Name _________________________________ School Year __________

Parent/Guardian Name_______________________________________________

Consent is voluntary.

Please place your initials beside any of the following items for which you give permission. Write “NO” for any item for which permission is not given. Assure that each item is clearly explained and understood before giving permission.

1. __________ I give permission for my child to take part in walking field trips.

2. __________ I give permission for photo, video taping, and publicity releases and name releases (if appropriate).

3. __________ I give permission for Head Start to put photos that include my child on their Northeast Nebraska Community Action Partnership, Inc. Agency website, facebook page. I understand that my child’s name will not be used.

4. __________ I give permission for Education Staff to administer the “Ages and Stages Developmental Screener”.

5. __________ I understand and agree it is vital that I abide by the Confidentiality Policy. All information regarding families and business will be kept in the strictest confidence. Information will not be discussed outside the center. This includes any information obtained while a volunteer at the center.

6. __________ I give permission for non-invasive screenings (vision, hearing, height, weight, blood pressure) to be administered to my child as needed.

I hereby certify that I have read and fully understand the above authorization.

______________________________________________________ ________________
Father/Guardian Signature                 Date

______________________________________________________ ________________
Mother/Guardian Signature                                                            Date
Name of Form: PARENT PERMISSION

Purpose: To document permission has been obtained from a parent/guardian of each enrolled child for listed activities and information sharing.

Instructions: A parent/guardian of each enrolled child must fill out and sign this form. The parent/guardian must place his/her initials next to each individual item to indicate that he/she has given permission for each item.

Returnee children - parent/guardian and staff should initial and date from the previous year. Initial in red any changes from previous year by the number.

Completed By: Staff
Date Due: Before child starts school/Orientation
Send To: --------
Filed At: Child’s File
Revised: 6/12
HEAD START
CHANGE OF STATUS
Submit this form to update child and family information

<table>
<thead>
<tr>
<th>Center Name</th>
<th>Class</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child's name (last) (first)

Parent/guardian

<table>
<thead>
<tr>
<th>Section I - ENROLLMENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSFER</td>
</tr>
<tr>
<td>From Center</td>
</tr>
<tr>
<td>To Center</td>
</tr>
<tr>
<td>Effective Date</td>
</tr>
<tr>
<td>DROP</td>
</tr>
<tr>
<td>Withdrawal date</td>
</tr>
<tr>
<td>Date last attended</td>
</tr>
<tr>
<td>Reason for withdrawal</td>
</tr>
<tr>
<td>Put back on wait list? Y N</td>
</tr>
<tr>
<td>What Center?</td>
</tr>
<tr>
<td>ABANDON</td>
</tr>
<tr>
<td>Abandon date</td>
</tr>
<tr>
<td>Received Services Yes or No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section II — PERSONAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANGE NAME</td>
</tr>
<tr>
<td>( ) Child ( ) Parent ( ) Date</td>
</tr>
<tr>
<td>Change from</td>
</tr>
<tr>
<td>Change to</td>
</tr>
<tr>
<td>Reason</td>
</tr>
<tr>
<td>CHANGE ADDRESS/PHONE</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Home/Message: ( )</td>
</tr>
<tr>
<td>Phone</td>
</tr>
<tr>
<td>Other: ( )</td>
</tr>
<tr>
<td>CHANGE OF CUSTODY</td>
</tr>
<tr>
<td>TO ( ) Foster ( ) Natural ( ) Other Date</td>
</tr>
<tr>
<td>New family name</td>
</tr>
<tr>
<td>Parent/Guardian Names for Labels</td>
</tr>
<tr>
<td>CHANGE INSURANCE/MEDICAID INFORMATION</td>
</tr>
<tr>
<td>( ) Add ( ) Drop Effective Date</td>
</tr>
<tr>
<td>Medicaid# Kid’s Connect. #</td>
</tr>
<tr>
<td>Insurance Co. Name</td>
</tr>
</tbody>
</table>

Staff Signature: __________________________
Date: __________________________

Comments to Central Office

---

---
This is the screen where you will update address changes and phone numbers. Update this information under Family Information and it will update it throughout for the family.
Name of Form: CHANGE OF STATUS

Purpose: To document changes in a child/family status such as:
- Transfer to or from another Head Start center within the agency
- Withdrawal or abandon from program
- Name, address, phone change
- Change of custody
- Change of number of people in family
- Change of Health Insurance Information
- Other

Instructions: Family Service Workers will update the following Change of Status Information directly on ChildPlus: Address change, phone number changes, and number in family changes. FSW will not need to send in a hard copy to the Central Office of the change made to address and phone numbers. If there is a change in family number, FSW will go into ChildPlus, add the additional person to the application, complete #5 Agency Specific Field on that person and run a new live report. The live report should be attached to the Change of Status form when sent into the Central office.

Family Service Workers will complete form to update all other Change of Status Information: Change of status forms must be completed and sent to Jean (i.e. custody changes, drops, abandons, transfers, additions/deletions to family, insurance/Medicaid information, and name changes).

This form must be filled out and sent to the Central Office ASAP after a change in a child/family status occurs. **In the case of a withdrawal, the Change of Status form must be faxed to the Central Office immediately.** A hard copy does not need to be sent to the Central Office if it has been faxed. Indicate whether or not the child should be placed back on the wait-list.

In the case that one or more family members are added, the Central Office needs all pertinent information for that person or person(s). In addition to the Change of Status, complete and send in page 3 (BIF) with new family member information. Fill out the entire column for each person added.

Completed By: Staff

Date Due: As needed

Send To: Central Office (white copy)-if form was not faxed into Central Office for a withdrawal.

Filed At: Child’s File (yellow copy); Copy to Education Staff

Revised: 6/2012
AUTHORIZATION FOR RELEASE OF INFORMATION

CONSENT IS VOLUNTARY

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

I/We, _________________________________, of ____________________________________,
(Parent/Guardian) (Child’s Name)

hereby authorize and consent for _______________________________ to release information
regarding my child to representatives of ____________________________________.

(information provided from)

Requested Information:

☐ Health information
☐ Dental information
☐ Any information regarding my child that happened in school
☐ Behaviors that occurred in school
☐ Concerns about your child
☐ Other: (list below)

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

(information provided to)

Information will be sent to: ____________________________________________

______________________________________ ______________________
Father/Guardian Signature                                 Date

______________________________________ ______________________
Mother/Guardian Signature                                 Date

If you have any questions, call Head Start at _________________________________.

______________________________________
Head Start Staff Signature                                 Date
Name of Form: AUTHORIZATION FOR RELEASE OF INFORMATION

Purpose: To document permission has been obtained from a parent/guardian to release information either to Head Start or to another entity. In addition, it may be used in cases of non-custodial parents seeking information.

Instructions: In the event that an agency, institution, or individual requests information about a Head Start child and/or family, this form must be filled out as specifically as possible, signed, and dated by the parent/guardian.

This form should also be completed when Head Start is requesting information from another entity.

Examples for using this form include: sharing information with grandparents, child care providers, non-custodial parents, etc.; requesting information from a doctor or dentist; and requesting or sharing information with another Head Start program.

This form should not be used at Orientation unless information is specifically requested. There should not be a blank form signed by the parents in the child file.

Completed By: Staff
Date Due: As needed
Send To: -------
Filed At: Child’s File
Revised: 6/10
Children will be released to biological parents unless a legal documentation states otherwise.

Father/Guardian Name__________________ Mother/Guardian Name__________________
Address______________________________ Address______________________________
Address______________________________ Address______________________________
Home/Cell Phone______________________ Home/Cell Phone______________________
Work Name____________________________ Work Name__________________________
Work Phone____________________________ Work Phone__________________________

Emergency Contacts/Release Child To(a minimum of one):
Name_________________________________________ Phone ________________________
   Relationship to child__________________________
Name_________________________________________ Phone ________________________
   Relationship to child__________________________
Name_________________________________________ Phone ________________________
   Relationship to child__________________________

DO NOT RELEASE TO:________________________________________________________

Physician
Name__________________________ Dentist
Name__________________________
Address__________________________ Address__________________________
Phone__________________________ Phone__________________________

Food Allergies:_________________________________________________________________
Medication Allergies:____________________________________________________________
Medication currently taking:_______________________________________________________
Asthma: _____Yes _____No
Diabetes: _____Yes _____No
Seizures/Convulsions: _____Yes _____No

CONSENT TO CONTACT IN EMERGENCY:
In the event that I/We cannot be reached to make arrangements, I/We hereby give my consent to
Head Start to contact the above named Doctor/Dentist, and, if necessary, take my/our
child to the Doctor, Dentist, Clinic, or Hospital.

_____________________________________ _______________________________________
Signature of Father/Guardian               Date Signature of Mother/Guardian                      Date

☐ Returnee Child- Determination of On-Going Health Care section completed last year.

DETERMINATION OF ON-GOING HEALTH CARE (completed by FSW)

<table>
<thead>
<tr>
<th>Does this child have a health Provider? ___Y ___N</th>
<th>Does this child have a dental provider? ___Y ___N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this an on-going health provider? ___Y ___N</td>
<td>Is this an on-going dental provider? ___Y ___N</td>
</tr>
<tr>
<td>This child’s health care is: ___Up-to-date</td>
<td>This child’s dental care is: ___Up-to-date</td>
</tr>
<tr>
<td>___Not up-to-date</td>
<td>___Not up-to-date</td>
</tr>
</tbody>
</table>

FSW Signature:__________________________ Date:__________________________
Name of Form: CHILD EMERGENCY CARE AND CONSENT

Purpose: To document emergency contacts and medical/dental information for each accepted child and to document permission has been obtained from a parent/guardian to take a child to the doctor, dentist, clinic, or hospital in the event of an emergency.

To document Determination of On-Going Health Care for the child.

Instructions: One or both parent(s)/guardian(s) of each accepted child must fill out and sign this form. It is absolutely necessary that this form be filled out completely and updated as necessary.

Original form is placed in the child’s file with an original signature. Copies of the form must be placed: in backpack to be taken with children when they are away from the center and in the Emergency Contact Book if book is not located in backpack. Copies must have original signature. Only one parent/guardian signature is required.

When the form needs updating the parent must be the one to update all forms, initial by the change and date it. Staff are not to do the change for the parent.

Any person picking up a child from Head Start must be listed on this form. Staff will not release a child to any person who has not been authorized in writing. Exceptions may be made in case of emergency only. Head Start Staff may ask to see a photo I.D. of any person picking up a child.

A new “Child Emergency Care and Consent” form must be completed for each child, each school year. A child will not be allowed to remain at the center unless working contact numbers are provided on the form.

Determination of On-Going Health Care - using information gathered from a child’s parent/guardian, physical and dental examinations, Orientation, and based on observations, the FSW must make a determination as to whether or not a child is “up-to-date” or not, concerning medical and dental care. A child should be considered “up-to-date” if age appropriate physical and dental exams are complete, and if the child has an identified medical home and dental home. (This does not include follow-up). This form is only completed once for each child. It should not be completed for Returnee children.

If no medical & dental home exists, an immediate referral must be made.

Determination of On-Going Health Care section should never be changed after it is completed.

Completed By: Family Service Worker or other staff

Date Due: Before a child attends Head Start/Orientation/ on-going for changes

Send To: -----

Filed At: Child File; Backpack, Emergency Contact Book

Revised: 6/10
PHYSICAL EXAMINATION

CHILD'S NAME: ____________________________ SEX: _______ BIRTH DATE: ____________

1. RELEVANT INFORMATION (from Health History, Parent Observations):

List Medications child is currently taking:

Allergies:

2. SCREENING TESTS (The following 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 minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively. Also, please include number results with applicable screens.):

<table>
<thead>
<tr>
<th>TEST</th>
<th>DATE</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Height/Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>inches   lbs.       BMI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Child's weight is within normal range</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Child Above IBW</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Child Below IBW</td>
</tr>
<tr>
<td>B. Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>#</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Blood Pressure is higher than 110/75 but still considered within normal limits for this child. (Mark box if applicable)</td>
</tr>
<tr>
<td>C. Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of test:</td>
<td></td>
<td>Right    Left</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Child has Tubes in ear(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Left    □ Right</td>
</tr>
<tr>
<td>D. Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of test:</td>
<td></td>
<td>Right    Left    Both</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Please use vision numbers if possible</td>
</tr>
<tr>
<td>E. Urinalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Hemoglobin</td>
<td></td>
<td>#</td>
</tr>
<tr>
<td>G. Lead (*only completed once in 2 yrs of preschool)</td>
<td></td>
<td>#</td>
</tr>
</tbody>
</table>

3. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS:

<table>
<thead>
<tr>
<th>Abnormal Findings/Diagnosis</th>
<th>Treatment Plan</th>
<th>Recommended Follow-up or Results</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>
<tr>
<td>C.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Attach an updated copy of the child's immunization record.

Physician Signature/Title: ____________________________ Date: ____________________________
ORAL HEALTH FORM

Center: ___________________________ Phone no. __________________ Fax no. __________

Child Name: ___________________________ Birth date: ____________ Sex: □ Male □ Female

Exam Completed By: □ DDS □ RDH □ Other: Specify ___________________________ Exam Date: __/____/

Brushing Frequency: __________ per __________ Flossing Frequency: □ Daily □ Occasionally □ Never

Patient: □ Uses Fluoride Toothpaste □ Drinks Fluoridated Water □ Takes Fluoride Supplement □ Other: __________

Oral Conditions: Please fill out chart as indicated in Key. Circle existing teeth:

Today's Visit:
□ Visual Screening
□ Full Exam
□ X-Rays
□ Cleaning
□ Fluoride Treatment
□ Oral Hygiene Instruction

Key: ■ Missing □ Decayed □ Filled

Recommendations:
□ Routine Exams
□ Improve Oral Hygiene at Home
□ Diet Modification
□ Discontinue Oral Habits
□ Fluoride Treatment (Circle all that apply)
    Supplement/ Varnish/ Rx Toothpaste
□ Other Information:

______________________________________________________________

Future Treatment:
Has treatment been scheduled? □ No □ Yes Date: __________________________

FOLLOW UP INFORMATION:
Date of Last Appointment: ____________ Has all Treatment Been Completed? __________

Does patient have an appointment scheduled?: □ No □ Yes Reason: □ Exam □ Restorative □ Other: __________

Comments: ____________________________________________________________

__________________________________________________________

Provider Signature: ____________________________________________ Completion Date: __/____/

Printed Name of Provider: ___________________________ Phone: _______________________

Address: ___________________________________________
LEAD SCREENING QUESTIONNAIRE

Date: __________________________________________________
Parent/Guardian: _________________________________________
Center: _________________________________________________

___Yes     ___ No  Is your child enrolled in the Medicaid/Kid’s Connection program?
___Yes     ___ No  Does your child live in or regularly visit a house built before 1978?
___Yes     ___ No  Does your child’s home have peeling or chipped paint (inside or out?)
___Yes     ___ No  Does your child live in a house built before 1978 with recent, on-going, or planned renovation or remodeling?
___Yes     ___ No  Does your child regularly visit a home or outbuildings that have peeling or chipped paint?
___Yes     ___ No  Does your child frequently come in contact with an adult who works with lead (construction, welding, pottery)?
___Yes     ___ No  Does your child live near a lead smelter, battery-recycling plant, or other industry likely to release lead?
___Yes     ___ No  Do you use any home or folk remedies that may contain lead?
___Yes     ___ No  Do you serve or store food in the original cans?
___Yes     ___ No  Does your home’s plumbing have lead pipes or copper with lead solder joints?
___Yes     ___ No  Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
___Yes     ___ No  Are old batteries stored around your home?
___Yes     ___ No  Is your child around anyone whose hobbies include stained glass, pottery, brass or copper work, painting, refinishing furniture, or reloading ammunition?
___Yes     ___ No  If you answered “yes” to any of the above questions, has your child had any of the following chronic or persistent symptoms: poor appetite, stomachaches, vomiting, constipation, crankiness, loss of energy, headaches, trouble sleeping?

* If you answered “yes” to any of the above questions, please visit with your family health care professional regarding a simple blood test for lead poisoning.

___Yes     ___ No  Has your child had a blood lead test in the last 12 months?
___Yes     ___ No  Has a family member or friend been tested for lead poisoning?
___Yes     ___ No  Has a family member or friend been treated for lead poisoning?

If you answered “yes” to the above questions, who was treated and what were the results?
_____________________________________________________________________________

Are you interested in additional information?  ___Yes     ___ No

Parent/Guardian Signature  Date

Head Start Staff  Date

Referral Made  ___Yes     ___ No
Name of Form: LEAD SCREENING QUESTIONNAIRE

Purpose: To identify children enrolling in the Head Start program that may be at risk for lead poisoning.

Instructions: The parent/guardian may fill out the questionnaire, or if necessary, Head Start staff may complete the form with the parent/guardian in an interview format. If the parent/guardian answers “yes” to any of the above questions, and the child has never had a blood lead test, an immediate referral to the child’s health care provider should be made. If a referral is made, a copy of the forms should be given to the parent/guardian.

Completed By: Head Start Staff

Date Due: Orientation

Filed At: Original in Child File

Sent To: Copy with the parent/guardian, if a referral is made

Revised: 6/06
NUTRITION QUESTIONNAIRE

Child’s Name: __________________________ Sex __________________________ Birthdate: __________________________

1. What foods does your child especially like?

2. Are there any foods your child dislikes?

3. List food allergies or any additional comments regarding your child’s eating:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>Does your child take vitamins &amp; mineral supplements?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) If &quot;yes&quot;: what kind are they?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Do they contain iron? Yes No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Were they prescribed? Yes No</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Is there any food your child should not eat for medical, religious, or personal reasons?</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Has there been a big change in your child’s appetite in the last month?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Does your child take a bottle?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Does your child eat or chew things that aren’t food?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*If yes, please list:</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Does your child have trouble chewing or swallowing?</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Does your child often have diarrhea or constipation?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(If yes; circle which one)</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Do you have any concerns about what your child eats?</td>
<td></td>
</tr>
</tbody>
</table>

Rate the approximate number of times a week your child eats food from each of the following groups listed below:

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>7+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk, cheese, yogurt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meat, poultry, fish, eggs; or dried beans/peas, peanut butter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rice, grits, bread, cereal, tortillas</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes</td>
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<tr>
<td>Oranges, grapefruit, tomatoes (fruit/ juice)</td>
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<tr>
<td>Other fruits and vegetables</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Oil, butter, margarine, lard</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cakes, cookies, sodas, fruit, drinks, candy</td>
<td></td>
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</tbody>
</table>

Comments: ____________________________________________________________
Name of Form: NUTRITION QUESTIONNAIRE

Purpose: To obtain parental input on dietary habits of their child to be assessed by a Registered Dietitian. The RD is provided with charted and recorded height, weight, and hemoglobin information to determine growth pattern and any possible dietary problems.

Instructions: This form is part of a child’s Nutrition Assessment. The is completed by the parent/guardian. The Family Service Worker will scan this form into ChildPlus under health. The RD will use this information to complete the child’s Nutrition Assessment, along with the hemoglobin reading, height & weight, and growth charts kept in ChildPlus.

*Both height & weights on a child need to be completed and entered into ChildPlus by the Family Service Worker for the RD to review, no matter what date the child begins the program.*

Completed By: Parent/Guardian and/or Staff

Date Due: Completed at Orientation
Scanned into ChildPlus

Send To: ChildPlus

Filed At: Child File

Revised: 6/2012
**FOOD RECALL FOR 24 HOURS**

**CHILD’S NAME**

Please record the amount of drinks and foods typically consumed by your Head Start child in a 24 hour period. Record ingredients used if foods are mixed, e.g. goulash, spaghetti, lasagna, etc. Use cups, ounces, or tablespoons when listing amounts.

<table>
<thead>
<tr>
<th>Time</th>
<th>Food and Drink</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Parent Comments
(List any special Dietary needs we should be aware of with your child):

Has child been participating in the WIC program within the past year?

☐ Yes  ☐ No

Scanned Nutritional Questionnaire and Food Recall for 24 hours into ChildPlus: ____________________________

(Date)
Name of Form: FOOD RECALL FOR 24 HOURS

Purpose: To document average daily intake of food according to parental input.

Instructions: This form is part of a child’s Nutrition Assessment. It should be completed by a parent/guardian within the first 45 days of school. The Registered Dietician will use this form to determine dietary habits of each child. Recommendations based on eating patterns may be given to the parent/guardian by the RD.

The Food Recall for 24 Hours must be reviewed by the RD. The Food Recall will be scanned into ChildPlus under health. The RD may contact the parent/guardian by phone, mail, or personal visit about dietary concerns.

An additional Food Recall for 24 Hours may be requested by the RD if concerns are identified.

Completed By: Parent/Guardian
Date Due: Within the first 45 days of school
Send To: Scanned into ChildPlus
Filed At: Child File/ChildPlus
Revised: 6/2012
<table>
<thead>
<tr>
<th>MEDICAL/ALLERGY CONCERN FORM</th>
<th>Center Name: ___________________________</th>
<th>Medication Allergy: □ No plan needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Name:</td>
<td></td>
<td>Type: ____________________________</td>
</tr>
<tr>
<td>Parent(s) Name:</td>
<td></td>
<td>Reaction that Occurs: ____________</td>
</tr>
<tr>
<td>Child date of birth:</td>
<td></td>
<td>Source: __________________________</td>
</tr>
</tbody>
</table>
| Date Completed:            |                                          | □ Doctor  
|                            |                                          | □ Parents |
| Food Allergies:            | □ No plan needed                         |                                    |
| Type:                      |                                          |                                    |
| Reaction that Occurs:      |                                          |                                    |
| Medication(s) used for    |                                          |                                    |
| allergy List:              |                                          |                                    |
| Is medication given at:    |                                          |                                    |
| □ Home                     |                                          |                                    |
| □ School                   |                                          |                                    |
| Source:                    |                                          |                                    |
| □ Doctor                   |                                          |                                    |
| □ Parents                  |                                          |                                    |
| Food Allergy Review:       |                                          |                                    |
| Food Substitution Form     |                                          |                                    |
| needed:                    |                                          |                                    |
| □ Yes                      |                                          |                                    |
| □ No                      |                                          |                                    |
| Training needed before    |                                          |                                    |
| child begins:              |                                          |                                    |
| □ Epi-pen Training        |                                          |                                    |
| Asthma:                    | □ No plan needed                         |                                    |
| □ Diagnosed by Doctor      |                                          |                                    |
| Triggers for Asthma:       |                                          |                                    |
| Reaction that Occurs:      |                                          |                                    |
| Medication(s) used for    |                                          |                                    |
| Asthma List:               |                                          |                                    |
| Is medication given at:    |                                          |                                    |
| □ Home                     |                                          |                                    |
| □ School                   |                                          |                                    |
| Source:                    |                                          |                                    |
| □ Doctor                   |                                          |                                    |
| □ Parents                  |                                          |                                    |
| Asthma Review:             |                                          |                                    |
| □ Asthma Action Plan needed |                                        |                                    |
| □ Prescription for Medication to keep at school  | |                                    |
| □ Medication (labeled with child name) to keep at school | |                                    |
| □ Medication Log needed    |                                          |                                    |
| Training needed before    |                                          |                                    |
| child begins:              |                                          |                                    |
| □ Asthma training on the child’s individual plan | |                                    |
| Other Allergies:           | □ No plan needed                         |                                    |
| Type:                      |                                          |                                    |
| If seasonal allergies what seasons are affected | □ Spring  
| (mark all that apply):     | □ Fall        
<p>| □ Summer                  | □ Winter     |
| Reaction that Occurs:      |                                          |                                    |
| Medication(s) used for     |                                          |                                    |
| allergy - List:            |                                          |                                    |
| Is medication given at:    |                                          |                                    |
| □ Home                     |                                          |                                    |
| □ School                   |                                          |                                    |
| Source:                    |                                          |                                    |
| □ Doctor                   |                                          |                                    |
| □ Parents                  |                                          |                                    |
| Allergy Review:            |                                          |                                    |
| □ Medical Action Plan      |                                          |                                    |
| needed                     |                                          |                                    |
| □ Prescription for Medication to keep at school  | |                                    |
| □ Medication (labeled with child name) to keep at school | |                                    |
| Restrictions and/or        |                                          |                                    |
| limitations:               |                                          |                                    |
| List:                      |                                          |                                    |</p>
<table>
<thead>
<tr>
<th><strong>Seizures:</strong></th>
<th><strong>Heart Murmurs:</strong></th>
<th><strong>Other:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type:</strong></td>
<td><strong>Type:</strong></td>
<td><strong>Type:</strong></td>
</tr>
<tr>
<td><strong>Reaction that Occurs:</strong></td>
<td><strong>Reaction that Occurs:</strong></td>
<td><strong>Reaction that Occurs:</strong></td>
</tr>
<tr>
<td><strong>Any restrictions or limitations:</strong></td>
<td><strong>Any restrictions or limitations:</strong></td>
<td><strong>Any restrictions or limitations:</strong></td>
</tr>
<tr>
<td><strong>Source:</strong></td>
<td><strong>Source:</strong></td>
<td><strong>Source:</strong></td>
</tr>
<tr>
<td>□ Doctor</td>
<td>□ Doctor</td>
<td>□ Doctor</td>
</tr>
<tr>
<td>□ Parents</td>
<td>□ Parents</td>
<td>□ Parents</td>
</tr>
<tr>
<td><strong>Medication(s) used for seizures - List:</strong></td>
<td><strong>Medication(s) used for Heart murmur - List:</strong></td>
<td><strong>Medication(s) used - List:</strong></td>
</tr>
<tr>
<td><strong>Is medication given at:</strong></td>
<td><strong>Is medication given at:</strong></td>
<td><strong>Is medication given at:</strong></td>
</tr>
<tr>
<td>□ Home</td>
<td>□ Home</td>
<td>□ Home</td>
</tr>
<tr>
<td>□ School</td>
<td>□ School</td>
<td>□ School</td>
</tr>
<tr>
<td><strong>Seizure Review:</strong></td>
<td><strong>Heart Murmurs Review:</strong></td>
<td><strong>Other Review:</strong></td>
</tr>
<tr>
<td>□ Prescription for Medication to keep at school</td>
<td>□ Prescription for Medication to keep at school</td>
<td>□ Prescription for Medication to keep at school</td>
</tr>
<tr>
<td>□ Medication (labeled with child name) to keep at school</td>
<td>□ Medication (labeled with child name) to keep at school</td>
<td>□ Medication (labeled with child name) to keep at school</td>
</tr>
<tr>
<td>□ Doctor Note for limitations/restrictions</td>
<td>□ Doctor note for limitations/restrictions</td>
<td>□ Doctor note for limitations/restrictions</td>
</tr>
<tr>
<td>□ Medication Log needed</td>
<td>□ Medication Log needed</td>
<td>□ Medication Log needed</td>
</tr>
<tr>
<td><strong>Tubes in Ears:</strong></td>
<td><strong>Failed Newborn Hearing Screen:</strong></td>
<td><strong>Reviewed:</strong></td>
</tr>
<tr>
<td>□ No plan needed</td>
<td>□ No plan needed</td>
<td><strong>Date:</strong></td>
</tr>
<tr>
<td><strong>Month/Year tubes were put in:</strong></td>
<td><strong>Returnee child, had passed hearing screen 1st year in Head Start</strong></td>
<td><strong>Family Service Specialist:</strong></td>
</tr>
<tr>
<td><strong>Location of tubes:</strong></td>
<td><strong>2nd screening completed:</strong></td>
<td><strong>Date:</strong></td>
</tr>
<tr>
<td>□ Both ears</td>
<td>□ Yes</td>
<td><strong>Health Services Director:</strong></td>
</tr>
<tr>
<td>□ Left</td>
<td>□ No</td>
<td></td>
</tr>
</tbody>
</table>
Name of Form: MEDICAL/ALLERGY CONCERNS

Purpose: To document medical/allergy concerns for enrolled children. The Medical/Allergy Concerns form is completed by the FSW at time of application and/or whenever a concern arises during the school year. The original is then attached to the new & returnee applications and sent to the Central Office. The Family Service Specialist and the Health Services Director will review and sign off on the form and send back to the center. If a medical action plan; food substitution form, asthma action plan, or other information is needed, it will be documented on the form by the Health Services Director. The original will then be reviewed by the FSW and shared with the center team. After the form has been initialed by all team members, it is placed in the child file.

Instructions: The FSW must fill out this form for every enrolled child with an identified medical/allergy concern at time of application. The original form then is attached to the application and sent into the Central Office. This is also the process for returnee applications. If a returnee child had a medical/allergy concern form in place, a new form must be filled out reflecting being reviewed with the parent. It is important to visit with the parents and not assume all Medical/Allergy Concerns are the same. The original is then attached to the returnee application and sent into the Central Office. This form must also be filled out every time an additional medical and/or allergy concern becomes evident. If a health concern is no longer a concern, a Medical/Allergy Concern form must be filled out indicating this, along with an explanation why. The completed forms must be shared with the center team after the Family Service Specialist and Health Services Director have signed off on the original form. The Medical/Allergy Concern form cannot be faxed. The information is entered into ChildPlus at the Central Office during review of application. From the Central Office it will be sent back to the center. The center team reviews and initials form. Any comments and/or recommendation made by the Health Service Director will then be implemented when the child is accepted to the program. A child may not be allowed to start classes until a plan is developed if a concern exists. A letter explaining this will be sent to the parent along with the acceptance letter.

Completed By: FSW

Date Due: During application process and/or as needed for both new and returnee children. Original

Send To: Original to Central Office

Filed At: Original in Child’s File

Revised: 6/12
HEAD START POLICY COUNCIL

DESCRIPTION:
The Head Start Policy Council is a federally mandated policy-making body that is elected at the local level. At least 51% of the members must be parents of Head Start children currently enrolled in the grantee Head Start program. It may also include representatives (up to 5) from the community.

PURPOSE:
The purpose of the Head Start Policy Council is to ensure that each grantee has an established policy group and a well-functioning governing body that share responsibility for overseeing the delivery of high quality services to children and families in accordance with Head Start legislation, regulations and policies. Head Start parents build leadership skills; without Policy Council- there is no Head Start Program!

FUNCTION:
1. Work in partnership with key management staff and the Board of Directors to develop, review and approve or disapprove the following policies and procedures:
   A. Funding Applications and budget planning for program expenditures.
   B. Procedures describing how the Board of Directors will implement shared decision making
   C. Procedures for program planning, philosophy, long and short range program goals & objectives.
   D. Composition of the Policy Council and procedures by which members are chosen.
   E. Criteria for defining, recruitment, selection, and enrollment priorities.
   F. Annual self assessment.
   G. Agency Personnel Policies, including standards of conduct.
   H. Decisions to hire or terminate any person who primarily works for the Head Start Program.
   I. Serve as a link to the local parent committees, Board of Directors, public and private organizations and the communities they serve.
   J. Bylaws for operation of Policy Council.
   K. Election procedures.
   L. Assist parent committees in communicating with parents enrolled in all program options to ensure that they understand their rights, responsibilities and opportunities in Head Start and to encourage their participation in the program.

MEMBERSHIP:
Representatives must be elected each year from their local Parent Committee. Representatives may serve no more than three one-year terms. Each term runs from September through September and is seated at the October Policy Council Meeting. No agency staff or pre-k center staff (or members of their immediate families- husband, wife, and children) may serve on Policy Council.

MEETINGS:
Policy Council generally meets monthly at the Pender Administration Offices. Meetings will be approximately two hours in length with subcommittees prior to the meetings for half an hour. Meeting date and times are determined by Policy Council Representatives at the October meeting.

RESPONSIBILITIES:
Representatives attend monthly meetings. The representative will RSVP by e-mail, phone, or through their FSW prior to the meeting whether they will or will not be attending the meeting that month. FSW will provide information for representatives to share at the meeting. Ex: volunteers that attended the classroom, activities, parent education, new equipment, etc.
DESCRIPTION: The Head Start Health Advisory Committee is a group of interested parents, health professionals, and community representatives created by Head Start as stipulated by Head Start Performance Standards.(1304.41)

PURPOSE: The purpose of the Head Start Health Advisory Committee shall be to advise and assist the Head Start program in the planning, implementation, and evaluation of the health services program. Health Services are services of a medical nature provided by Head Start through community physicians, dentists, clinics, mental health professionals, ESU programs, Northeast Nebraska Community Action Partnership WIC, Immunization Clinics, and trained staff.

FUNCTION:
1. To advise the Family Service Specialist on all aspects of health services.
2. To serve as a liaison between the Head Start program and professional service providers and the community.
3. To be an advocate within the community, identifying resource and improving the service delivery system for Head Start children.
4. To provide assistance and advice in finalizing the Health Component of the Written Plan and other health procedures and protocols.
5. To identify other health service agencies and providers within the community.
6. To advise on the most efficient and appropriate use of funds in the health budget and to provide guidance in the pursuit of funds in the area of health services.
7. To suggest speakers, materials, and information for health education programs in the classroom and for parents.
8. To monitor the quality of the ongoing program in the area of health.

MEMBERSHIP:
Members of the Head Start Health Advisory Committee shall consist of, but are not limited to, the following:

Mental Health Professionals  Head Start Parents
Physicians/Physicians Assistants  Nutritionists
Dental Providers  Health Services Representatives
Public School Representatives  E.S.U. Representatives
Registered Nursing Staff  Head Start Staff

MEETINGS:
The Head Start Health Advisory Committee will meet a minimum of two times a year, more if needed, and will be scheduled at times and locations to accommodate the members.
# FAMILY DEVELOPMENT SCALE

Circle the number that best describes your family.

Child Name: ________________________________  Center/Classroom: ________________________________

<table>
<thead>
<tr>
<th>Needs Assistance</th>
<th>TRANSPORTATION</th>
<th>(Strength)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**FAMILY RELATIONS**

| 1 | 2 | 3 | 4 | 5 | 6 |

**PARENTING**

| 1 | 2 | 3 | 4 | 5 | 6 |

**ALCOHOL/DRUG USE**

| 1 | 2 | 3 | 4 | 5 | 6 |

**CHILDREN’S EDUCATION**

| 1 | 2 | 3 | 4 | 5 | 6 |

**ADULT EDUCATION/CAREER DEVELOPMENT**

| 1 | 2 | 3 | 4 | 5 | 6 |

**EMPLOYMENT**

| 1 | 2 | 3 | 4 | 5 | 6 |

**INCOME/BUDGET**

| 1 | 2 | 3 | 4 | 5 | 6 |

**HEALTH CARE**

| 1 | 2 | 3 | 4 | 5 | 6 |

**NUTRITION**

| 1 | 2 | 3 | 4 | 5 | 6 |

**HOUSING**

| 1 | 2 | 3 | 4 | 5 | 6 |

Father/Guardian Signature ________________________________ Date __________________

Mother/Guardian Signature ________________________________ Date __________________

Family Service Worker Signature __________________________ Date __________________

☐ 1st Family Visit  ☐ 2nd Family Visit  Date __________________
Name of Form: FAMILY DEVELOPMENT SCALE

Purpose: To document a parent/guardian’s self-assessment in each of the areas of the Family Development Assessment.

Instructions: This form is completed by parents/guardians as a self-assessment of strengths and needs. It is completed 2 times per year.

FSWs must provide each accepted family with the first Family Development Scale at 1st Family Visit.

The 2nd Family Development Scale may be completed during the 2nd regular Home Visit.

A copy (yellow) must be given to the parent/guardian. A separate FDS must be done at each home visit.

Completed By: Parent/Guardian
Date Due: 1st- 1st Family Visit
          2nd- 2nd Family Visit
Send To: Copy (yellow) given to parents
Filed At: Child File
Revised: 6/2012
PARENT/COMMUNITY MEMBER GRIEVANCE

If you have a complaint or grievance regarding the Head Start Program please explain in detail below.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Send this copy to: Head Start Director
Northeast Nebraska Community Action Partnership, Inc.
Box 667
Pender, NE 68047

Before a final decision is rendered both parties involved will have an opportunity to express their viewpoint. If a grievance is not signed no action will be taken.

____________________________
Parent/Other Signature (Required)

____________________________
Date
Name of Form: PARENT/COMMUNITY MEMBER GRIEVANCE

Purpose: To document and resolve grievances regarding the GHCA Head Start Program.

Instructions: The Parent/Community Member Grievance Procedure is handed out at orientation, along with this form. This form should be given to a parent or community member who wishes to file grievance against the program. That individual should also be referred to the grievance procedure. If the grievance is not signed no action will be taken.

The Head Start Director will follow-up on all grievances.

Completed By: Parent/Guardian, Community member

Date Due: As needed

Send To: Head Start Director

Filed At: Central Office

Revised: 6/05
# CHILD FILE CHECKLIST

**Center:** ______________________________________

<table>
<thead>
<tr>
<th>Child Name _________________________</th>
<th>School Year ______________</th>
<th>Date Enrolled _____________</th>
</tr>
</thead>
</table>

## ADMINISTRATION

- ___ Change of Status*
- ___ Application-New or Returnee: (Proof of Birth, Documentation of Income, Immunizations, Medical/Allergy Concerns*, MDT and IFSP/IEP* attached to application)
- ___ Authorization for Release of Information*
- ___ Parent Orientation Checklist
- ___ Other: ______________________________

## HEALTH

- ___ Child Emergency Care and Consent
- ___ Consent of Parent/Guardian for Head Start Health Services
- ___ Health Screening Summary*
- ___ Lead Screening Questionnaire
  (First year only)
- ___ Physical
- ___ Lab Work*
- ___ Updated Immunizations*
- ___ Health Reports*
- ___ Dental
- ___ Nutrition Questionnaire
- ___ Food Recall for 24 Hours
- ___ Nutrition Assessment Summary
  1st: __________________ 2nd: __________________
- ___ Growth Charts (End of Year)
- ___ Medical/Allergy Concerns*
- ___ Health Services Waiver*
- ___ 45 Day:______________
- ___ 90 Day:______________
- ___ Individual Follow-Up Plan*
- ___ Medical/Asthma Action Plan*
- ___ Medical Statement for Food Substitutions*
- ___ WIC Release*
- ___ Consent to Administer Medication/
  Medication Log*
- ___ Documentation of Medication Error*
- ___ Federal Immunization Waiver*
- ___ Communicable Disease Report*
- ___ Copy of ChildPlus #3030
- ___ Other

## FAMILY SERVICES

- ___ Parent Permission
- ___ Parent Interest Sheet (copy from teacher)
  ____________ Mother
  ____________ Father
- ___ Family Contact Logs-#4410
  (copy at end of year from ChildPlus)
- ___ Parent Activity/Parent Meeting/Parent Training #4410 (copy at end of year from ChildPlus)
- ___ Documentation of Absences
  (file most current date on top)
- ___ Emergency Care and Consent (parent)
- ___ Felony/Misdemeanor Statement*
- ___ Volunteer Job Description-parent (copy from teacher)*
- ___ NENCAP Referral Form *
- ___ Home Visit Waiver *
- ___ State Immunization Waiver*

## Other

- ___ Family Partnership Agreement
  ____ Family Development Assessment
  ____ Family Development Plan
  ____ Family Development Scale:
  1. ______________________
  2. ______________________
  ____ Other: ______________________

- ___ Copies of Communication sent to parents
  *(ie: e-mails, letters)*
- ___ Other

* If applicable
Name of Form: CHILD FILE CHECKLIST

Purpose: To document contents of every enrolled child’s file.

Instructions: Every enrolled child must have a complete child file containing a complete Child Checklist. FSW is responsible to see that all forms in the Administration, Health, and Family Service sections of the checklist are complete and in the child’s file at the end of the school year. It is the FSW responsibility to compile all forms in the child’s file at the end of the school year and to forward the files to the central office.

Place a check mark beside each form contained in the child’s file. If a form is not applicable for a particular child, mark “N/A” beside the form.

FSW’s are required to have a file on each child containing dividers for the 4 different categories: Administration, Health, Family Services, & Other for easy access and organization.

Completed By: FSW

Date Due: End of the school year

Send To: Central Office in Child File

Filed At: Central Office

Revised: 6/12
**RESOURCE BINDER**

**Purpose:** This binder will be given to each family as a tool to organize the resources sent home and given during family visits by our staff. The resource book is then utilized as an ongoing, usable tool throughout the year for parents.

The Family Service Worker will provide each new family with a Resource Binder and explain the purpose and process during orientation. If the family is a returnee family, Family Service Workers will review the book purpose with them during orientation. It will be the parents choice if they utilize their resource book they received the year before. FSW’s will discuss this option with the parents and document parents choice in the contact log. If family chooses to utilize their Resource Binder the second year, FSW’s will follow same process as with 1st year parents.

These binders should each contain a minimum of three dividers. Required dividers need to be labeled:
- Parent/Child Education
- Nutrition
- Policy Council

It is the choice of the Family Service Worker if they choose to add more dividers.

One way parents will have an understanding and knowledge about Policy Council is through the Resource Binder. Policy Council will be one category that every center must use. Parent Summary Sheets should be placed in this section showing parents received a review of the monthly meeting and giving them opportunity to respond to the summary. Family Service Workers, as good practice should take a copy of the last Policy Council Summary Sheet Parent Summary Sheet sent out with them on the family visit, in case the parents misplaced the sheet. The sheet is reviewed between the Family Service Worker and the parents for any questions. Knowing how we share information regarding Policy Council is reflected in the Written Plan as an objective to the Performance Standards.

It is the Family Service Workers responsibility to continue working with the families to keep the book up-to-date as an on going, usable resource during family visits and routine contact. All handouts need to be three hole punched before putting them in the School-to-Home daily folder or handing them out to families. All information sent home needs to be individualized to each parents needs. This information will be recorded in the contact logs and recorded under Parent Training in ChildPlus.
SCHOOL-TO-HOME DAILY FOLDERS

**Purpose:** This folder will be given to each family as a tool to communicate information between staff and parents.

Centers will provide each family with a daily pocket folder during the Orientation process. These folders contain two labels.

One labeled: Keep at Home (these are items that should be placed in the parents resource binder if they are utilizing the binder, three hole punched)

One labeled: Return to school (these are items such as health and nutrition papers)

School-to-Home folders will be sent out and returned **DAILY**. This will create consistency, routine and habit for the parents. Folders are placed in the cubbies each day before the child leaves, by the Family Service Workers. The family reviews the folder that night and returns it the next day to a designated labeled place in the Parent Corner. Family Service Workers will refill the folder with needed papers and repeat the process. There may be days that the folder will be empty. Folders should still be sent home to continue the routine. Parents may have to send something back to staff. There will be items that teachers and nutrition aides will want put in the folder. It is their responsibility to provide all items that need to be sent home to the Family Service Worker at least one or two days prior to placing in the folder with the date on the sheets reflecting the date they are to be sent out.

Daily Folders should be placed in the child’s cubby so that the child and/or parent remember to take it at the end of each day. If the Family Service Worker is out of the office, a back up staff person should be assigned to maintain routine for the families. The assigned staff member should complete the daily folder process of taking the contents out of the folders and placing items on the Family Service Workers desk. They should then fill with items marked for that day and place back in the cubbies for each child.

There will be those families who continuously lose their folders or cannot find them. Every parent should be given an additional folder (two pocket paper), one time, if they become lost or ruined. After the family has been through two folders, you will have to start sending the papers home without a folder and label them with a sticky note to either return to school or place items in Resource Binder at home.

It will be the FSW responsibility to put names on the folder. You may choose to have the children and parents decorate a paper to place under the plastic front cover for an activity. This shows the child’s individuality and creativity and a sense of knowing it is their folder.