



Zhiⁿ-Ga-Ma (Little Ones) Center

The Ponca Tribe Early Childhood Programs

20 White Eagle Drive♦♦(580) 762-7927♦♦Ponca City, Oklahoma 74601
Fax Number (580) 762-2743

Dear Parents/Guardians:

Attached you will find a recruitment application for the 2009-2010 school year at the Ponca Tribal Head Start Program. Recruitment activities are year round and enrollment will begin the week of July 6, 2009. Please contact the Head Start office at 580-762-7927 to schedule an appointment or if you have questions.

Our first day of class is August 10, 2009. We only have 35 slots and these will fill up quickly. ***Therefore, it is urgent if your child is a first year student at the Head Start their application is returned as soon as possible.*** Students will be prioritized and selected based upon a point system.

The following items must be submitted with your child's application:

- ✓ Copy of Birth Certificate or Certificate of Degree of Indian Blood
- ✓ Social Security Card
- ✓ Proof of Public Assistance (TANF or SSI) or Proof of Income (foster care children are eligible regardless of income)
- ✓ Immunization Record
- ✓ Copy of Sooner Care Card/Insurance
- ✓ Completed dental & physical exam

We look forward to working with you and your child during the coming school year.

Ponca Tribal Head Start Staff ♥

Parent's name & address: _____
Child's name: _____ 3 yr. old 4 yr. old
D.O.B. _____

Recruitment Application 3 & 4 Yr. Olds

Date received: _____
By whom: _____
Class: 3 or 4

Application Date: _____

Name of Child: _____ M or F DOB: _____

Parent/Guardian Name: _____

Child's Mailing Address: _____ City: _____ St.: _____

Zip: _____ Telephone: _____ Mess. Phone: _____

Directions to child's home: _____

Do you need transportation to and from the Head Start Center? Y or N

Has this child previously been enrolled in another Head Start or child development program? Y or N

If yes, what program: _____ Address: _____

City: _____ St: _____ Zip: _____ Telephone: _____

Both Parents in the home () Single parent family () ___ Mother ___ Father ___ Other

Relationship to child if not parent: _____

Number of children living in the home: ___ applicant ___ younger ___ older ___ total

Number of adults (other than parents) living in the home: _____

Family members living in the home:

First/Last Name	DOB	Gender	Relationship to child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is any female in the home pregnant? Y or N

Primary language spoken in the home: _____

Does your child have a disability that you know of? Y or N

If so, what is it? _____

Has it been diagnosed by a professional? Y or N

Is it okay for Head Start Staff to visit in your home? Y or N

Do you need childcare beyond Head Start hours? Y or N

****CHILD'S SOCIAL SECURITY NUMBER, INCOME, AND IMMUNIZATION STATUS MUST BE VERIFIED TO DETERMINE ELIGIBILITY BEFORE THE CHILD IS ELIGIBLE TO ATTEND HEAD START.****

Do you have any special reason for your child to be enrolled in Head Start?

Parent/Guardian Signature

For office use only:

Copy of birth certificate _____

Immunization record _____

Social Security Card _____

Copy of sooner care card _____

CDIB _____

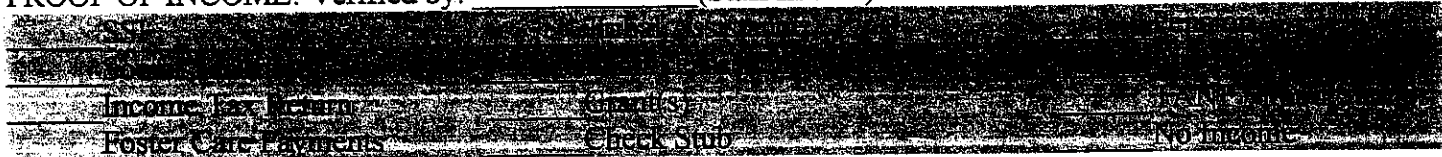
Proof of Public Assistance _____

Completed dental _____

Completed physical _____

PROOF OF INCOME: Verified by: _____

(Staff Initials)



Income Tax Return

Child Support

Foster Care Payments

Check Stub

No Income

Gross income for household per year: _____

Household Size _____

Poverty Level \$ _____

Is family income eligible? Y or N

Comments:

Staff Signature

Criteria of Needs

The criteria of needs must be filled out by a parent or guardian at the time of recruitment before application will be accepted.

Please put an X by all that apply to your or your immediate family member.

- Immediate family member with documented diagnosed disability.
- Court-ordered enrollment or referred from another agency.
- Family violence and/or substance abuse in the home.
- Single-parent family with no extended family or community support.
- Family crisis in the last 12 months(includes, but not limited to: fire, death, life threatening illness, homelessness, etc.)
- Child was enrolled and participated in a head start program(includes home based, center based, and/or early head start) last year.
- Family is receiving TANF.
- Non-English speaking and/or literacy needs within the family.
- Child being raised by persons other than parent(s). This includes foster child care.
- Single-parent family with non-related adults living in the home.
- Child with a suspected disability.
- Child has little or no opportunity to interact with children close to his/her own age.
- Pregnant woman without available prenatal care.
- Parents of 0-2 year old child(ren) are working or full time students.
- Other-decribe: _____

PONCA TRIBE HEAD START

20 White Eagle Dr. * Ponca City, OK 74601
(580) 762-7927 * FAX (580) 762-1978

Dental Exam/Treatment

Child's Name: _____ Birth date: _____

Physician's Name: _____

I give my permission for mutual exchange of information concerning my child.
 Parent permission received

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Medical Personnel Only

Based on this exam, the following findings and recommendations are made:

- ____ 1. No needs.
- ____ 2. Treatment needed
Date of next dental visit: _____
- ____ 3. Dental hygiene education
- ____ 4. Treatment Complete
- ____ 5. Are you serving as this child's "Dental Home" or "Primary Dental Provider"?
 No Yes

COMMENTS:

Signature of Dental Physician

Date

Any questions? Call (580) 762-7927 ext. 222

PLEASE RETURN THIS FORM TO PONCA TRIBE HEAD START OR FAX TO 762-1978

WELL CHILD EXAM

Name: _____

Date completed: _____

Provider Setting: Doctor/Clinic Other: Specify _____

Completed by: Medical Provider Specify: _____

PHYSICAL EXAM/ASSESSMENT

Height _____

Weight _____

BMI _____

*Hematocrit _____

*Hemoglobin _____

*Lead Results _____

(*must be completed)

or Date of Last Lead Test _____

	Normal	Abnormal		Normal	Abnormal
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Posture, Gait	<input type="checkbox"/>	<input type="checkbox"/>	Bones, Joint, Muscles	<input type="checkbox"/>	<input type="checkbox"/>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	Neurological/Social	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>
Eyes External aspects	<input type="checkbox"/>	<input type="checkbox"/>	Communication skills	<input type="checkbox"/>	<input type="checkbox"/>
Ears External Canal	<input type="checkbox"/>	<input type="checkbox"/>	Cognitive	<input type="checkbox"/>	<input type="checkbox"/>
Nose, Mouth, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	Self-help skills	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Social skills	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	Glands (Lymphatic/Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Coordination	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen (including hernia)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Allergies: _____

Medications: _____

Acute or Chronic Description:

Comments:

Yes No

In accordance with Oklahoma EPSDT guidelines, this child is up-to-date on their well child.

Physician's Signature: _____