Siletz Tribal Head Start Health Summary

This form must be completed and signed by a physician. Please do not defer any tests.

Return this form to Siletz Tribal Head Start, P.O. Box 549, Siletz, OR 97380-0549.

Child's Name: _____ Sex: M F DOB: _____

Parent/Guardian Name: _____Phone #: _____

Height: _____ **Weight:** _____ **Vision: R** _____ **L** _____

Hearing: R _____ **L** _____ **Blood Pressure**: _____

Immunizations Needed: _____

Physical Examination Summary

Date of Exam: _____ Examiner's Name: _____

This is a Very Important Piece for Head Start: Hct. or Hgb.: _____

When recording results for the following, enter:
N-normal, A-abnormal, NE-not evaluated

General Appearance: ___ Head: ___ Skin: ___ Abdomen: ___ Glands: ___

Nose/Mouth/Pharynx: ___ Heart: ___ Lungs: ___ Muscular Coordination: ___

Bones/Joints/Muscles: ___ Eyes: ___ Ears: ___ Genitalia: ___

1. Does this child's medical history and/or examination indicate any condition that would limit her/his participation in Head Start activities: **NONE YES**

Specify: _____

_____

_____

2. Is any further medical treatment or specific health recommendation necessary for this child? **NONE YES**

Specify: _____

_____

_____

Physician Signature: _____

Clinic/Office Address:_____

Telephone: _____

CTSI Team
Relay For Life Fund-raiser

Car Wash
May 18 • Noon to 4 p.m.

Behind the USDA warehouse next to the administration building in Siletz

We are asking for a donation of $5 for cars and $8 for big trucks. Thank you for helping us raise money for the fight against cancer!

Siletz Tribal Head Start 2007-2008 Family Needs Assessment

Siletz Tribal Head Start is conducting a survey to identify needs that exist in our community. This information is used to determine what programs and services would be relevant for Head Start to offer in the future. Your assistance will help ensure that our program meets your needs. Your input and support are valuable. Thanks!

Check One (Optional): ___Native American ___Other_____

Where do you live:_____City _____ County

Family Data: Single-Parent Household NO YES

Foster Parent/Grandparent NO YES

Total Number of Household Members:_____

Total Number of Children in Family:_____

Age(s) of Primary Caregiver:_____ Age(s) of Children:_____

Are any of your children disabled? NO YES

Have any of your children been in Head Start? NO YES

Economic Information:

Parent(s) Employed: ____Full-time ____Part-time ____Not Employed
____In Training/School

Gross Monthly Income:_____ Highest Grade Completed by Caregiver:___

Does Family Receive: ____TANF ____Food Stamps ____SSI ____GA
____OHP ____WIC

Do you own or rent your home?_____ Monthly Rent/House Payment_____

Transportation:
Do you have reliable transportation? NO YES

Do you have access to public transportation? NO YES

Childcare:
Do you have children in child care now? NO YES

How much do you pay for care?_____

Is it easy to find and use childcare services? NO YES

How would you rate your child care? __Poor __Good __Fair __Tremendous

Please rate the following from highest to lowest priority of need; 1 = highest priority to 14 = lowest need.

____Employment ____Education ____Preschool/Head Start
____Recreation ____Housing ____Literacy
____Health Care ____Dental Care ____Nutrition
____Childcare ____Parenting ____Cultural Activities
____Alcohol & Drug Awareness ____Other

Should Head Start Services be (circle one for each of the 3 questions):

1. Full-day or Part-day **2.** Full-Year or Part-Year

3. Classroom or Home Based

Should Head Start services serve children age 0 – 3 years? YES NO

Any other comments?_____

_____

_____