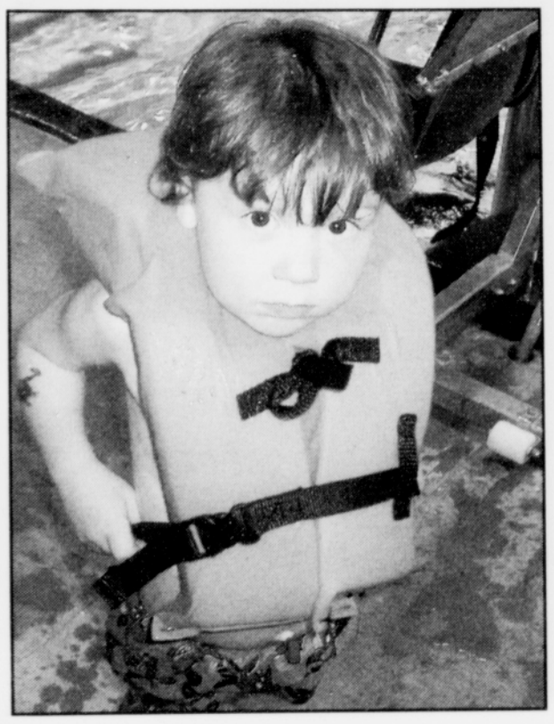

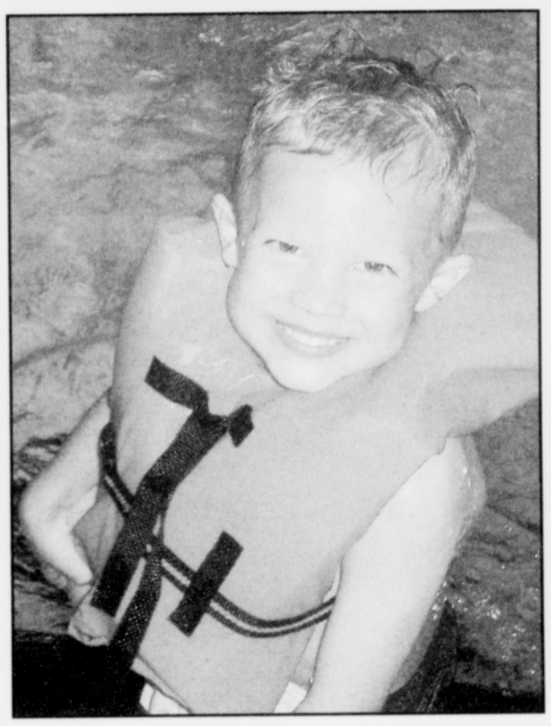

Above: Children are seen observing the "No Diving" sign at the Toledo pool as they await their turns in the water.
Left photos: Head Start students approach their time at the Toledo pool with varying degrees of trepidation and glee. (photos by Tracey Worman)

Siletz Tribal Head Start Family Needs Assessment 2008-2009

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 is 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 childcare 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 childcare? _____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 (please circle one for each of the three questions):
1. Full-day or Part-day 2. Full-Year or Part-Year
3. Classroom or Home-Based

Should Head Start services serve children ages 0 – 3 years? Yes No

Any other comments?_____
_____

Siletz Tribal Head Start Health Summary

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

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

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

Parent/Guardian Name: _____ Phone #: _____

Medical Personnel Only
At risk for Iron Deficiency Anemia
[] Yes [] No
If yes please perform Hct. Or Hgb.

Medical Personnel Only
At risk for Lead Poisoning
[] Yes [] No
If yes, please perform lead screen/results

Date of Exam: _____ Examiner's Name: _____

Height: _____ Weight: _____ Vision: R_____ L_____
Hearing: R_____ L _____ Blood Pressure: _____
Immunizations Needed: _____

When recording results for the following, please 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: _____