THE NAVAJU NATION



P.O. Box 9000 • Window Rock, Arizona 86515 • (928) 871-6000



Ben Shelly President Rex Lee Jim Vice President

NHSPC 219-01-2014

RESOLUTION OF THE NAVAJO HEAD START POLICY COUNCIL

NAVAJO HEAD START POLICY COUNCIL SUPPORTS AND APPROVES THE IMPLEMENTATION OF THE NAVAJO HEAD START ANNUAL REVISION OF POLICY & PROCEDURES (INCLUDING FORMS, PROFESSIONAL DEVELOPMENT, FLOW CHART & TRACKING) AND SERVICE DELIVERY PLANS 2013-2014 IN THE AREA OF HEALTH & NUTRITION.

WHEREAS:

- The Navajo Nation Board of Education (hereinafter the "Board" is the education agent in the Executive Branch for the purposes of overseeing the operation of all schools serving the Navajo Nation, including the Navajo Head Start program. 10 N.N.C. §106[A]; 10 N.N.C. §51. The Board carries out its duties and responsibilities through the Department of Diné Education. 10 N.N.C. §106[G][3]; and
- 2. Pursuant to 45 CFR 1304-50. Program Governance and Appendix A. The Navajo Nation Head Start Policy Council is duly elected and constituted Head Start Policy Council and an authorized entity of the Navajo Nation government; and
- 3. Pursuant to 45CFR 1304.51(a)(1)(iii) Management Systems and procedures-Program planning must include: the development of written plans(s) for implementing service in each of the program areas covered by this part (e.g. Early Childhood Development and Health Services, Family and Community Partnership, and program Design and Management);
- 4. Pursuant to 45 CFR 1304.51 (a)(2) All written plans for implementing services, and the progress in meeting them, must be reviewed by the grantee staff and revie2ed and approved by the Policy Council or Policy Committee at least annually, and must be revised and updated as needed; and
- 5. Pursuant to 45 CFR 1304.20 Health and Developmental Services. Grantee must determine health status; Screen for developmental, sensory and behavioral concerns; Extended follow up and treatment; Ongoing Care and Individualization of the program; and
- 6. Pursuant to 45 CFR 1304.23 Child Nutrition. Identification of nutritional needs. Staff and families must work together to identify each child's nutritional needs, taking into account staff and family discussions concerning; Grantee and delegate agencies must design and implement a nutrition program that meets the nutritional needs and feeding requirements of each child, including those with special dietary needs and children with disabilities. Also, the nutrition program must serve a variety of foods which consider cultural and ethnic preferences and which broaden the child's food experience; and
- 7. The purpose of Navajo Head Start is to promote the school readiness of low-income children by enhancing their cognitive, social and emotional development: (a) in a learning environment that supports children's growth in language, literacy, mathematics, science, social and emotional functioning, creative arts, physical skills, and approaches to learning; and (b) through the provision to low-income children and their families of health, educational nutritional social, and other services based on family needs assessment; and
- 8. Navajo Head Start provides children with experiences that encourage and stimulate intellectual and social growth opportunities, promote Navajo Language and culture, and provides access to necessary medical, dental, and nutritional services under the Head Start and Early Head Start programs; and
- 9. The Navajo Nation Head Start Policy Council has the best interest of the Navajo Head Start to continue in providing quality services to children and families.

NOW, THEREFORE BE IT, RESOLVED:

Supports and approves the implementation of the Navajo Head Start Annual Revision of Policy & Procedures (including forms, professional development, flow chart & tracking) and Service Delivery Plans 2013-2014 in the area of Health & Nutrition.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Navajo Head Start Policy Council at a duly called meeting in Window Rock, AZ at the DoDE Education Building which a quorum was present and that it was passed by vote of 12 in favor, opposed, and 2 abstained, this 23rd day of January 2014.

Motion by: Gregory Nells
Second by: Brady Clark

Olin Kieyoomia, President

DODE/Navajo Head Start Policy Council



DEPARTMENT OF DINÉ EDUCATION THE NAVAJO NATION

The Navajo Nation

P.O. Box 670 · Window Rock, Arizona 86515 PHONE (928) 871 – 7475 · FAX (928) 871 – 7474

Rex Lee Jim Vice-President

NNBEJA-NHS-010-2014

RESOLUTION OF THE NAVAJO NATION BOARD OF EDUCATION

Approving the Implementation of the Navajo Head Start annual revision of policy & procedures (including forms, professional development, flow charts, and tracking) and Service Delivery plans 2013-2014 in the area of Health and Nutrition Services.

WHEREAS:

- 1. The Health, Education, and Human Services Committee is the oversight committee for the Department of Diné Education and Navajo Nation Board of Education [2 N.N.C. § 401 (C)(1); 10 N.N.C. § 1(B)]; and
- 2. The Navajo Nation Board of Education (hereinafter the "Board") is the education agent in the Executive Branch for the purposes of overseeing the operation of all schools serving the Navajo Nation. [10 N.N.C. § 106 (A)] The Board carries out its duties and responsibilities through the Department of Diné Education (hereinafter the "Department") [10 N.N.C. §106 (G)(3)]; and
- 3. The Department of Diné Education (hereinafter the "Department") is the administrative agency within the Navajo Nation with responsibility and authority for implementing and enforcing the educational laws of the Navajo Nation. 2 N.N.C. §1801(B); 10 N.N.C. §107(A). The Department is under the immediate direction of the Navajo Nation Superintendent of Schools, subject to the overall direction of the Navajo Nation Board of Education. 10 N.N.C. §107(B); and
- 4. The Navajo Head Start ("NHS") Program, which is located within the Department of Diné Education as approved by the Department's Plan of Operation, Resolution No. GSCMY-19-07. The NHS also is funded by a grant from the Office of Head Start, Administration of Children and Families (ACF), under the terms of the Head Start Act, 42 U.S.C. §9801 et seq., and applicable regulations; and,
- 5. The Navajo Nation is named the grantee and is responsible for ensuring compliance with the Head Start Act and performance standards in delivering the services to Navajo children and their families. The 2013-2014 Navajo Head Start Policy and Procedures and Service Delivery Plans is revised annually for implementation of Head Start/Early Head Start services
- 6. The Board acknowledges the Navajo Head Start Resolution #219-01-2014 passed on January 23, 2014, Approving the Navajo Head Start to implement the policy and procedures

and service delivery plans, as it relates to services within the program; and Recommending Approval through the Navajo Nation Board of Education, and the Health, Education, and Human Services Committee of the Navajo Nation Council.

NOW THEREFORE BE IT RESOLVED THAT:

- 1. The Navajo Nation Board of Education hereby approves the Navajo Head Start Policy and Procedures and Service Delivery Plans.
- 2. The Navajo Nation Board of Education further recommends that the Navajo Nation Superintendent of Schools or his designee(s) and other designated members of the Navajo Nation Council to advocate on behalf of the Navajo Nation consistent with the services stated in this resolution.
- 3. The Navajo Nation Board of Education hereby directs and empowers the Superintendent of Schools to take any actions deemed as necessary and proper to carry out the purposes of this resolution.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Board of Education of the Navajo Nation at a duly called meeting at Window Rock, Arizona (Navajo Nation) at which a quorum was present, motion by <u>Katherine D. Arviso</u> and seconded by <u>Gloria Johns</u> and that the same was passed by a vote of <u>5</u> in favor; <u>0</u> opposed; <u>0</u> abstained, this <u>29th</u> day of January 2014.

Jimmle C. Begay, President Navajo Nation Board of Education

	1304.23 Child Nubrition			
Performance Standard	NHS Plan of Action	Time Frame	Responsibility	Reference
1304.23(a) - Identification of nutritional needs. Staff and families must work together to identify each child's nutritional needs, taking into account staff and family discussions concerning:		Enrollment	Health/NutritionSpec. Quality Assurance Manager ERSEA HS Engagement Spec.	Policies/Procedures Childplus Database
~	Information will be obtained from age appropriate growth assessment well child care per EPSDT guidelines and per HSAC recommended screenings.	Within 90 days of enrollment.	Health/Nutrition Spec. ERSEA Spec. and Liaison	Policies/Procedures
1304.23(a)(2) - Information about family eating patterns, including cultural preferences, special dietary requirements for each child with nutrition-related health problems, and the feeding requirements of infants and toddlers and each child with disabilities (see 45 CFR 1308.20)	from health/nutrition history, physical redividual Health Care Plan, CACFP onent requirements, and IEP/IFSP will plan and individualize food service for	Enrollment On-going	Health/Nutrition Spec. ERSEA Spec. and Liaison	Policies/Procedures Chilplus Database
1304.23(a)(3) - For infants and toddlers, current feeding schedules and amounts, and types of food provided, including whether breast milk or formula and baby food is used; meal patterns; new foods introduced: food intolerances and preferences, voiding patterns; and observations related to developmental changes in feeding and nutrition. This information must be shared with parents and updated regularly, and	و ن ⊈	Enrollment Monthly As needed	Health/Nutrition Spec.	Policies/Procedures Childplus Database
ation about major ssues, as identified through sment or by the Health amittee or the local health	The Health Services Advisory Committee, with representation of the local health department, will review the Community Assessment and will be asked for any additional input on community nutritional issues.	Quarterly	Health/Nutrition Spec & Liaison Liaison Engagement Spec.	Policies/Procedures
of of	be made argies or ods, available nd ariences	Annually (2 times for Staff and once for parent)	Health/Nutrition Spec. & Liaison ERSEA Engagement Spec. Mental Health/Disability Coordi.	Policies/Procedures NM/Menu RecordBook , Production Worksheets CACFP Monitoring
1304.23(b)(1)(i) - All Early Head Start and Head Start grantee and delegate agencies must use funds from USDA Food and Consumer Services Child Nutrition Programs as the primary source of payment for meal services. Early Head Start and Head Start funds may be used to cover those allowable cost not covered by the USDA.	Budget will indicate inclusion of CACFP reimbursements as primary source of payment for food services, and will show Head Start/EHS funding as secondary source.	Annualiy	Assistant Superintendent Health/Nutrition Spec, Quality Assurance Mgr. Manager	Policies/Procedures CACFP Renewal Application

1304.23(b)(1)(ii) - Each child in a part-day centerbased setting must receive meals and snacks that oprovide at least 1/3 of the child's daily nutritional needs. Each child in a center-based full-day program must receive meals and snacks that provide 1/2 to 2/3 of the child's daily nutritional needs, depending upon the length of the program day.	The program will use CACFP meal patterns for creating menus and have menus reviewed by a Registered Dietitian to ensure appropriate nutrition needs are met for program option.	Annually	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures NHS Menus NM/Menu Record Book AZ/Production Worksheets
4.23(b)(1)(iii) - All children in morning center- ed settings who have not received breakfast at ime they arrive at the Early Head Start or Start program must be served a nourishing kfast.		On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures Daily Sign/In Sheet
1304.23(b)(1)(iv) - Each infant and toddler in center-based settings must receive food appropriate to his or her nutritional needs, developmental readiness, and feeding skills, as recommended in the USDA meal pattern or nutrient standard menu planning requirements outlined in 7 CFP parts 210, 220, and 226.		On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
food food ving terns r ents		On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures NM/Menu Record Book AZ/Production Worksheet
in group	1.5	On-gaing	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
iods in ately ary, to ifants and I on propriate	guidelines for meals, ommodated. on demand to the	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
		On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
1304.23(b)(3) - Staff must promote effective dental hygiene among children in conjunction with meals.	Children will brush teeth after each meal service per day, including gum wiping for infants.	Daily	Health/Nutrition Spec. Quality Assurance Manager Center Staff	Policies/Procedures

agencies must ensure that nutritional services in center-based settings contribute to the development and socialization of enrolled children by providing that: 1304.23(c)(3) - All toddlers and preschool children and assigned classroom staff, including volunteers, eat together family style and are not laid down to sleep with a bottle; 1304.23(c)(5) - Infants are held while being fed and are not laid down to sleep with a bottle; 1304.23(c)(5) - Infants are held while being fed and not laid down to sleep with a bottle;	nes	Annually	VNutrition	Policies/Procedures
E 60	ACFP recommended times A		Spec. Quality Assurance Manager	NHS Menus
ol children I share the sing fed ottle;	מון אווו ספ מווסאכת וס במו מו	As needed.	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
ille being fed r a bottle;		On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures
		On-going	utrition Assurance iff	Policies/Procedures
		On-going	93	Policies/Procedures
1304.23(c)(7) - As developmentally appropriate, Children will participate in a developmentally opportunity is provided for the involvement of appropriate food related activities at least twice children in food-related activities.		Twice	utrition ssurance	Policies/Procedures
В		On-going	lity ager	Policies/Procedures
g	ce of	On-gaing	ce Manager	Policies/Procedures
1304.23(e)(2) - For programs serving infants and Infant toddler classrooms will facilities for the toddlers, facilities must be available for the proper storage and handling of breast milk and formula.	ula.	On-going	Health/Nutrition Spec. Quality Assurance Manager	Policies/Procedures

	Reference	olicies/Procedures	olicies/Procedures	Policies/Procedures	Policies/Procedures
	Responsible Person	Health and Nutrition Quality Policies/Procedures Assurance Manager	Health and Nutrition Quality Polities/Procedures Assurance Manager	Health and Nutrition Quality Policies/Procedures Assurance Manager	Health and Nutrition Quality Policies/Procedures Assurance Manager
Services	Тіте Frате	At enrollment	At enrollment	Enrollment and monthly	Monthly
Child Health and Developmental Services	NHS Plan of Action	At enrollment, families complete health/nutrition histories, and other enrollment documents which provide information about their ongoing source of continuous, accessible health care. If children do not have a medical/dental home and health coverage, program staff will work with families to establish a medical home and make referrals to providers.	At enrollment, staff work with parents to establish if child is on a schedule of well child care, including referral for current EPSDT exam, immunizations and dental exam if needed. With parental permission, staff will request information from providers if needed.	When it is established a child is not up-to-date on a schedule of well child care, program staff will work with parents to understand what service the child needs, why it is important and will assist parent as needed to complete the service.	Staff will reveiw ChildPlus reports and child files periodically to allow them to alert parents ahead of time to schedule new health exams and dental exams to keep their child up-to-date.
	Performance Standard	1304.20 - Child Health and Developmental Services 1304.20(a) (1) - In collaboration with the parents and as quickly as possible, but no later than 90 calendar days (with the exception noted in paragraph (a)(2) of this section) from the child's entry into the program (for the purposes of 45 CFR 1304.20 (a)(1), 45 CFR 1304.20 (a)(1), and 45 CFR 1304.20 (a)(1), "entry" means the first day that Early Head Start or Head Start services are provided to the child), grantee and delegate agencies must: 1304.20(a)(1)(i) - Make a determination as to whether or not each child has an ongoing source of continuous, accessible health care. If a child does not have a source of ongoing healthcare, grantee and delegate agencies must assist the parents in accessing a source of care;	1304.20(a)(1)(ii) - Obtain from a health care professional a At enrol determination as to whether the child is up-to-date on a schedule of age appropriate preventative and primary health care which includes medical, dental, and mental health. Such a schedule must incorporate the requirements for a schedule must incorporate the requirements for a schedule of well child care utilized by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State in which they operate, and the latest immunization recommendations issued by the Center for Disease Control and Prevention, as well as any additional recommendations from the local Health Services Advisory Committee that are based on prevalent community health problems:	1304.20(a)(1)(ii)(A) - For children who are not up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must assist parents in making the necessary arrangements to bring the child up-to-date;	1304.20(a)(1)(ii)(B) - For children who are up-to-date on an age-appropriate schedule of well child care, grantee and delegate agencies must ensure that they continue to follow the recommended schedule of well child care; and;

Policies/Procedures	Policies/Procedures	Policies and Procedures ChildPlus Review Folders Tracking reports FSL Contact Logs
Health and Nutrition Quality Policies/Procedures Assurance Manager	Health and Nutrition Quality Policies/Procedures Assurance Manager	Health and Nutrition Specialist Disability Specialist Mental Health Coordinator School Readiness Coaches School Readiness Manager
Молthly	As needed	Within 45/90 days of enrollment On-Going Monitoring
Program will use ChildPlus computer database program to Monthly monitor and track the provision of health care services. Staff will run reports on a regular basis and review to Identify gaps in service, expiring health events, and monitor progress of referrals or treatment.		the h
1304.20(a)(1)(ii)(C) - Grantee and delegate agencies must pestablish procedures to track the provision of health care in services.	tation - Obtain or arrange further diagnostic for each child with an observable, known or suspected testing, examination, and treatment by an appropriate licensed or certified professional for each child with an observable, known or suspected health or developmental problem; and 1304.20(a)(1)(iv) - Develop and implement a plan so that follow-up treatments is started follow-up plan for any condition identified in 45 CFR and completed if possible. 1304.20 (a)(1)(ii) and (iii) so that any needed treatment that begun.	behavioral concerns 1304.20(b)(1)/(2) - In collaboration with each child's family, and within 45/90 calendar days of children within 45 days of enrollment. The program will the child's family, and within 45/90 calendar days of children within 45 days of enrollment. The program will the child's family, and within 45/90 calendar days of children within 45 days of enrollment. The program will the child's family, and within 45/90 calendar days of children within 45 days of enrollment. The program will the child's family, and within 45/90 calendar days of children within 45 days of enrollment. The program will adopt age-appropriate and culturally sensitive screening agencies must be sensitive to use the findings to address ldentified needs. 1304.20(b)(3) - Grantee and delegate agencies must be sensitive to use the findings to address ldentified needs. 1304.20(b)(3) - Grantee and delegate agencies must be sensitive to use the finding sto address ldentified needs. 1304.20(b)(3) - Grantee and delegate agencies must be sensitive to use the finding sto address ldentified needs. 1304.20(b)(3) - Grantee and delegate agencies must within the child's typical behavior. 1304.20(b)(3) - Grantee and delegate agencies must within the child's typical behavior. 1304.20(b)(3) - Grantee and delegate agencies must utilize familiar with the child's typical behavior. 1304.20(b)(3) - Grantee and delegate agencies must utilize ration on all aspects of each child's development and behavior, including input from are familiar with the child's typical behavior. 1304.20(b)(3) - Grantee and delegate agencies must utilize gencies must utilize are familiar with the child's typical behavior. 1304.20(b)(3) - Grantee and delegate agencies must utilize community partners to screen children with qualified community partners to screen children with the child's typical behavior. 1304.20(b)(3) - Grantee and delegate agencies must utilize gencies must utilize contracted mental hard provide appropriate trained staff on growth are familiar with th

1304.20(c) - Extended follow-up and treatment 1304.20(c)(1) - Grantee and delegate agencies must establish a system of ongoing communication with the parents of children with identified health needs to facilitate the implementation of the follow-up plan. 1304.20(c)(2) - Grantee and delegate agencies must provide assistance to the parents, as needed, to enable them to learn how to obtain any prescribed medications, aids or equipment for medical and dental conditions. 1304.20(c)(3) - Dental follow-up and treatment must include; 1304.20(c)(3)(3) - Fluoride supplements and topical fluoride treatments as recommended by dental professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay; and 1304.20(c)(3)(i)) Other necessary preventive measures and further dental treatment as recommended by the dental professional.	1. Staff will consult with parent to create a follow-up plan when a health need is identified. 2. Staff will assist parents through education or referrals, if needed, to learn how to obtain medication, aids or equipment for medical/dental conditions. 3. Staff will assist parents if needed, to access dental treatment and follow-up that may include additional fluoride or topical fluoride, along with regular, routine professional preventative dental visits and to complete any dental treatment as prescribed.	s needed	Health and Nutrition Specialist Health and Nutrition Coordinator	Policies/Procedures	
1304.20(c)(4) - Grantee and delegate agencies must assist Staff will with the provision of related services addressing health create a concerns in accordance with the Individualized Education Program (IEP) and the Individualized Family Service Plan (ISPP).	review IEP/IFSP for health related services and foilow-up plan to address them.	As needed	Health and Nutrition Specialist Health and Nutrition Coordinator Disability Specialist	Policies/Procedures	
1304.20(c)(5) - Early Head Start and Head Start funds may be used for professional medical and dental services when no other source of funding is available. When Early Head start or Head Start funds are used for such services, grantee and delegate agencies must have written documentation of their efforts to access other available sources of funding.	gram	Annually	Assistant Superintendent Health and Nutrition Quality Assurance Manager Health and Nutrition Specialist Health Nutrietion Coordinator	Policies/Procedures	

1304.20(d) - Ongoing Care. In addition to assisting children's participation in a schedule of well child care, as described in section 1304.20(a) of this part, grantee and delegate agencies must implement ongoing procedures by which Early Head Start and Head Start Staff can identify any new or recurring medical, dental, or developmental concerns so that they may quickly make appropriate referrals. These procedures must include: periodic observations and recordings, as appropriate, of individual children's developmental progress, changes in physical appearance (e.g., signs of injury or illness) and enotional and behavioral patterns. In addition, these procedures must include observations from parents and staff.	Through the process of 45 day screenings, dental screenings by staff, and health and dental exams by professionals health concerns may be identified. In addition to this process, teachers will make and record daily observations of individual children and daily health checks will take place. In the event of changes in physical behavioral/emotional patterns of individual children, parents will be consulted. Parental observations will be solicited when observed changes occur and during home visits and parent/feacher conferences.	As needed	Health and Nutrition Quality Policies/Procedures Assurance Manager Indian Health Services NN Division of Health 1st Things First (AZ) BVU Nutrition Awareness University of Colorado Denistry Young Orthodox 638 Programs Coccnino County Summit Health Care (AZ)	Policies/Procedures	
as described in sections 1304.20 (a), (b), and (c), and in making all possible efforts to ensure that each child is making all possible efforts to ensure that each child is making all possible efforts to ensure that each child is making all possible efforts to ensure that each child health or developmental and receiving appropriate health care procedures and delegate agencies must and obtain advance parent or guardian attachment procedures and ongoing care are shared and treatment procedures of ongoing care are shared and treatment procedures and ongoing care are shared and the procedures about how to familiarize their children in a system of ongoing family health care process; and: 1304.20(e)(3) - Talk with parents about how to familiarize their children's make and elegate adencies must maintain written documentation of the legaly responsible adult refuses to give earth mouth and understood by the parents; 1304.20(e)(3) - Talk with parents about how to familiarize their children's make and keeping provider agencies must maintain written documentation of the legaly responsible adult refuses to give authorization for health services, grantee and delegate engines in a system of ongoing care are shared the program of ongoing care are shared and the parents about how to familiarize their children's make and keeping provider appointments and ongoing family health care process; and: 1304.20(e)(3) - If a parent or other legaly responsible adult refuses to give authorization for health services, grantee and delegate active parents in their children's make and keeping provider appointments and following health care process; and: 1304.20(e)(5) - If a parent or development may required treatment or further agencies.	1. Teachers will make general observations of individual children throughout the day, noting changes in physical appearance, developmental and social emotional behavior in addition to daily health check and will notify parents immediately if significant changes are observed. 2. During enrollment and when needed, staff will explain to parents why screenings, health and dental exams are important to the health and well being of their child prior to asking them to sign consents for screenings or health/dental exams arranged by the program. The results of these screening/exams will be shared with parent on first home visit by the teacher, unless there are concerns raised during screening/exam. It that event, parents will be notified as soon as possible. 3. During enrollment and when needed, staff will talk to parents about how the parents can work with their child to help the child be more comfortable with the screenings/exam is procedures. 4. At enrollment and when needed, staff will help parents enroll in a system of ongoing family health care and will encourage parents to actively participate in their child's health care by being informed consumers, make and keeping provider appointments and following through with any required treatment or further evaluation. 5. If parents/guardians indicate they are refusing any health/developmental services, after explanation of reason for service by staff, they will be asked to sign a refusal of services.	Enrollment As needed	Assurance Manager Assurance Manager	Policies/Procedures	

1304.20(f) - Individualization of the program	1. Program will individualize for nutrition/health/dental co Enrollment As needed	Health and Nutrition Quality Policies/Procedures	Policies/Procedures	
1304.20(f)(1) - Grantee and delegate agencies must use		Assurance Manager		
the information from the screening for developmental,		Disabilities/Mental Health		
sensory, and behavioral concerns; the ongoing		Quality Assurance Manager		
observations, medical and dental evaluations and		Education Quality Assurance		
treatments, and insights from the child's parents to help		Manager		
staff and parents determine how the program can best				
respond to each child's individual characteristics,				
strengths and needs. 1304,20(f)(2) - To support				
individualization for children with disabilities in their				
programs, grantee and delegate agencies must assure				
that; 1304.20(f)(2)(i) - Services for infants and toddlers				
with disabilities and their families support the attainment				
of the expected outcomes contained in the individualized				
Family Service Plan (IFSP) for children identified under the				
Infants and toddlers with disabilities program (Part C) of				
the Individuals with Disabilities Education Act, as				
implemented by their State or Tribal government;				
1304.20(f)(2)(ii) - Enrolled families with infants and				
toddlers suspected of having a disability are promptly				
referred to the local early intervention agency designated				
by the State Part C plan to coordinate any needed				
evaluations, determine eligibility for Part H services, and				
coordinate the development of an IFSP for children				
determined to be eligible under the guidelines of that				
State's program. Grantee and delegate agencies must				
support parent participation in the evaluation and IFSP				

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Head Start Program Performance Standards: 1304.22(c) (1-6)

(c) Medication administration. Grantee and delegate agencies must establish and maintain written procedures regarding the administration, handling, and storage of medication for every child. Grantee and delegate agencies may modify these procedures as necessary to satisfy State or Tribal laws, but only where such laws are consistent with Federal laws. The procedures must include:

(1) Labeling and storing, under lock and key, and refrigerating, if necessary, all

medications, including those required for staff and volunteers;

(2) **Designating a trained staff member**(s) or school nurse to administer, handle and store child medications;

(3) Obtaining physicians' instructions and written parent or guardian authorizations for all medications administered by staff;

(4) Maintaining an individual record of all medications dispensed, and reviewing the

record regularly with the child's parents;

- (5) **Recording changes in a child's behavior** that have implications for drug dosage or type, and **assisting parents in communicating with their physician** regarding the effect of the medication on the child; and
- (6) Ensuring that appropriate staff members can **demonstrate proper techniques** for administering, handling, and storing medication, including the use of any necessary equipment to administer medication.

Medication Storage and Labeling

Prescribed medication shall be in the original container **labeled** by a Pharmacist with the following:

- o Child's first and last name
- o Medication name
- Date the Prescription was filled
- o Dosage
- o Name of the prescribing Healthcare Provider
- Expiration date of the medication. No medication shall be dispensed to a child after the expiration date on the label.
- a. Prescription Medication shall be accompanied by the Drug Fact Sheet/Patient Insert provided by the Pharmacist and **stored** per manufacturer's or pharmacist instructions.
- b. Rescue Medications such as EpiPens for severe allergic reaction and rescue Inhalers for asthma shall be kept in a child resistant locking bag, so that it is maintained locked and inaccessible to children, yet readily accessible to staff. Trained staff will carry medication in a fanny pack on playground, field trips and bus routes. Classrooms must maintain the medication in locking bag where all staff members are aware of location, and medication is inaccessible to children.

Over the Counter Medication (OTC):

- a. OTC medications will not be given without a written Health Care Provider order. Order should include Child Name, Dosage, Route, When and How Long the medication should be given, and the condition for which it should be given.
- b. OTC Medications must be in an original child resistant container with a legible label for dosing and side effects, and expiration date. Medication shall not be dispensed after the expiration date.

c. OTC Medication shall be stored according to manufacturer's storage recommendations and locked and inaccessible to children.

Medication Required By Staff:

All Prescription and Over the Counter medications required by staff shall be labeled, stored and maintained as per child medication. However, adult medications should be stored in a separate locked box from children's medications. Staff purses should be maintained in a locked area while children are present on site. It is highly recommended to notify another staff about your medical condition, as well as the prescribed medication(s).

Storage and Inaccessibility to Children:

- a. All Medication shall be stored in a secure, locked location inaccessible to children and separate from food.
- b. Medication requiring refrigeration shall be stored in a locked box in a refrigerator that is separate from food refrigeration.
- c. Medication shall be stored in separate zip type bags for each person requiring medication. The bags shall be labeled with child's name, and all required paperwork and drug fact/patient insert sheets shall be in the bag.
- d. No more than a four week supply of medication will be accepted at one time.
- e. Rescue Medications such as EpiPens for severe allergic reaction and rescue Inhalers for asthma shall be kept in a child resistant locking bag, so that it is maintained locked and inaccessible to children, yet readily accessible to staff. Trained staff will carry medication in a fanny pack on playground, field trips and bus routes. Classrooms must maintain the medication in locking bag where all staff members are aware of location, and medication is inaccessible to children.

Transporting Medication:

- a. Parents cannot give medication to bus drivers or monitors to take to Head Start. Parents are responsible for bringing the medication to the classroom, completing all required Medication Administration paperwork, and verifying with responsible staff that the medication is properly labeled.
- b. Medication cannot be transported by the student or in the student's back pack.
- c. Medication required for a field trip shall be transported in a child resistant locked box with all required paperwork or in a fanny pack by a medication trained staff person.
- d. In the event a child that rides the bus regularly requires rescue medication, training will be arranged for the bus driver and the bus monitor prior to the child riding the bus.

General Medication Training for Staff:

- a. All staff shall be trained on general medication storage, administration procedures, safeguards, emergency medication procedures for Epipens and use of inhalers/nebulizers for asthma annually.
- b. Medication training records will be kept at centers per Office of Environmental Health requirements.

- c. Medication that requires injection other than Epipens for severe allergic reactions, will be administered by a Licensed Health Care Provider or designee, depending on local/state laws.
- d. Training will be arranged for staff working with a child with special health conditions or medications. Parents will orient staff to use of medication/equipment. For more severe conditions, health care providers may need to offer the training to staff.
- e. Trained staff members who are designated to administer medications in classrooms are as follows: teachers, teacher assistants, and bus drivers. The bus monitor will be trained in the event a child who rides the bus routinely may need a rescue medication during regular transport.

<u>Parent Orientation for Medication</u>: Navajo Head Start shall provide parent orientation the procedures and policies for Medication Administration at the beginning of the school year and individually if their child requires medication while at school.

Parent Responsibilities:

- a. Parents are responsible to bring the child's medication to the center, complete all required paperwork and to verify with staff that medication is properly labeled.
- b. Staff will not accept medication that is not labeled according to policy.
- c. Parents, along with health care provider, should arrange when possible to give medication before or after school.
- d. Parents must give first dose of medication at home.

Physicians' instructions and written authorization from parent or legal guardian:

- a. Prescription Medications shall be accompanied by a written health care provider order in the form of the prescription label.
- b. OTC medications will not be given without a written Health Care Provider order. Order should include Child Name, Dosage, Route, When and How Long the medication should be given, and the condition for which it should be given.
- c. OTC Medications must be in an original child resistant container with a legible label for dosing and side effects, and expiration date. Medication shall be not be dispensed after the expiration date
- d. Parental Consent and Parent Authorization must accompany the medication and kept on file.
- e. All medication shall be accounted for. Spills or spoilage of medication shall be documented and kept on file. Parents shall be notified of medication loss.
- f. Refusal to take medication shall be documented and shared with parents as soon as possible.
- g. Designated staff shall immediately notify Healthcare provider of any reactions to medication and follow the directions of the Healthcare Provider and parents should be notified also at this time.

Created 8/8/12 Page 3

Individual Records:

- a. Navajo Head Start shall maintain individual records of all medications dispensed and review the child's record with the parents/guardians on a regular basis, at least weekly for regularly dispensed medications, review with parent should be documented on the Medication Dispensation Log.
- b. Medication Dispensation Log shall be documented at the time child's medication is administered.
- c. Refusal to take medication shall be documented on the Medication Dispensation Log.
- d. Adverse reaction or changes in child's behavior shall be documented on the Medication Dispensation Log.
- e. Spills or spoilage of Medication shall be documented on the Medication Dispensation Log.
- f. Medication logs shall be reviewed with parents on a regular basis.

Recording a child's behavior caused by implications of medication dosage and will assist parents in consulting with their child's physician regarding medication.

- a. Staff members responsible to dispense medication shall review the possible side effects listed on the Drug Fact Sheet/Patient insert prior to initial dose of the medication.
- b. Staff Members shall observe the reactions of the child to the medication and monitor the child's activity for a minimum of 30 minutes for adverse reactions to the medication.
- c. If needed, provide parents with copy of Medication Dispensation Log with comments, so parent can take to doctor to communicate staff observations.
- d. In the event of an adverse reaction, the staff member shall immediately notify the child's Healthcare Provider and the parent of the adverse reaction. Staff shall follow directions from the Healthcare provider. If the adverse reaction is severe, the staff member shall immediately notify emergency medical services.

Implementing written policies and procedures of the proper techniques for administering, handling and the storing of medication.

- a. The staff members designated to dispense medication shall ensure that all policies regarding medication are followed and documented.
- b. Staff shall wash all equipment used to dispense medication in hot water with dish soap and air dry after each use (separated from everything else).
- c. Staff administering medication shall notify parents of the need for refills of medication when the supply of medication is 5 days doses prior to running out.
- d. Staff shall properly dispose of expired, spoiled, or unused medication by returning it to the parent.
- e. Herbal or Traditional Medication shall be not be administered at Head Start.

ESTIMITATED COST	\$1,500.00 (Supplies, ink, copies, and mailing)	\$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)	\$5,500.00 (Supplies, printing, advertisement, Consultant Fee, etc.)	\$5,000.00 (Supplies, printing, advertisement, Consultant Fee,
COMPLETION DATE	August 2014	August 2014	July 2014	July 2014
PERSON RESPONSIBLE	Health/Nutri. Specialist	Health/ Nutr. Specialist	Health/Nutri. Specialist AZ Lions Vision	Health/Nutri. Specialist
TRAINING OBJECTIVES	Train and implement the revised policies and procedures along with forms to be utilized by all staff and parents to meet the 45-day mandate up to 90 days for followup of all health requirements.	Attend training on height/weight intake and graphing along with BMI reading. (Hands On training)	Attend training to receive certification for Vision screening and reading.	Attend training to receive certification for Audio screening and reading. Calibrate audio
TOPICS	Health Tracking Policies	Height/Weight Intake and BMI reading	Vision Training and Certification	Audio Training and Certification

Calibration Fee, etc.)	\$1,500.00 (Supplies, printing, Consultant Fee, etc.)	\$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)	\$1,500.00 (Supplies, printing, advertisement, Consultant Fee, etc.)	\$1,500.00 (Supplies, snacks, printing, advertisement, etc.)
	July 2014	July 2014	July 2014	Sept 45 Day Mandate Oct- 90- Day Mandate
	Health/Nutri. Specialist IHS Providers	Health/Nutrì. Specialist IHS Providers	Health/Nutri. Specialist IHS Providers	Health/Nutrition Spec.
machines on a yearly basis.	Attend training to receive certification for intake and reading of HCT/Hgb, Blood Pressure, and Immunization, of enrolled children	Attend training in Oral Health for proper screening of children.	Attend Lead Screening training for reading purposes of lab results.	Conduct Health Fair within the community to implement screenings along with the Health Check-up Days at NNMC, DZlith Clinic, FCMC, and Tohatchi Health Clinic in order to meet the 45-day mandate, with follow-up
	Hematocrit/Hemoglobin, Blood Pressure, and Immunization, Reading and Certification	Oral/Dental Health Screening Training	Lead Screening and Reading Training	Health Fair, Screenings, and Health Check-up Days for enrolled children.

)			
	no later than 90 calendar days.			
Abuse/Neglect Conference	Gain knowledge and understanding the focal points of policies and procedures along with new implementations.	Health/Nutri.Specialist		\$15,024.00 (Total) \$350.00 x 06 staff = \$2,100.00 (Registration) \$169.00 x 06 staff =\$1,014.00 x 5 nights =\$5,070.00 (Lodging) \$64.00 x 06 staff = \$384.00 x 6 days = \$2,304.00 (Meals) \$800.00 x 6 staff = \$2,304.00 (Flight Fare) \$2,300.00 x 6 days = \$4,800.00 (Flight Fare) \$50.00 x 2 rental cars = \$100.00 x 6 days = \$100.00 x 6 days = \$500.00 (Rental) \$25.00 x 6 days = \$500.00 (Rental)
Alchini Nizhoni Activities (Celebrating the Month of the Young Child)	Provide various activities for children in celebration of Alchini Nizhoni	Head Start Children Head Start Staff	April 2014	\$5,000.00 (Rental Fee, Meals and Refreshments)
Health Wellness Day Activities for staff and Parents.	Provide physical activities for staff and parents inviting various resources to assist with activities.	Health/Nutrition Specialist Head Start Staff	April 2014	\$4,000.00 (Rental Fee, Meals, and Refreshments)
CPR/1st Aide		NHS Staff	July/Aug. 2014	$$40.00 \times 06 \text{ staff} =$

\$740.00	00.0475	\$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)	\$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Ci		July/Aug. 2014	July/Aug. 2014
Haalth Mistri Caccialist	nealth appealant	All Agency Staff All Central Staff Office Of Environmental Health Sanitarians	All Agency Staff All Central Staff Local Fire District Trainers
Attend a refresher	training to meet required mandate.	Attend OEH mandated Trainings to be incompliance with the CFR45/Tribal Health Codes.	Attend Fire Safety Mandated Trainings.
Contification		Office of Environmental Health Trainings: Blood Borne Pathogens Infection Control Injury Prevention Medication Administration Recognizing Adverse Reaction to Medication Playground Safety MSDS Carbon Monoxide Lead Screenings Hand Washing Food Handlers Certification	Fire Safety: Fire Protection Fire Suppression Fire Detection

		CALCALLACIANO O	3	
Model Health And Safety Code	Attend Model Health and Safety Code Training.	All Agency Staff All Central Staff OEH Sanitarians NNEnvironmental Health	July/Aug. 2014	\$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Health Plans	Attend Health Plan Training.	All Agency Staff All Central Staff OEH Sanitarians	July/Aug. 2014	\$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Emergency Management Training	Attend Emergency Management Training.	All Agency Staff Health & Nutrition Spec. & Liaisons NN Emergency Management Trainers	July/Aug. 2014	\$1,200.00 (Supplies, printing, advertisement, Consultant Fee, etc.)
Native Family/Child Conference	Attendance Conference	Family Engagement Liaisons & Specs NHS Staff Health/Nutri. Spec. & Liaisons	Schedule	
National Health Training	Attend Traiming	NHS Parents Family Engagement Specialist & Liaisons Health/Nutri. Spec. & Liaisons		
Native American Responsible Father	Attend Conference	NHS Parents Family Engagement	June 14, 2014- January 8-10, 2014	\$1,800.00 per person \$1,800.00 per person

	a		u			
	\$510.00 per person		\$845.75 per person			
	April 13-16, 2013	March 25-28, 2014	Feb. 7- Apr. 20, 2014	April 28- May 2, 2014	Jan. 30- Feb. 1, 2014	Jan. 21-22, 2014
Spec. & Liaisons Health/Nutri. Spec./Liaisons	Family Engagement Spec. & Liaisons Health/Nutri.Specialist & Liaison	Family Engagement Spec. & Liaisons Health Nutri. Specialist & Liaisons Disabilities Specialist	Family Engagement Spec./Liaison Health & Nutrition Spec. & Liaison	NHS Staff	NHS Staff Health & Nutrition Specialist/ Liaison Family Engagement Spec./ Liaison	NHS Staff Health & Nutrition
	Attend Conference	Attend Conference	Attend Conference 2014 San Francisco, CA	Attend Conference 2014 Long Beach, CA	Attend Conference in Barcelona, Spain	Attend Conference 2014 Boston, MA
	31st Native American Child Abuse/Neglect	National Conference Disabilities	Nutrition & Health Conference 2014	41st Annual Head Start Conference 2014	2 nd International Conference on Nutrition and Growth (NEC 2014)	SNA Annual Conference 2014- School Nutrition

	-	
Specialist/Liaisons	Family Engagement	Spec. & Liaisons
Association		

45/90 Day Mandate upon Enrollment for Center/Homebase/EHS sites

Indian Health Service Consent Form Parent Contact/Follow Up Child Health History able of Content

Health Screening Form (Vision, Audio, Dental,

Dental Information / Treatment form (6 months) mmunization Record (Updated annually) On-Site Dental Consent for Treatment Physical Examination (EPSDT/NHS)

Growth Chart:

Weight-for-Age/Length Percentiles (EHS only) Weight-for-Stature Percentiles (EHS only) Date Date Date Sud Sud Date Date

Length for Age Percentiles (EHS only) Date Date

BRIGANCE: Self Help Social/Emotional Scale/Behavorial Support Team Patient Referral Notice (IHS)

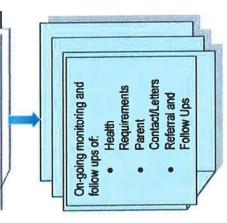
Indian Health Service Authorization Disclosure

Allergies (Food, Medications, Animals, etc.) BRIGANCE: Developmental Screening Infant Feeding Preference (EHS only)

Teacher, Paraprofessional, FEL, H/NL, H/NC, NHSHSAC, DS, MHC.

2012-2013 HEALTH FLOW CHART NAVAJO HEAD START

Upon completion of all required needed and to be forwarded to Examinations; a determination specified service providers. will be made if a referral is Health Screenings and



Referral and Follow-up Logs

HVWt/BMI. Tracking

Dental Tracking

Immunization Tracking

Childplus Database

Health Tracking

REGION I - V

Family Engagement Liaison &

Health/Nutrition Liaison

Analyze Tracking

and Referral /

Service Areas

Follow-up Logs

HSAC

HEALTH STATISTICS

COMPILATION OF

CENTRAL ADMINISTRATION

STATISTICS (CHILDPLUS) (5) Regions OVERALL HEALTH MONITOR/REPORT

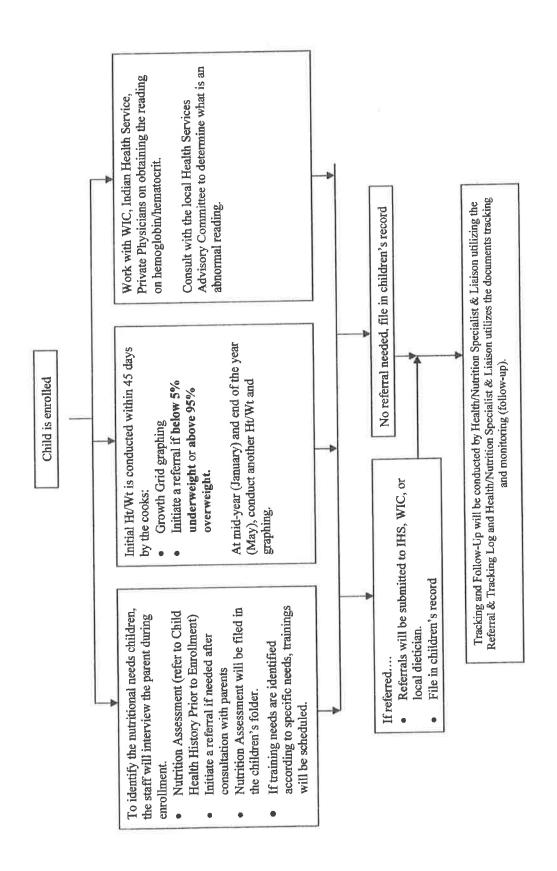
Analyze Tracking Follow-up Logs and Referral / NHSHSAC

Health/Nutrition Specialist & Family Engagement Specialist

HEALTH/NUTRITION SPECIALIST

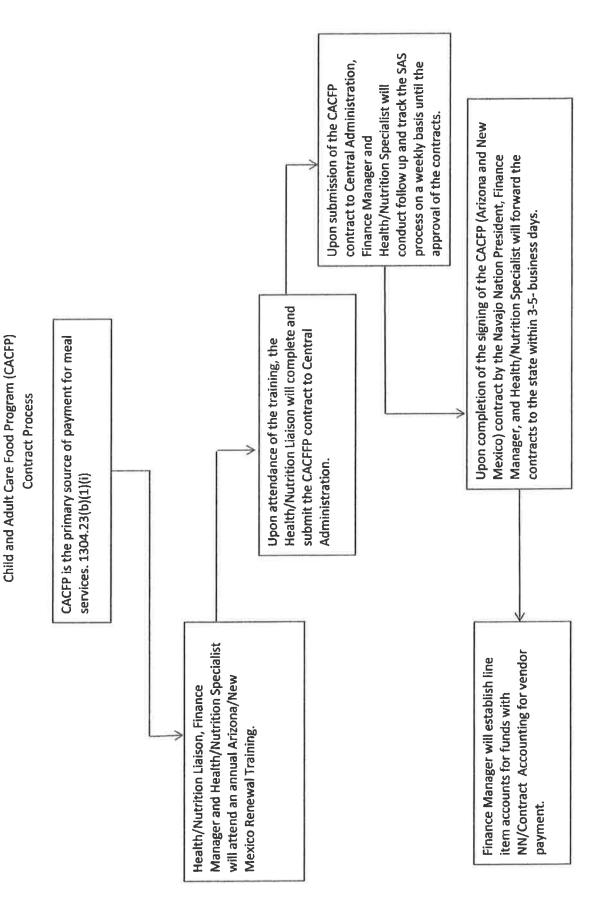
NAVAJO HŁAD START CHILD NUTRITION

FLOWCHART FOR CHILD NUTRITION ASSESSMENT



NAVAJO ' D START CHILD NO RITION

FLOWCHART



NAVAJO HEAD START

REGION (AGENCY):_____

INDIVIDUAL FOLLOW UP / ACTION STEP PLAN

CENTER:

CHILD'S NAME:		DATE/TIME:		
COMMENTS:				
STAFF NAME/DATE/TIME:				
ACTION STEP 1:				
STAFF NAME/DATE/TIME: ACTION STEP 2:				
ACHON STEP 2:				
STAFF NAME/DATE/TIME:				
ACTION STEP 3:				
STAFF NAME/DATE/TIME:				
□ INTAKE		□ PENDING		□ CLOSED
☐ HEALTH ☐ NUTRITION	☐ DISABILITY	□ EDUCATION	□ FPA	☐ MENTAL HEALTH

DEFINITIONS

1. HEALTH CARE:

Health care is the provision of health services of preventive, diagnostic, therapeutic and/or rehabilitative nature that do not involve major surgical procedures.

The purpose of a medical examination is to appraise the child's health and physical condition. The medical examination consists of two parts. In the first part, questions are asked relative to the health present and past, of the child and his/her parents, in the second part a thorough examination is made of the child's body, including weight, height, blood pressure, vision, and hearing.

Laboratory studies include tests of urine and blood.

X-rays are taken when necessary to see if there is any abnormality within the body.

A skin test consists of the injection into the skin of about a drop of a substance such as "tuberculin" or "coccidioidin." By means of these tests and x-rays of the chest, the physician determines whether the patient has or has had tuberculosis of valley fever.

2. DENTAL CARE:

Dental care begins with the dental examination, which consists of (a) examining teeth, gums, tongue, and other parts of mouth with dental mirror and explores (probe) and (b) taking dental x-rays as needed.

Routine dental care includes those services necessary to prevent the loss of teeth, such as cleaning the teeth, applying fluoride to the teeth, filling decayed teeth, and pulling teeth in order to prevent infection or clear up existing infection.

Necessary emergency dental care consists of those services that cannot be deferred without endangering the child's health or life, such as the relief of pain, the clearing up of infection, and the control of bleeding.

3. MENTAL HEALTH SERVICES:

Mental health services include psychological and psycho-educational testing, psychiatric evaluation, and consultation or assessment by mental health professionals. The information obtained is used to determine if it is appropriate or necessary to develop a treatment program for the child.

4. EMERGENCY HEALTH CARE:

Emergency health care includes surgical and/or non-surgical procedures that cannot be deferred without endangering the child's health or life, surgical procedures that can be deferred are not authorized by the consent in this form. In such cases, the specific authorization for surgery from the parent or legal guardian is required.

PRIVACY ACT NOTICE TO PARENTS OR GUARDIANS

The Privacy Act of 1974 establishes procedures to protect information which the Federal government collects from individuals. It also requires that you be provided with the following information:

- Records of health care provided to your child are maintained by IHS under the following laws:
 - Public Health Service Act, Section 321;
 - o Indian Self-Determination and Education Assistance Act;
 - Synder Act;
 - o Indian Health Care Improvement Act;
 - o Construction of Community Hospitals Act
 - Indian Health Service Transfer Act.
- IHS personnel will not reveal to anyone what is in your child's medical record without your written permission, except to:
 - Individuals or organizations who are authorized by an IHS medical staff member to provide health service to your child or to relmburse contractors for the services provided to him/her;
 - Federally approved organizations that evaluate the health care your child receives;
 - Persons performing health related research where IHS is assured the research will help native American people and the information will be adequately protected;
 - State or local governmental agencies when required by State or local law for purposes such as law enforcement and communicable disease control:
 - Local schools for the purpose of providing health care to the children they teach;
 - To the Bureau of Indian Affairs and their contractors for the identification of American Indian and Alaska Native handicapped children in support of P.L. 94-142, the Education for All Handicapped Children Act of 1975.
 - Organizations (Medicare/Medicald, Insurance companies) for them to reimburse IHS and contract health service providers for services provided to your child;
 - o Agencies acting on behalf of IHS to collect reimbursable payments or to make payments on behalf of the Indian Health Service.
- IHS employees are required to keep a list of people to whom they release information from your child's medical
 record. You have a right to see that list. The list must show what was release, to who m (name and address), for
 what purpose and the date of release. You may speak with personnel in the Medical Records Department to find out
 how to do this
- The information you provide will be maintained in Health and Medical Records System, HHs/PHS/HIS, (System Number 09-17-0019). The following are the reasons why Indian Health Service 9IHS) and contract health service providers need to collect information from and about your child (name, date of birth, mailing address, and past and present health information):
 - To find out how he/she feels or what they think is wrong;
 - O To find out if a member of your family as a condition that could affect your child's health;
 - To locate their medical record among all the others;
 - o To reach you and your family (for follow-up care, or to mail medical test results or future appointments to you) to maintain your child's health;
 - To determine your child's health condition and the kind of care that is right for him/her.
- It is not necessary to answer these questions to receive medical care. However, if you give complete and correct information to the best of your ability, then HIS and contract health service staff will be better able to decided what the proper care is that your child needs. If you have any questions about this form or your child's health record, you may ask an Indian Health Service doctor or nurse to explain it o you. Thank you for your help.

PUBLIC HEALTH SERVICE INDIAN HEALTH SERVICE

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON1 WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

Name of	Birth
Student:	Date:
(We),	
have read the Cons	ent Form for the Indian Health to arrange for or to provide the following
health services for t	his child:
Health care in skin tests.	cluding medical examinations, routine laboratory studies, x-ray procedures, and
Dental care in dental care.	cluding dental examinations, preventive use of fluorides and necessary emergenc
Mental health	services including evaluation and treatment as necessary.
Emergency he	ealth care for accidents or illness.
Transportatio	n of the child to and/or from another health facility for these services.
	I hereby give consent for all of the above services.
	Exceptions or Special Instructions.
	Signed:
	Address:
	Relationship:
	Date: Valid until:

PLEASE RETURN THIS FORM TO THE SCHOOL

IHS-810 (4/09) FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES Indian Health Service

FORM APPROVED: OMB NO. 0917-0030 Expiration Date: 1/31/2013 See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

co	MPLETE ALL SECTIONS,	DATE, AND SIGN					
ī.	, hereby voluntarily authorize the disclosure of information from my						
	health record. (Name of Pallient)						
īī.	The information is to be	disclosed by:			And is to be provided to:		
	NAME OF FACILITY				NAME OF PERSON/ORGANIZATION/FACILITY		
	ADDRESS				ADDRESS		
	CITY/STATE				CITY/STATE		
	CITTISTATE				Citionale		
Ш.	The purpose or need for						
	Further Medical Care	Attorney	School	ليا	search		
	Personal Use	Insurance	Disability		er (Specify)		
IV. The information to be disclosed from my health record: (check appropriate box(es)) Only information related to (specify)							
	Only information related to						
					to to		
	Only the period of events from Other (specify) (CHS, Billing, etc.)						
	=	ny, etc.)					
Entire Record If you would like any of the following sensitive information disclosed, check the applicable box(es) below:							
Alcohol/Drug Abuse Treatment/Referral HIV/AIDS-related Treatment							
	Sexually Transmitted [ealth (Other than Psychotherapy Notes)		
Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)							
٧.	V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoke will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.						
				(Specify new dal	al .		
	Lunderstand that IHS will r	not condition treatme	nt or ellaibility for ca	y providing this authorization except if such	·		
	(1) research related or (2)	provided solely for th	e purpose of creatl	cted Health Information for disclosure to a th	aird party.		
	I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Path 164], and the Privacy Act of 1974 [5 USC 552a].						
SIG	NATURE OF PATIENT OR PER	RSONAL REPRESENTA	ATIVE (State relations	ship to pat	ient)	DATE	
			•				
SIGI	NATURE OF WITNESS (If signs	ature of patient is a thur	mbprint or mark)	-		DATE	
	, -	·					
This	information is to be released for	w the nurness stated abo	ove and may not be us	ed by the	recipient for any other purpose. Any person who k	nowingly and willfully requests or	
obta	ins any record concerning an ir	ndividual from a Federa	l agency under false p	pretenses s	shall be guilty of a misdemeanor (5 USC 552a(i)(3	5)).	
P.	ATIENT IDENTIFICA	ATION		2	NAME (Last, First, MI)	REÇORD NUMBER	
				-			
				1	ADDRESS		
Í				1			
					OLD VIOTATE	DATE OF BIRTH	
					CITY/STATE	DATE OF BIRTH	
Inches				and the second			

Instructions for Completing IHS Form 810 --

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- Print legibly in all fields using dark permanent ink.
- 2. Section I, print your name or the name of patient whose information is to be released.
- 3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
- 4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc.
- 5. Section IV, check the appropriate box as applicable.
 - a. Only information related to -- specify diagnosis, injury, operations, special therapies, etc.
 - b. Only the period of events from -- specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.
 - c. Other (specify) e.g., CHS, Billing, Employee Health.
 - d. **Entire Record** -- complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
 - e. IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.
 - f. Psychotherapy Notes ONLY -- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM.
 AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.

IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

- 6. Section V, if a different expiration date is desired, specify a new date.
- 7. Section V, Please sign (or mark) and date.
- 8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, 801 Thompson Ave., TMP Suite 450, Rockville, MD 20852, RE: PRA 0917-0030. Please DO NOT SEND this form to this address.

Navajo Head Start/Early Head Start Prenatal Health/Nutrition History

Name:			Today's	Date:			
Expected Due Date::							
How far along are you in your	pregnancy?						
Do you have health insurance							
Prenatal Care:							
Is this considered a high risk p	regnancy? Explain:						
13 this considered a high risk p	rogitatio): Inpression						
Are you already receiving prer	natal care?						
Date of first prenatal visit?		Date of most red	ent visit?				
Date of next scheduled visit?							
Name of provider: Provider type:							
Address:							
Phone Number:							
Dental:							
Date of last dental exam:		14.					
Do you have dental insurance	? Yes/No Medicaid	, private, or othe	r?				
Name of provider: Provider type:							
Address:							
Phone Number:							
Health History:							
What complications have you	experienced with this pregn	ancy or a previo	us one?				
Please circle any that apply:							
headaches	high blood pressure	Irritabilit	У	Anxiety/stress			
Diabetes	Low birth weight baby	Pre-term la	bor	Premature birth<35 weeks			
Neonatal death	C-section	Swelling	3	Fatigue			
Bleeding	anemia						
Please add any additional con	ments regarding above com	plications?					
,	_			147)			
Has this or a previous pregnar	ncy required bed rest or hosp	oitalization? Fo	or how lor	ıg?			
If not your first pregnancy, ho	w long has it been since you	r last pregnancy	?				
Have you used any of the follo		/? Please circle a	ill that ap	οιγ:			
Caffeine Cigarettes/toba		edication/presci	ription ari	ıgs			
Alcohol Other drugs: plo	ease specify						
Do you have any mental healt	h concerns such as depressi	on?					
Are you receiving services for	mental health or substance	abuse?	If yes,	with what agency?			
, , , , , , , , , , , , , , , , , , , ,							
E .							

Navajo Head Start/Early Head Start Prenatal Health/Nutrition History

Prenatal Nutrition History						
Are you receiving services from WIC?						
Do you plan to breast feed your baby?						
Do you take prenatal vitamins?						
Do you have any questions or concerns about breast feed	ding?					
Do you eat 4 or more servings of milk products a day?						
This can be milk or milk products, yogurt, cottage cheese, or hard cheese, tofu with extra servings of almonds, nuts, and kale.						
Do you eat at least 3 or more servings of protein a day?						
Meat, poultry, fish, eggs or nuts are sources of protein.						
Do you eat a source of folic acid daily?						
Choose at least one good source of folic acid every day, like dark green leafy vegetables, veal, and legumes (lima beans, black beans, black-eyed peas and chickpeas). Every pregnant woman needs at least 0.4 mg of folic acid per day to help prevent neural tube defects such as spina bifida.						
Do you eat a serving of Vitamin A daily?						
Choose at least one source of vitamin A every other day. Sources of vitamin A include carrots, pumpkins, sweet potatoes, spinach, water squash, turnip greens, beet greens, apricots, and cantaloupe. Know that excessive vitamin A intake (>10,000 IU/day) may be associated with fetal malformations.						
Do you eat a source of Vitamin C every day?						
Choose at least one good source of vitamin C every day, such as oranges, grapefruits, strawberries, honeydew, papaya, broccoli, cauliflower, Brussels sprouts, green peppers, tomatoes, and mustard greens. Pregnant women need 70 mg of vitamin C a day.						
Do you have 6-11 servings of breads/grains daily?						
Do you have 2-4 servings of fruit daily?						
Do you have 4 or more servings of vegetables daily? Do you have any concerns about your diet?						
Do you have any concerns about your dietr						
Enrollment Signatures						
Mother:	Date:					
Staff:	Date:					

Created 7/25/12 Page 2 of 3

Navajo Head Start/Early Head Start Prenatal Health/Nutrition History

INSTRUCTIONS

WHO

- 1. The form is for Pregnant Program ONLY.
- 2. This is to be completed for Pregnant women and concludes with a signature on page 3.
- 3. A Navajo Head Start staff will interview the enrolled pregnant woman.

HOW

When interviewing the participant make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If they need resources or well child checkup; provide them with resources, pamphlets, hospitals. Fully complete the following sections:

- 1. Prenatal Care
- 2. Dental
- 3. Health History
- 4. Prenatal Nutrition History
- 5. Enrollment Signature

Page 3 of 3

APPENDIX B

EPSDT STANDARDS AND TRACKING FORMS



AHCCCS EPSDT TRACKING FORMS

The AHCCCS EPSDT Tracking Forms must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. Only the AHCCCS forms may be used; paper form substitutes are not acceptable. If Provider chooses to utilize an electronic EPSDT form, this electronic substitute will be acceptable provided the following conditions are met:

- 1. Provider's electronic form includes all fields that are present on the AHCCCS EPSDT form.
- 2. In the future AHCCCS may create an electronic EPSDT form. In that event, provider agrees to convert to AHCCCS electronic EPSDT form.

AHCCCS Contractors are required to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the Contractor EPSDT Coordinator) and to distribute these forms to their contracted providers. Interested persons may refer to Chapter 400 in this Manual for a discussion of EPSDT responsibilities and services.

A copy of the completed form signed by the clinician should be placed in the member's medical record.

If the member is enrolled with an AHCCCS Contractor, a copy of the completed and signed form must be sent to that Contractor.

If the patient is an AHCCCS fee-for-service member [e.g., enrolled in the American Indian Health Program (AIHP)], the provider should maintain a copy of the EPSDT tracking form in the medical record, but does not need to send a copy elsewhere.

AHCCCS Contractors and AHCCCS medical providers may reproduce the EPSDT forms as needed. All others may reproduce the forms with permission of the Arizona Health Care Cost Containment System. Written requests for the Tracking Forms may be directed to:

AHCCCS
Division of Health Care Management
CQM/Maternal and Child Health
701 E. Jefferson, Mail Drop 6500
Phoenix, AZ 85034
(602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. Please do NOT alter or amend these forms in any way without discussion with our Maternal and Child Health Manager at the address above.

Contact information for AHCCCS' subcontracted health care plans may be found at www.ahcccs.state.az.us.

Revised: 10/01/2009, 07/01/2001, 11/01/2007, 01/01/2004, 11/01/2003, 06/01/2003

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REFERRALS:	X INDICATES REFERRE	D CRS WIC ALTCS PT cialty Early Head Start 2nd No	□ OT □ Speech □ AzEIP/	DDD Developmental needed) Developmental
Date/Time Clinici	an name (print)	Clinician Signati	ıre	See Additional Supervisory note TYes TNo

AHCCCS EPSDT Tracking Form

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Revised November 1, 2007

Clinician name (print)

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Venna Lean Dr	ev Apercement	X INDICATES GUIDANCE GIVEN: At	risk fives ino	(if yes, a blo	od lead	test is req	uired)	
							,	
Rice cereal TS	Solids Soda/Ju	ES GUIDANCE GIVEN: Adequate in Lice Supplements:						
Vocal imitation	Sits with supr	CATES ACCOMPLISHMENTS "Dac port © Explores with hands and	mouth \square Peck-a-	boo/patty c	ake	Other		
A CE A PPROPRIAT	TE EDUCATION A	ND GUIDANCE: X INDICATES GUI	DANCE GIVEN: Dro	owning prev	entior	ı 🗌 Eme	rgency 911	
Sun safety Ra	by proofing C	ar seat/rear facing Introduce	e board books/mo	uthing 🗊 In	troduc	ce cup	Passive s	smoke
	orushing 🗆 Sleep	/wake cycle Parent reads to c	child 🛛 Refrain fr	om jump se	at/wal	lker 🗆 B	segin using	nign c
Other				Family Ad	inatma	ant/nare	nt reemand	e nositis
BEHAVIORAL HE	ALTH SCREEN::[X INDICATES OBSERVED BY CLINICIAN elf calming Wary of strangers	Recognizes fa	miliar peop	le ∃ [Distingui	ishes emot	ions by
tone of voice \Box E	niovs social nlav	Other	, recognized in	FL		0		•
tone of voice 12	njoys soeiai pias							
COMPREHENSI	VE PHYSICAL	EXAM:						
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	X INDICATES ORI	DERED [Pt. Needs immunization		elayed/Defe			nt refuses	
MMUNIZATIONS:	X INDICATES ORI	DERED Pt. Needs immunization	□ IPV □ I	PCV Influ	ienza	□ Rota	virus 🗇	Other
MMUNIZATIONS:	X INDICATES ORI	DERED Pt. Needs immunization patitis B DTaP Hib	☐ IPV ☐ I	CV Influence CV	ienza	□ Rota	virus 🗇	Other
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Risk indicators of	hearing loss:	Medications:		Ι	174	1 04				
□ yes □ no		, and the same of		1	Wt:	%	Length:	%	Head circ:	9
PARENTAL CONC	CERNS/HISTORY									L
GE APPROPRIATE Sun Safety Ba Soft texture finge child Follow c	SCREEN: GRepeats sounds/green Screen Schools Control of	oes from sitting to a gestures for attention. OD GUIDANCE: X INDICATE Seat/rear facing A Redirection/position. Parent community. Parent community.	Explores CATES GUIDA Sleep/waki ve parentin	e cycle Wa g Explora	Drown try of statements	aves bye ning prev strangers earning	-bye □ □ vention □ s □ Introd □ Passiv	Prinks from Emerge duce boarde smoke	om cup 3 O ency 911 and books o 3 Languag	ge/re
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in/Hair/Nails	WNL	Abnormal (see not	es below)	,		WNL	Abno	rmal (se	e notes belo	w)
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SESSMENT/PL	AN/FOLLOW I	UP		1 - Total Group Inc.	**					_
BS ORDERED:	X INDICATES ORDE	ered 🛘 Hgb/Hct (perfo	rm at 9 mon	ths) 🗆 Other						
MUNIZATIONS:	X INDICATES ORDE	RED 7 Pt. Needs immi	unization to	oday 🗇 🛭	Delaye	d/Deferr	ed Par	ent refus	ses 3 Other	-
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Date Last Name		First	Name	AHC	CCS ID #	ע	OB	Age
	1						1	
Primary Care Provide		PCP ph. # Healt	h Plan Acc	companied	by (name	e)	Relations	ship
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Risk indicators of hear	2.5	Medications:	w	t: %	Len	gth: %	Head cir	e:
yes ono PARENTAL CONCERN	-/17							
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Primary Care Prov NICU: □ yes □ no Risk indicators of h □ yes □ no	PEDS: □ yes □ no	PCP ph. #	First Nan						
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PARENTAL CONCE	ERNS/HISTORY								
JEDRAL I EAD DIO	K A COPON -								
DENEAL CONTROL	K ASSESSMENT	X INDICATES GUIDAN	NCE GIVEN: At	risk 🗓 yes 🗍 n	no (if yes a l	olood lea	d test is re	quired)	
VENTAL SCREENIN	G:X INDICATES	GUIDANCE GIVEN: B	rushing daily	/ 🗆 l st Dental a	appointment	Whit	e spots of	n teeth	
OTRITIONAL SCH	REEN: XI INDICAT	es guidance given: Activity Supp	Foods salf	☐ Breast fed/w	hole milk 📋	Nutritio	onally bal	anced diet	☐ Jun
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note Yes No

Parental Concerns/History: Medications: Birth Wt: % Length: % Head cire:	Primary Care Provider PCP ph. # Health Plan Accompanied by (name) NICU:	1	
Primary Care Provider	Primary Care Provider PCP ph. # Health Plan Accompanied by (name) NICU:	1	1 00
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PEDS :	Sisk indicators of hearing loss: Medications: Birth Wt: % Length: % Yes	Relationshi	hip
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ENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing daily 1st Dental appointment White spots on teeth UTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed/whole milk Feeds self Nutritionally balanced diet Junk food Soda/Juice Over weight Activity Supplements Solids Solids EVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS Uses a cup Walks Says 10-20 words Says "No" Name letter/2 colors/ Follows simple rules/bring me the book Knows animal sounds Other GE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Drowning prevention Emergency 911 Discipline/limits Read to child Dental caries prevention Sibling interaction Nutrition/mealtimes Defiant chavior/offer child choices Never leave toddler alone Growing independence Encourage expression of wide range of motions Other EHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/parent responds positive child Encourage holding Self calming Frustration/hitting/biting/impulse control Communication/language Demonstrates increasing independence Begins to show defiant behavior Other OMPREHENSIVE PHYSICAL EXAM: WNL Abnormal (see notes below) Lungs yes/Vision Abdomen Genitourinary Jouth/Throat/Teeth Extremities	ENTAL SCREEN: INDICATES GUIDANCE GIVEN: Brushing daily 1st Dental appointment White spots on UTRITIONAL SCREEN: Indicates GUIDANCE GIVEN: Breast fed/whole milk Feeds self Nutritionally Junk food Soda/Juice Over weight Activity Supplements Solids EVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENTS Uses a cup Walks Says 10-20 words Steture/2 colors/ Follows simple rules/bring me the book Knows animal sounds Other GE APPROPRIATE EDUCATION AND GUIDANCE: INDICATES GUIDANCE GIVEN: Drowning prevention En Discipline/limits Read to child Dental caries prevention Sibling interaction Nutrition/mealtimes shavior/offer child choices Never leave toddler alone Growing independence Encourage expression motions Other EHAVIORAL HEALTH SCREEN: INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: Family adjustment/paren child Encourage holding Self calming Frustration/hitting/biting/impulse control Communication Demonstrates increasing independence Begins to show defiant behavior Other OMPREHENSIVE PHYSICAL EXAM: Ungs WNL Abnormation Abdomen Barronial Self calming Cantourinary Cantourinary Barronial Cant		
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ABS ORDERED: Noticates ordered Hgb/Hct Urinalysis TB skin test (if at risk) Blood Lead Test (perform at 36 – 72 months if not already done) Other	child Self Symptom Chinterest in of COMPREH Skin/Hair/Na Eyes/Vision Ear Mouth/Throa Nose/Head/I Heart	Fealming [17] hecklist [17] her children HENSIVE PH ails at/Teeth Neck ENT/PLAN/H	Monster" as words f Feels c IYSICAL WNL FOLLOW	fear Fru for feelings competent EXAM: Abnorma VUP	gb/Hct Urinaly	ARENT REPOR /impulse color parent Other Lungs Abdomen Genitouri Extremiti Spine Neurolog	ntrol Good	WNL (if at risk) Other	A	t/parent	respon lage Troutine	Pediat U Sho	oric ows	ly w)
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LABS ORDERED: INDICATES ORDERED Hgb/Hct Urinalysis TB skin test (if at risk) Other Blood Lead Test (perform at 36 - 72 months if not already done) IMMUNIZATIONS: INDICATES ORDERED [Pt. Needs immunization today [] Delayed/Deferred [] Parent refuses [] Other reason Had chicken pox HepA HepB MMR Varicella DTaP Hib IPV PCV C Other REFERRALS: N INDICATES REFERRED □ CRS □ WIC □ DDD □ ALTCS □ PT □ OT | Audiology □ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other See Additional Supervisory Date/Time Clinician name (print) Clinician Signature note TYes No Revised November 1, 2007

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Revised November 1, 2007

Clinician name (print)

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Revised November 1, 2007

Clinician name (print)

See Additional Supervisory note Yes No

Clinician name (print)

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Date	Last Name		ETA . BY							
	Dast Marie	w	First Name		A	HCCCS	ID#	DOB	Age	
Primary Care	Provider	PCP ph. #	Health Plan							
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Vision Char		Audiometry	Menses		Allerg	es:	B/P:	Temp:	Pulse:	Re
OD OS O	Chable to perio		il yes li no							
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Over weight	SCREEN: X INDICATE Activity Supp	TES GUIDANCE GIVEN: : Nu	tritionally ba	lanced o	diet 🛭 J	unk food	□ Soda/J	uice		
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The state of the s	enuncy/ Or Ichtanion	Chilet								
		AND GUIDANCE: X INDICAT								ty
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ochaviotai nea	itui Screen: XIND	ICATES OBSERVED BY CLINICIA	AN/PARENT REP	ORT C	omforta	ble body	image 🗇	Other		
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yes/Vision ar			Ab	domen						
ar.			Ge	nitourina	ary					
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ABS ORDERED:	Indicates on Tdap (11 - 12)	DERED Pt. Needs immun years only) Meningococo Hepatitis B Td Influ	nization toda; cal (11 – 12 yo enza EIPV	ears only)	Delayed HP	l ID6	eferred years) 🗀 I	lepatitis A		
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Revised November 1, 2007

note Yes No

Date Last Name Primary Care Provider						~~~	rm u	DOB		
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Parent/Patient Concerns/	History:	-								
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Clinician name (print)

Date/Time

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(Birth to One Year)

Child's Name:	Male/female	
Date of Birth:	A CONTRACTOR OF THE CONTRACTOR	
Date of Billion		

Diath Info						
Birth Infor			اخدنوا	h Maight:	Birth Length:	
Type of De C-section				h Weight:	Dirtii Leiigtii.	
Where was	your c	hild bornî	}			
Where the	re any c	oncerns \	with mo	om or baby during the	pregnancy or delivery?	
Was your b	aby bo	rn earlier	or latei	r than expected?		
Was there	use of c	drugs/alco	hol/tol	bacco/caffeine during	the pregnancy?	
De	velopm	ental His	tory			
Most of the time	Some- times	Rarely	Never			
dille	tillios .			Does your child arch	n/stiffen when picked up?	
		1			ke eye contact when being	fed/held?
		1		Do you have concer	ns about your child's sleep	pattern?
				Does your child lool	k at objects and follow then	n with her/his eyes?
					ke sounds or babble?	
					oond to your voice by looking	ng at you?
				Does your child hav happy?	e different cries when he/s	he is upset, uncomfortable or
		1			d her/his head steady wher	being held?
					ncerns about your child's d	
Does your	child sle	eep on his	her (P	lease circle: stomacl		·
How do yo	u put vo	our child t	o sleep)?		
				Administration forms to b	e completed.	
	No	equire inc.				
103		Does you	r child t	take medication on a	regular basis?	
		If yes, wh			•	
		Will your	child n	eed this medication v	while at Early Head Start?*	
				have medication for e		
		If yes, wh			.	
Dental				-		
	No					
103		Does you	r child l	have any teeth yet?		
	-			ur child's teeth/gums	?	
				concerns about your		
		Does you	r child t	take a fluoride supple	ment? (6 months and older	r)
		DOE3 YOU	Cillia	tare a macriae supple	and the land of the land of the land	

(Birth to One Year)

Yes	No	Condition	If yes, please describe:
		Allergy other than food*	
		Asthma/breathing concern*	
		Cerebral Palsy*	
		Colic	
		Constipation	
		Diabetes*	
		Diarrhea	
		Frequent earaches/infections	
		Eczema	
		Lead exposure	
		Tuberculosis exposure	
		Fetal alcohol	
		Heart Condition*	
		Low Birth Weight	
		Seizures*	
		Sickle cell	
		Yellow Jaundice	
		Other	
		Surgery	

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(Birth to One Year)

Feeding/N	lutritio	n * May require a health care plan.
Yes	No	
		Does your child have any known food allergies?*
		If yes, to what food?
		What happens when child had that food?
		Do you breast feed your baby?
		How often?
		How many times in 24 hours?
		Does your child drink from a bottle?
		How often?
		How many times in 24 hours?
		What kind of bottle/nipple do you use?
		Do you feed your child formula?
		If yes, what brand?
		Has your child been diagnosed with reflux*
		Did she/he receive treatment?
		How is the baby doing now?
		Does your child take a vitamin supplement, iron supplement?
		Please list what kind and for how long:
		Does your baby drink a bottle in bed?
		Has your child been diagnosed with anemia?
		Do you give your child milk?
		If yes, what kind?
		Do you have any questions or concerns about what/how your baby eats or his/her growth?
		If yes, what:
		Is your child on WIC? If yes, where:
Which of	these fo	ood do you offer your child: (Please circle) Eggs Poultry Vegetables Bread Fruit Meat
Cereal Ri		
		nich vegetables, fruits, cereal you have offered your child:
i icase spe	cony wi	, , , , , , , , , , , , , , , , , , , ,

	Enrollment Signatures
Parent:	Date:
Staff:	Date:
Second Year Signatures: Second year,	please review information and record any changes with date and initials
Parent:	Date:
Staff:	Date:

(Birth to One Year)

INSTRUCTIONS

WHQ

- 1. The form is for children ages BIRTH to 1 year of age ONLY.
- 2. This is to be completed for new enrollees and concludes with a signature on page 3.
- 3. For second year children, have parents review and record any changes with date, and initials and have them sign on page 3
- 4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

- 1. Personal/Birth Information: The first portion will consist of name, birth, and labor.
- 2. <u>Child Health Information</u>: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child may need health plan completed.
- 3. <u>Behavioral Information:</u> If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
- 4. <u>Nutrition Information</u>: If there are any concerns please include in this section and child may need health plan for any known allergies.
- 5. <u>Allergies/Medications</u>: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
- 6. Ensure that all signatures and date are completed.

(Ages 1 Year-5 Years)

Child's Name:		
Date of Birth:		
Male/female		
Birth Information:		
Birth Weight:	Birth Length:	
Was your baby born early or late?		
How early?		
Were there complications during preg	nancy or birth?	
If yes, please describe:		

Yes	No	Health Concern	If yes, please describe:
		Anemia	
		Asthma/breathing problems*	
		Bowel/bladder problems	
		Diabetes*	
		Frequent ear ache/ infections/hearing concerns?	
		Heart condition*	
		Frequent nose bleeds	
		Seizures*	
		Skin Condition	
		Tuberculosis exposure	
		Walking/climbing difficulties	
		Vision concerns/wears glasses	Date of last exam if done:
		Tested for lead?	Date & results:
		Any other concerns? Or any concerns about your child's teeth?	
		Has your child had a serious illness, injury, hospitalization or is being seen by a specialist?	

^{*}Indicates child should have health care plan completed.

Behavioral Information

Do you have concerns about your child's development or behavior? If yes*, please describe below:

^{*}A referral to mental health services may be required.

Nutrit	ion Inf	ormation
Yes	No	Please answer the following:
		Is your child on WIC?
		Do you have any questions about feeding your child? If yes, please explain:
		Are you satisfied with what your child eats? How many meals and snacks are offered? If no, please explain:
		Do you share meals together as a family?
		Does your child drink from a cup?
		Is your child currently breast feeding?
		Do you have any concerns about your child's height or weight or growth?
		Does your child take a vitamin? With fluoride? Does your child take a supplement with iron? Why and how often?
		Does your child currently use any nutritional supplements (pediasure, ensure, herbs etc)? If yes, how often and for what reason?
		Does your child eat non-food items? Please list:

Med	ication	S
Yes	No	
		Does your child take any medication? Please list, including vitamins:
		*Will your child need to take any medication during preschool hours?
		*If medication is required during school hours, please review Medication Policy with parent and assist to completed necessary paperwork.

Allergies	
Does your child have any allergies or severe react	ions to any of the following? Please circle all that
apply, if other please explain.	n o sell Marie Park
6	ns/hay fever Medications Food
Other	
Di la sila sangabilda manation?	
Please describe your child's reaction?	
How do you treat your child's allergy?	
Has the allergy been diagnosed by a doctor?	
Does your child have an Epi-pen prescribed?	C) L L' C L'and manidan
If your child has a food or milk allergy, we will ask	you for documentation from your medical provider
that includes a list of foods that can be substituted.	and the second s
If your child's allergy is severe and an Epi-pen or ot	her medicine is prescribed we will ask you to obtain
Medication Administration paperwork and other co	ire plan information from your medical provider.
Enrollmen	t Signatures
Parent:	Date:
1 4. 0.10.	
Staff:	Date:
Second Year Signatures: Second year, please rev	iew information and record any changes with date
and in	nitials.
Parent:	Date:
Staff:	Date:

INSTRUCTIONS

WHO

- 1. The form is for children ages 1 year to 5 years of age ONLY.
- 2. This is to be completed for new enrollees and concludes with a signature on page 3.
- 3. For second year children, have parents review and record any changes with date, and initials and have them sign on page $\bf 3$
- 4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

- 1. Personal Information: The first portion will consist of name, birth, and labor.
- 2. <u>Health History</u>: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child should have health plan completed.
- 3. <u>Behavioral Information</u>: If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
- 4. Nutrition Information: If there are any concerns please include in this section.
- 5. <u>Allergies/Medications</u>: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
- 6. Ensure that all signatures and date are completed.

NAVAJO HEAD START VISION, HEARING, DENTAL SCREENING

Center/Homebase	e:							Na	Langua; vajo/English	ge Used: n/Other:	
Child's Name:				DOB:		_ Ag	e:		Gend	ler:	
				Visual	Acuitu		_	-			
VISION SCREENIN	٠ ا	Right	Left	Pa			Di	ate	Scre	епег	
1st Scre	ening	(tight									
	screen										
	NC	TE: If n	ot completed	on PE (includ	les-EPSDT) a scre	ening	will be	conducted	i by Head S	tart staff.	
			Stereop	sis							
		Pass	Fail	Da	te		Scre	ener			
1st Scre	ening									Į.	
Res	screen										
Referred to:							_		Date:		
HEARING SCREEN Date:		reener:			Date of Res	creen			Screer	ner:	
Ī	500 Hz @	1000 Hz		4000 Hz @			Hz @0	1000 Hz @	2000 Hz @ 20 db	4000 Hz @	
Right	25 00	20 01	20 00	2005	Right	1-					
Left					Left						
Results:	Pass:	1	Fail:		Results:		Pass:		Fall;		
Visual Observatio Referred to:					OT) a screening w	vill be 4	onduc	ted by Hea	d Start staf		
DENTAL SCREENIN	NG:	A scree	ning is not the sa	ame as a dent	al exam. In a screen in the den	ening y tal exa	ou are minatio	only prioritiz on and treats	ing the need nent.	for the child	to see a
-		-	The delication	4					Severe		
BBTD:		None		Mild	Mod	erate			Severe		
Referred to:				Ref	erred by:					Date:	
Priority 1 EME	RGENCY C	ARE:	Children with dea	ntal problems r d's general hea	eeding immediate c ith. (Trauma, Pain, S	are beca	use of p - face/n	pain or conditi nouth, Absces	ions that may ses, infections	or soon or is al	ready
			These children sh	ould be referre	ed for dental service	s Immed	liately.				
Priority 2 ROU	TINE CARE	i:	Children with der health problem.	ntal problems 1 (obvious caviti	hat need treatment es, no pain, no swell	but whi	ch do no o absces	ot at the time (sees).	of the screeni	ng, pose a serk	ous general
			These children sh	nould be referr	ed to dental clinic fo	r routine	exami	nation.			
Priority 3 EXA	MINATION	l :	Children with no examination don	obvious denta e by a dentist.	i problems that will o (No obvious cavitles	effect ge s, no pal	neral h	ealth. These c	hildren will st bscesses).	ill need to have	a dental
			These children st	ould be seen l	y a dentist for an ex	aminati	on.				
Applied Fluoride			De	•				Date			
Date:											
Ву:			Бу					-1			
Height & Weight	(EHS Four	Times	& HS Two Tin	nes)							
EHS: Ht: W	t:	Head (Circum:	Date:	-	HS:	_	Wt:			
Ht: W	t:	Head (Circum: Circum:	Date:			Ht:_	Wt:	BMI:	Date:_	
Ht: W	t:	Head (Circum:	Date:	_						
			Circum:						Re	evised: 7/31/20	12

LABS ORDE	RED: X INDICATES	ORDERED 12nd Newborn screening (5-10 days of	age or first PCP visit) [Other
IMMUNIZAT	TIONS: Y INDICATES	ORDERED [] 1st Hepatitis B vaccine date:	☐ Pt. Needs immunization today
IMMONIZAT	Shot reco	rd initiated Delayed/Deferred Parent re	fuses Other reason
REFERRALS	W DOLGATES D	EFERRED □ CRS □ WIC □ ALTCS □ PT □ C □ Specialty □ Early Head Start □ 2 nd Newbo	OT Speech AzEIP/DDD Developmental
Date/Time	Clinician name (print)	Clinician Signature	See Additional Supervisory note TYes No
Date/Time	Clinician name (print)		See Additional Supervisor

					t	ì
	First Nar	ne	AHCCCS II) #	DOB	Age
		1			1	
P	CP ph. # Health Plai	n Accom	panied by (n	ame)	Relation	iship
	PEDS Pathway: Allergies	:		Temp:	Pulse	Resp
□no				1	1 4150.	Певр
	Birth wt:	Wt: %	Length:	%	Head cire:	%
reen:	ABR DOAF: Rt ear linese	T wofon I t				
en (if 2"	d needed/completed): ABR	OAE: Rt. ear Tinns				2 17 1
ORY: He	w are you feeling about the baby?	Do you feel safe in you	r home?			
C	GUIDANCE GIVEN: Breast fed	_ Formula:				
Suppl	ements:					
INDICAT	TES ACCOMPLISHMENT: Respoi	nds to sounds 🗆 Re	sponds to pa	arent's voi	ce Follow	s with
tolles /	Degining Limmy Time Pla	V (Ither				
ON AND	GUIDANCE: X INDICATES GUID	DANCE GIVEN: 🔲 Sup	ine sleep 🔝	Car seat/re	ar facing	Infant
OIIW WIIO	call nein? Intant crying/w/	hat to do? Sofo l	oathing/wate	er tempera	ture Shake	en baby
	CHCV/911 Nun satety 1 H	ther				
3N: 🔀 in	DICATES ORSERVED BY CLINICIAN	PARENT REPORT: I I	amily Adju	stment/pa	rent responds	3
- C+*	. C				The second	
of time	infant cries \Box Infant hands to	mouth/self calmin	g Encou	rage holdii	ng 🗓 Other	
of time	infant cries _ Infant hands to	mouth/self calmin	g L Encour	rage holdi	ng 🗓 Other	
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CAL E	XAM:	mouth/self calmin	g 🛚 Encou		ng Other	s belov
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CAL E	XAM:	Lungs Abdomen Genitourinary	g 🛚 Encou			s belov
CAL E	XAM:	Lungs Abdomen	g 🛚 Encou			s belov
CAL E	XAM:	Lungs Abdomen Genitourinary Extremities Spine	g 🛚 Encou			s belov
CAL E	XAM:	Lungs Abdomen Genitourinary Extremities	g 🛚 Encou			s belov
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Other reason REFERRALS: X INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ 2nd Newborn hearing screen (if needed) ☐ Other See Additional Supervisory Date/Time Clinician name (print) Clinician Signature note Wes No

NDICATES ORDERED ☐ 1st Hepatitis B vaccine date: ☐ Pt. Needs immunization today record initiated ☐ 2nd Hepatitis B vaccine date: ☐ Delayed/Deferred ☐ Parent

Delayed/Deferred Parent refuses

IMMUNIZATIONS:

T Pulsas Paens	Date Last Nar	ne		First N	ame		AHCCCS ID	#	DOB	Age
Resp: Ped Pe				i					1	
Richard Response	rimary Care Provider]	PCP ph. #	Health P	lan	Accomp	panied by (na	ame)	Relatio	nship
Birth wt: Wt: % Length: % Head circ: % Misk indicators of hearing loss: yes no lospital Newborn Hearing Screen; ABR OAL: Rt. ear pass refer Lt. ear pass refer Unknown lecond Newborn Hearing Screen (if 2nd needed/completed): ABR OAL: Rt. ear pass refer Lt. ear pass refer Lt. ear pass refer Unknown lecond Newborn Hearing Screen (if 2nd needed/completed): ABR OAL: Rt. ear pass refer Lt. ear pass refer Unknown lecond Newborn Hearing Screen (if 2nd needed/completed): ABR OAL: Rt. ear pass refer Lt. ear pass refer Unknown lecond Newborn Hearing Screen (if 2nd needed/completed): ABR OAL: Rt. ear pass refer Lt. ear pass refer Unknown lecond Newborn lecond Ne	11001		PEDS Pathway	Allerg	ies:			Temp	Pulse:	Resp;
Risk indicators of hearing loss: yes	Auto- unanthoni	по по	Pie	th wt	Wr.	0/0	Length:	%	Head circ:	%
NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed Formula:	Aedications:		Dil	tii w t.	ļ ,,,,,	,,,	20119			
NUTRITIONAL SCREEN: INDICATES GUIDANCE GIVEN: Breast fed Formula:	lospital Newborn Hearin econd Newborn Hearin	ng Screen: [g Screen (if 2	ABRIOAE: R	t. ear ∐ pa ed): □ ABI	ss refer	Lt. ear	□ pass □ ref ss □ refer	er 🗆 Ur Lt. ear 🗈	known pass refer	Unknov
Cereal Adequate intake Supplements: DEVELOPMENTAL SCREEN: INDICATES ACCOMPLISHMENT: Some Head Control Coos, babbles Makes Eye Contact Fixes/follows with eyes Begins imitation of movement and facial expressions Tummy Time/ lifts head, neck with forear Indicates Startles at loud noises Other	ARENTAL CONCERNS/	HISTORY:								
Cereal Adequate intake Supplements:										
Cereal Adequate intake Supplements: Developmental Screen: Inducates Accomplishment: Some Head Control Coos, babbles Makes Eye Contact Fixes/follows with eyes Begins imitation of movement and facial expressions Tummy Time/ lifts head, neck with forear upport Startles at loud noises Other										
Cereal		. 😡		□ Deccat	fed D Form	ular				
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upport ☐ Startles at loud noises ☐ Other AGE APPROPRIATE EDUCATION AND GUIDANCE: ☐ Infant crying/what to do ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Pacifiers ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Parent reads to child ☐ Other BEHAVIORAL HEALTH SCREEN: ☐ Infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Social smile ☐ Enjoys interacting with others ☐ Other COMPREHENSIVE PHYSICAL EXAM: WNL Abnormal (see notes below)	Fixes/follows with ev	es Begins	imitation of mov	ement and	l facial expre	ssions [Tummy Ti	me/ lifts	head, neck w	ith forear
AGE APPROPRIATE EDUCATION AND GUIDANCE: Indicates Guidance Given: Supine sleep Car seat/rear facing Infant conding Bottle prop Support/who can help? Infant crying/what to do Safe bathing/water temperature Shaken baby prevention Pacifiers Passive smoke Emergency/911 Sun safety Parent reads to child Other BEHAVIORAL HEALTH SCREEN: Indicates Observed by Clinician/Parent report: Family Adjustment/parent responds positive of child Length of time infant cries Infant hands to mouth/self calming Encourage holding Social smile Enjoys interacting with others Other COMPREHENSIVE PHYSICAL EXAM: WNL Abnormal (see notes below) Skin/Hair/Nails Lungs Abdomen Genitourinary Mouth/Throat/Teeth Nose/Head/Neck Nose/Head/Neck	unport Startles at low	id noises. 🗆	Other							
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ASSESSMENT/PLAN/FOLLOW UP										
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LABS ORDERED; X INDICATES ORDERED 3 2nd Newborn screening (If needed) 1 Other							*			es 🗆 Otn
LABS ORDERED: INDICATES ORDERED 2 nd Newborn screening (if needed) \(\text{Other} \) [MMUNIZATIONS: X INDICATES ORDERED \(\text{P} \) Pt. Needs immunization today \(\text{Delayed/Deferred} \(\text{Delayed/Deferred} \)		ason 🗆 Hep	autis B UDTai				LOW		- ****	
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LABS ORDERED: Noticates ordered 2nd Newborn screening (if needed) Other [MMUNIZATIONS: NDICATES ORDERED Pt. Needs immunization today Delayed/Deferred Parent refuses Other reason Hepatitis B DTaP Hib RPV PCV Rotavirus Other REFERRALS: NINDICATES REFERRED CRS WIC ALTCS PT OT Speech AZEIP/DDD Development	REFERRALS: X IN	DICATES REFI	ERRED CRS W	IC 🗆 AI	TCS UPT		□ Speech □	AzEIP/	DDD Dev	elopment
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Trimary Care Provi	lder	PCP ph. # Hea	lth Plan	Accompan	ied by (nai	me)	Relation	ship
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Risk indicators of he		Pathway: Medications:						
□ yes □ no		tyredications:	Wt:	%	Length:	%	Head circ	2: 9
PARENTAL CONCE	RNS/HISTORY	;	-					
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Soda/Juice - Ade	equate intake	Supplements						
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Revised November 1, 2007

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_See Additional Supervisory

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Revised November 1, 2007

Clinician name (print)

Date/Time

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Revised November 1, 2007

Date/Time

Clinician name (print)

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Revised November 1, 2007

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Revised November 1, 2007

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Date/Time

Revised November 1, 2007

Clinician name (print)

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Revised November 1, 2007

note TYes No

(Birth to One Year)

Child's Name:	Male/female	
Date of Birth:	A	

Birth Infor	mation:					
Type of De	liver: Va	aginal or	Birth	n Weight:	Birth Length:	
C-section						
Where wa						
Where the	re any c	oncerns w	vith mo	om or baby during the	pregnancy or delivery?	
Was your l	oaby bo	rn earlier	or later	than expected?		
Was there	use of c	drugs/alco	hol/tol	pacco/caffeine during	the pregnancy?	
De	velopm	ental Hist	orv			
Most of the time	Some- times	1	Never			
				Does your child arch	/stiffen when picked up?	
					ce eye contact when being	fed/held?
					ns about your child's sleep	
					at objects and follow ther	
					ke sounds or babble?	
				Does your child resp	ond to your voice by looki	ng at you?
				Does your child have happy?	e different cries when he/s	he is upset, uncomfortable or
					her/his head steady when	n being held?
				Do you have any cor	ncerns about your child's d	evelopment?
Does your	child sle	ep on his,	her (P	lease circle: stomach		
How do yo	u put vo	our child to	sleep	?		
				dministration forms to be	e completed.	
	No					
103		Does vour	child t	ake medication on a	regular basis?	
		If yes, wha				
		Will your	child ne	eed this medication w	hile at Early Head Start?*	
				nave medication for e		
		If yes, wha			<u> </u>	
Dental						
	No					
		Does vour	child h	nave any teeth yet?		
				ir child's teeth/gumsi)	
				concerns about your		
		Does vour	child t	ake a fluoride supple	ment? (6 months and olde	r)
		2005 70di	3 C	IIII 0		

(Birth to One Year)

Yes	No	Condition	If yes, please describe:
		Allergy other than food*	
		Asthma/breathing concern*	
		Cerebral Palsy*	
		Colic	
		Constipation	
		Diabetes*	
		Diarrhea	
		Frequent earaches/infections	
		Eczema	
		Lead exposure	
		Tuberculosis exposure	
		Fetal alcohol	
		Heart Condition*	
		Low Birth Weight	
		Seizures*	
		Sickle cell	
		Yellow Jaundice	
		Other	
		Surgery	

(Birth to One Year)

Feeding/N	lutrition	* May require a health care plan.
Yes	No	
		Does your child have any known food allergies?*
		If yes, to what food?
		What happens when child had that food?
		Do you breast feed your baby?
		How often?
		How many times in 24 hours?
		Does your child drink from a bottle?
		How often?
		How many times in 24 hours?
		What kind of bottle/nipple do you use?
		Do you feed your child formula?
		If yes, what brand?
		Has your child been diagnosed with reflux*
		Did she/he receive treatment?
		How is the baby doing now?
		Does your child take a vitamin supplement, iron supplement?
		Please list what kind and for how long:
		Does your baby drink a bottle in bed?
		Has your child been diagnosed with anemia?
		Do you give your child milk?
		If yes, what kind?
		Do you have any questions or concerns about what/how your baby eats or his/her growth?
		If yes, what:
		Is your child on WIC? If yes, where:
Which of 1	these fo	od do you offer your child: (Please circle) Eggs Poultry Vegetables Bread Fruit Meat
Cereal Ri	ce Juic	e
Please spe	ecify wh	ich vegetables, fruits, cereal you have offered your child:
	•	

	Enrollment Signatures
Parent:	Date:
Staff:	Date:
Second Year Signatures: Second	year, please review information and record any changes with date and initials.
Parent:	Date:
Staff:	Date:

(Birth to One Year)

INSTRUCTIONS

WHO

- 1. The form is for children ages BIRTH to 1 year of age ONLY.
- 2. This is to be completed for new enrollees and concludes with a signature on page 3.
- 3. For second year children, have parents review and record any changes with date, and initials and have them sign on page 3
- 4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

- 1. Personal/Birth Information: The first portion will consist of name, birth, and labor.
- 2. <u>Child Health Information</u>: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child may need health plan completed.
- 3. <u>Behavioral Information:</u> If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
- 4. <u>Nutrition Information</u>: If there are any concerns please include in this section and child may need health plan for any known allergies.
- 5. <u>Allergies/Medications</u>: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
- 6. Ensure that all signatures and date are completed.

(Ages 1 Year-5 Years)

Child's Name:	
Date of Birth:	
Male/female	
Birth Information:	
Birth Weight:	Birth Length:
Was your baby born early or late?	
How early?	
Were there complications during pregnancy or birth	?
If yes, please describe:	
h - 1 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2	

Does	your	child have any of the following:	Y
Yes	No	Health Concern	If yes, please describe:
		Anemia	
		Asthma/breathing problems*	
		Bowel/bladder problems	
		Diabetes*	
		Frequent ear ache/ infections/hearing concerns?	
		Heart condition*	
		Frequent nose bleeds	
		Seizures*	
		Skin Condition	
		Tuberculosis exposure	
		Walking/climbing difficulties	
		Vision concerns/wears glasses	Date of last exam if done:
		Tested for lead?	Date & results:
		Any other concerns? Or any concerns about your child's teeth?	
		Has your child had a serious illness, injury, hospitalization or is being seen by a specialist?	

^{*}Indicates child should have health care plan completed.

Behavioral	Information

Do you have concerns about your child's development or behavior? If yes*, please describe below:

^{*}A referral to mental health services may be required.

Nutri	tion Inf	ormation
Yes	No	Please answer the following:
		Is your child on WIC?
		Do you have any questions about feeding your child? If yes, please explain:
		Are you satisfied with what your child eats? How many meals and snacks are offered? If no, please explain:
		Do you share meals together as a family?
		Does your child drink from a cup?
		Is your child currently breast feeding?
		Do you have any concerns about your child's height or weight or growth?
		Does your child take a vitamin? With fluoride? Does your child take a supplement with iron? Why and how often?
		Does your child currently use any nutritional supplements (pediasure, ensure, herbs etc)? If yes, how often and for what reason?
		Does your child eat non-food items? Please list:

Medi	ication	S
Yes	No	
		Does your child take any medication? Please list, including vitamins:
		*Will your child need to take any medication during preschool hours?
		*If medication is required during school hours, please review Medication Policy with parent and assist to completed necessary paperwork.

Allergies	
Does your child have any allergies or severe react	ions to any of the following? Please circle all that
apply, if other please explain.	
	ns/hay fever Medications Food
Other	
Please describe your child's reaction?	
How do you treat your child's allergy?	
Has the allergy been diagnosed by a doctor?	
Does your child have an Epi-pen prescribed?	
If your child has a food or milk allergy, we will ask	you for documentation from your medical provider
that includes a list of foods that can be substituted.	
If your child's allergy is severe and an Epi-pen or of	ther medicine is prescribed we will ask you to obtain
Medication Administration paperwork and other c	are plan information from your medical provider.
Enrollmen	t Signatures
Parent:	Date:
Staff:	Date:
Second Year Signatures: Second year, please rev	iew information and record any changes with date
***************************************	nitials.
Parent:	Date:
Staff:	Date:

INSTRUCTIONS

WHO

- 1. The form is for children ages 1 year to 5 years of age ONLY.
- 2. This is to be completed for new enrollees and concludes with a signature on page 3.
- 3. For second year children, have parents review and record any changes with date, and initials and have them sign on page $\bf 3$
- 4. A Navajo Head Start staff will interview the parent(s) or legal guardian and conclude on page 3 with signatures.

HOW

When interviewing the parent(s) and/or legal guardians make certain of information is to their best of their knowledge. If there should be any known allergies or health concerns; ask if they are under Doctor's care. If there is medication administered for the known allergy or health concern; encourage the meds to be administered before and after class.

- 1. Personal Information: The first portion will consist of name, birth, and labor.
- 2. <u>Health History</u>: Answer several questions by answering "Yes or No." If the parent should answer "Yes" then the child should have health plan completed.
- 3. <u>Behavioral Information</u>: If the answer is "Yes" to the behavioral information then they will be referred to the Mental Health Specialist.
- 4. Nutrition Information: If there are any concerns please include in this section.
- 5. <u>Allergies/Medications</u>: If medications need to be administered during class hours then the interviewer will review the Medication Administration policies/procedures with parent(s) or legal guardian.
- 6. Ensure that all signatures and date are completed.

NAVAJO HEAD START VISION, HEARING, DENTAL SCREENING

Center/Homebas	e:							Na	Langua <u>r</u> vajo/English	•	
Child's Name:				DOB: Age			ge: Gender:				
				Visual	Acultu						
VISION SCREENIN	G	Right	Left	Pas			Da	ite	Scre	ener	
1st Scr	eening	(tight									
	screen										
	NC	OTE: If n	ot completed (on PE (includ	es-EPSDT) a scre	ening	will be	conducted	l by Head S	tart staff.	
			Stereop	sis						C.	
		Pass	Fail	Da	te		Scre	ener			
1st Scr	eening										
	screen								Datos		
Referred to:									Date:		
HEARING SCREEN Date:		reener:			Date of Res	creen	_		Screen		
	500 Hz 🥷	1000 Hz	-	4000 Hz @			Hz @ 5 db	1000 Hz @ 20 db	2000 Hz @ 20 db	4000 Hz @ 20 db	
[n: 4 a	25 db	20 dk	20 db	20 db	Right		o ub	20 00	2000	1,40	
Right					Left	-					
Left Results:	Pass		Fail:		Results:		Pass:		Fail:		
Visual Observation					OT) a screening w	rill be o	ondu	cted by Hea			
Referred to:	N====								Date:		
DENTAL SCREENI BBTD:	NG:	A screen dentist.	ning is not the sa The dentist is t	ame as a dent he person wh	al exam. In a scree o initiates the den Mod	tel exa	minatio	on and treati	ing the need nent. Severe	for the child	to see a
Referred to:		_		Ref	erred by:					Date:	
Priority 1 EMI	ERGENCY C	ARE:	affecting the chil	d's general hea	peeding immediate co ith. (Trauma, Pain, S ed for dental services	welling	- face/r	pain or condit nouth, Absces	ions that may ises, infection	ar soon or Is a s)	fready
Priority 2 ROU	UTINE CARI	E:	health problem.	(obvious caviti	hat need treatment es, no pain, no swell ed to dental clinic for	ing or n	o absce	sses).	of the screeni	ng, pose a seri	ous general
Priority 3 EXA	MINATION	ł:	examination don	e by a dentist.	problems that will e	, no pal	n, no sv	ealth. These o	children will st obscesses).	iii need to hav	e a dental
			These children si	hould be seen b	ry a dentist for an ex	aminati	on.				
Applied Fluoride			D	***				Date:			
Date:				many and a second			6				
Ву:											
Height & Weight	(EHS Four	r Times	& HS Two Tir	nes)							
EHS: Ht: W			Circum:			HS:				Date:	
Ht: V			Circum:				Ht:_	Wt:	BMI:	Date:	
Ht: W	Vt:	Head	Circum:	Date:	_						
			Circum:						Re	evised: 7/31/2	012

NAVAJO HEAD START PHYSICAL FORM

Name:			DOB:		Date of Visit:	
Chart#:			Parents Name:			
Ht:	Wt: _		вмі:	BP:	Hemo./Hct:	· · · · · · · · · · · · · · · · · · ·
Head Circumfere	n ce (up to 24	months)		Fluoride Varnis	h Applied: Yes or	No
Vision: R	L		-	Wearing Glasse	es: Yes or No	
					1-	
Allergies (Food a	ınd Medicir	ne):		Previous Refer	rals:	
Medications:				New Referrals	Made:	
Significant Past I	Medical His	tory:			iting completed: Ye need to be provided	
Hearing Normal:					normal findings on opment, mental hea	alth)
Physical Exam	Normal	Abno	ormal	Was the antic	ipatory guidance co	mpleted for
Skin Head/Fontanel				Child: Yes or	-	•
Speech						
Eyes						
Ears				Head Start Fo	llow-up Needed:	
Mouth						
Neck						
Chest				sending Falls	Noododi	
Heart				Medical Folio	w-up Needed:	
Abdomen						
Back						
Genitals				Dental Follow	un Needed:	
Extremities				Dentalionon	-up recucui	
Neuro						
Fine Motor				-		
Gross Motor						
Other			-1			
Facility Name: _				Medical Care F	Provider:	
				Signature:		_ Date:
				Phone#:		_

Notes: if any medication is to be administered during classroom hours please attach a treatment or action plan.

Attach a copy of his/her updated immunizations.



NAVAJO HEAD START DENTAL EXAMINATION & TREATMENT

Child's Name:					Sex:	Μ□	F	Date of Birth:				
Par	ents(s)	/ Guardian	1						Chart #:			
Cen	ter / H	ome Base:										
I.	1. Ch	Allerg Asthm Bleedi Bleedi Bished Epilep child under sysician's N child now a repical Fluctuoridated	ng	(V) all that Liver Dis Rheumat Sickle Ce Heart Mu Other?	at applies order lc Fever ll Disease armur Yes	No No	Has child p Dentist's na Date of last	reviously ime:	seen a dentist?	Yes No		
II.	EXA	MINATIO	N / TREATMENT:	To be co	mpleted by	y Dentist	-					
	A.	Date	Dental Hygiene		ECC		# Filling		# Extraction(s)	Pulp Therapy		
				None	Mild	Severe						
	Rema	rke:										
			aminer / Date:									
	- 6											
	B.	Date	# Filling	E	extractions		Pulp Therap	у	Sealents	SSC		
								_				
III.		ild Planned , explain:	d Treatment Comp	leted?	☐ Ye	s 🔲 N	0					
IV.		· •	on for On-going De	ntal Care:								
_ • •			cialist:									
V.	T	ifer that T b	ave completed the									

ON SITE DENTAL

P.O. Box 767 Camp Verde, AZ 86322 (928) 567-1832 Phone (928) 567-6500 Fax onsitedentalaz@gmail.com

Please return this form to the school!

DEAR CONCERNED PARENT:

Your child may be eligible to receive routine dental care at no charge! The Indian Health Service has contracted with OnSite Dental to provide care for most Headstart children in your area. OnSite Dental has expanded that program to include your child's school. This care is conveniently provided at the school. OnSite Dental is well known throughout the Native American communities, having provided excellent dental care for over 20 years at numerous locations in Arizona and New Mexico.

To participate in this valuable service, your child must be enrolled in an appropriate New Mexico Medicaid or Arizona AHCCCS program.

Please complete the following information

Child's Name______Male___Female____ Child's Social Security Number_______Date of Birth____/____ Emergency Contact_____Phone #____ School Name______Teacher's Name_____Grade____ **HEALTH HISTORY** PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOUR CHILD: NO YES Has your child had? NO YES **Heart Murmur** Allergy to medication ____ Bleeding Disorders Rheumatic Fever High Blood Pressure ____ Psychiatric Treatment ____ Asthma Seizure Disorder Hepatitis/Jaundice Diabetes Anemia AIDS/HIV Positive Latex Allergy Hospitalizations Other Serious Illness Is your child under a Physician's care? NO YES Is your child taking any medication? PLEASE EXPLAIN ANY "YES" ANSWERS:_____

PLEASE TURN OVER. OTHER SIDE MUST BE COMPLETED AND SIGNED

Revised 2012

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination and cleaning, they may require additional dental treatment, including silver fillings, stainless steel crowns, and pulp treatments. In the event no other treatment is practical, removal of the tooth may be necessary.

On Site dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. Our dentists make the decision to refer very carefully and take all factors into consideration, including the very limited number of general anesthesia appointments available at IHS.

We have had a great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program may affect future benefits your child may receive under private insurance or from another private dentist.

CONSENT FOR TREATMENT AND AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)
1YES. I give permission for my child to receive treatment!
2No. I do not want my child to receive necessary treatment.
3. I am aware that I have rights outlined in the <u>Notice of Privacy Practices</u> and that a copy of this notice is available for my review.
I understand that I may refuse to sign this Consent and Acknowledgement.
X Date
Parent or Guardian
Please print your name
PLEASE TURN OVER AND COMPLETE

Topical Fluoride Permission Form

Dear Parent or Guardian,

Over 80% of American Indian and Alaska Native Head Start children have dental cavities. However, cavities can be prevented through the use of fluoride, dental sealants, and xylitol.

We will provide a fluoride varnish program for Head Start children this year. Because your child is a minor, you consent is needed to allow your child to receive this preventive service.

Fluoride Varnish

<u>Procedure:</u> A high concentration fluoride varnish is painted directly onto the teeth. <u>Benefits:</u> Fluoride Varnish coats the outside of the tooth and can provide some cavity-fighting power for up to 3 months.

I give my son or daughter,, permission to he fluoride varnish placed on his or her teeth multiple times in a year by a trained staff or prowith prescription or standing orders. I understand the Fluoride Varnish program is a prevent program and the product is safe and effective.								
Please list any physical conditions that the school should be aware of (asthma, allergies, ring illnesses, disabilities, chronic illnesses, etc.):	recu							
Fluoride Varnish:								
I do NOT want my child to have fluoride varnish applied.								
I DO want my child to have fluoride varnish applied.								
Parent or Guardian Name (print)								
Signature Date								
Telephone Number								

You can prevent cavities at home. Brush daily with a fluoride toothpaste.

MEDICAL/DENTAL/HOME INSURANCE

*Primary Health Coverage:		At Iment		d of Iment					
,	Yes	No	Yes	No					
CHIP									
Combined Medicaid/CHIP									
No insurance	77								
Medicaid									
Other:									
Private									
State Funded									
Other Health Coverage		Ir	suran	e No.		Medic	aid Sta	tus	Medical No.
Other Coverage Notes:									
								End of	
						Enroll		Enrollme	
						Yes	No		lo
, the child:				adiaal aa		163	IVO	163 1	10
Have an on-going source of co	ntinua	us acce	essible	medicai ça	re.				
Receive services through IHS.						-	-		_
Receive services migrant. Have an on-going source of ac	cessibi	le dent	al care.	,		-			
*Did the child receive preventive		All	inf	mens icats page	he g				
*Medical treatment for condition Anemia Hearing	n:]	EN	who	cat	m		!s] Lead	
Doctor's Name:		ap	pe	auce.).				-
Address:			19	pus			-		
Telephone Number:			/	/			_		•
Dentist's Name:							_		-
Address:							1/12		.
Telephone Number:							· ·		-
Child Name:				Dat	e of Birth	n:)	

e: *PIR Question kevised: 7/31/2012

PATIENT REFERRAL NOTICE

O (Name, title, and address of person or organization or institution	n to whom referral i	s made).		
NAME OF PATIENT (Last Name, First Name, Middle Name)	3	. ŞEX	4. BIRTH DATE	5. REGISTRATION NO.
ADDRESS	7. TRIBE			8. RESERVATION
ADDITIONAL IDENTIFICATION				
REASON FOR REFERRAL (Type of service requested)				
		44 A4- I		
SIGNIFICANT MEDICAL OR DENTAL FACTORS (including diagnosis,	prognosis, treatme	11, 210.)		
REPORT BY PARAMEDICAL PERSONNEL				
FROM (Name, title, and address of person making referral)				14. DATE

Navajo Nation Head Start/Early Head Start

Individual Health Care Plan

IHCP should be completed for children with identified health concerns that may require emergency treatment or modifications to diet or activity such as asthma, seizures, serious allergies, acute/chronic medical conditions.

Child's Name:	Today's Date:
Birth Date:	
Agency/Classroom:	
Health Condition/Diagnosis	
Medications:	Dose/time:
Allergies:	
Dietary Concerns/restrictions:(Please indicate food substitution	s)
Any other concerns/restrictions on activity:	
Parent Signature:	Date:
Doctor Signature:	Date:
Doctor's Phone Number:	
In the event of an emergency, emergency contacts listed on contacted if parent is unavailable.	will be

Navajo Head Start/Early Head Start Parent/Guardian Permission for Medication Administration

Dear Parent: In order for your child to receive medication while at Head Start or Early Head Start, the program must have your authorization and have all required paperwork completed. Please take a moment to complete this form. Thank you.

Child's Name:	
Date of Birth:	
Reason Child is taking Medication:	
Prescribing Doctor:	
Doctor's Phone Number:	
Name of Medication:	
How often/when should it be given:	
What is the dose/how much?	
Are there any symptoms we should watch for?	
I,(parent/guardian name) Start staff to give my child,(c	give my permission for Head Start or Early Head child's name) the medication as indicated above.
Date: Parent Signs	ature:
Date: Staff Signat	ure:
I,,(parent/guardian trained the following staff to the use of the above nuse the medication.	nedication, including the equipment necessary to
Date	ture:
*A healthcare professional may be asked to provide training if child has a severe illness, an uncommon medication or complicated treatment plan.	Staff name:
Staff name:	Staff name:
Staff name:	Staff name:

Navajo Head Start Medication Dispense Log

Name:

Receipt of Medication

Type Medication:

Staff	Initials		
Parent or Guardian	Signature		
Drug Fact Doctor's	Order		
Drug Fact	Sheet		
	nose		
Expiration	Date		
End	Date		
Start	Date		
Refrigeration	No		
Refrige	Yes		
	Date		

Dispensation Log

ı		_						
	Discussion with Parents or Comments							
Sor normander	Observation							
	Refusal							
	Method							
	Dose							
	Time							
	Date							

Medication Returned to Parents

Parent Signature: Staff Signature:

Date: ____Comments: ____

Revised: 8/16/12

COMPARTMENT 3 NUTRITION

School Year: 2012 - 2013

1	Health and Nutrition History – See Compartment 2
2	Parent Consent (WIC), if applicable
3	Child & Adult Care Food Program Medical Statement (if applicable)
1	Infant Reading Preference (FHS Only)



THE NAVAJO NATION

5

Navajo Head Start, P.O. Box 3479 • Window Rock, Arizona 86515 • 928.871.6902, Fax 928.871.7866

REX LEE JIM
Vice President

BEN SHELLY
President

PARENT CONSENT FORM

Provider's Name and Title

Note: Women, Infant, Child Program (W.I.C) clients Non-W.I.C. clients take your child to the nearest Information requested.	ts contact the nearest W.I.C. Office and for idian Health Service (I.H.S) for the following
*********	*********
Early Head Sta	rt Only
I,, hereby give my conse	ent for the Women, Infants and Children
Program or Indian Health Services to withdraw/rele	ase blood for the Hematocrit Reading to the
Navajo Head Start-Early Head Start Pregnant Wome	en Program.
Client's Signature	Social Security Number
Date	Date of Birth
***********	******
Head Start	Only
I,, hereby give my cons	
Program or Indian Health Services to withdraw/rele	
child,, to the Navajo	Head Start.
Parent's Signature	Mother's Social Security No.
Date	Child's Date of Birth
*****	********
Hematocrit Reading	Date Given

Date

Arizona Department of Education Tom Horne, Superintendent of Public Instruction

CHILD & ADULT CARE FOOD PROGRAM

MEDICAL STATEMENT FOR PARTICIPANTS REQUIRING FOOD SUBSTITUTIONS

Name of Participant:	Date of Birth:					
Parent Name:	Parent Telephon	e Number:				
Name of Center:	Telephone Num	Telephone Number of Center:				
Lance de la constant						
Dear Parent/Guardian:						
This day care center participates in the Child a	and Adult Care Food Progr	ram (CACFP) and must serve				
meals and snacks meeting the CACFP require	ments. Food substitutions i	nay be made only when supported				
by a recognizaed medical authority. A recogniz	zed medical authority may	include, but is not limited to				
medical physician, registered nurse, or register	red dientian. The recognize	on choice of foods that may be				
in writing, the food to be omitted from the par	ticipant's diet and the 1000	Deturn the completed form to				
substituted. Please ask a medical authority to	complete and sign this for n	i. Return the completed form to				
your center.	1					
List the foods to be omitted from	om the diet and foods that	may be substituted				
		Additional Requirements (i.e.				
Foods to be omitted	Allowed Substitutions	special equipment, texture,				
		thickness, etc.				
7.4		l				
List any additio	nal instructions or requirement	ents				
I certify that the above participant	must be provided a special of	liet or requires special				
accommod	dations as indicated above.	•				
Printed Name		Title				
Signature		Date				

CACFP INFANT FEEDING PREFERENCE - CENTERS

N of infant		Date of Birth	
		will feed your infant breast	milk provided by you
(name of provider)			
and/or we will provide iron fortified infant form	nula.		
The formula we provide is:			****
This center/home/ministry participates in the C for serving nutritious meals to infants and child patterns according to the age of the child being	Iren. Participation in this page.	program requires caregivers	to follow specific meal
Policy requires a center/home/ministry particip service times. Parent/guardians, however, may	ating in the CACFP to offer decline what is offered, and	er formula to infants who and supply the infants formu	re in care during meal la.
Please mark your preference (chose all that	Today's Date	Today's Date	Today's Date
apply)	Birth - 3 months	4 - 7 months	8 - 11 months
I will bring expressed breastmilk for my infant.			
I will come to the center to breastfeed my infant.			
bring formula for my infant. Please list kind of formula you will bring:			
In order to claim meals for reimbursement, the developmentally ready for them.	center must provide infan	t cereal and other foods who	en your baby is
Please mark your preference	Today's Date	Today's Date	
	4 - 7 months	8 - 11 months	
I want the center to provide infant cereal and other foods for my infant based on CACFP guidelines.			
Signature of Parent/Guardian		Date	
1. This form must be kept on file for each infa	int enrolled for child care.		
 As situations change, such as a medical aut This form must be kep current and accurate 	hority changing the infant's	s formula, a new form shou or child care until the infant	ld be comleted. reaches one year
age or is no longer on infant formula. the parent/guardian declines the formula be claimed for reimbursement.	and the provider provides	meal and/or snack compone	ents, the meal may
5. If the parent/guardian declines infant meals	/snack, meals and snacks i	nay NOT be claimed for re-	imbursement.

NAVAJO HEAD START

2013-2014 & 2014-2015 Family Engagement / Partnership Building

FE/PB 01:

Subject: Family Services

Grantee Program must have a Family Partnership

Scope: Novajo Head Start networks with surrounding resources to collaborate services based on Family Partnership Building. Earthership Building, Earthership Building is developed with parents of enrolled children in Early Head Start, / Head Start, to meet their needs/strengths through referral process, goal setting and planning. The program will maintain confidentiality and sensitivity of language, culture, and ethnicity.

Policy:

Family Support: Navajo Head Start will respect Head Start Families Culture, Diversity and Ethnic Back Ground to build family support:

Procedures

- Trainings
- i. Self Sufficiency
- ii. Family Partnership Categories
- Parental Involvement: General and Leadership
- Promoting Family Literacy

 - Parent Education Ö,
 - Self Sufficiency Crisis Support ė
- Honoring Primary Language
- Head Start / Early Head Start / Case Management for: Navajo Head Start Referrals (inclusive of Early Head Start) 7
 - Health Referrals
 - Family Referrals
- Other Referrals (ex. Attendance) ιĖ

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- FPA Agreement Referrals .≥
- Family Partnership Agreement (FPA)
- Should a family decline FPA the Family Engagement Liaison/ teaching staff will do a follow-up in 30 working days for any changes. ż

Provide Orientation on Individualized Family Partnership Agreement during enrollment process.

- A copy of the FPA will be forwarded to the ERSEA/Family Engagement Liaisons Specialist (NCR Sets: Original to Child's Folder; FE/ERSEA Spec.; FSL;
- Teaching staff/Family Engagement Liaison will enter information into childplus and file original completed form in child's folder in compartment

Page 1 of 9

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language, culture, and ethnicity.

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NOTE: Should a family prefer to meet with teaching staff during the FPA Process instead of the FSL, the Teacher will follow the policy and procedure with the assistance of the FSL and ERSEA/FE Spec.

Case Management:

- Navajo Head Start Referrals: FEL will maintain confidential case management documents for enrolled Navajo Head Start Families. Navajo Head Start referrals will be documented on case notes for any follow ups and further assessment. This information will be gathered from the from the childPlus Reports. ...
 - Partnership Building: COMPILING and Categorizing: Partnership Building (PB) data.
- COMPILING: Family Engagement Liaisons will enter all Family. Partnership Agreement Form in Child Plus, for compilation and Prioritizing.
- Categorizing
- Using PB Form (categories 1-5) FEL will determine the family strengths, readiness and interest ö
 - The FEL will use Child Plus Report 4110 to prioritize needs of each family.
 - Prioritizing:
- 1. Upon the results of the Prioritizing needs the FEL and Family will begin developing short/long term goals using page 2 of the FPA Form. To avoid duplication of services, FELs and Family will review any pre-existing plans and build upon the pre existing plans in collaboration with the following programs:
 - Early Head Start program
 - Home Base program,
- Self Reliance Nutrition Assistance Program GENERAL ASSISTANCE
 - Social Service OTHERS
- 2. Goal Setting:
- Short Term Goals: including but not limited Written Materials/Handouts, Referrals, Support letters (COPY ON FILE and pritered into Child Plus)
- Family Engagement Liaisons will contact surrounding resources through phone calls, internet, conferences, community gatherings, and written referrals/support letters, based on the family readiness and interests. ri
- Family Engagement Liaisons will follow up, completion/accomplishment of short term goals recording visits on proper documentation. (Parent contact form, FPA page 2, and Child Plus). Family Engagement Liaisons will make follow-up through home visits, phone calls, parent/teacher conferences, and setting up appointments for families. Ď.
 - FEL will copy proper documentation to close short term goals and record in Child Plus. J
- Long Term Goals: (Any Pending ongoing, at risk, special and / or sensitive cases that requires the full attention of Family Content Specialists (FRSEA/FESPEC FEL, DIS and MH).
- Family Forgagement Liaisons will contact surrounding resources through phone calls, internet, conferences, community gatherings, and written referrals/support letters, based on the family readiness and interests. ė

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Deleted: FSI ...EL will maintain confidentiat Delebed: Family ...artnership Agreement...(=_ [1]) **Deleted:** Family Service Liaisons / will make onsite center/home base visits to compile completed Shannon S., Wilson 1/13/14 10 28 AM Shannon S Wilson 1/13/14 10:48 AM on S. Wilson 1/13/14 10:48 All Tion S., Wilson 1/13/14 10:27 Atu

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Page 2 of 9

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inplishment of Long term goals recording visits on proper Family Engagement Liaisons will conduct a follow up, completion/ documentation. (Parent contact form, FPA page 2and Child Plus). ف

Shannon S. Wilson 1/1

Family Engagement Liaisons will make follow-up through home visits, phone calls, parent/teacher conferences, and setting up appointments for families.

ن

- Case Management meetings will be held on a monthly basis to update family data, debriefing of case loads to assist with cases for i.e. resources, direction and recommendations. ö
- 3 a. Referral Process: Navajo Head Start Referrals and Partnership Building identified needs will be referred to available resources.
- A Home visit shall be conducted by the Teaching staff and/or FE.
 Navajo Head Start Staff (ALL) will Fill out referral forms and write support letters to resources in reference of identified needs of enrolled families and entered into child Plus. Staff may also use the Individual follow up / action step plan form to assist staff in organizing their case plans;
 - Navajo Head Start Staff will contact identified resources utilizing written referrals and/or support letters through:
- FAX/e-mail

Telephone

- Tesxting
- In person
- d) ERSEA/FE Spec, FEL, and/or teaching staff will make a follow-up on all referrals submitted to identified resources to ensure families needs are met and documented on the referral/follow-up log.. FEL will maintain original documents in child's folder and enter into Child Plus.

NOTE: Should an emergency crisis or sensitive case arise: (SCAN, Displacement of Home, Domestic Violence, Death and Natural Disasters).

- Refer to the Navajo Health Plan Booklet
 - Refer to the NHS Disaster Plan
- Suspected child abuse and neglect (SCAN) Policy and Procedure
 - Social Services
- Mental Health Services

Tracking: Navajo Head Start uses Child Plus to track Partnership Building with Families:

CHILD PLUS REPORTS:

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Deleted: Family Service Coordinators and Family Service Liaisons will maintain record keeping and tracking for Navajo Head Start and Family Partnership Agreement Referrals.

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Management Tracking Form: FSLs will be doing their own service areas and submitted to Age and Deleted: Exhibit A: Service Area Case

Page 3 of 9

Family Reports

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Select a report by clicking on the list below

4063 - Management Report - Family Services Action Status 4002 - Management Report - Family Services

4010 - Master List of Families

4015 - Family Participant Groups

4110 - Family Service History

4120 - Family Services Referrals 4130 - Family Service Actions

4140 - Home Visits

3 c. Follow Up - All Follow ups are documented on the individual Follow up/Action Step Plan, Parent Contact, and entered into Child Plus.

a. Navajo Head Start Referrals

b. Family Partnership Agreement

Follow Up includes:

Transition **⊹**i

Parent Trainings, Referrals, and Case Management Meetings

Review and up-date of pre-existing plans Closures: of Family Accomplishments and Reflections are Documented on the FPA page 2 goal setting and recorded* in Child Plus.

3 d. Monthly Case Management Meetings

1. Meetings are designated each month in the school year calendar;

Facilitator: FRSEA/FE Spec.; Participants: FELs and DIS / Mental Health Cograinators and Mental Health Consultants; but; when a particular case and child is discussed that needs further or additional information the specific Head Start Content Specialist that has a vested duty to assist the child will need to be in attendance for example Information discussed is kept confidential 3 e. Record Keeping:

Child Plus
 Referrals/Fc

Referrals/Forms

Case Notes ന് Case Management Meeting: Case Staff Documentation Form and Case Progress Notes 4

Emergency Crisis Form

Onsite Visitation Form

Parent Contact Form

Partnership Building Form Goal Setting

Confidentiality Folder Review Control Sheet

3 f. Case Management Tool Kit

Deleted: , and Education Specialist, Mental Health changes on the Parent Contact Follow Up Service Deleted: During the duration of each referral, regardless all shall document and report any Shannon S. Wilson 1/13/14 10:58 AM Shannon S Wilson 1/13/14 11:02 AM Shannon S. Wilson 1113/14 11:03 AM Information discussed must be kept confidential Shannon S Wilson 1/13/14 11:02 AM Shannon S. Wilson 1/13/14 11:03 AM Shannon S Wilson 1/13/14 11:04 AM Shannon S. Wilson 1/13/14 11:05 AM Shannon S. Wilson 1/13/14 10:58 AM Deleted: and Family Partnership Agreement Deleted: b. Family Partnership Agreement: mon S Wilson 1/13/14 11:05 AM Shannon S Wilson 1/13/14 11:06 AM Shannon S. Wilson 1/13/14 11 06 AM Tracking will be report on a quarterly basis Coordinator and/or Disability Specialist. All Deleted: Family Partnership Agreement Deleted: Family Service Coordinator Formatted: Indent: Left: 1" (October, January, May) Deleted: Consultant Deleted: Tracking Deleted: FS

Page 4 of 9

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Sy and Procedure

Guidance Forms

Child Plus

Subject: Accessing Community Services and Resources

Navajo Head Start works with local resources access their family needs.

Scope:

FE/PB 02

Navigo Head Start Works collaboratively with all participating parents to identify and continually access, either directly or through referrals; services and resources that are responsive to each family's needs, interests and goals.

Policy

• Navajo Head Start works with <u>Self Reliance, Local Chapters, American Red Cross, and local Churches/Charities, Navajo Clothing Program and other outside entities to meet</u> family needs

Procedures:

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Shannon S. Wilson 1/13/14 11:09 AM

participating parents to identify and continually access, either directly or through referrals, services and resources that are responsive to each family's interests and

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Deleted: Family Partnership Agreement identifying each family's interesty goals: FSC,FSL, PIC and teaching staff will work collaboratively with Resources for such cases as:

Page 5 of 9

A1., Familles referred to resources for Emergency/crisis assistance using the Emergency Crisis Form and documented information is updated into child plus, in the

annon S., Wilson 1/13/14 11:13 AM Shannon S Wilson 1/13/14 11:28 AM

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Non S. Wilson 1/13/14 11 18 AM

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- Food_
 - Housing,
- Clothing.
- TransportationFinancial assistance

NOTE: Emergency Crisis or Sensitive Issues: (Child Sexual Abuse and Neglect, Displacement of Home, Domestic Violence, Death and Natural Disasters).

- Refer to the Navajo Health Plan Booklet Refer to the NHS Disaster Plan
- Child Abuse and Neglect Policy and Procedure
 - Social Services 4
- Mental Health Services

9

Homeless: Navajo Head Start will respect Head Start Families Culture, Diversity and Ethnic Back Ground to build family support. Though homeless is defined as "a lack of permanent housing (not having a fixed, regular, adequate residence) resulting from extreme poverty, or, in the case of unaccompanied youth, the lack of a safe and stable living environment".

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cases and medical emergency situations)

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Red Cross, and local Churches/Charities)

- "unaccompanied youth" includes youth in homeless situations who are not in the physical custody of a parent or guardian.

 Preschool children, migrant children, and youth whose parents will not permit them to live at home or who have run away from home (even if their parents The term "homeless" is broadly defined by the McKinney-Vento Act's Education for Homeless Children and Youth Program, as quoted (below). The term
- are willing to have them return home) are considered homeless if they fit the definition.
- Education and other appropriate interventions, including opportunities for parents to participate in counseling programs and/or receive information on:
 - Mental Health Services.

ਹ

- Substance Abuse
- Child Abuse and Neglect
 - Domestic Violence
- Opportunities for continuing education and employment training, utilizing surrounding resources within the community. ভ
 - GED/High School courses

Vocational courses/trainings

- College/University courses
- e) Additional services and resources including assistance and / or referrals for::
 - Self-Employment
- Enhancing Financial Literacy/Budget
 - Home-Buyer Assistance
- Medical Assistance (Medicaid/AHCCCS)

f) The Licensed Mental Health Professional must provide services in order of priority listed below, to align with Head Start Performance Standards:

Priority 1 – Any and all services directly or indirectly delivered for children.

Page 6 of 9

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Priority 2 – Any and all services directly or indirectly delivered for staff.

Priority 3 – Any and all services directly or indirectly delivered for parents/guardians/families of children, and only in cases of emergency situations that directly or indirectly or indirectly inpacts the child. Sessions for parents/guardians/families will not exceed 8 sessions, unless a request is done in writing to exceed 8 sessions. Requests can be done by the client and/or the Licensed Mental Health Professional. mi

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FE/PB 03_Subject: Services to Pregnant Woman, infants, and toddlers

, Navajo Head Start has an Early Head Start Program Services to Pregnant Women, Infants, and Toddlers.

Page 7 of 9

Scope: Navajo Head Start assists pregnant women in receiving comprehensive prenatal and postpartum care through referrals, immediately after enrollment in the Early Head Start program. Deleted: Develop Family Partnership Agre...[111]

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Policy

Develop Family Parmership Agreement that outlines and individualizes services for mothers to receive during their prenatal care will include: (EHS staff serves as advocates and Liaison between pregnant women and health care providers)

Procedures:

- 1_{\star} EHS Home Visitor and expected mother will complete the nutrition assessment. 2_{\star} Encourage expectant mother to attend all prenatal appoints (Comprehensive Prenatal Health Care):
 - Health promotion ė
- Medical examinations ۵
 - Dental examinations
- 3. Mental Health interventions
- A. The Licensed Mental Health Professional must provide services in order of priority listed below, to align with Head Start Performance Standards: Priority 1 – Any and all services directly or indirectly delivered for children.
 - Priority 2—Any and all services directly or indirectly delivered for staff. -- mi mi
- directly or indirectly impacts the child. Sessions for parents/guardians/families will not exceed 8 sessions, unless a request is done in writing to exceed 8 sessions. Requests can be done by the client and/or the Licensed Mental Health Professional. Priority 3 – Any and all services directly or indirectly delivered for parents/guardians/families of children, and only in cases of emergency situations that
- Substance abuse prevention and treatment
- Prenatal health education efforts include information about:
- Fetal Development, including the risks of smoking and drinking alcohol. اخ. ا≝ ا≒ ا۔
 - What to expect during labor and delivery.
 - **Nutrition Education**
- Postpartum Recovery, including maternal depression.
 - D. Breastfeeding Education:
- Being sensitive to cultural differences. Provide benefits of breastfeeding. ن ام اه
- Support mothers who chooses to breastfeed by:
- Providing a quiet, comfortable, and private, space.
- Providing mothers necessary fluids or nutritious snacks.

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Exhibit A: Service Area Case Management Tracking Form: FSLs will be doing their own service areas and submitted to Agency

2. Exhibit B: Agency Case Management Tracking Form: FSC will compile Exhibit B in overall and submitted to Central

3. Exhibit C: Navajo Head Start Case Management Tracking Form: Central Office will compile for each Agency

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b. Family Partnership Agreement: Tracking will be report on a quarterly basis (October, January, May)

1. Exhibit D: Center/Home Base Family Partnership Tracking; FSL will compile all information from the Family Partnership Agreement and forward to Agency.

2. Exhibit E: Service Area Family Partnership Tracking; FSC will compile all information from Exhibit D and submitted to Central

3. Exhibit F: Navajo Head Start Family Partnership Tracking; all information for Exhibit E will be compiled on this form and reported.

c. Family Profile Tracking: Tracking will be compiled three times a school year by the FSC (October, January, and May).

1. Exhibit G: Family Profile Tracking

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Related Regulations: 1304.40 a; 1304.40 a 1; 1304.40 a 2; 1304.40 a 3; 1304.40 a 4; 1304.40 a 5; 1306.33 b

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Develop Family Partnership Agreement that outlines and individualizes services for mothers to receive during their prenatal care will include: (EHS staff serves as advocates and Liaison between pregnant women and health care providers)

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Develop Family Partnership Agreement that outlines and individualizes services for mothers to receive during their prenatal care will include: (EHS staff serves as advocates and Liaison between pregnant women and health care providers)

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NAVAJO HEAD START EARLY CHILDHOOD MENTAL HEALTH POLICIES AND PROCEDURES

Policy ID: NHS MENTAL HEALTH 01

Subject: Prevention and Early Intervention

Performance Objective: Navajo Head Start (NHS) must collaborate with parents and community members to educate them about the importance of early.childhood mental health for children, families and staff.

Operational Procedures:

Navajo Head Start must conduct trainings to educate parents/guardians and staff to comprehend the importance of <u>early childhood mental health</u> wellness to support their overall growth and development.

- A. The information will assist in addressing early childhood mental health needs:
 - 1. Education for Staff and Families: Trainings will be provided according to annual educational trainings for staff and parents specific to mental health topics.
 - 2. Solicitation of parent input: Parent input must be obtained to complete the Social/Emotional checklist.
 - 3. The Social/Emotional Checklist will be completed if needed and utilized if there is a child behavioral concern in the classroom setting, or if the Brigance results indicates a need for further assessment, observation and follow recommended recommendation thereafter.
 - 4. Training Topics (include but are not limited to the following):
 - a. Attachment: promote a nurturing relationship with primary caregivers.
 - b. Separation: encourage primary caregiver's participation to establishing positive separation and reunion practices.
 - c. Child Development: information collected by parents/guardians will provide a better understanding of a child's behavior, which will include prenatal health through the current age of the child.
 - d. Recognizing and Understanding Behavior: cultural sensitivity will be taken into account for each child's/family when sudden changes in child behavior occurs.
 - e. Supporting new parents during pregnancy, during the first few months after birth; and to provide support and assistance in understanding the development of their newborn through childhood, and adolescents.
 - 5. Encourage the importance of a nurturing, stable and supportive environment at home and in the classroom.
 - 6. Support parents/guardians/families in their child's behavior intervention process

Related regulations: 1304.24 a; 1304.24 a (1) (i-vi); 1304.40

Policy ID: NHS EARLY CHILDHOOD MENTAL HEALTH 02

Subject: Prevention and Early Intervention

Performance Objective: Navajo Head Start Licensed Mental Health Professionals will provide <u>early childhood</u> mental health services and trainings for children, families, and staff.

Operational Procedures:

Navajo Head Start's License Mental Health Professionals must provide <u>early childhood</u> mental health services on a schedule of sufficient frequency to enable the timely and effective identification of and intervention in a family or staff's concerns about a child's <u>early childhood</u> mental health. <u>Early Childhood</u> Mental Health services may extend into the summer months per budget allocations, client needs and continuity of services

for Navajo Head Start children, families and staff. In cases of emergencies/crisis for individualize services for parents/guardians/families, referrals will be made to locate community resources along with referrals to Navajo Head Start's Licensed Mental Health Professionals.

A. The Licensed Mental Health Professional must:

- 1. Implement program policies per Navajo Nation Personnel Policies, contractual agreements, job descriptions, and/or scope of work, and Navajo Head Start Policies and Service Delivery Plans.
- 2. Resources: Utilize community resources to assist children, families, and staff with <u>early childhood</u> mental health services, as needed.
- 3. Review all children's Social/Emotional Checklist in accordance to the need of a child's behavioral concern, if needed.
- 4. <u>Licensed Mental Health Consultants will provide feedback/summarizes to teachers/center staff/home visitors and the Mental Health Coordinator's.</u>
- 5. Conduct classroom, home base, and Early Head Start observations two times a year.
- 6. Provide written on-site observation reports.
- 7. Provide copies of reports to the classroom and home base programs with feedback and discussion with the staff to assist with their comprehension of observation reports.
- 8. Provide written documentation that children and their families, and staff are receiving services.
- 9. Provide <u>early childhood</u> mental health education through individual and group settings for children and their families.
- 10. Provide <u>early childhood</u> mental health education through individual and group settings for staff to understand and supplement their classroom or home base environments/curriculum.
- 11. Provide on-site consultation on a regular basis.
- 12. Provide a supportive contact to each center or home base program at least once a month via phone call, visit or staff/parent meeting.
- 13. Provide professional <u>early childhood</u> mental health services to Navajo Head Start children, and staff through individual sessions or group sessions based on client needs.
- 14. Must seek written consent to provide individualized services from parents/guardians when appropriate.
- B. The Licensed Mental Health Professional must provide services in order of priority listed below, to align with Head Start Performance Standards;
 - 1. Priority 1 Any and all services directly or indirectly delivered for children.
 - 2. Priority 2 Any and all services directly or indirectly delivered for staff pertaining to their work with children. For staff needing services for personal issues, Mental Health Consultants can provide services at staff's written request. Mental Health Consultants will provide assistance to staff with the goal of having staff work effectively and positively with children and their families.
 - 3. Priority 3 Any and all services directly or indirectly delivered for parents/guardians/families will not exceed 8 sessions, unless a request is done in writing to exceed 8 sessions. Requests can be done by the client and/or the Licensed Mental Health Professional.
- C. The Licensed Mental Health Professional must provide <u>early childhood</u> mental health services, and, guidance and support when referring clients as needed for services for the following:
 - 1. Psychiatric Services
 - 2. Psycho Therapy
 - 3. Substance Abuse/Addiction Services
 - 4. Marriage and Family Therapy
 - 5. Professional for Social Work services
 - 6. Counseling Services
 - 7. Traditional Practitioner Services
 - 8. Other Faith Based Counseling Services

- 9. Crisis Prevention and Intervention Services
- 10. Implement Best Practices in supporting direst service staff in using Positive Behavior Interventions and Support in working with children.
- 11. Establish and facilitate family/staff support groups, as needed.

Related Regulations: 1304.24. a (2)

Policy ID: NHS EARLY CHILDHOOD MENTAL HEALTH 03

Subject: Prevention and Early Intervention

Performance Objective: Navajo <u>Early Childhood</u> Head Start Mental Health Coordinators will assist and support the Licensed Mental Health Professional in coordinating and managing the mental health services and education/trainings for children, families, and staff within their respective agencies.

Operational Procedures:

The Mental Health Coordinator and the Licensed Mental Health Professional must provide regularly scheduled early_childhood mental health services throughout the school year. Early_Childhood Mental Health services may extend into the summer months per client needs and continuity in service delivery for Navajo Head Start children, families and staff.

- D. The Mental Health Coordinator must:
 - 1. On-site visitations will be done at least once every two months for all classroom and home base programs.
 - 2. Implement program policies per Navajo Nation Personal Policies, job descriptions, and/or scope of work, and Navajo Head Start Policies and Service Delivery Plans.
 - 3. Resources: Utilize and collaborate with community resources to assist children, families, and staff with <u>early childhood</u> mental health services as needed.
 - 4. Referrals must be completed, submitted, tracked and forwarded to the appropriate service providers.
 - 5. Review, file, track and monitor all Social/Emotional Checklists, <u>Brigance</u>, Devereux Early Childhood Assessment (DECA) or the Devereux Early Childhood Assessment-Infant Toddler (DECA-I/T), in accordance to the needs of child behavioral concerns, and/or Brigance results.
 - 6. Review, file, track and monitor classroom observation reports.
 - 7. Review, file, track and monitor written documentation that supports children and their families are receiving services.
 - 8. Provide <u>early childhood</u> mental health education, when appropriate and with assistance from a Licensed Mental Health Professional, through individual and group settings for children and their families.
 - 9. File all mental health services documentation while maintaining confidentiality. Locked file cabinets must be used to file documents.
 - 10. Research, attend trainings, and assist in coordinating the initial implementation of Positive Behavior Intervention and supports in Navajo Head Start.
 - 11. Initiate introduction of Best Practices in supporting the staff whom provide direct services in using Positive Behavior Interventions and Supports when working with children, where applicable.
 - 12. Mental Health Coordinators will work with Licensed Mental Health Professionals in reporting mental health services and hours of services delivered in monthly reports. For Program information reporting (PIR), mental health service hours will be calculated in increments of quarter hours; ie., 1.00=1 hour, 1.25=1 hour 15 minutes, 1.50 hours=1 hour 30 minutes, and 1.75 hours=1 hour and 45
 - 13. Must attend all agency staff meetings, Family Service Liaison meetings, Education Component meetings, to ensure thorough early-childhood mental health service delivery for children and families.
 - 14. Will attend all $\frac{\text{Conscious Discipline}}{\text{Discipline}}$ $\frac{\text{best practices}}{\text{Discipline}}$ meetings with Licensed Mental Health Professionals, Consultants, etc.

Related Regulations: 1304.24 a 3; 1304.24 a 3 i; 1304.24 a 3 ii; 1304.24 a 3 iii; 1304.24 a 3 iv

Mental Health

Standard 1304.24 (a)(1)(i-vi); 1304.40(f)

Purpose: Early Childhood Mental Health: Coordinate with Mental Health Professionals to provide quality, culturally sensitive mental health services for children for families, and staff.

Objective: Scheduling of Services; Established <u>Early Childhood</u> mental health training plans for parents and staff to meet the children needs.

Plan of Action:

- 1. The Mental Health Professional-shall, on a schedule of sufficient frequency, provide timely and effective identification of and intervention in, family and staff concerns about <u>early childhood</u> mental health. Navajo Head Start' on-site visits will be at the minimum of 2 hours per each head start center, home-based centers and home-based centers, consultations, observations or follow-ups for children/families/staff. Monthly schedules will be provided before the 1st of every month to each center, home base program, and Mental Health/Disability Coordinator for respective agencies.
- 2. The Mental Health Professional must collaborate with program staff, and parents to create and provide a schedule of regular on-site <u>early childhood</u> mental health consultations, sessions, observations, and follow-up visits.
- 3. The mental health professional shall provide a schedule of on-site trainings and support groups for parents and staff. Such schedules shall be provided to the Mental Health/Disability Coordinators (Region and Central), Administrative Staff member at regional offices, classrooms and home base programs.
- 4. Service Delivery Time Frame: <u>Early Childhood</u> Mental Health services will be provided during the school year and exceptions may be granted to provide services through the summer based on client needs, case loads and best practices with continuity of services.

Responsible: Mental Health Professional, Mental Health/Disability Specialist, Mental Health/Disability Coordinators, Sr. Education Specialist, Parent Involvement Coordinator, Administrative Assistant, and other key staff as needed.

Reference: Family Partnership Agreement, Mental Health Parent and Staff training Plan relating to <u>Early Childhood</u> Mental Health topics, and Navajo Head Start Policies and Procedures.

Standards: 1304.24 (a)(1)(i-vi); 1304.40 (f)

Purpose: Services for Children (Birth to 5 Years of age/Pregnant Women Program):

Plan of action:

- 1. For children identified as needing assistance per referrals from the social-emotional checklist data, mental health professional, parents, or staff, periodic conferences will be held formally or informally with parents and/or staff. Conferences will take place to collaborate and provide support for developmentally appropriate practices in the home and in the classroom to assist the identified child/children.
- 2. The mental health professional will collaborate with local community programs and resources to assist the identified behavioral and early childhood mental health concerns of an individual child or group of children.
- 3. The mental health professional will provide individual counseling sessions to children who are identified as needing assistance.
- 4. Review of Behavioral Support Plan will be implemented as needed for children. Review of Behavioral Support Plan will be based on a decision from the review of Behavioral Support Plan that will consist of at least the following members:
 - a. Parent/Guardian
 - b. Teacher
 - c. Mental Health Coordinator
 - d. Licensed Mental Health Professional (as needed)
- 5. Crisis Prevention and Intervention Services

Responsibility-Mental Health/Disability Specialist, Mental Health/Disability Coordinators, Mental Health Professional, Sr. Education Specialist, Mental Health Professional,

Reference: Navajo Head Start Mental Health Contracts, Community Resources, Navajo Head Start Policies and Procedures.

Standards 1304.24 (a)(3)(i-iv); 1304.24 (a)(3)(i-iv)-

Purpose: Early Head Start Services

Plan of Action:

1. The mental health professional will provide <u>early childhood</u> mental health services to infants, toddlers, and pregnant women participating in the Early Head Start program through individual sessions or group socialization activities to foster and strengthen healthy, positive parent-child relationships.

2. The mental health professional will provide <u>early childhood</u> mental health services and education for staff to assist them with providing quality services and to implement practices that are responsive to infants, toddlers, and pregnant women and their rapidly changing needs.

Responsible:

Mental Health Professional (s), Mental Health/Disability Specialist, Mental Health/Disability Coordinators, Disabilities, Mental Health Professionals, Sr. Education Specialist, etc.

Reference:

Navajo Head Start Mental Health Contracts, Community Resources, Navajo Head Start Policies and Procedures.

Standards: 1304.24(a)(2)

Purpose: Education and Support Groups

Plan of Action:

- 1. The mental health professional must promote <u>early childhood</u> mental wellness by providing individual and group education for staff and parents regarding mental health topics/issues, providing positive environments at home and in the classroom, and on building nurturing parent-child relationships.
- 2. The mental health professional must promote <u>early childhood</u> mental wellness by providing support groups for staff regarding their <u>early childhood</u> mental health issues.
- 3. The mental health professional must promote <u>early childhood</u> mental wellness by providing support groups for parents regarding their <u>early childhood</u> mental health issues.
- 4. Positive Behavior Interventions and Supports will begin to be implemented and taught Navajo Head Start parents, and Navajo Head Start staff to support and provide quality service delivery for children.
- 5. Training and technical assistance to parents and staff.

Training Topics to include, but not be limited to, the following:

- Domestic Violence
- Stress Management
- Anger Management
- Early Childhood Development
- Conflict Resolution, etc.
- Impact of Trauma on Children/Families
- Early Brain Development
- Developing Positive Self-Esteem in Children
- FAS Prevention / Education
- Positive Behavior Interventions and Supports
- Suspected Child Abuse and Neglect Training (SCAN),
- Implementing and Incorporating: Conscious Discipline (Hand On),
- Conscious Discipline Management,
- Classroom Management,
- Improving Relationships between staff and children
- Promoting Alternative Thinking Strategies

Responsible:

Mental Health Professional(s), Sr. Education Specialist, Parent Involvement Coordinator, Mental Health/Disabilities Specialist, Education Specialists, Family Service Liaisons, Home Visitors and other pertinent staff as needed.

Reference:

Navajo Head Start Mental Health Contracts, Community Resources, Navajo Head Start Policies and Procedures

Referrals for children, families and staff

Purpose: To provide <u>Early Childhood</u> Mental Health services for children and their families; and to provide quality <u>early childhood</u> mental health services to staff in order to support their personal, emotional professional development to enhance service delivery for Navajo Head Start children and parent/families.

Plan of actions:

Referrals will be acted upon in a timely manner, and service delivery will be provided, in order of importance, for:

- 1. Children
- 2. Parents/Families
- 3. Staff

Services for staff will be provided to support the personal, emotional professional development to ensure quality service delivery for children and their parents/families.

Crisis situations will also take precedence when addressing referrals.

Responsible:

Mental Health Professional, Mental Health/Disabilities Specialist, Mental Health/ Disability Coordinator, Education Specialists, Family Service Liaisons, Home Visitors and other pertinent staff as needed.Navajo Head Start Policies and Procedures,

Reference:

Navajo Head Start policies and Procedures, Classroom Observation, Staff, Parents.