



**THE
MUSCOGEE (CREEK) NATION**

Head Start
P.O. Box 580 | OKMULGEE, OK 74447
T 918.732.7898 | F 918.732.7906

JAMES R. FLOYD
PRINCIPAL CHIEF

LOUIS A. HICKS
SECOND CHIEF

Hesci/Hello,

Thank you for your interest in the Muscogee (Creek) Nation Head Start Program!

Attached you will find the MCN Head Start Application. Please fill out all areas of the application.

Copies of the following documents need to be submitted with the application:

- Medical Card (Private Insurance or Sooner Care)
- Muscogee (Creek) Citizenship Card or other Tribal Citizenship, if applicable
- Verification of Income (W2's or previous 12 months of Pay Stubs/Envelopes)
- TANF or SSI Documentation
- Shot Record
- Birth Certificate
- Copy of IEP or IFSP (if child has a disability)

Once your child has been accepted into the program you will need to schedule a physical and dental exam.

Please ensure the following screenings are conducted during the Physical Exam: Hemoglobin, Lead Screening, Strabismus, and Scoliosis (with results). Physical Exam must indicate if it is complete and be signed and dated by the physician. Also, the dental exam must indicate if it is complete or if treatment is needed and be signed and dated by the dentist.

If you have any questions please call the center located in your area for assistance.

MVTO/Thank you,

MCN Head Start Staff

Checotah Head Start: 918-473-0605

Eufaula Head Start: 918-618-6220

Okemah Head Start: 918-623-2000

Okmulgee Head Start: 918-732-7904

Tulsa Head Start: 918-296-0357

Wetumka Head Start: 405-452-1180

Other Centers Served: 918-732-7898

| Applicant | | | | | | | | | |
|---------------------------------------|--|-------------------|------------------------------|---|----------------|--------------------------------|-------------------------------------|--------|--|
| First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID | |
| Race | | | Hispanic | English Proficiency | Other Language | | Other Language Proficiency | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaska Native | | <input type="checkbox"/> Yes | <input type="checkbox"/> None | | | <input type="checkbox"/> Poor | | |
| <input type="checkbox"/> Black | <input type="checkbox"/> Hawaiian/Pacific Islander | | <input type="checkbox"/> No | <input type="checkbox"/> Little | | | <input type="checkbox"/> Moderate | | |
| <input type="checkbox"/> White | <input type="checkbox"/> Multi-Racial | | | <input type="checkbox"/> Moderate | | | <input type="checkbox"/> Proficient | | |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> Proficient | | | | | |
| Primary Health Coverage | | Other Coverage | Insurance # | Medicaid Eligibility | Medicaid # | | Doctor/Medical Home | | |
| | | | | <input type="checkbox"/> Not Eligible | | | | | |
| | | | | <input type="checkbox"/> On Medicaid | | | | | |
| | | | | <input type="checkbox"/> Potentially | | | | | |
| Dental Coverage | | Dental Coverage # | Dentist/Dental Home | Diagnosed Disability | | Suspected/Potential Disability | | | |
| | | | | <input type="checkbox"/> Yes If yes, Please list Disability: | | <input type="checkbox"/> Yes | | | |
| | | | | <input type="checkbox"/> No | | <input type="checkbox"/> No | | | |

| Primary Adult | | | | | | | | | |
|---|--|-------------------------------------|---|--|----------------|--|---|--------|--|
| First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID | |
| Race | | | Hispanic | English Proficiency | Other Language | | Other Language Proficiency | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaska Native | | <input type="checkbox"/> Yes | <input type="checkbox"/> None | | | <input type="checkbox"/> Poor | | |
| <input type="checkbox"/> Black | <input type="checkbox"/> Hawaiian/Pacific Islander | | <input type="checkbox"/> No | <input type="checkbox"/> Little | | | <input type="checkbox"/> Moderate | | |
| <input type="checkbox"/> White | <input type="checkbox"/> Multi-Racial | | | <input type="checkbox"/> Moderate | | | <input type="checkbox"/> Proficient | | |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> Proficient | | | | | |
| Highest Grade Completed | | Employment Status | | Child's Relationship | | Custody | Check all that apply: | | |
| <input type="checkbox"/> Associate's | <input type="checkbox"/> Grade 10 | <input type="checkbox"/> Full Time | <input type="checkbox"/> Full Time & Training | <input type="checkbox"/> Biological/Adopted/Step | | <input type="checkbox"/> Yes | <input type="checkbox"/> Lives with Family | | |
| <input type="checkbox"/> Bachelor's | <input type="checkbox"/> Grade 11 | <input type="checkbox"/> Part Time | <input type="checkbox"/> Part Time & Training | <input type="checkbox"/> Grandchild | | <input type="checkbox"/> No | <input type="checkbox"/> Provides Financial Support | | |
| <input type="checkbox"/> Col Deg/Train | <input type="checkbox"/> Grade 12 | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Training or School | <input type="checkbox"/> Other Relative | | <input type="checkbox"/> Teen Parent | | | |
| <input type="checkbox"/> Col or Adv Train | <input type="checkbox"/> < Grade 9 | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Retired or Disabled | <input type="checkbox"/> Foster | | | | | |
| <input type="checkbox"/> GED | <input type="checkbox"/> HS Graduate | | | <input type="checkbox"/> Other | | If teen parent, subsidized? | | | |
| <input type="checkbox"/> Master's | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Email Address: | | | | | | | | | |

| Secondary or Other Adult | | | | | | | | | |
|---|--|------------------------------------|---|--|----------------|--|---|--------|--|
| First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | Alt ID | |
| Race | | | Hispanic | English Proficiency | Other Language | | Other Language Proficiency | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaska Native | | <input type="checkbox"/> Yes | <input type="checkbox"/> None | | | <input type="checkbox"/> Poor | | |
| <input type="checkbox"/> Black | <input type="checkbox"/> Hawaiian/Pacific Islander | | <input type="checkbox"/> No | <input type="checkbox"/> Little | | | <input type="checkbox"/> Moderate | | |
| <input type="checkbox"/> White | <input type="checkbox"/> Multi-Racial | | | <input type="checkbox"/> Moderate | | | <input type="checkbox"/> Proficient | | |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> Proficient | | | | | |
| Highest Grade Completed | | Employment Status | | Child's Relationship | | Custody | Check all that apply: | | |
| <input type="checkbox"/> Associate's | <input type="checkbox"/> Grade 10 | <input type="checkbox"/> Full Time | <input type="checkbox"/> Full Time & Training | <input type="checkbox"/> Biological/Adopted/Step | | <input type="checkbox"/> Yes | <input type="checkbox"/> Lives with Family | | |
| <input type="checkbox"/> Bachelor's | <input type="checkbox"/> Grade 11 | <input type="checkbox"/> Part Time | <input type="checkbox"/> Part Time & Training | <input type="checkbox"/> Grandchild | | <input type="checkbox"/> No | <input type="checkbox"/> Provides Financial Support | | |
| <input type="checkbox"/> Col Deg/Train | <input type="checkbox"/> Grade 12 | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Training or School | <input type="checkbox"/> Other Relative | | <input type="checkbox"/> Teen Parent | | | |
| <input type="checkbox"/> Col or Adv Train | <input type="checkbox"/> < Grade 9 | <input type="checkbox"/> Unemploye | <input type="checkbox"/> Retired or Disabled | <input type="checkbox"/> Foster | | | | | |
| <input type="checkbox"/> GED | <input type="checkbox"/> HS Graduate | | | <input type="checkbox"/> Other | | If teen parent, subsidized? | | | |
| <input type="checkbox"/> Master's | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Email Address: | | | | | | | | | |

| Additional Child (Non-Applicant) * | | | | | | | | | |
|---|--|------|------------------------------|-------------------------------------|----------------|--------|-------------------------------------|--|--|
| First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | | |
| Race | | | Hispanic | English Proficiency | Other Language | | Other Language Proficiency | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaska Native | | <input type="checkbox"/> Yes | <input type="checkbox"/> None | | | <input type="checkbox"/> Poor | | |
| <input type="checkbox"/> Black | <input type="checkbox"/> Hawaiian/Pacific Islander | | <input type="checkbox"/> No | <input type="checkbox"/> Little | | | <input type="checkbox"/> Moderate | | |
| <input type="checkbox"/> White | <input type="checkbox"/> Multi-Racial | | | <input type="checkbox"/> Moderate | | | <input type="checkbox"/> Proficient | | |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> Proficient | | | | | |

| Additional Child (Non-Applicant) * | | | | | | | | | |
|---|--|------|------------------------------|-------------------------------------|----------------|--------|-------------------------------------|--|--|
| First | Middle | Last | Suffix | Nickname | Birthday | Gender | SSN | | |
| Race | | | Hispanic | English Proficiency | Other Language | | Other Language Proficiency | | |
| <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaska Native | | <input type="checkbox"/> Yes | <input type="checkbox"/> None | | | <input type="checkbox"/> Poor | | |
| <input type="checkbox"/> Black | <input type="checkbox"/> Hawaiian/Pacific Islander | | <input type="checkbox"/> No | <input type="checkbox"/> Little | | | <input type="checkbox"/> Moderate | | |
| <input type="checkbox"/> White | <input type="checkbox"/> Multi-Racial | | | <input type="checkbox"/> Moderate | | | <input type="checkbox"/> Proficient | | |
| <input type="checkbox"/> Other: _____ | | | | <input type="checkbox"/> Proficient | | | | | |

* If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.

Applicant Name: _____ Birthday _____

Family Information, Income & Contacts

| Family Information | | | | | | | | | |
|--|-----------------------------|--|---|---|---|---|---|---|--|
| Family Living Address | | | | | | | | | |
| Started Living At Date | Living Address | Address Line 2 | ZIP | City | State | County | | | |
| Family Mailing Address | | | | | | | | | |
| Same as living? | Started Using Date | Mailing Address | Address Line 2 | ZIP | City | State | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | | | | | | |
| Phone Number(s) | | Type (check one) | | Note (for example, an extension or best time to call) | | | | | |
| | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other | | | | | | | |
| | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other | | | | | | | |
| | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other | | | | | | | |
| Parental Status (check one) | Primary Language at Home | Homeless Family | Active Duty Military | Referred by Child Welfare Agency | Receiving SNAP | WIC | TANF Status | SSI | |
| <input type="checkbox"/> One <input type="checkbox"/> Two | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Formerly/Not now | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| Emergency Contacts | | | | | | | | | | |
|---|---------|--|---|--------------|--|---|--|--|--|--|
| Contact 1 | Name | | | Relationship | | | Emergency Contact | | Release To | |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Address | | | ZIP | | | City | | State | |
| | | | | | | | | | | |
| Phone Number 1 | | | Phone Number 2 | | | Phone Number 3 | | | | |
| <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | | |
| Contact 2 | Name | | | Relationship | | | Emergency Contact | | Release To | |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Address | | | ZIP | | | City | | State | |
| | | | | | | | | | | |
| Phone Number 1 | | | Phone Number 2 | | | Phone Number 3 | | | | |
| <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | | |
| Contact 3 | Name | | | Relationship | | | Emergency Contact | | Release To | |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Address | | | ZIP | | | City | | State | |
| | | | | | | | | | | |
| Phone Number 1 | | | Phone Number 2 | | | Phone Number 3 | | | | |
| <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | | |

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during normal business hours.

Parent/Guardian Signature _____ Date _____

CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
 HEAD START CENTER: _____ PHONE: _____
 ADDRESS: _____

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

2. SCREENING TESTS. Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.

| TEST | DATE | RESULTS | TEST | DATE | RESULTS |
|--|------|----------------------|-------------------------------|------|---------|
| a. PRESENT AGE* | | ____ Yrs., ____ Mos. | g. VISION (Type of Test)* | | |
| b. HEIGHT (no shoes, to nearest 1/8 in.)* | | | ACUITY, R/L | | |
| c. WEIGHT (light clothing to nearest 1/4 lb.)* | | | RESCREENING | | |
| d. BLOOD PRESSURE | | | STRABISMUS | | |
| e. HEMATOCRIT or HEMOGLOBIN* | | | COMMENTS | | |
| f. HEARING (Type of Test)* | | | h. OTHER TESTS (if indicated) | | |
| RESULTS, R/L | | | (1) TB | | |
| RESCREENING | | | (2) Stickle Cell | | |
| COMMENTS | | | (3) Lead | | |
| | | | (4) Ova & Parasites | | |
| | | | (5) Urinalysis | | |
| | | | (6) Other | | |

3. PHYSICAL EXAMINATION/ASSESSMENT. Complete and return top three copies to Head Start.

| | NORMAL FOR AGE | ABNOR- MAL | NOT EVAL | COMMENTS (Use Additional sheet if necessary) |
|---|----------------|------------|----------|--|
| a. GENERAL APPEARANCE | | | | |
| b. POSTURE, GAIT | | | | |
| c. SPEECH | | | | |
| d. HEAD | | | | |
| e. SKIN | | | | |
| f. EYES: (1) External Aspects (2) Optic Fundlescope (3) Cover Test | | | | |
| g. EARS: (1) External & Canals (2) Tympanic Membranes | | | | |
| h. NOSE, MOUTH, PHARYNX | | | | |
| i. TEETH | | | | |
| j. HEART | | | | |
| k. LUNGS | | | | |
| l. ABDOMEN (include hernia) | | | | |
| m. GENITALIA | | | | |
| n. BONES, JOINTS, MUSCLES | | | | |
| o. NEUROLOGICAL/SOCIAL (1) Gross Motor (2) Fine Motor (3) Communication Skills (4) Cognitive (5) Self-Help Skills (6) Social Skills | | | | |
| p. GLANDS (Lymphatic/Thyroid) | | | | |
| q. MUSCULAR COORDINATION | | | | |
| r. OTHER | | | | |

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS: CHILDS PHYSICAL IS COMPLETE yes no

Signature: _____ Date: _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

| ABNORMAL FINDINGS/DIAGNOSIS | TREATMENT PLAN | RECOMMENDED FOLLOW-UP OR RESULTS (Initial when complete) | DATE |
|-----------------------------|----------------|---|------|
| a. | | | |
| b. | | | |
| c. | | | |
| d. | | | |

PART II. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT



Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: Yes No

Current Oral Health Status

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? Yes No

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: Yes No

X-rays: Yes No

Risk assessment: Yes No

Cleaning: Yes No

Fluoride varnish: Yes No

Dental sealants: Yes No

Counseling/Anticipatory Guidance

Yes No

Referral to Specialty Care

Yes No

(Please specify specialist)

Restorative/Emergency Care

Fillings: Yes No

Crowns: Yes No

Extractions: Yes No

Emergency care: Yes No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: Yes No

Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? Yes No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name (please print) _____

Phone number _____

Fax number _____

Practice name _____

Address _____

Provider signature _____

Date of service _____