Leech Lake Early Childhood Program

Phone (218)335-8345 Fax (218)335-8255

Child's name________________________________ D.O.B.______________

Please Initial

____I understand that completing this enrollment packet does not guarantee my child/ren a spot in the program.

____I understand that my child/ren's enrollment packet cannot be scored without providing income verification.

____I understand that I am responsible for notifying the Leech Lake Early Childhood Program with any changes to my contact information. This also includes pick up drop off information for Head Start children.

____ I understand that enrollment packets must to be completed yearly. This includes children on the waiting list.

____ I understand **Hep A, MMR,** and **Varicella** are required immunizations for my child/ren to be eligible to attend the Leech Lake Early Childhood program. If a child already in the program becomes old enough to receive these immunizations and the parent fails to do so the child may be suspended.

____ I understand that if a parent chooses not to immunize their child whether for medical or non-medical reasons they **MUST** sign an exemption notary form.

Information needed:

	Date submitted	Comments
Income Documentation		
Birth Certificate		
Well Child Exam -Hemoglobin: (between 9-12 months) -Lead: (12 & 24 months)		
Immunizations		
Dental (over 12 months)		

Parent/Guardian Signature________________________ Date______________

Staff signature________________________ Date______________

Leech Lake Early Childhood – Early Head Start and Head Start Programs

Consents/Refusal & Release Form

Date: ___/___/______ ☐ NEW ☐ Modify Record

Child's Name: ________________________________ Birthdate: ___/___/______

Parent/Guardian(s) Name: ____

Contact Information: Cell phone: (____) - ____-_____ Home: (____) - ____-_____

Please initial each line item, sign and date below:

____ I hereby give my consent for Leech Lake Early Childhood Development Early Head Start/Head Start Program to screen my child for growth assessment, blood pressure, speech, vision, hearing, developmental, and behavioral. I understand that the results of the screening is to assist in the educational and health programming for my child and this data, as well as any other health or nutrition information on my child, will be available to me. If you wish to deny consent of a specific screening, please check below.

___ I **deny** consent for the following screenings to be completed by LLECD HS/EHS Program: (check only those you wish **not to have completed**)
___ Growth Assessment ___ Blood Pressure ___ Hearing ___ Vision
___ Developmental ___ Behavioral ___ Speech

___ I hereby give my consent for Leech Lake Early Childhood Development Early Head Start/Head Start Program to obtain or arrange for my child to receive physical examination (unclothed with HS Staff supervision), dental examination, blood lead, hemoglobin, audiology exam, eye exam, or mental health assessment to be completed by a licensed medical or dental provider, or laboratory technician, as required by the Head Start Performance Standards, **if up-to-date information has not been provided by the parent/guardian within specified timeframe.**

___ I **deny** consent for the following to be obtained or arranged by LLECD HS/EHS Program. (check only those you wish **not to have completed**)

I understand by denying, I am and will be responsible for providing this information as required by within a specific timeframe. Must be received prior too or within 45 days of start of services.

___ I hereby give my consent for Leech Lake Early Childhood Development Early Head Start/Head Start Program to take/use photos/videos of my child for publications such as classroom display (example – photo used for labeling), yearbook, SNAP-ED Program, newsletters, newspapers (example the DeBahJiMon), printed and electronic media (including the internet). Without compensation, now or in the near future.

___ I **deny** consent for the all of the above
___ I **deny** consent for the following:
___ Classroom display ___ Yearbook ___ SNAP_ED ___ Newsletters
___ Newspapers ___ Printed/Electronic Media (including internet)

___ I hereby give Leech Lake Early Childhood Development Early Head Start/Head Start Program to administer general first aid for minor injuries and illnesses. In the event further medical treatment is required, I give permission for my child to be transported by the program or emergency personnel to the nearest medical facility.

My authorization expires one (1) year from date of signature

Parent/Guardian Signature: ______________________________ Date: ____/____/_____

Staff Signature/Print Name: ______________________________ Date: ____/____/_____

Leech Lake Early Childhood Head Start Programs

Child Health & Nutrition History

Date of last Physical Exam: ___________________ Last Dental Exam: ___________________

Child's Name	Birth Date	Sex: ☐ Male ☐ Female

Parent/Guardian Name	Mailing Address	Phone #

Child's Doctor	Medical Home	Dental Home

Hospitalization and Illnesses	**YES**	**NO**	**Explain "YES" Answers**
1. Has child ever been hospitalized or operated on?			
2. Has child ever had a serious accident (broken bones, head injury, falls or burns)?			
3. Has child ever had a serious illness?			
Health Problems	**YES**	**NO**	**Explain "YES" Answers**
1. Does child have frequent: __cough __stomach pain, vomiting, diarrhea __sore throat __urinary infections or trouble urinating			
2. Is your child up to date on their immunizations? If no, are they on a catch up schedule?			Complete an **Immunization Exemption Form** if parents/guardians wish to not immunize.
3. Does child have difficulty seeing (squint, cross eyes, look closely at books or objects)?			
4. Has your child had a vision exam by an eye doctor? Were they prescribed glasses?			*If "yes", when and where was exam?*
5. Is there any family history of: __vision problems (wears glasses) __glaucoma __blindness			
6. Was your child born before 32 weeks?			
7. Does your child have problems with ears/hearing (pain in ear, frequent earaches/infections, discharge, rubbing or favoring 1 ear, tubes)?			
8. Is there any family history of deafness or any family that wears hearing aids?			
9. Has child ever had a convulsion or seizure? When did it last happen? Is child taking medicine for seizures? What medicine?			If "yes", complete **Seizure plan**
10. Is child taking other medicines now? What medicine? (Special consent must be signed for Early Head Start to administer any medication)			*Complete the **Medication Permission and Record Form***
11. Is your child now being treated by a physician or dentist?			Reason:

12. Has child had: __hives __polio __boils __chicken pox __measles __mumps __eczema __whooping cough __scarlet fever __german measles			
13. Has child had: __asthma __liver disease __heart/blood vessel disease __diabetes __bleeding tendencies __rheumatic fever __epilepsy			*If **asthma** or **diabetes**, complete appropriate form **(Diabetes Record, Asthma Care Plan)***
14. Does your child have any allergy problems (rash, itching, swelling, difficulty breathing, sneezing)? a) When eating foods? b) When taking medications? c) When near animals, fur, insects, dust, etc?			*a) If food allergies, complete **Special Diet Statement** What foods do they have allergies to?* *b) What medication?* *c) What things?* *How does the child react:* *Fill out **Severe Allergy Care Plan** if allergy is severe*
15. If child has allergies, does it require the use of an epi pen if exposed? (Special consent must be signed and an epi pen left at school).			*Complete the **Medication Permission and Record Form***
16. Do any of the conditions covered so far get in the way of the child's everyday activities? Did a doctor or other health professional tell you the child has this problem?			*Describe how:* *When:*
17. Could any concerns be life-threatening?			*If "YES", explain:*
Hemoglobin	**YES**	**NO**	**Explain "YES" Answers**
1. Has your child had their hemoglobin checked?			*Results: ___Normal ___Abnormal (Please provide latest test results)*
2. If they have had a low level, were they placed on an iron supplement or recommended to add iron rich foods to their diet?			
3. Are they currently still taking an iron supplement?			
Lead	**YES**	**NO**	**Explain "YES" Answers**
1. Has your child had their lead checked?			*Results: ___Normal ___Abnormal (Please provide latest test results)*
2. Has your child ever had lead poisoning?			
3. Is your child currently being treated for lead poisoning?			
4. Does your child chew on unusual things (examples: wood, pencils, paint chips, paper, clay, soil, cigarettes?)			
5. Does your child live or regularly visit a house built before 1950?			
Safety	**YES**	**NO**	**Explain "YES" Answers**
1. Does your child use a car seat when in the car?			
2. Does your home have working smoke and carbon monoxide detectors?			

3. The source of water in your home is ___city ___private well ___don't know			
4. Does anyone smoke in the house/car when children are present?			
Nutrition Intake	**YES**	**NO**	**Explain "YES" Answers**
1. Does your child receive WIC? If not, would you like assistance with obtaining WIC?			
2. Does your child's weight appear normal?			
3. Do you have any concerns with your child's weight?			
4. Is your child a picky eater?			
5. Is your child involved in physical play daily?			
6. Is your child having any dental problems that may affect their eating?			
7. If so, are they being treated by a dentist?			Date of treatment: Name of dental clinic where treatment is being completed: Provide documentation when treatment when completed
8. Does your child have difficulty chewing or swallowing now?			
9. Is your child lactose intolerant?			If "yes", what milk do they drink
***Infants** (6 weeks up to 1 year)*	**YES**	**NO**	**Explain "YES" Answers**
1. What is your child's feeding method:	__Breast fed __ Bottle Fed __Both		
2. What type of formula is your child currently on?	Type:		
3. Was this specially prescribed by your child's doctor?			Please provide copy of prescription
4. Has child been introduced to baby food?			What?
5. Have they had any reactions to foods they've tried?			
***Toddlers** (1 year up to 3 years)*	**YES**	**NO**	**Explain "YES" Answers**
1. Does your child drink from a cup or sippy cup?			If "yes", which cup:
2. Does child feed themselves with a spoon or fork?			
3. Does your child eat fruits and vegetables daily?			

Signature of Parent/Guardian: ______________________________ Date: ______________

Staff Signature: ______________________________

Health Services Signature: ______________________________ Review date: ______________

Leech Lake Early Childhood

Child's Name____________________________

Your Privacy Rights

Under the Minnesota Government Data Practices Act

The Minnesota Government Data Practices Act seeks to protect the privacy of the individual about whom government ~~agencies, their subdivisions, and agencies under with them collect data. The Minnesota Government Data Practices Act~~ also facilitates the release of information which is public. The information on this sheet applies to your current and future contacts with this agency, whether the contract is in person, by mail or by phone. This Act requires that whenever we ask you to provide us with private or confidential information about yourself or your child you be told:

- The purpose and intended use of the data within this agency;
- The legal requirements, if any, of providing the information;
- The consequences of providing or refusing to provide the information requested and;
- The identity of other persons or agencies authorized by statue to receive the information.

Purposes:
Details about the purpose of the information we collect from you are often listed on the forms you are asked to complete. The data we collect may be used for the following purposes:

- Determine you eligibility for services provided by this agency;
- Provide effective care and treatment of medical / social / psychological problems;
- Enable us to collect Federal, State, and local funds for services and reimbursement;
- Prepare statistical, reports and evaluations;
- Conduct program and financial audits, and
- Collect reimbursement from other agencies or individuals for the services may be delay.

Legal Requirements:
In most cases, you are not legally required to provide the information requested. If you are legally required, you will be informed of the law. If you do not provide the information requested, we may not be able to determine your eligibility for services, and in some cases, providing you with services may be delayed.

Sharing Information:
The information you provide will be shared with other employees or agencies ONLY when programs require access. The information will also be shared under the following circumstances:

- To individuals, persons, agencies, institutions or organizations you authorize, via a valid consent for the release of information.
- To court via a valid court order.
- To administer Federal and State funds or programs.
- To appropriate parties in an emergency.

By law, some other government and contractor agencies have access to certain information about you if they provide a service which requires access to your records. The type of data released and to whom, depends upon the program effected. Details about how the information is also available for the staff person assisting you.

YOU HAVE THE RIGHT TO KNOW AND HAVE ACCESS TO INFORMATION MAINTAINED ABOUT YOU AND YOUR CHILD. YOU ALSO HAVE THE RIGHT TO HAVE THIS INFORMATION EXPLAINED TO YOU.

I have read this explanation of my Privacy Rights and understand the purpose of giving the information and who is authorized to use it.

__________________________________ ____________________
Signature Date

Please-read this Privacy Rights information, sign and turn in with your child's Head Start Enrollment packet.

March 2019

Leech Lake Head Start / Early Head Start

AUTHORIZATION TO VOLUNTARY RELEASE/EXCHANGE INFORMATION

To: Provider/Agency/Other

- ☐ **Name:** ______________________________
- ☐ **Address:** ____________________________
- ☐ **Phone:** ______________ **Fax:** ______________

You are hereby authorized to release/exchange the following requested information to

Leech Lake Early Childhood Development
190 Sailstar Drive NW
Cass Lake, MN 56633
Phone: (218) 335-8345 Fax: (218) 335-8255

Purpose for release is for school participation.

______________________________ ______________________________
Child's Name **Child's Date of Birth**

______________________________ ______________________________
Parent/Guardian **Date of Birth**

Please send: ____

I understand that my records are protected under appropriate Privacy Laws, and cannot be disclosed to any other party without my written consent. I understand that this consent expires automatically one (1) year from the date below. I understand I may revoke authorization by written request at any time.

______________________________ ______________________________
Parent / Guardian Signature Date

Child Enrollment Form—Child and Adult Care Food Program

Dear Parents or Guardians,

Your child care center participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP) which ensures healthy meals are served to your children. To meet CACFP requirements specific enrollment information must be collected annually. Please complete this form and return it to your child care center.

Name of the Child Care Center: ______________________________

Child's First Name	Child's Last Name	Date Of Birth	Beginning Date of Child Care

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Enter the normal hours your child is in care*							

Check the meals your child normally receives while in care:

Weekdays	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack
Weekends	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack

*(for example, 7:30 a.m. – 5 p.m.; for a split schedule, 7:30 a.m. – 9 a.m. and 12:30 p.m. – 5 p.m.)

Child's First Name	Child's Last Name	Date Of Birth	Beginning Date of Child Care

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Enter the normal hours your child is in care*							

Check the meals your child normally receives while in care:

Weekdays	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack
Weekends	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ Eve Snack

*(for example, 7:30 a.m. – 5 p.m.; for a split schedule, 7:30 a.m. – 9 a.m. and 12:30 p.m. – 5 p.m.)

Infants Only: Your center is required to offer Iron-Fortified Infant Formula (IFIF). The iron-fortified infant formula this center offers is: ______________________. You have the option of providing your own IFIF, providing expressed breastmilk or breastfeed on-site. Please indicate your preference (choose one or more):

☐ I want the center to supply formula for my infant.
☐ I will provide breastmilk for my infant.
☐ I will provide the following formula for my infant: ____________
☐ I will breastfeed my infant at the center.

The center will introduce semi-solid foods to your infant according to the decisions made by you and your infant's doctor.

If there are other children in care, please complete additional forms as needed.

Parent's Signature: ______________________ Date Signed (form completed annually): ____________

Parent's Name (please print): ______________________ Home Phone: ____________ Work Phone: ____________

Mailing Address: ______________________ City: ____________ State: ________ Zip: ________

Child enrollment information needs updates annually. If the above information is the same, initial and date below.

Initial:							
Date:							

LEECH LAKE HEAD START & EARLY HEAD START PROGRAMS

I hereby give my child's classroom permission to administer the following products according to the manufacturer's instructions or as specified in writing by my child's physician.

Child's Name: ______________________________

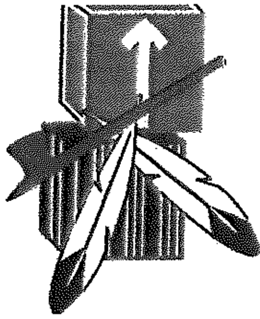
Classroom: ______________________________

YES	NO	Product	Brand
○	○	Lotion	____________________
○	○	Diaper Ointment	A&D ointment and Destin
○	○	First Aid Cream	____________________
○	○	Itch Cream	____________________
○	○	Lip Balm	____________________
○	○	Sunscreen	Coppertone Brand SPF 50
○	○	Baby oil	____________________
○	○	Insect Repellant	____________________
○	○	Shampoo	____________________
○	○	Burn/ Sunburn Remedy	____________________

****<u>This form must be updated annually</u>****

Parent's signature: ______________________ **Date:** ________________

190 Sail Star Dr · Cass Lake, MN 56633
Phone: 218-335-8345 · 1-800-551-0969 · Fax: 218-335-8255
Website: www.llboearlychildhood.com



Leech Lake Early Childhood Fluoride Varnish Program Permission Form

Dear Parent:

The Leech Lake Early Childhood program has a high rate of dental caries each year. Fluoride prevents cavities by making teeth stronger. Fluoride can even stop cavities when they are still tiny. This protective coating is applied twice during the school year.

To receive these no-cost services you must provide consent.

____ YES . . . I want my child to receive fluoride varnish 2 times a year.
____ NO . . . I do not want my child to receive preventive fluoride varnish.

Name of Child: ____

Classroom: ____

Parent Signature: __________________________ Date: ____________

****** This service does not replace a regular dental exam or treatment******

Your child must have regular dental checkup

If you have, any questions regarding the fluoride varnish program or need assistance making a dental appointment. Please call 335-8254 or 335-4465.

FOR OFFICE USE ONLY

Varnish date: ____________ Applied by: ____________________________
Varnish date: ____________ Applied by: ____________________________

Revised March 2019

Date: ____________

Leech Lake Tribe
SNAP - Ed

STUDENT PARTICIPANT INTAKE FORM

First Name: ____________________ **Last Name:** ________________________

City: ____________________________

State: MN

Does family currently receive: (Please check ONE only)

___ SNAP, Food Stamps ,EBT ___ Commodities ___ None

Birthday: Month ______ Day_______ Year______

Gender: Female ____ Male ____ Prefer to Self-Identify ____

Ethnicity (check one)
____ Hispanic/Latino
____ Non-Hispanic/Non-Latino

RACE: (You may mark more than one)

___ American Indian/Alaskan Native

___ African American

___ Asian

___ White

___ Native Hawaiian or other Pacific Islander

Food Allergy/Restrictions: ____________________
____

Optional: If offered, I wish to receive nutrition messages from MN SNAP-Ed by:
___ Email
___ Text Message (standard text message rates may apply)
Email Address: ______________________
Cell Phone Number: ______________________

___ By initialing here, I hereby release and hold harmless Leech Lake Early Childhood and partners including SNAP-Ed, to publish photographs taken 1 YEAR AFTER DATE of myself and/or the minor child and our names and likenesses, for use in print, online and video-based marketing materials, as well as other SNAP-Ed related publications.

Privacy Notice

The information on this form is gathered for statistical purposes and to advise participants about the availability of future nutrition programs and services. The Minnesota Chippewa Tribe and its constituent Bands will provide program participation statistics on the age, gender, race and ethnicity of participants to the USDA, Food Nutrition Services.
No information which identifies an individual participant will be disclosed for any purpose without the written consent of the person to whom the information pertains.

Leech Lake Education Division

JOHNSON O'MALLEY
STUDENT CERTIFICATION FORM

All information requested is voluntary. However, failure to fully complete the student and parent information sections may result in delays and/or make it impossible to process this certification request and student may be considered ineligible for JOM services. The information obtained as a result of this request will be used for educational purposes only.

School Name: ______________________

STUDENT INFORMATION

Student Name: ______________________ Date of Birth: __________

Tribe/Agency: ______________________ Degree of Blood: __________

Enrollment #: ______________________ Social Security Number: __________

PARENT INFORMATION

Mother's Name: ______________________ Date of Birth: __________

Tribe/Agency: ______________________ Enrollment #: __________

Father's Name: ______________________ Date of Birth: __________

Tribe/Agency: ______________________ Enrollment #: __________

AUTHORIZATION FOR RELEASE OF INFORMATION

Parent/Legal Guardian Requesting Information: (This form will be considered invalid if this section is not fully complete with signature.)

Print Name: ______________________ Relationship to Child: __________

Mailing Address: ______________________

Signature : ______________________

Mail Form to:	Fax Form to:	Drop Form off at:
LL Education Division 115 Sixth Street NW, Suite E Cass Lake, MN 56633	JOM Program Coordinator 218-335-8339	LL Education Division/JOM Program Office located in the Cass Lake Facility Center on 16126 John Moose Drive NW Cass Lake, MN

*** OFFICE USE ONLY ***

Based on the records and information available for this family, I certify that the above named student is:

☐ 1. An enrolled member of this Tribe/Agency: ______________________

Degree of blood: __________ Enrollment #: __________

☐ 2. Eligible for enrollment with: ______________________

☐ *Enrollment pending Tribal Action* ☐ *Not Applicable*

☐ 3. Not eligible for enrollment, but has the following degree(s) of Indian blood decedent of:

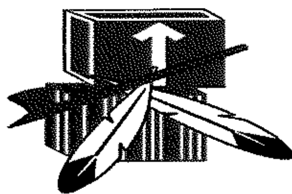
Tribe/Agency: ______________________ Degree of blood: __________

Tribe/Agency: ______________________ Degree of blood: __________

☐ 4. No information as listed on this form, and/or in current Tribal office records, reflect that this student has a combined total of one fourth (1/4) Indian blood degree as required for Johnson O'Malley eligibility.

Tribal Official Signature: ______________________

Tribal Official Name Printed: ______________________ Date: __________



Leech Lake Early Childhood

Volunteer Background Check

Classroom: ________________ Date: __________

Child's Name____

Dear Parent or Guardians:

A policy is in place to help support staff and parents in the classroom and on field trips to ensure the safety of all our children.

We have worked with the Leech Lake Department of public Safety and the BCA to come up with a process where we can check the background of any person wishing to serve as a volunteer in our program.

If you as parents / guardians have any extended family members that will be volunteering in the program, we need their information as well.

PLEASE PROVIDE FULL NAMES AND DATES OF BIRTH OF INDIVIDUALS WHO WILL BE VOLUNTEERING

All volunteers must be 18 years or older

Volunteer's Full Name	DOB	Relationship to Child

If you have any questions, please feel free to contact the Early Childhood Development Program.

Phone: 218-335-8345 or 1-800-551-0969 Fax: 218-335-8255

Early Head start

Emergency Contact Form

My Child:_________________________ Classroom:______________________

Parent/Guardian:_________________________ Phone:___________________

Parent/Guardian:_________________________ Phone:___________________

Emergency Contacts:

	Name:	Relationship to child:	Phone:	Release to:
1.				Yes / No
2.				Yes / No
3.				Yes / No

**Allergies:____

Parent/Guardian signature:_________________________ Date:_______________

Revised 4/19/18 - NZ

☐ Revised
Date: ___/___/___

Leech Lake Early Childhood

Head Start Transportation/Emergency Contact

Child's Name:			
Parents/Guardians Name:	Home Phone:	Cell Phone:	Work Phone:
Home Address: (house number & street address)			

☐ My child will be picked up and dropped off at home.

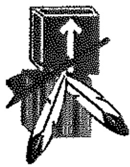
AM Pick Up Information
Address: (house number & street address)
PM Drop Off Information
Address: (house number & street address)

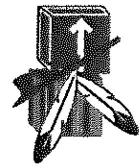
Emergency Contacts:				
Name:	Address:	Phone Number	Release to:	Do Not Release to:
			☐	☐
			☐	☐
			☐	☐

Allergies: (Food, Insects, etc.)

______________________________ ___/___/___
Parent/Guardian Signature Date

March 2019





Leech Lake Head Start Classroom Information

Head Start would like to get to know your child better, please fill in the following information.

Child's Name: ______________________________ **Nick Name:** ______________________________________

Birthday: __________________________________

Child Development: (Put an X in the blank if your child does the following)

1) **Large Motor: Does your child…**
   a. Ride a tricycle___
   b. Kick a ball forward ___
   c. Throw a ball with one hand___
   d. Use a swing to pump his/herself___
   e. Hop on one foot___

2) **Large Motor: Does your child…**
   a. Copy a circle___
   b. Cuts across paper ___
   c. Draw a person with at least three body parts___
   d. Prints a few letters___

3) **Communication Development: Does your child…**
   a. Use words "and" "or" "but" ___
   b. Understands sizes, shapes, numbers ___
   c. Identifies three colors correctly ___
   d. d. Follows a series of three directions ___

4) **Social/Emotional Development: Does your child…**
   a. Play with other children ___
   b. Play make-believe ___
   c. Share/takes turns when with a group of children___
   d. Likes to play: alone ___ with others ___
   e. Have any fears ___

5) **Self Help: Does your child…**
   a. Wash and dry face without help ___
   b. Put away toys ___
   c. Dress/Undress self ___
   d. Brush/comb their hair ___

6) **When your child does not get his/her way, he/she will**
   Cry ___ Pout___ Withdraw___
   Hit something___ Hit someone___
   Throw tantrum___ Talk about it___
   Other___ Explain________________

General Information:

1) My Child: Washes up before meals ___ Takes a bottle ___ Uses the bathroom ___
2) Is there anything about your child or has anything happened to your child that we should be aware of? (Example: recent move, separation from caregiver, etc.) Explain:_______________________________________
   ____
3) Any special needs your child may have such as: Not potty trained ___ Behavior problems ___ Other ___
   Explain: ____
4) Is your child currently receiving Special Education Services such as: IEP ___ IFSP ___ Other___
5) Is your child currently receiving any other counseling or therapy services? Yes___ No___
6) Does your child have a spirit name? ____
7) What is your child's clan? ____
8) Is there anything else you would like us to know that would help us better understand your child? _________
   ____
   ____

Teachers: Keep this form for the child's classroom file

Revised: 7/22/2019 CR