+ EMERGENCY INFORMATION +

Child's Name: _____

Birthday: _____

Home Address: _____

Home Phone: _____

Father's Name: _____

Mother's Name: _____

Contact Information:

Father: home: _____ work: _____ cell: _____ e-mail: _____

Mother: home: _____ work: _____ cell: _____ e-mail: _____

Alternate Emergency Contact Person(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Medical information (allergies to medications, foods, other substances, etc.):

Hospital Preference: _____

Child's Doctor: _____ Phone: _____

I agree that the operator may authorize the physician of his/her choice to provide emergency medical care in the event that neither I, my spouse, alternate contact(s), nor my child's doctor can be located immediately.

Parent's Signature: _____ Date: _____

Operator's Signature: _____ Date: _____

Leech Lake Early Childhood Development
TB Risk Assessment Form

Child's Name: _____ **Date of Birth:**____/____/____

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	❑ Yes ❑ No	If yes, name of symptoms:
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	❑ Yes ❑ No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	❑ Yes ❑ No	If yes, in what country was the child born:
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	❑ Yes ❑ No	If yes, in what country did the child travel to:
5. Have any members of the child's household come to the United States from another country?	❑ Yes ❑ No	If yes, name of country:
6. Is the child exposed to a person who: • Is currently in jail or who has been in jail? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker?	❑ Yes ❑ No	If yes, a TB Skin test will be required and name the risk factors the child is exposed to:
7. Does the child have any medical conditions that may increase the risk of progressing to TB disease, if infected (such as diabetes, silicosis, cancer of head or neck, low body weight)?	❑ Yes ❑ No	If yes, name of disease or medications:
8. Is the Child exposed to adults in high-risk categories?	❑ Yes ❑ No	

If YES, to any of the above, the child will need to have an actual TB Skin test. If the test result is positive, the child must have a medical evaluation, including a chest X-ray, and any further requirements.

_____ _____

Parent/Guardian Signature **Date**

Tuberculosis
TB SKIN TEST

Name:
DOB:
Chart#

Date Given: _____
Time Given: _____
Location: Right / Left Arm (Please circle one)
Manufacture: _____ Lot #: _____ Exp date: _____

Nurse administering: _____

RESULTS

Date Read: _____
Time Read: _____

_____ Title _____ ___Positive ___Negative
____MM
Signature of Health Care Provider Assessing Test

Please return with this card to the clinic about 48-72 hours (2-3 days) after the skin test was applied to have the results read. Results must be read within 48-72 hours or the test will need to be repeated and cannot be done for 6 weeks after the initial test.

****I HAVE BEEN NOTIFIED AND UNDERSTAND THE IMPORTANCE OF GETTING THIS TEST READ. THIS MAY DELAY MY CHILD'S START DATE.**

_____ _____
Print Name Date

_____ _____
Signature Phone Number(s)

Comments:

Leech Lake Early Head Start Classroom Information

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

Child's Name: _____ **Nick Name:** _____

Birthday: _____ Does your child separate easily from you? Yes No

Has your child stayed with anyone else besides you? Other child care Programs? If so, who and please describe these experiences: _____

_____

_____

Does your child have siblings? Name and ages:_____

_____

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: _____

_____

Is your child currently receiving Special Education Services such as: IEP___ IFSP___ Other___

Do you have any concerns about your child's development or behaviors? Yes No

If yes, please comment: _____

Age your child begin to: Sit _____ Crawl _____ Walk _____ Talk _____

Any difficulties with speech? Yes No

If yes, please specify: _____

What are some of your child's favorites? (toys, songs, activities)_____

_____

How does your child play: (Check all that apply)

Mostly Alone ___ With others___ Plays well with others___ Bossy___ Aggressive___ Shares well___

Please explain: _____

_____

What is something that provides comfort/security for your child? (pacifier, toys, blanket, etc.)_____

_____

What makes your child frustrated, upset, or afraid? _____

_____

Describe your child's basic personality (good natured, clingy, fussy, etc.): _____

_____

_____

PLEASE CONTINUE ON BACK

Please describe a typical day with your child: _____

_____

_____

Does your child have a spirit name? _____

What is your child's Clan? _____

Sleeping: Note: All infants will be placed on their back when being put to sleep.

When does your child wake up in the morning?

AM Nap: From _____ To_____ PM Nap: From _____ To _____

When going to sleep, what does your child need: Pacifier___ Blanket___ Other:_____

Does your child usually cry or become upset when going to sleep? Yes No

Describe ways to help your child go to sleep: _____

_____

What is your child's disposition upon waking up? _____

_____

Diapering/Potty Training

Is your child potty trained? Yes No

If not, please describe your child's diapering routine: _____

_____

If your child is using the toilet, what are you using (Please circle one): Pull-ups Underwear

What words does your child use for the bathroom? _____

How many times a day does your child have a bowel movement? Once Twice More:____

Is the bowel movement usually: Solid Normal Diluted

How do you treat diaper rash? _____

Do you have products or brands you do not want used on your child? _____

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