PETER CHRISTENSEN DENTAL CLINIC

128 Old Abe Rd Lac du Flambeau, WI 54538 (715)588-4269

PCDC Fluoride Varnish and Yearly Exam Permission Slip

Dear Parent/Guardian,

The Peter Christensen Dental Clinic is offering preventative dental programs for the Zaasijiwan Head start. These programs are not meant to be a substitution of regular dental visits.

Fluoride Varnish Program (every three months at Head Start):

- Oral health assessment by a licensed dental professional (dental hygienist or dentist)
- Fluoride Varnish application

Yearly Exam

- Dental exam by a dentist
- Fluoride

If you elect to have your child participate in the yearly exam you will receive a letter describing your child's dental health status and what was completed. All procedures will follow recommendations from the American Dental Association and Centers for Disease Control and Prevention for school-based dental prevention programs.

Benefits: Fluoride varnish has a sticky consistency which helps adhere to tooth and allows fluoride to stay in contact with the tooth for several hours.

Fluoride helps with remineralization of hypocalcified areas that are susceptible to decay and/or cavities.

If you are interested in your child participating, please sign and return the permission slip

PETER CHRISTENSEN DENTAL CLINIC

128 Old Abe Rd Lac du Flambeau, WI 54538 (715)588-4269

PCDC Fluoride Varnish and Yearly Exam Permission Slip

□ **YES!** I give permission for my child to participate in both programs

□ **NO.** I do not want my child to participate.
(optional) reason for declining?_____

Child's Last Name:_____First:_____DOB:_____

Teacher:_____Room:_____

Parent/Guardian Name:_____DOB:_____

Responsible Party's Mailing Address:_____

Phone Number:_____Email:_____

Your insurance will be billed if applicable but no child will be refused services based on their insurance coverage.

What type of **DENTAL** insurance does your child have?

□ Forward Health/Medicaid/BadgerCare □ Private Insurance (i.e. Delta, Cigna) □ No Insurance □Other

Is your child a member of a Federally Recognized Tribe? □ YES or □ NO What tribe? _____

If Enrolled-Tribal Enrollment #: _____ If 1st Descendant: _____

Please answer the following questions about your child. Does your child:

1. Take medicine prescribed by a doctor? Y/N If yes, what kind?_____
   What are these medications taken for?_____
2. Any ongoing significant medical conditions that your child is being treated for? Y/N
   If yes what conditions?_____
3. Have any allergies (i.e. medications, food, latex)_____Y/N
4. Has your child ever been seen by a dentist? Provider:
   □ Yes, within one year □ Yes, over one year ago □ Never

PLEASE RETURN TO THE HEADSTART'S FRONT OFFICE

Signing this document gives permission for ZHS and PCDC to share participant information

PRINTED PARENT/GUARDIAN NAME SIGNATURE DATE

Zaasijiwan Head Start 0-5

Nutrition Assessment

Name: **Date:**

What types of fluids does your child usually drink?

o Whole Milk o 2% Milk o 1% Milk o Juice

o Water o Soft Drinks o Other :

	Yes	No	Comments
Do you have concerns about your child eating habits?			
Does your child have a good appetite?			
Does your child enjoy meal time?			
Are you concerned about your child's weight?			
Have ther been any changes in your child's appetite in the last month?			
Does your child take vitamin supplements?			
Does your child have trouble chewing or swallowing?			
Does your child eat or chew anything that isn't food?			
Does your child have any food allergies?			
Is your child on a special diet?			
Does your child often have diarrhea or constipation?			
Does your child still drink from a bottle?			

What are your child's favorite foods?

What are their least favorite foods?

How often does your child eat the following?					
	Never or Rarely	Once A Week	Several Times A Week	Once A Day	Two or More Times A Day
Dairy (cheese, yogurt, milk)					
Meats (beef, chicken, fish, pork, etc.)					
Other Protein (dried beans, eggs, peanut butter, tofu					
Grains (bread, rice pasta, cereal, tortillas; etc.)					
Fruits (bananas, oranges, apples, berries, etc.)					
Vegetables (corn, green beans, peas, carrots, etc.)					
Sweets (cake, cookies, candy, soda, etc.)					
Fats (butter, margarine, mayo, etc.)					

Parent's signature: **Date:**

Zaasijiwan LDF Head Start 0 to 5
2899 Hwy. 47
P.O. Box 67
Lac du Flambeau, WI 54538

Sunscreen / Insect Repellant Authorization

*If provided by the parent, the sunscreen or repellant will be labeled with the child's name, otherwise the program will supply both.

Student Name: _____

I am this child's legal guardian and I authorize Head Start staff to apply sunscreen to my child.

Signed: _____ Date: _____

I also authorize Head Start staff to apply insect repellant to my child.

Signed: _____ Date: _____

This authorization will be valid for one year after it is signed.

Zaasijiwan Head Start

Blanket Special Event and Field Trip Authorization

During the school year, your child's class may participate in special events such as family socials and field trips. Please fill out the authorization below so that your child can participate. This form will be kept on file for the duration of the school year.

Name of Special Event/Field Trip: Lac du Flambeau Zaasijiwan Head Start
Destination of Field Trip: School Year 2022-2023

Child's First and Last Name: _____
Child's Classroom Name: _____
Home Address: _____
Parent/Guardian Name: _____
Daytime Contact Number: _____
Emergency Contact Name: _____
Daytime Contact Number: _____

I, _____, the parent of _____, ("my child"), give permission for my child to attend family socials, field trips, and other special events sponsored by the Zaasijiwan Head Start program. In signing this agreement, I understand that I will be notified of planned events in advance and that I assume any risk associated with the activity. Should it be necessary for my child to receive medical treatment while participating in this activity/field trip, I give my permission for Zaasijiwan Head Start personnel to use their judgment to obtain medical services for my child and for the physician selected by Zaasijiwan Head Start personnel to render any medical treatment deemed necessary.

_____

Parent/Guardian Signature Date

CACFP ENROLLMENT FORM

Child Care Name:

Lac du Flambeau Zaasijiwan Head Start

Parent/Guardian Instructions:
This form can be used for up to three children per household. In the spaces below list the child's name, current age, the days and hours normally in care, and the meals normally received while in care. If the child is of school age report the hours in care both before and after school. Child and Adult Care Food Program (CACFP) regulations require that the enrollment form be updated annually and signed by the child's parent or guardian. This form can be used for three years for the same child(ren), to meet the annual updating requirements.

HOURS AND MEALS WHILE IN CARE

Child's Name:

Date of Birth:

Days Normally In Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
☐ Sunday					☐	☐	☐	☐	☐	☐
☑ Monday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☑ Tuesday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☑ Wednesday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☑ Thursday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☐ Friday					☐	☐	☐	☐	☐	☐
☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

Child's Name:

Date of Birth:

Days Normally In Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
☐ Sunday					☐	☐	☐	☐	☐	☐
☑ Monday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☑ Tuesday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☑ Wednesday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☑ Thursday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☐ Friday					☐	☐	☐	☐	☐	☐
☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

HOURS AND MEALS WHILE IN CARE

Child's Name:

Date of Birth:

Days Normally In Care (Check ✓)	From	To	From	To	Breakfast	AM Snack	Lunch	PM Snack	Supper	Evening Snack
☐ Sunday					☐	☐	☐	☐	☐	☐
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☑ Thursday	8:00 am	3:30 pm			☑	☐	☑	☑	☐	☐
☐ Friday					☐	☐	☐	☐	☐	☐
☐ Saturday					☐	☐	☐	☐	☐	☐

Additional Information (Year One):	Additional Information (Year Two):	Additional Information (Year Three):

PARENT/GUARDIAN SIGNATURE

Parent/Guardian Signature (Year One):	Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Two):*	Date *Mo./Day/Yr.*	*Parent/Guardian Initials (Year Three):*	Date *Mo./Day/Yr.*

This Institution is an equal opportunity provider.

Privacy, Parental Rights, and Sharing of Directory Information

Zaasijiwan Head Start, with certain exceptions, will obtain your written consent prior to the disclosure of personally identifiable information (PII) from your child's records. As a parent/guardian, you have the right to request information from your child's records as well as the right to obtain copies of your child's records and information on certain disclosures. Please be advised that disclosure without parental consent may occur in situations where officials at a program, school, or school district in which the child seeks or intends to enroll or where the child is already enrolled so long as the disclosure is related to the child's enrollment or transfer in which case you will be notified and presented with the opportunity to refuse. Disclosure without consent may also occur in situations where the program is working with officials within the program or acting for the program, such as contractors, and officials from state, federal, or other entities if the officials are providing services for which the program would otherwise use employees, requesting information in connection with an audit, evaluation, or to conduct studies intended to improve outcomes. Additional disclosures without consent may occur to address a disaster, health or safety emergency, or a serious health and safety risk such as a serious food allergy, if the program determines that the disclosure is necessary to protect the health or safety of children or other persons or to address court orders and/or cases in which child maltreatment/abuse/neglect or child welfare is a concern.

Although, Zaasijiwan Head Start adheres to policies and procedures governing the dissemination and disclosure of personally identifiable information (PII), the program may disclose appropriately designated "directory information" without written consent, unless you have advised the program to the contrary. The primary purpose of directory information is to allow Zaasijiwan Head Start to include information from your child's education records in certain school publications and notices. Examples include:

- **Photos showing your child participating in program activities;**
- **Program publications;**
- **Attendance or other recognition lists;**
- **Graduation programs; and**
- **Social media pages**

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent.

If you do not want Zaasijiwan Head Start to disclose any or all of the types of information designated below as directory information from your child's education records without your prior written consent, you must notify the program in writing within 30 days of your child's enrollment into the program. You may also opt-out by completing the form provided with this notice and returning to Zaasijiwan Head Start. The following information has been designated as directory information:

- **Student and/or Parent/Guardian name**
- **Photograph**
- **Date of birth**
- **Dates of attendance**
- **Grade level**
- **Participation in activities**
- **Honors and/or awards received**

I, _____, have received information on Zaasijiwan Head Start's procedural approach to privacy, parent rights, and directory information. I am choosing to opt out of sharing the following directory information with regard to my child(ren): _____.

- ☐ Student and/or Parent/Guardian name
- ☐ Photograph
- ☐ Date of birth
- ☐ Dates of attendance
- ☐ Grade level
- ☐ Participation in activities
- ☐ Honors and/or awards received

_____ _____/_____/_____

Parent/Guardian Signature Date

Medication Consent Form
Zaasljlwan Head Start 0 to 5

(For prescription and non-prescription medications)

Name of child:_____ Date of birth:_____

Name of parent / guardian:_____

*Child's home address:*_____

Name of Physician prescribing this medication: _____

Physician's phone #: _____

Name of medication & dosage:

_____

Time(s) this med is to be given:

_____

For how long: _____

The reason for this medication is:

_____

_____

I give my permission to the Head Start Health Service staff, or designee, to give the medication(s) to my child according to the directions written above and authorize them to contact the child's physician. I agree to hold the Head Start program and its employees who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication.

I agree to notify the Head Start program staff in writing when any change in the above order is necessary.

_____ _____

Signature of Parent / Guardian Date

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44102 (Rev. 12/2017)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within 30 school days (6 calendar weeks) of admission to the child care center. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 PERSONAL DATA — PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

STEP 3 REQUIREMENTS

The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
6 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1] If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2] If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3] MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4] Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child WITHIN ONE YEAR and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

To the best of my knowledge, this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian — Date Signed

Authorization to Screen, Obtain, and Release Information

2899 Highway 47 • Lac du Flambeau • WI 54538 • 715-588-9291 Fax 715-588-9576

Name of Child _____ Date of Birth ___/___/_____

HIPPA – Compliant authorization to screen, obtain, exchange, or release health, education information and/or use of child's photograph/video for ZHS activities:

Zaasijiwan Head Start 0 to 5 Program PO Box 67, Lac du Flambeau, WI 54538
- ☐ Health/Oral Health Screening and Results
- ☐ Mental Health and Developmental Screening and Results
- ☐ Blood/Lab Screening and Results
- ☐ Other_____

Peter Christensen Health Center PO Box 67, Lac du Flambeau, WI 54538
- ☐ Health Records and Examination Results
- ☐ All Screening/Rescreening and Results
- ☐ Referral follow-up
- ☐ Other_____

Peter Christensen Dental Clinic PO Box 128, Lac du Flambeau, WI 54538
- ☐ Dental Screening and Results
- ☐ Dental Examination/Treatment and Results
- ☐ Referral/follow-up
- ☐ Other_____

Marshfield Clinic – Minocqua Center and FHC 9601 Towline Road, Minocqua, WI 54548
- ☐ Health Records and Examination Results
- ☐ Immunization records
- ☐ Referral follow-up
- ☐ All Screening/Rescreening and Results
- ☐ Other_____

Human Service Center 705 E Timber Drive, Rhinelander, WI 54501
- ☐ Developmental screening and results
- ☐ Individual Family Service Plans (IFSP)
- ☐ Referral follow-up
- ☐ Other_____

Lac du Flambeau Public School 2899 Highway 47, Lac du Flambeau, WI 54538
- ☐ All official student records and reports
- ☐ Individualized education plans (IEP) and related reports
- ☐ All Health Records and Screening Results
- ☐ Other_____

Family Resource Center PO Box 67, Lac du Flambeau, WI 54538
- ☐ Psychological observation reports
- ☐ Referral follow-up
- ☐ Behavioral observations
- ☐ Other_____

GLITC PO Box 9, Lac du Flambeau, WI 54538
- ☐ Permission to share family information for referral of services.

Family Services PO Box 67, Lac du Flambeau, WI 54538
- ☐ Guardianship/Custodial/Placement Documents
- ☐ Referral follow-up
- ☐ Other_____

Parental / Guardian Authorization/Permission

This authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice of withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. This authorization also gives permission for ZHS and community care partners to perform required screenings and observations of participants. I recognize that these records, once received by the agency, may not be protected by the HIPPA Privacy Act and may become educational records protected by the Family Educational Rights and Privacy Act-FERPA with additional protection afforded by Wisconsin Statutes 118.25(2m)(a)(b) and 146.82-146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to participate in this program. I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the information I have authorized to be used or disclosed by this authorization form. Arrangements to inspect this information can be made by contacting the Zaasijiwan Head Start-ZHS Director.

_____ ___/___/_____

Signature of Parent or Guardian **Date**

(Fax or photocopy effective as original)(Copies to parent/guardian, physician or other health care provider releasing the protected health information, school official requesting/receiving the protected health information, student SpEd file. Information also to be used to maintain health status record for participants in a Federal program.)

March 2020 revised