Mid- West New Mexico Community Action Program

549 Don Pasqual Rd. Los Lunas, NM 87031
Phone (505) 866-0466 Fax (505) 865-1506

April 1, 2024

Dear Applicant,

Thank you very much for your interest in the MWNMCAP Head Start Program. MWNMCAP has been successfully providing high quality Head Start services to our communities of Cibola, McKinley, Socorro and Valencia Counties for over 50 years. Our program believes that all children deserve the chance to learn and grow in a safe and vibrant environment. We also believe that the child's family is their first and most important source of learning. At MWNMCAP Head Start we not only concentrate on providing quality educational services to our children, but we believe that it is important to prepare the entire family for life-long growth and learning. Parent participation is not only welcome; it is at the cornerstone of what we do.

We have a limited number of open slots for new Early Head Start and Head Start children, so the earlier that you turn the application in, the better. It is also important to gather all requested documents (such as proof of income, Birth Certificate, Immunization Records, etc.). Once again, the more complete the application, the better chance of being eligible and accepted into the program.

As mentioned earlier, MWNMCAP Head Start provides high quality early childhood services. Although your child will definitely grow educationally, we are also concerned with the physical and mental health of your child. It is very important that your child receives a full **physical BEFORE school begins.** This allows us to better understand the needs of your child, whether it be a food allergy or the need to give them their prescribed medication. Making sure that your child has a complete **physical BEFORE school starts** will also ensure that your child is eligible for the program the entire year. There are Federal, State and local standards that require physical examinations, immunizations, etc. If you have any questions or concerns about the application process or need help to schedule a physical, please contact your local center and they will be more than happy to assist you.

Once again, thank you for your interest in the MWNMCAP Head Start Program. We look forward to welcoming you to our family!

Sincerely,
Molly Sanchez, M. Ed
Head Start / EHS Director
MWNMCAP

When submitting your application, please bring the following documents with you:

- **Proof of Income (All Household Members) - This may include one or more of the following:**

- 2023 Income Tax Forms
- W-2 Form(s)
- Pay Stubs/Pay Envelopes -most current
- Written statement from employer
- Documentation showing current status as recipients of public assistance (TANF, SNAP or SSI)
- Documentation showing foster care status for the applying child

- **Original Certificate of Birth (or foreign equivalent) or a hospital certificate of birth until an official certificate of birth can be obtained**

- **Child's Health Insurance or Medicaid Card**

- **Child's Immunization Records**

Please provide the following documents at time of application (if not currently available, please provide "Notice of Appointment" or speak to our Parent, Family and Community Engagement Department for assistance):

- Child's Physical (HS within the last 12 months, EHS within the last 3 months)

- Child's Dental Screening(s)/Exam(s) (within the last 12 months) and if applicable:

- Certificate of Indian Blood

If your child has not had a physical within the last 12 months, please schedule one as soon as possible. It is a requirement that all Head Start children have a physical within the last 12 months. If you have any questions or problems, please contact your local Head Start and they will be happy to assist you.

EMERGENCY CONTACT/PICK-UP FORM

(Anyone other than Parent/Guardian must be 18 or older to sign-out child)

Applicant/Child's Name_____

Parent /Guardian 1

First Name	Last Name
Address:	
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___ Relationship to Child:	Pick-Up Child

Parent /Guardian 2

First Name	Last Name
Address:	
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___ Relationship to Child:	Pick-Up Child

Emergency Contacts in Local Area Who May Also Pick Up Child

Contact 1 - First Name	Contact 1 - Last Name
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___ Relationship to Child:	

Contact 2 - First Name	Contact 2 - Last Name
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___ Relationship to Child:	

Contact 3 - First Name	Contact 3 - Last Name
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___ Relationship to Child:	

Additional Individuals Who May Pick-up My Child

NAME	PHONE #	RELATIONSHIP

_____ _____

Parent/Guardian Signature Date

CONSENT FOR CHILD'S EMERGENCY MEDICAL/DENTAL TREATMENT AND TRANSPORTATION PERMISSION FORM
(By Parent or Legal Guardian)

I, _____, hereby give my consent for emergency medical and/or dental treatment of the child listed below by any licensed physician or dentist while under the care of Mid West NM CAP Head Start and for emergency transport of the child to and from the source of emergency treatment. My child will be transported by an ambulance or other such vehicle when necessary.

This emergency care may include examinations and any tests which in the opinion of the physician or dentist are deemed necessary or advisable.

This does not include the right to perform surgical operations without my further consent, except in the case of an emergency and when an effort has been made to locate me or if I am found to be unavailable.

I understand that emergency treatment will not be given without parental consent, except in a life-threatening situation. Since consent must be given at the time of the incident, I understand that I must leave numbers where I, my spouse or a responsible adult designated by me, may be reached.

I understand the procedure to be followed and hereby authorize the Center to follow this procedure in the event of an emergency.

This consent is valid for one year after the date signed.

Child's Name: _____ Date of Birth: _____

Allergies/Medical Condition(s): _____

Physician: _____ Dentist: _____

Hospital: _____ Insurance: _____

Staff Use			
DTAP :			
Assigned Bus Stop:			
Re-Assigned Bus Stop:		Effective Date:	
Re-Assigned Bus Stop:		Effective Date:	

CONSENTS
Consents/Permissions/Verifications Form
PROGRAM YEAR 2024-2025

Eligible Child: _____

CONSENT AND APPROVALS

I give permission to Mid West NMCAP Head Start Program to do the following screenings.

Screenings:

☐Vision	☐Hearing	☐Developmental Screenings and Assessments
☐Height and Weight	☐Behavior Health & Wellness Observation	

Permissions:

☐Transportation of Child

☐Use of child's photograph/pictures on Social Media and for Recruitment/Advertisement

☐Use of child's photograph/pictures for classroom use only.

Parent/Guardian Signature:	_____	Signature Date:	_____/_____/_____ Month Day Year

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DECLINATIONS

I do not give permission for the following screenings. I acknowledge and remove all responsibility from the Mid West NMCAP Head Start Program for denial of services.

Screenings:

☐Vision	☐Hearing	☐Developmental Screenings and Assessments
☐Height and Weight	☐Behavior Health & Wellness Observation	☐Medical Release

Permissions:

☐Transportation of Child

☐Use of child's photograph/pictures

Parent/Guardian Signature:	_____	Signature Date:	_____/_____/_____ Month Day Year

RELEASE OF INFORMATION FORM

Name of Child: _____ Date of Birth: __/__/____

Address: _____

City: _____State: _____ Zip: _____

I, _____ hereby authorize _____
print name of Parent/Guardian* (person)

of _____
(name of doctor's office, school, other)

to obtain the following information about the above-named child:
(Check all that apply)
[ ] all medical records currently on file at _____ .
Medical Provider
[ ] only following medical records _____

currently on file at _____ .

[ ] all dental records currently on file at _____

[ ] In addition, I authorize

(1) _____ to release information concerning

the above named child to: _____

(2) _____ to release information concerning

the above named child to: _____

This authorization will automatically terminate on _____ unless previously revoked or extended by me, the undersigned.

_____ _____
Signature of Parent/Guardian* date

__ I hereby revoke this authorization _____ _____
Signature of Parent/Guardian* date

__ I hereby extend this authorization for __ months _____ _____
Signature of Parent/Guardian* date

*If the patient is over __ years of age, he or she may sign in place of parent/guardian.

Adapted from the American Academy of Pediatrics.

Mid-West New Mexico Community Action Program

Child Health History Questionnaire

Child's Name:	DOB:	Sex: M F
Parent/Guardian Name:	Date:	

PREGNANCY/BIRTH HISTORY	Y	N	EXPLAIN "YES" ANSWERS
1. Did mother have any health problems during this pregnancy or delivery?			
2. Did mother visit physician fewer than two times during pregnancy?			
3. Was child born outside of a hospital?			
4. Was child born more than 3 weeks early or late?			
5. What was child's birth weight?			lbs. _oz.
6. Was anything wrong with the child at birth?			
7. Was anything wrong with the child in the nursery?			
8. Did child or mother stay in hospital for medical reasons?			
9. Is mother pregnant now?			
HOSPITALZATIONS AND ILLNESSES	**Y**	**N**	**EXPLAIN "YES" ANSWERS**
10. Has child ever been hospitalized or operated on?			
11. Has child ever had a serious accident?			
12. Has child ever had a serious illness?			
HEALTH PROBLEMS	**Y**	**N**	**EXPLAIN (Use additional sheets if needed)**
13. Does child have frequent: ___sore throat; ___cough; ___urinary infections or trouble urinating; ___stomach pain, ___vomiting or diarrhea			
14. Does the child have difficultly seeing? (squints, cross eyes, look closely at books)			
15. Is child wearing (or suppose to wear) glasses?			If yes, was last checkup more than a year?
16. Does the child have problem with ears/hearing?			
17. Have you ever noticed child scratching their behind while asleep?			
18. Has child ever had a convulsion or seizure? Is the child taking medication for seizures?			When did it last happen? What medicine?
19. Is child taking any other medicine now?			
20. Is child now being treated by a physician or a dentist?			Physician Name: Dentist Name:
21. Has child had: ___boils; ___chickenpox; ___eczema; ___German measles; ___measles; ___mumps; ___scarlet fever; ___whooping cough			
22. Has child had: ___hives; ___polio			
23. Has child had: ___asthma; ___bleeding tendencies; ___diabetes; ___ epilepsy; ___heart/blood vessel disease; ____liver disease; ___kidney disease;____rheumatic fever; ____sickle cell disease?			
24. Does child have any allergies?			
25. Does the child have any condition that will get in the way of the child's everyday activities? Did a doctor or other health professional tell you the child had this problem?			Describe how? When?

Mid-West New Mexico Community Action Program

Parent Transition Questionnaire

Child's Name:	DOB:	Sex: M F
Parent/Guardian Name:	Relationship to Child:	

1. Can you tell us one or two things your child is interested in or does especially well?

2. Does your child take a nap? ___Yes ___No
If yes, how long?

3. Does your child sleep less than 8 hours a day or have trouble sleeping?____ Yes ___ No
Explain if yes:

4. How does your child tell you when they need to use the restroom?

5. Does your child need help going to the restroom? ___Yes ___No
Explain:

6. Does your child often wet their pants? ___Yes ___No
Explain:

7. How does your child act with adults they do not know?

8. How does your child act when playing with a group of other children?

Mid-West New Mexico Community Action Program

Parent Transition Questionnaire

9. Does your child worry a lot or is he/she afraid of anything? ____ Yes ___ No Explain:
10. Has your child ever been identified as having a developmental delay? ____ Yes ___ No If yes, please explain:
11. Does your child have any difficulties saying what they want to do? ____Yes ____No Explain:
12. Do you have any trouble understanding your child? ____Yes ____No Explain:
13. Does your child often get cranky or cry at other times, when you can't figure out why? ____Yes ____No Explain:
14. What do you do to comfort your child when they cry or are scared?
15. Please describe any major changes in your child's life in the last six months:
16. Are you or your family having any problems that might affect the child at school? ____Yes ____ No Explain:
17. Does your child currently wear diapers or pull-ups? ____ Yes ___ No If yes, what brand? Size?
18. Name of school your child will transition to from Early Head Start.
19. Is there any additional information that you would like us to know about your child?

Child Lead Exposure Questionnaire

Child's Name:_____ DOB:_____ Center:_____

Please answer these questions with: **Yes, No,** or **Don't Know**. The answers will help you and your health care provider decide if your child needs a blood test for lead.

1.	**Is your child enrolled in or eligible for Medicaid?** *Children enrolled in Medicaid are required by law to be tested for lead at 12 months and again at 24 months of age, and between the ages of 36 months and 72 months of age, if not tested at 12 and 24 months of age.*	Yes	No	Don't know
2.	**Is your child enrolled in any public assistance programs such as WIC or TANF?**	Yes	No	Don't know
3.	**Does your child live in, or regularly visit (for daycare or babysitting), a house built before 1950?** *Older houses may have lead-based paint, which breaks down into dust that can be swallowed or inhaled by your child.*	Yes	No	Don't know
4.	**Does your child live in or regularly visit a house that has recently been remodeled?** *Remodeling in an older house, or even one built as late as 1978, can create dust that contains lead, if lead-based paint is present.*	Yes	No	Don't know
5.	**Does any other child of yours or a child of a relative or friend have an elevated blood lead level?**	Yes	No	Don't know
6.	**Does your child live with or regularly visit an adult whose work or hobby uses lead?**	Yes	No	Don't know
7.	**Do you (or any family members, or a curandera or sobador) give your child orange, red, or yellow powder such as Greta or Azarcon, or use "Navajo" clay for stomach ache, nausea, and diarrhea?**	Yes	No	Don't know
8.	**Do you use Kohl, Alkohl, or Surma on your child's skin? Or use traditional Middle Eastern, Oriental, and Ayurevedic preparations?**	Yes	No	Don't know
9.	**Does your home have imported plastic/vinyl mini-blinds?** *Some imported plastic mini-blinds made before 1996 have lead in them.*	Yes	No	Don't know
10.	**Does your child eat, put things in his/her mouth, or chew on things that aren't food?** *Dirt, wood (especially window sills), paint chips, jewelry, shell casings, fishing sinkers, lead shot, shoes, or socks can have lead or lead dust on/in them.*	Yes	No	Don't know
11.	**Do you use imported pottery for cooking, storing, or serving food?** *Some Mexican, Chinese, and Italian potteries have lead in the glaze, which can get into the food.*	Yes	No	Don't know
12.	**Does your child live or play near a junkyard, dump, mine, smelter, busy street, or highway?** *These places can have lead dust in the air or in the dirt. Even if the smelter or mine is closed, lead can still be in the dirt.*	Yes	No	Don't know
13.	**Does your child eat tamarind/chile candy or salt/lemon/chile seasonings or chapulines that are made in Mexico?** *Some of these products may contain lead*.	Yes	No	Don't know

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

NM Childhood Lead Poisoning Prevention Program
Environmental Health Epidemiology Bureau
505-827-0006 • DOH-eheb@state.nm.us

nm CLPPP

NEW MEXICO DEPARTMENT OF HEALTH

Rev 4/2024

MWNMCAP Hematocrit/Hemoglobin Risk Assessment Questionnaire

Child's Name: _____ DOB:_____ Center: _____ Class: _____

Iron deficiency anemia is surprisingly common, yet it often goes undiagnosed and untreated.. When diagnosed, there are treatments available to help correct and manage iron deficiency anemia. If you don't get treatment, however, you may end up feeling worse and worse. By answering this simple questionnaire, you can help us determine if your child needs a Hemoglobin/Hematocrit test. Just answer as many of the questions as you can, and be sure to share the results with your physician.

1. Does your child feel tired or fatigued?
□Always □Often □Sometimes □Never

2. Does he/she feel weak?
□Always □Often □Sometimes □Never

3. Does your child's skin look pale?
□Always □Often □Sometimes □Never

4. Does your child get short of breath?
□Always □Often □Sometimes □Never

5. Does your child get dizzy?
□Always □Often □Sometimes □Never

6. Is it difficult for your child to concentrate?
□Always □Often □Sometimes □Never

7. Has your child experienced a rapid heartbeat?
□Always □Often □Sometimes □Never

8. Does your child complain of numbness or coldness in their hands or feet?
□Always □Often □Sometimes □Never

9. Is your child irritable?
□Always □Often □Sometimes □Never

10. Does your child feel sad or depressed?
□Always □Often □Sometimes □Never

11. Is child's hemoglobin count below 11 g/dL (**grams per deciliter**) of blood?
□Yes □No □I Don't Know

12. Have you ever been told that your child was anemic?
□Yes □No

Parent Signature: _____ Date: _____

Child □Does □Does not need a follow-up Hematocrit/Hemoglobin or Lead test.
(If follow-up is needed, check the box and circle test needed)

Staff Signature: _____ Date: _____

(Parent/Guardian - PRINT NAME) (Child's Name – PRINT)

I hereby acknowledge that I have received orientation and have been provided with a copy of the Mid-West NM CAP–Early Childhood Development Center Family Handbook.

I further acknowledge that I have read and understand its contents.

(Parent/Guardian Signature) (Date) (County)

THE NATIONAL CENTER ON Health

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 _____

This document was prepared under grant #9OHC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Health.

Mid-West New Mexico Community Action Program

Child Health Record-Screenings, Physical Examination/Assessments

Child's Name:	Center/Class:
Parent/Guardian Name:	Child's Birth Date:

Provider Information

Provider Name:	Phone #:
Address:	

Section 1-Physical Assessment

	Normal	Abnormal	Refer	Not Examined
General Appearance	☐	☐	☐	☐
Posture, Gait	☐	☐	☐	☐
Head	☐	☐	☐	☐
Skin	☐	☐	☐	☐
Eyes	☐	☐	☐	☐
Ears (external canal)	☐	☐	☐	☐
Nose, Mouth, Pharynx	☐	☐	☐	☐
Teeth	☐	☐	☐	☐
Heart	☐	☐	☐	☐
Lungs	☐	☐	☐	☐
Abdomen (hernia)	☐	☐	☐	☐
Bones, Joints, Muscles	☐	☐	☐	☐
Neurological				
Gross Motor	☐	☐	☐	☐
Fine Motor	☐	☐	☐	☐
Glands Lymphatic/Thyroid	☐	☐	☐	☐
Muscular Condition	☐	☐	☐	☐

Abnormal Conditions _____

Asthma/Allergies _____

Current Medications

Section 2-Child Health Status

	Yes	No
Child is up-to-date on a schedule of age appropriate preventative and primary care?	☐	☐
Child needs to establish the following services:		
Well Child Care	☐	☐
Immunizations Update	☐	☐
Routine Dental Care	☐	☐
Mental Health	☐	☐
Child has acute and chronic conditions and :	☐	☐
is receiving adequate ongoing care	☐	☐
needs to establish services	☐	☐
needs to update or re-establish services	☐	☐
Child has suspect or significant concerns. Explain:	☐	☐
Child's status was determined by:		
Parent Report	☐	☐
Medical History	☐	☐
Today's Exam	☐	☐

Section 3-Standard Tests & Measurements

	Normal	Abnormal
Blood Pressure _____/_____	☐	☐
Height _____ inches	☐	☐
Weight _____lbs. _____oz.	☐	☐
Other:	☐	☐

	Normal	Abnormal
Vision Test	☐	☐
Hearing Test	☐	☐
Lead _____		
HGB/HCT _____		

Section 4-Overall Results

	Normal	Abnormal
Overall Impression of Health	☐	☐

	Yes	No
Follow-up or Referral Needed	☐	☐

Comments:

Health Professional Signature: _____ **Date:** _____

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Diet Restriction/Food Allergy Form

Child's Name: _____ DOB_____

Diet Restriction:

- ☐ None
- ☐ Cultural Preference/Religious Preference
- ☐ Allergy/Medical Restriction (*physician signature is **required** by the entry date of the child*)

****Your child's physician must complete the portion below prior to the first date of entry****

If your child requires a special diet, please have the physician include a detailed description of what food(s) your child is allergic to, and describe any reactions or adverse consequence that may occur if your child is exposed to that food(s).

_____
_____
_____
_____

List specific food to be omitted and suggested substitutions:

Omissions	Substitutions
_____	_____
_____	_____
_____	_____

Parent/Guardian's Signature _____Date_____

Physician Signature _____Date_____

Your child's special needs information will be posted in places that are accessible to staff in order to keep your child safe, but out of access to others.

If your child is on a Health Plan, it will follow the child while he/she is enrolled in the Program. The Health Plan may be withdrawn ONLY with a physician statement explaining that the condition no longer exists or no longer needs monitoring.

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Early Head Start Program

Early Head Start Child Health Record
Nutrition

Child's Name: _____ Date of Birth: _____ Sex: M F

Parent/Guardian: _____ Relationship: _____

Name of Interviewer: _____ Title: _____

The following questions will help us understand your child's nutrition needs better:

1. Are there any foods that child cannot eat due to religious, cultural, or medical reasons? ☐ No ☐ Yes
   If "Yes," what foods are these? _____
2. Does your child take a vitamin/supplement? ☐ No ☐ Yes If "Yes," what kind?
   _____
   Do they contain Iron? ☐ No ☐ Yes Do they contain Fluoride? ☐ No ☐ Yes
3. Does your child have a food allergy? ☐ No ☐ Yes If "Yes," please explain:
   _____
4. Is your child on a special diet? ☐ No ☐ Yes If "Yes," what kind?
   _____
   Was it prescribed by a physician? ☐ No ☐ Yes
5. Does your child use a bottle? ☐ No ☐ Yes
6. Does your child drink milk? ☐ Breast Milk ☐ Formula ☐ Cow's Milk Other: _____
   What kind (formula or Cow's milk)? _____ How much? _____ How often? _____
7. Does your child eat solid foods? ☐ No ☐ Yes If "Yes," what type of food (i.e. baby food, table food)?
   _____
8. Does your child have the following issues? ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Difficulty Chewing
   ☐ Difficulty Swallowing ☐ Pain while eating ☐ None
9. Does your child ever eat non-food items such as, clay, dirt, paper? ☐ No ☐ Yes If "Yes," what?
   _____
10. Do you have concerns about what your child eats? ☐ No ☐ Yes. If "Yes," what are your concerns?
    _____
11. Does your family have at least one meal together? ☐ No ☐ Yes
    Is the TV on during meal time? ☐ No ☐ Yes
    Do the children and adults eat the same meal? ☐ No ☐ Yes
12. Does your child feed themselves? ☐ No ☐ Yes

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13. How often does your family have take-out food?

_____

14. Does your child use the following:

Utensils (fork, spoon, knife)? ☐ No ☐ Yes

Open cup? ☐ No ☐ Yes

Sippy cup? ☐ No ☐ Yes

15. What are some of your child's favorite foods? _____

16. What are some foods that your child dislikes? _____

17. How much does your child eat from each of these food groups in a typical day?

Milk, cheese, yogurt _____ Fruits (Not Juice) _____

Vegetables _____ Meat, poultry, fish, eggs, dried beans/peas, peanut butter _____

100% Fruit Juice _____ Kool-Aid, soda, sports drinks, fruit flavored drinks, tea, coffee _____

Salty snacks, chips, etc. _____ Cookies, candy, cakes, ice cream, sweet snacks _____

Bread, cereal, crackers, tortillas, rice, muffins, rolls _____

Parent/Guardian Signature:_____ Date: _____