GUAM HEAD START PROGRAM
DEPARTMENT OF EDUCATION
500 Mariner Avenue, Barrigada, GU 96913-1608
Tel: (671) 475-0484 • Fax: (671) 477-1535
www.gdoe.net/headstart

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Application Information For School Year 2021 – 2022

What is the Guam Head Start Program?

Head Start is a comprehensive preschool program that provides education, health, nutrition and social services to children and their families that support SCHOOL READINESS and FAMILY ENGAGEMENT.

Who should apply?

- Families that meet the Federal Income Guidelines and have a child who is age-eligible:
  - 5 years old (born August 1 to December 31, 2016)
  - 4 years old (born January 1 to December 31, 2017)
  - 3 years old (born January 1 to July 31, 2018)
- Families who receive TANF or SSI and have an age-eligible child
- Families who are homeless and have an age-eligible child
- Age-eligible child in foster care
- Families with an age-eligible child with a current IEP from GDOE Special Education

2021 Federal Income Guidelines	
Family of 1 .....$12,880	Family of 6 .....$35,580
Family of 2 .....$17,420	Family of 7 .....$40,120
Family of 3 .....$21,960	Family of 8 .....$44,660
Family of 4 .....$26,500	For families with more than 8 persons,
Family of 5 .....$31,040	add $4,540 for each additional person

Stimulus Payments and Pandemic Unemployment Assistance DO NOT COUNT as income for determining Head Start eligibility.

Who can register a child? (Child is not required to be present)

- Household Parents
- Household Legal Guardians appointed through the court must register the child

How can I register my child for Head Start?

1. Call 475-0484 to schedule an appointment to register your child.
   - Go to https://guamheadstart.gdoe.net for additional information.
     - The Head Start Application Packet may be downloaded for your convenience.
2. Head Start staff will review your documents and contact you to determine your child's eligibility and complete the registration process. Please update any changes in your home, mailing or contact information to ensure that we are able to contact you.
   - Visitors are reminded that they are required to wear a mask and follow posted safety requirements while present in GDOE facilities. Individuals who are ill or who have COVID-19 symptoms should stay home and will not be permitted into GDOE campuses or facilities.

Outside of the mass registration period, registration is conducted throughout the school year by appointment only. Registered children are placed on their center's waiting list until space becomes available.

Documents Required to Determine Eligibility:
(Note: Other documents may be required depending on your household situation.)

- ✓ Identification for Parents and/or Guardians in Household (valid driver's license, Guam ID, Passport)
- ✓ Child's Birth Certificate
- ✓ Child's Immunization Card (shot record)
- ✓ Child's Social Security Number (Social Security card or receipt of application for a number)
- ✓ Income documents for all household parents and guardians for the last 12 months:
  - Earned Income: 2020 W2 or Income Tax forms; check stubs from 2020-2021
  - Unearned Income: TANF Certification from Public Health, Child Support, Financial Aid, Social Security benefits, GHURA Utility Reimbursements, LES for military (monthly)
  - If no source of income, Statement of Support
- ✓ Unemployed Status:
  - Letter of termination/resignation and the date and reason for leaving employment; Certification layoff or reduction of hours
  - If unemployed for a total of 6 months or more, Unemployment Verification
  - Stimulus Payments and/or Pandemic Unemployment Assistance (PUA)
- ✓ If applicable, Legal documents relating to guardianship, child custody or name changes such as Restraining Order; Marriage Certificate or Divorce Decree when parent's name is different from child's birth certificate or Identification Cards
- ✓ If child has a certified disability, copy of current IEP documents from GDOE Special Education

Health Requirements:

- If your child qualifies, you will be provided with a Head Start Health Packet to complete BEFORE your child can attend school.
- In order to attend Head Start, your child needs to complete the following minimum health requirements:
  - Tuberculosis (TB) Skin Test - The results of a TB skin test must have been done WITHIN ONE (1) YEAR of enrollment in the classroom. If you recently moved to Guam, the TB skin test must have been done within six (6) months. *Note that the TB test must be done BEFORE your child is given any additional live vaccines (MMR and Varicella).*
  - Minimum Immunizations to attend school include at least One (1) dose of DPT, Polio, MMR, and Varicella; Four (4) doses of Hib (Haemophilus influenzae type b) OR one (1) dose after 15 months of age; and Hepatitis B vaccine
  - Physical Examination or an Appointment Card for a Physical Examination - The Physical Examination must have been done WITHIN ONE (1) YEAR of enrollment, meet EPSDT recommendations, and include a vision and hearing screening.
- In order to remain in Head Start, your child will need to complete additional health requirements which are specified in the Head Start Health Packet.

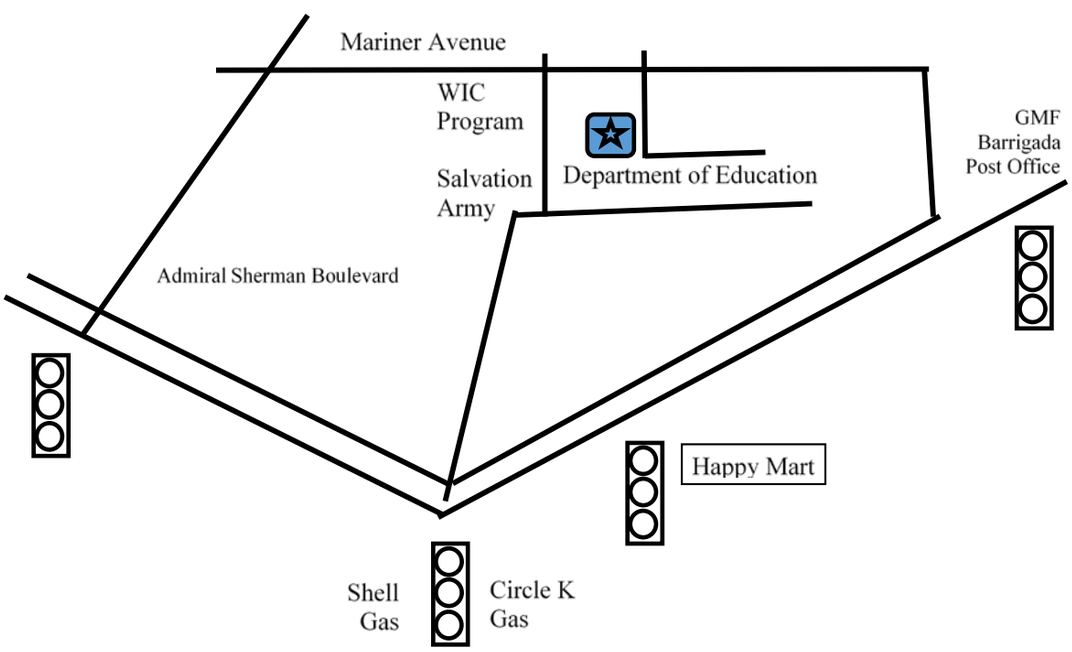
What happens next?

- The Program selects 534 children to enroll in the Program each school year and will notify you by mail whether your child is on a Waiting List or selected for Enrollment. Registered children are placed on their center's waiting list until space becomes available.
- Please update any changes in your home, mailing or contact information to ensure that you are notified promptly and that your child is placed in the correct school district.
- **IF YOUR CHILD IS SELECTED,** we will contact you to ensure your child will be attending Head Start and that health requirements are met. If we are unable to contact you or your child does not attend school, then your child will be transferred to a **WAITING LIST**.

SCHOOL PLACEMENT

Head Start has 27 centers with a funded enrollment of 534 children. Centers are located in nearly all of the public elementary schools on island. While registration is ongoing throughout the school year, we encourage you to come and find out if you are eligible. There are a limited number of slots per center.

Children will be placed according to school districts with an available Head Start center as determined by Head Start. Special requests for out-of-district placement will be considered based on any of the following: Special Education placement, needs of foster parents, after school care for parents who are working or going to school. Head Start does NOT require school supplies or the use of school uniforms.



Check our website or Facebook page for updates.

Contact the Head Start Central Office for inquiries or special accommodations.

Department of Education
Guam Head Start Program
APPLICATION (Part One)

FOR OFFICAL USE ONLY Center: _____Application Number: _____

CHILD INFORMATION – Child's name MUST reflect birth certificate for documentation purposes.				
Child's Legal Name (Last)	**(First and Middle Initial)**	**Date of Birth**	**Sex**	**Social Security #**

Mailing Address:

City State Zip Code

Citizenship: ☐ U.S. Citizen ☐ FSM Citizen ☐ Belau Citizen ☐ Resident Alien ☐ Non-Resident

RACE (check ALL that apply): ☐ American Indian/Alaskan ☐ Asian ☐ African American [ ]Caucasian [ ]Hispanic
[ ]Pacific Islander [ ]Other(s) – Specify:_____

Child's PRIMARY Language: **Family's PRIMARY Language:**

CHILD'S MEDICAL INFORMATION

Medical Diagnosis: _____ Any prescribed medication(s): _____

Medical Insurance:_____ **Dental Insurance:**_____
Medicaid Status: [ ] Ineligible [ ] Eligible [ ] Applied [ ] Former MIP Status: [ ] Yes [ ] No

Medical Clinic:_____ **Dental Clinic:**_____

HOUSEHOLD PARENT/GUARDIAN INFORMATION

First and Last Name	**DOB**	**Ethnicity (ex. Chamorro, Filipino, etc.)**	**Highest Grade Completed**	**Diploma/GED /NA**	**Occupation**	**Full/Part Time**
[ ]Mother [ ]Guardian [ ]Foster [ ]POA [ ]Not in Household						

Contact Information
H /C /W /e-mail _____

First and Last Name	**DOB**	**Ethnicity (ex. Chamorro, Filipino, etc.)**	**Highest Grade Completed**	**Diploma/ GED /NA**	**Occupation**	**Full/Part Time**
[ ]Father [ ]Guardian [ ]Foster [ ]POA [ ]Not in Household [ ]In Birth Certificate						

Contact Information
H /C /W /e-mail
_____

Number in Family: _____ **Marital Status**: [ ]Single [ ]Married [ ]Divorced [ ]Separated [ ]Widowed [ ]Common-Law
Family's Primary Contact Person for Head Start (MUST be listed above): _____
Are you a former Head Start parent? [ ] Yes [ ] No Are you interested in being a parent volunteer? [ ] Yes [ ] No

OTHER MEMBERS IN HOUSEHOLD SUPPORTED BY THE PARENTS AND GUARDIANS

First and Last Name	**DOB**	**Relation to child: brother, sister, etc.**	**First and Last Name**	**DOB**	**Relation to child: brother, sister, etc.**

EMERGENCY CONTACT INFORMATION (Please list persons not listed in family application)

Name of Adult	**Relationship to Child**	**Phone Numbers**

FAMILY INFORMATION (Check all that apply)

SNAP [ ] Yes [ ] No TANF [ ] Past [ ] Current [ ] Never WIC [ ] Yes [ ] No U.S. Veteran [ ] Yes [ ] No

PARENTS AND GUARDIANS INCOME FROM THE PAST 12 MONTHS THAT SUPPORTED THE FAMILY (Check all that apply)

[ ] Work Income [ ] Rental Income [ ] Gambling/Lottery Winnings [ ] Other: _____
[ ] Retirement [ ] Social Security [ ] Self Employment
[ ] Child Support [ ] Alimony [ ] Unemployment Compensation (May need to provide Statement of Support, Unemployment Verification, or other supporting documents)
[ ] Recycling Income [ ] Food Sales [ ] Flea Market Sales
[ ] Pell Grant/Scholarships /Work Study [ ] Veterans Benefits [ ] Military Family Allotment
[ ]Child Care Assistance [ ] GHURA Section 8 [ ] GHURA Utility Reimbursement [ ] GHURA Public Housing

FOR OFFICAL USE ONLY Center: _____Application Number: _____

MAP TO RESIDENCE

Child's Name: _____
Primary Parent: _____Secondary Parent: _____
Primary Contact Numbers: H_____ C_____ W_____
Home Address: _____
House Number **Street Name**
Village
House Color: _____ Obvious Landmarks (church, bridge, store, etc.): _____
Housing Status : [ ]Own [ ]Live with Relative/Friends [ ]Rent [ ]GHURA Public Housing [ ] Military/Federal Housing
Type of Building: [ ] Full Concrete [ ] Semi-Concrete [ ] Wooden Frame and Tin [ ] Other _____

CENTER HOURS OF OPERATION / BUSSING SERVICES:

- Morning session of from 8:30am to 12:30pm. Bussing services are provided to and from designated bus stops within the district.
- Afternoon session is from 12:30pm to 4:30pm. Some afternoon sessions have bussing to school. Parents are responsible for transportation after school.
- Full Day session is from 8:30 am to 2:43pm. Bussing services are provided to and from designated bus stops within the district. Parents are responsible for transportation after school.

SCHOOL PLACEMENT: Children will be placed according to school districts with an available Head Start center as determined by Head Start. Special requests for out-of-district placement will be considered based on any of the following: Special Education placement, needs of foster parents, after school care for parents who are working or going to school.

If there is no bussing for my district, I am able to provide transportation as needed. [ ] YES [ ]NO
Are you in need of an OUT OF DISTRICT placement? [ ]No [ ]Yes, Requested Out of District School: _____
Reason: _____
If no space is available at your district school, would you be willing to transport your child to an alternate school? This option will ONLY apply if there is low enrollment at the alternate school and all efforts to recruit within that district have been exhausted. [ ]No [ ]Yes, Requested Alternate School: _____

CHILD'S SPECIAL NEEDS INFORMATION

Disability Status: [ ]None [ ] **Diagnosed** – Attach signed consent and related document (Current IEP)
Do you have concerns about your child's development that have not been evaluated? Check all that apply:
[ ] None [ ]Vision [ ]Developmental [ ]Hearing [ ]Speech [ ] Behavior [ ]Other_____
Attach signed Consent form, Universal Referral form, and completed ASQ and/or ASQ:SE
Has your child ever received services from the following: [ ]Never [ ] Past [ ] Present
[ ] Karinu [ ]Shriners [ ]Special Needs Clinic [ ]GEIS [ ] Isa Psychology [ ]Guam Behavioral Health & Wellness Center
[ ]Other:_____
Any specific family need or crisis at this time? [ ] No [ ] Yes – Specify _____

PLEASE READ BEFORE SIGNING

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT ALL INCOME IS REPORTED. I UNDERSTAND THAT THIS INFORMATION IS GIVEN TO DETERMINE ELIGIBLITY FOR A FEDERAL PROGRAM AND WILL BE VERIFIED FOR ACCURACY. I UNDERSTAND THAT DELIBERATE MISREPRESENTATION OF THE INFORMATION MAY SUBJECT ME TO PROSECUTION UNDER APPLICABLE LOCAL AND FEDERAL LAWS AND MAY RESULT IN MY CHILD'S INELIGIBILITY FOR HEAD START. THIS PROGRAM DOES NOT DISCRIMINATE BASED ON DISABILITY IN ACCORDANCE WITH THE AMERICANS WITH DISABILITIES ACT.

PARENT SIGNATURE: _____ DATE: _____

REVIEWED BY (STAFF SIGNATURE):_____ DATE: _____

Guam Head Start School Readiness Assessment

Help us to identify ways that Head Start can support you in creating positive child outcomes.

Name of Child:_____Registration #:_____Center:_____

Help us identify ways that Head Start can support you in creating positive child outcomes by entering the number that best describes your family in each area of the table below

1 = My family is not sure how to help my child in this area and needs lots of ideas.

2 = My family needs some help finding activities to help my child.

3 = My family knows activities, but wants more ideas.

4 = My family knows a lot of activities in this area and shares this knowledge with others.

PARENT RIGHTS	Prior to SY	Update
I understand my Parent Rights under the Department of Education. 1. I have **limited knowledge** or understanding of Parent Rights under DOE, FERPA, or the IDEA. 2. I have **some knowledg**e of Parent Rights and I know who and where to go to voice their complaints. 3. I have **past experience** using Parent Rights under DOE, FERPA or the IDEA. 4. I am **able to help other parents** to understand their Parent Rights under DOE, FERPA, or the IDEA.		
APPROACHES TO LEARNING	**Prior to SY**	**Update**
Emotional and Behavioral Self-Regulation – We can help our child take care of their feelings; follow classroom rules and routines; take care of classroom materials; and control actions, words, and behavior.		
Cognitive Self-Regulation – We can help our child to control strong feelings and behavior; keep themselves focused on what they are doing; follow directions with some reminders; and think of different ways to do things or solve problems by themselves or with other children.		
Initiative and Curiosity – We can help our child make choices and tell other adults and children; ask questions and look for more information; do new things even if it seems difficult.		
Creativity – We can help our child express their thoughts, feelings, or ideas; think of new ways to solve problems that they might not have thought of before; and use their imagination to play or create things.		
SOCIAL AND EMOTIONAL DEVELOPMENT	**Prior to SY**	**Update**
Relationships with Adults – We can help our child to feel comfortable doing things with other people who they may not know; ask adults for help or permission when needed; and listen to directions from adults.		
Relationships with Other Children – We can help our child to take turns or share toys with other children; develop friendships; play with at least one other child; and express them		
Emotional Functioning – We can help our child express their different feelings through sounds, gestures or words; understand how others are feeling; and show care and concern for others.		
Sense of Identity and Belonging – We can help our child to know their abilities and feelings; to be aware of the thoughts and feelings of others; recognize their name; and know some characteristics that are the same or different between themselves and others.		
LANGUAGE AND COMMUNICATION	**Prior to SY**	**Update**
Attending and Understanding – We can help our child to join in conversations with others; remember directions; and show that they understand questions by using sounds, gestures, or words.		
Communicating and Speaking – We can help our child to explain exactly what they need; use words (spoken or sign) to questions when they do not understand something; communicate clearly; and express themselves in different ways such as using a whisper to tell a secret.		
Vocabulary – We can help our child use two to three new words a day during activities; recognize words; guess the meaning of new words using clues; identify things that are shared in common; and use different words that have similar meanings (such as glad or happy)		
LITERACY	**Prior to SY**	**Update**
Phonological Awareness – We can help our child use words that rhyme and say the beginning sound in a spoken word (such as “Dog begins with d”).		
Print and Alphabet Knowledge – We can help our child understand that words are made by putting letters in a group; identify the parts of a book (such as front, back, title, author); and recognize letters and their sounds.		
Comprehension and Text Structure – We can help our child to re-tell a story that was read; tell a personal story using two to three events that happened; identify characters in a book or story; and ask and answer questions about a book that was read aloud.		
Writing – We can help our child to copy simple words; try to write words on their own; and write their first name.		
MATHEMATICS DEVELOPMENT	**Prior to SY**	**Update**
Counting and Cardinality – We can help our child to count or sign to at least 20 by ones; count up to 5 objects; understand whether the number in one group is more or less than the number in another group; and recognize and write some numbers up to 10.		
Operations and Algebraic Thinking – We can help our child add and subtract with fingers, objects and drawings; and understand simple repeating patterns (such as red, blue, red).		

Measurement – We can help our child measure objects based on height or weight; and use words such as shortest, heavier, or biggest.		
Geometry and Spatial Sense – We can help our child use words to identify, compare and explain positions such as up/down or front/behind.		
SCIENTIFIC REASONING	**Prior to SY**	**Update**
Scientific Inquiry – We can help our child identify the five senses (smell, touch, sight, sound, taste) and use them to make observations; describe things that they observe with their senses (such as lemons taste sour or play dough feels sticky); and use scientific words such as observe, describe, compare, contrast, question, predict, experiment, reflect, cooperate, or measure.		
Reasoning and Problem-Solving – We can help our child ask questions that can be answered through an investigation such as "What do plants need to grow;" make a prediction based on what they know such as "I think that plants need water to grow;" and tell others what happened in their experiment.		
PERCEPTUAL, MOTOR, AND PHYSICAL DEVELOPMENT	**Prior to SY**	**Update**
Health, Safety, and Nutrition – We can help our child dress themselves; brush their teeth on their own; listen to adults when in unsafe situations such as holding an adult's hand to cross the street; understand safety such as not touching a hot stove; tell others what they like to eat; choose healthy foods; and tell adults when they are hungry, thirsty, or have had enough to eat.		

Parent Interest Survey

Head Start provides training, referrals, support, and resources to help meet your family's interests and needs. Please put a check mark (✓) all topics that interest you.

Preventive Health Practices – please specify:

- ☐ Nutrition Education
- ☐ Exercise / Physical Fitness
- ☐ Dental Care
- ☐ Prenatal & Postpartum Care
- ☐ Hypertension / High Blood Pressure
- ☐ Tobacco Cessation (smoking / chewing)
- ☐ Stress/Anger Management
- ☐ Chronic Diseases – Heart disease, Stroke, Cancer, Diabetes, Arthritis, Other – specify:_____

Family Issues – please specify:

- ☐ Effective Parenting and Discipline
- ☐ Effective Communication
- ☐ Fun Activities for Children and Families
- ☐ Helping Children Cope with Loss – Divorce, Separation or Grief
- ☐ Family Literacy – "How to Read to Your Child"
- ☐ Child Growth and Development
  - ☐ Challenging Behaviors
- ☐ Male / Father Involvement Activities
- ☐ Family Planning
- ☐ Guardianship Issues
- ☐ Parent Rights
- ☐ Parenting Teenagers
- ☐ Child Mental Health & Wellness
- ☐ Parenting Children with Special Needs/Disabilities – Specify:_____
- ☐ Parenting Children with Special Health Care Needs – Specify:_____

Issues that Place Families at Risk – please specify:

- ☐ Depression/Extreme Sadness
- ☐ Suicide
- ☐ Maternal Depression
- ☐ Family Violence Prevention
- ☐ Child Abuse & Neglect Prevention
- ☐ Substance Abuse Prevention ☐

Personal Improvement – please specify:

- ☐ GED / Adult High School
- ☐ Time Management
- ☐ Self-Esteem
- ☐ Starting Your Own Business
- ☐ Budgeting and Money Management
- ☐ Job Search
- ☐ Financial Aid –grants/scholarships

Safety Issues – please specify:

- ☐ First Aid & CPR
- ☐ Fire Safety
- ☐ Accident / Injury Prevention
- ☐ Pedestrian Safety
- ☐ Car / Passenger Safety

Other – Specify: _____

- ☐ I would like information presented in my primary language – Specify:_____
- ☐ I am interested in being a Parent Volunteer ☐ Regularly (more than twice a month) ☐ Occasionally

Sometimes families find themselves in difficult situations and may need extra assistance. Head Start staff are available as a source of support during these difficult or stressful times. If we cannot give direct assistance, we will try to connect you to other community support services. Please contact your Family Service Worker if, at any time, you need assistance in any situation, emergency/crisis or otherwise.

PRINT Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Staff: _____ Date: _____

CHILD HEALTH RECORD

CENTER: _____ APPLICATION #:_____

Name of Child: _____ DOB: _____ Gender: [ ] Male [ ] Female

Name of Parent(s)/Guardian(s): _____

Contact Number(s):_____ Email Address:_____

PREGNANCY / BIRTH HISTORY	NO	YES	EXPLAIN "YES" ANSWERS
Did MOTHER have any health problems DURING THIS PREGNANCY OR DURING DELIVERY?			
Did mother visit a Doctor LESS THAN TWO TIMES DURING PREGNANCY?			
Was child born OUTSIDE OF A HOSPITAL?			
Was child born MORE THAN 3 WEEKS EARLY OR LATE?			
What was child's BIRTH WEIGHT?			_____lbs. _____oz.
Did child NEED ADDITIONAL MEDICAL CARE AFTER BIRTH? (Admission to NICU, oxygen, jaundice, etc.)			
Did child or mother STAY IN HOSPITAL FOR MEDICAL REASONS LONGER THAN USUAL?			
Is mother PREGNANT now?			If yes, expected due date:_____
HOSPITALIZATIONS AND ILLNESSES	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Has child ever been HOSPITALIZED OR OPERATED ON?			
Has child ever had a SERIOUS ACCIDENT (broken bones, head injuries, falls, burns, poisoning)?			
Has child ever had a SERIOUS ILLNESS?			
HEALTH PROBLEMS	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Does child have FREQUENT: ___SORE THROAT ___COUGH ___STOMACH PAIN, VOMITING, DIARRHEA ___URINARY TRACT INFECTIONS OR TROUBLE URINATING			
Does child have DIFFICULTY SEEING? (Squint, cross eyes, look closely at books)		★	
Is child WEARING (or supposed to wear) GLASSES?			If yes, LAST VISION EXAM?_____
Does child have problems with EARS/HEARING? (Pain in ear, frequent earaches, discharge, rubbing one ear)		★	
Have you ever noticed child SCRATCHING HIS/HER anus (butt) WHILE ASLEEP?			If yes, this may be a sign of pinworms
Has child had: ___BOILS ___CHICKENPOX ___ECZEMA ___MEASLES ___GERMAN MEASLES ___MUMPS ___SCARLET FEVER ___WHOOPING COUGH ___HEPATITIS ___TUBERCULOSIS			
Has child had: ___HEART/BLOOD VESSEL DISEASE ___ASTHMA ___DIABETES ___EPILEPSY ___LIVER DISEASE ___RHEUMATIC FEVER ___SICKLE CELL DISEASE ___BLEEDING TENDENCIES		★	WHAT MEDICINE?_____
Does child have ALLERGY PROBLEMS (Rash, itching, swelling, difficulty breathing, sneezing)?		★	
a. WHEN EATING ANY FOOD? – *Request for Special Meal Accommodation Due to Medical Condition* must be completed by Physician.	____	____	WHAT FOODS?_____
b. WHEN TAKING ANY MEDICATION?	____		WHAT MEDICINE?_____
c. WHEN NEAR ANIMALS, FURS, INSECT, DUST, ETC? (RASH, itching, swelling, difficulty breathing, sneezing)	____		WHAT THINGS?_____ HOW DOES CHILD REACT?_____
Has child ever had any CONVULSION or SEIZURE?		★	
	____	____	If yes, WHEN DID IT LAST HAPPEN?_____
Is child TAKING MEDICINE FOR SEIZURES?	____	____	WHAT MEDICINE?_____

Is child TAKING ANY MEDICINE NOW? If yes, will it have to be given WHILE CHILD IS AT HEAD START? ***Signed consent & doctor's prescription are required for school nurse to administer any medication.*	____ ____	____ ____	WHAT MEDICINE?_____ HOW OFTEN?_____
Are there ANY CONDITIONS that get in the way of child's EVERDAY ACTIVITIES? Did a DOCTOR OR OTHER HEALTH PROFESSIONAL tell you that child had this problem?	____ ____	____ ____	
Does child need SPECIAL ACCOMMODATIONS WHILE IN SCHOOL? (G-Tube feeding, stroller or walker for mobility, oxygen, etc.)	____	____	
SOCIAL AND EMOTIONAL DEVELOPMENT	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Have there been any BIG CHANGES in your child's life in the LAST SIX MONTHS?			
Does your child SLEEP LESS THAN 8 HOURS A DAY or HAVE TROUBLE SLEEPING (such as being fretful, having nightmares, wanting to stay up late)?			
Does your child WORRY A LOT or is your child *VERY* AFRAID OF ANYTHING?			
Does your child SEEM DEPRESSED or WITHDRAWN?			
Does your child have any UNUSUAL or UNCONTROLLABLE BEHAVIORS?			
Do you have any concerns about HOW YOUR CHILD ACTS WITH ADULTS?			
Do you have any concerns about HOW YOUR CHILD ACTS WITH CHILDREN HIS/HER OWN AGE?			
Do you have any concerns about HOW YOUR CHILD ACTS AT HOME OR IN THE COMMUNITY?			
Has your child ever experienced NEGLECT?			
Has your child ever experienced PHYSICAL OR SEXUAL ABUSE?			
Has your child ever been exposed to VIOLENT BEHAVIOR or TRAUMA?			
Do you want your child REFERRRED FOR FURTHER EVALUATION of a SOCIAL-EMOTIONAL concern? ***If YES, complete Universal Referral and ASQ and/or ASQ:SE***			
CHILD DEVELOPMENTAL CONCERNS	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
Does your child have a CERTIFIED DISABILITY?			
Is your child CURRENTLY RECEIVING SERVICES for a DISABILITY or DEVELOPMENTAL CONCERN?			___GEIS ___SPED Preschool ___Karinu ___Shriners ___Special Needs Clinic ___GBHWC ___ Other: _____
Do you have any OTHER CONCERNS about your child's development?			
Do you want your child REFERRRED FOR FURTHER EVALUATION of a SUSPECTED developmental concern? ***If YES, complete Universal Referral and ASQ and/or ASQ:SE***			

SIGNATURE OF PARENT/GUARDIAN: _____ DATE:_____

Guam Head Start Program
Nutrition Profile

CHILD'S NAME: _____Center:_____ Application #:_____

CHILD'S GROWTH INFORMATION	YES	NO
BODY SHAPE HAS CHANGED OVER THE PAST FEW MONTHS [ ] MORE SLIM [ ] MORE HEAVY		
CHILD'S EATING PATTERN	**YES**	**NO**
EATS _____ MEALS A DAY EATS _____ SNACKS A DAY		
EATS BETWEEN MEALS		
ENJOYS EATING MEALS AND SNACKS		
ALLOWED TO CHOOSE: [ ] WHETHER OR NOT TO EAT [ ] HOW MUCH TO EAT [ ] WHAT TO EAT		
NEW FOODS: REACTION TO NEW FOOD: [ ] ACCEPTS [ ] IFFY [ ] REFUSES RECENT NEW FOOD: _____ CHILD'S REACTION:_____		
NEW FOODS ARE OFFERED WITH FAMILIAR FOOD		
DIET: EATS MILK, CHEESE, OR YOGURT – _____ TIMES A DAY		
EATS VEGETABLES – _____ TIMES A DAY		
EATS FRUITS – _____ TIMES A DAY		
EATS MEAT, FISH, EGGS, OR PEANUT BUTTER (PROTEIN) – _____ TIMES A DAY		
EATS RICE, BREAD, CEREAL, ETC. (GRAINS) – _____ TIMES A DAY		
EATS BUTTER, MARGARINE, COOKING OILS (FRIED FOOD) – _____ TIMES A DAY		
EATS DIRT OR OTHER OBJECTS THAT ARE NOT FOOD – DESCRIBE_____		
DRINKS: _____# OF GLASSES OF WATER A DAY _____# OF GLASSES OF SODA OR TEA A DAY _____# OF GLASSES OF JUICE A DAY – 100% JUICE: [ ]YES [ ] NO		
FEEDING SKILLS: [ ] ABLE TO FEED SELF [ ] CHEWS FOOD WELL **USES:** [ ] SPOON [ ] FORK [ ] KNIFE [ ] FINGERS [ ] OPEN CUP [ ] SIPPY CUP [ ] BOTTLE [ ] STRAW		
IS CHILD ALLERGIC TO ANY FOOD? IF "YES," SPECIFY WHICH FOOD:_____ **Submit doctor's note for any allergies* **ALLERGIC REACTION:** [ ] RASH [ ] ITCHING [ ] SWELLING [ ] SNEEZING [ ] DIFFICULTY BREATHING		
DOES CHILD REQUIRE A **SPECIAL DIET**? IF "YES," SPECIFY:_____ **Submit "Request for Special Meal Accommodation due to Medical Condition" form completed by Physician*		

DOES YOUR CHILD TAKE VITAMINS? IF "YES" SPECIFY WHAT KIND:_____		
HYGIENE: WASHES HANDS BEFORE EATING OR TOUCHING FOOD		
FAMILY MEAL AND SNACK PRACTICES	**YES**	**NO**
FAMILY EATS TOGETHER AT A TABLE - IF "NO," OTHER PRACTICE_____		
CONVERSATION IS ALLOWED DURING MEALS		
DISTRACTIONS ARE KEPT TO A MINIMUM (TV, TOYS, PHONE, ETC.)		
WANDERING OR PLAYING IS ALLOWED AT THE TABLE OR DURING MEALS		
PARENTS /ADULTS: [ ] EAT MEALS WITH KIDS [ ] EAT SNACKS WITH KIDS [ ] EAT SAME MEALS AS KIDS		
PARENTS /ADULTS USE FOOD AS A REWARD AND/OR PUNISHMENT		
FAMILY EATS AT HOME		
FAMILY EATS AT RELATIVE'S HOUSE (GRANDMA, AUNT, ETC.) _____ TIMES A WEEK		
FAMILY EATS OUT _____TIMES A WEEK FAVORITE PLACE TO EAT:_____		
DENTAL CARE	**YES**	**NO**
BRUSHES TEETH _____ TIMES A DAY WHEN? _____ [ ] BY SELF [ ] DOES NOT BRUSH TEETH AT ALL [ ] NEEDS HELP [ ] BY PARENT OR OTHER ADULT		
HAS HAD FLUORIDE VARNISH TREATMENT – IF "YES," DATE OF LAST TREATMENT:_____		

MY CHILD'S FAVORITE FOODS ARE:_____

_____

MY CHILD DOES NOT LIKE TO EAT:_____

_____

PARENT CONCERNS THAT HEAD START NEEDS TO KNOW ABOUT:_____

_____

PARENT CONCERNS THAT MY FAMILY NEEDS HELP WITH:_____

_____

Signature of Parent/Guardian: _____ **Date:**_____

Guam Head Start Program
School Year 2021 – 2022

REGISTRATION SURVEY

Buenas! Please complete this survey to help Head Start prepare for the upcoming school year. Your responses will provide critical information allowing us to meet compliance with COVID-19 regulations. GDOE is working very closely with local public health agencies to ensure your child's health and safety during this pandemic.

Child's name:	Center	Registration Number:	Date Completed

Learning Models: As part of GDOE, Head Start will follow GDOE plans for the reopening of school.

- At this time, there will likely be both face-to-face classes and online/virtual classes.
- All students will be contacted weekly by Teaching Staff for routine Parent-Child Intervention to work with you and your child individually, discuss your child's progress, and provide strategies to help your child meet their school readiness goals.

Please select your preferred Model of Learning for your child below:

FIRST CHOICE

- ☐ Traditional/face-to-face class only
- ☐ Traditional/face-to-face class with hard copy learning packets
- ☐ Online/virtual class only
- ☐ Online/virtual class with hard copy learning packets

SECOND CHOICE

(If there is no available slot for face-to-face classes *OR* if schools close after reopening)

- ☐ Traditional/face-to-face class only
- ☐ Traditional/face-to-face class with hard copy learning packets
- ☐ Online/virtual class only
- ☐ Online/virtual class with hard copy learning packets

Equipment: Which of the following item(s) does your child have access to? *(Select all that apply)*

- ☐ Desktop computer
- ☐ Laptop
- ☐ Tablet or iPad
- ☐ Landline telephone
- ☐ Smartphone (with data or Wi-Fi)
- ☐ Printer
- ☐ Scanner
- ☐ Smart TV
- ☐ Regular TV
- ☐ None of the above

Internet Access: *(Select all that apply)*

- ☐ My child has access to **reliable** internet (Wi-Fi or wired) on a computer, tablet or other device.
- ☐ My child has access to **reliable** internet on a cell phone (data service).
- ☐ My child DOES NOT have **reliable** access to the internet.

Transportation:

1. When the school year opens, how will your child be getting to school if in traditional/face-to-face classes?
   ☐ My child will be riding the bus.
   ☐ I will be walking or transporting my child to & from school.
2. Do you have reliable transportation to pick up and return weekly learning packets? ☐ Yes ☐ No
   - List name(s) of other persons authorized to pick up learning packets:

     _____

Child Developmental Concerns:

1. Is your child able to wear a mask for extended periods?
   ☐ Yes ☐ No, Why not?_____
2. Is your child CURRENTLY RECEIVING SERVICES for a DISABILITY or DEVELOPMENTAL CONCERN?
   ☐ Yes - Specify:_____ ☐ No
3. Do you have CONCERNS about your child's development that have NOT yet been evaluated?
   ☐ None ☐ Vision ☐ Developmental ☐ Hearing ☐ Speech ☐ Behavior ☐ Other_____

Food Security:

1. Over the last 30 days, the food that I bought just DID NOT LAST, and I did not have the money to buy more.[ ] Often true [ ] Sometimes true [ ] Never true [ ] I don't know
2. Over the last 30 days, I WORRIED about whether our food would run out before I had money to buy more.
   ☐ Often true ☐ Sometimes true ☐ Never true ☐ I don't know
3. Over the last 30 days, I couldn't afford to eat balanced meals.
   ☐ Often true ☐ Sometimes true ☐ Never true ☐ I don't know
4. Did you EVER have to cut the size of your meals because there wasn't enough money for food?
   ☐ Yes ☐ No ☐ I don't know

ReadyRosie: Head Start follows a two-generational approach to learning. This means that while Teaching Staff are working with your child, Family Services Staff will be working with your family. We will be using a resource called ReadyRosie to communicate with you and to provide meaningful activities that you can do at home to support your child's learning. ReadyRosie is a simple tool for you to:

- Discover activities and games you can play that relate to classroom learning
- Have more fun than ever with your child through meaningful interactions

The best part is that each activity/ game is modeled in a 2 minute video so you and your child can watch together and then play the game! You will receive these videos and communication via text message and/ or email. ***Please provide an email address and/ or mobile phone to receive the invitation to register:***

Name of Parent or Caregiver	Name of Parent or Caregiver
Email Address:	Email Address:
Cell phone:	Cell phone:

Questions/Comments: _____

_____