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:_____

Use this scale to help us identify ways that we can support you in creating positive child outcomes.

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; use different words that have similar meanings (such as glad or happy); and tell the difference between similar words (such as “I don’t like it, I love it!”).		
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.		

FOOD SECURITY **The next section has statements people have made about their food situation.** **Choose the answer that <u>best</u> fits your food situation over the last 30 days.**	**Prior to SY**	**Update**
The food that I bought just didn't last, and I didn't have money to buy more. **1** - I don't know **2** - Often true **3** - Sometimes true **4** - Never true		
I couldn't afford to eat balanced meals. **1** - I don't know **2** - Often true **3** - Sometimes true **4** - Never true		
Did you ever cut the size of your meals or skip meals because there wasn't enough money for food? **1** - I don't know **2** - Yes **3** - No		

Supporting Learning During Temporary School Closures

Throughout the pandemic, the Office of Head Start (OHS) has approved virtual and remote services during **TEMPORARY school closures** due to emergencies, disasters, or other weather-related closures. Thus, if centers TEMPORARILY CLOSE at any time during the year, then teaching staff will transition to virtual or remote services (depending upon the capacity of the family) within 24 hours of shutdown until the center reopens.

What is your preferred model of learning for YOUR Head Start child DURING TEMPORARY SCHOOL CLOSURES?

☐ VIRTUAL online learning ☐ REMOTE learning (educational materials or individual teacher-parent contacts)

Does your child have access to <u>equipment</u> needed for online class?

☐ Yes ☐ No ☐ Maybe - Several children must share the equipment

Does your child have <u>internet access</u> needed for online class?

☐ Yes ☐ No ☐ Maybe - Our internet is unreliable.

Sometimes families find themselves in difficult situations and may need extra assistance. Contact your Family Service Worker if, at any time, you need assistance in any situation, emergency/crisis or otherwise. If we cannot give direct assistance, we will try to connect you to other community support services.

PRINT Name of Parent/Guardian: _____

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

Signature of Staff: _____ **Date:** _____

GUAM HEAD START PROGRAM Application #:_____

PARENT INTEREST SURVEY

Name of Child:_____Center: _____

Head Start provides training, referrals, support, and resources to help meet your family's interests and needs. Please put a check mark (☐) by the topics that are of interest to you. Select as many topics as you like

Preventive Health Practices – please specify:

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

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
- ☐ Parenting Children with Special Needs/Disabilities – Specify:_____
- ☐ Parenting Children with Special Health Care Needs – Specify:_____
- ☐ Male / Father Involvement Activities
- ☐ Family Planning
- ☐ Guardianship Issues
- ☐ Parent Rights
- ☐ Parenting Teenagers
- ☐ Child Mental Health & Wellness

Issues that Place Families at Risk – please specify:

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

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 topic(s): _____

- ☐ 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 (once or twice a month)
  - ☐ Not Interested

Sometimes families find themselves in difficult situations and may need extra assistance. Please contact your Family Service Worker if, at any time, you need assistance in any situation. If we cannot give direct assistance, we will connect you to other community support services.

ReadyRosie

EVERY CHILD CAN BE READY TO LEARN WHEN SCHOOLS AND FAMILIES WORK TOGETHER

While Teaching Staff are working with your child, Family Services Staff will be working with your family to provide fun 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. 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(s) or Caregiver(s):_____

Email Address: _____ Cell phone:_____

Name of Parent(s) or Caregiver(s):_____

Email Address: _____ Cell phone:_____

Signature of Parent/Guardian: _____ Date: _____

CHILD HEALTH RECORD

APPLICATION #:_____

Name of Child: _____ DOB:_____ Gender: ☐ Male ☐ Female

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

PREGNANCY / BIRTH HISTORY	NO	YES	EXPLAIN "YES" ANSWERS
DID MOTHER HAVE ANY HEALTH PROBLEMS DURING THIS PREGNANCY OR DURING DELIVERY?	☐	☐	
DID MOTHER VISIT PHYSICIAN FEWER 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 YOUR 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 BEHIND (Rear end, anus, butt) WHILE ASLEEP? (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. b. WHEN TAKING ANY MEDICATION? c. WHEN NEAR ANIMALS, FURS, INSECT, DUST, ETC? (RASH, itching, swelling, difficulty breathing, sneezing)	☐ ☐ ☐ ☐	★ ☐ ☐ ☐ ☐	WHAT FOODS?_____ WHAT MEDICINE?_____ 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? WILL IT NEED TO BE GIVEN WHILE CHILD IS AT HEAD START? ***Signed consent & doctor's prescriptions are required for School Health Counselors to administer any medication.*	☐ ☐	☐ ☐	WHAT MEDICINE?_____ HOW OFTEN?_____
SOCIAL AND EMOTIONAL DEVELOPMENT – This will help us identify if additional screening may be needed upon enrollment.	**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 UNUSUAL OR UNCONTROLLABLE BEHAVIORS?	☐	☐	
DO YOU HAVE CONCERNS ABOUT HOW YOUR CHILD ACTS WITH ADULTS?	☐	☐	
DO YOU HAVE CONCERNS ABOUT HOW YOUR CHILD ACTS WITH CHILDREN HIS/HER OWN AGE?	☐	☐	
DO YOU HAVE ANY CONCERNS REGARDING YOUR CHILD'S BEHAVIOR 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?	☐	☐	
DEVELOPMENTAL CONCERNS and/or SPECIAL NEEDS and ACCOMMODATIONS	**NO**	**YES**	**EXPLAIN "YES" ANSWERS**
ARE THERE ANY CONDITIONS THAT GET IN THE WAY OF YOUR CHILD'S EVERYDAY ACTIVITIES? DID A DOCTOR OR OTHER HEALTH PROFESSIONAL TELL YOU YOUR CHILD HAD THIS PROBLEM?	☐ ☐	☐ ☐	
DOES YOUR CHILD HAVE A CERTIFIED DISABILITY?	☐	☐	
IS YOUR CHILD CURRENTLY RECEIVING SERVICES RELATED TO A DISABILITY OR DEVELOPMENTAL CONCERN?	☐	☐	☐ GEIS ☐ SPED Preschool ☐ Karinu ☐ Shriners ☐ Special Needs Clinic ☐ GBHWC ☐ Other: _____
DOES YOUR CHILD NEED SPECIAL ACCOMMODATIONS WHILE IN SCHOOL? (G-TUBE FEEDING, STROLLER OR WALKER FOR MOBILITY, OXYGEN, ETC.)	☐ ☐	☐ ☐	
DO YOU WANT YOUR CHILD REFERRED 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:**_____