PARENT(S)/GUARDIAN(S):

Please read the forms very carefully.

Please **sign each statement** to indicate that you understand and agree to each statement and/or policy.

These **forms must be returned** to the Center before or on the day your child begins classes.

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ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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Child Name:_____ Child's Date of Birth:_____
(Please Print)

Parent/Guardian Name:_____
(Please Print)

ARRIVAL & DEPARTURE PLAN: Early Head Start, Head Start and Child Care

I give permission for my child to be released from the center at the end of the program day to the designated person(s) listed below and in the manner noted above. If **only** the parent/legal guardian is authorized to pick up the child, indicate below "NO ONE". **If a child is covered under a restraining order, you must submit a copy of that order to the center.**

Please CHECK if the person named is to Pick Up only, Emergencies only, or is available for BOTH activities.

1. Name_____ ☐ **PICK UP** ☐ **EMERGENCIES** ☐ **BOTH**

Relationship_____ **Daytime Phone**_____

Address_____ **Cell Phone**_____

2. Name_____ ☐ **PICK UP** ☐ **EMERGENCIES** ☐ **BOTH**

Relationship_____ **Daytime Phone**_____

Address_____ **Cell Phone**_____

3. Name_____ ☐ **PICK UP** ☐ **EMERGENCIES** ☐ **BOTH**

Relationship_____ **Daytime Phone**_____

Address_____ **Cell Phone**_____

My child will ARRIVE at the Early Head Start, Head Start or Child Care Center:

- ☐ Parent/Guardian Drop Off
- ☐ Supervised walk in the company of a person 14 years or older (Head Start) or an adult (Early Head Start)
- ☐ By MBTA (train/bus) in the company of a person 14 years or older (Head Start) or an adult (Early Head Start)
- ☐ Private transportation arranged or hired by the parent
- ☐ Private transportation arranged by the local public school system or DCF
- ☐ Other *(Be specific)*_____

My child will DEPART the Early Head Start, Head Start or Child Care Center:

- ☐ Parent/Guardian Drop Off
- ☐ Supervised walk in the company of a person 14 years or older (Head Start) or an adult (Early Head Start)
- ☐ By MBTA (train/bus) in the company of a person 14 years or older (Head Start) or an adult (Early Head Start)
- ☐ Private transportation arranged or hired by the parent
- ☐ Private transportation arranged by the local public school system or DCF
- ☐ Other *(Be specific)*_____

PARENT/GUARDIAN SIGNATURE: **DATE:**

ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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SCREENING PERMISSION: I give permission to ABCD staff to conduct the following screenings as part of regular Head Start services as described on pages 19 - 20 of the handbook:

Vision: The Health staff check your child's vision using the SPOT Vision Screener and Near Visual Acuity screening tools. This is done to assess the risk of your child having vision problems. Head Start Performance Standards require that a vision screening be conducted within the first 45 days of child's enrollment.

Hearing: The Health staff checks your child's hearing using an OAE hearing screening tool to detect if your child has a hearing problem. Head Start Performance Standards require that a hearing screening be conducted within the first 45 days of child's enrollment.

Height/Weight: The Health staff weigh and measure each child twice a year using scales and a stadiometer to ensure appropriate growth rate. These screenings are done in a group atmosphere, and most children really enjoy the activity.

The purpose of these screenings is to provide you and the staff with a brief check of your child's health and development. Some screening results may indicate the need for further evaluation. If there is any indication that further evaluation is needed, you will be informed and included in designing a plan that best meets your child's needs. If you have questions, you should contact your program's Health & Nutrition Services Manager for questions regarding vision and hearing screenings or heights and weights. **Check the box below only if you DO NOT want staff to conduct the above mentioned screenings.**

☐ **No,** I do not give my permission for ABCD Head Start staff to conduct vision, hearing, or height/weight screenings.

PARENT/GUARDIAN SIGNATURE: **DATE:**

CONSENT TO RELEASE PERSONAL INFORMATION TO MASSACHUSETTS WIC PROGRAM:

Child Legal Name:_____ Child's Date of Birth:_____
(Please Print)

Address:_____ Phone Number:_____

Please read this form carefully and check one of the boxes below before signing this consent. ABCD Head Start & Children's Services provides high-quality health, oral health, mental health, and nutrition services to support each enrolled child's growth and school readiness. The purpose of this consent is to permit ABCD to share certain demographic and health information on your child listed above with authorized staff of the Massachusetts Department of Public Health who administer the Supplemental Nutrition Program for Women Infants and Children (WIC). Sharing of this information is intended to increase enrollment in WIC and Head Start and to facilitate coordination of health and nutrition services in order to improve health education and well-being of individuals who are participants in the Massachusetts WIC program and are enrolled in ABCD's Head Start/Early Head Start program.

☐ I authorize ABCD Head Start & Children's Services to share with authorized staff of the Massachusetts Department of Public Health who administer the Massachusetts WIC program (WIC Program Staff) my name and my address and the following personal information about my child listed above: (1) name; (2) date of birth; (3) height and weight measurement values; (4) hemoglobin/hematocrit values; (5) dietary intake; and (6) lead levels.

OR

☐ I authorize ABCD Head Start & Children's Services to share with WIC Program Staff the following information only: (1) my name; (2) my address; (3) my child's name; and (4) my child's date of birth.

I have read and understand this form and my questions about it have been answered. I understand that this consent is voluntary and will be effective for one year from the date listed below, unless I notify ABCD Head Start & Children's Services sooner in writing that I am withdrawing my consent in whole or in part. I understand that withdrawal of this consent cannot apply to information that was shared before the consent was revoked. I understand that I have a right to receive a copy of this form after I have signed it.

PARENT/GUARDIAN PRINTED NAME:

PARENT/GUARDIAN SIGNATURE: **DATE:**

ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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AUTHORIZATION TO RELEASE HEALTH INFORMATION:

Child Name:_____ Child's Date of Birth:_____
(Please Print)

Parent/Guardian Name:_____
(Please Print)

We understand that your child's health information is personal, and we will protect the privacy of that information. We need your permission before we can get your child's health information from your child's health care providers. ABCD Head Start staff will help you complete the form and answer any questions you may have. Please read the information below carefully before signing this form.

	Name & Address	Phone	Fax
Medical			
Dental			

I authorize ABCD Head Start & Children's Services to release and/or obtain my child's health information as described in pages 24 - 25 of this handbook.

By signing this permission form, you authorize the use or sharing of your child's protected health information as described above. You have a right to see and copy the health information described on this permission form. You also have a right to receive a copy of this form after you have signed it.

If you sign this permission, you can change your mind at any time, except if health information has already been shared based upon your authorization. To cancel this permission, please provide written notification to the Program Director at your child's Head Start Center.

I have read this form and all of my questions about this form have been answered. By signing, I acknowledge that I have read and accept all of the above.

☐ **No,** I do not authorize ABCD Head Start & Children's Services to release and/or obtain my child's health information. ***If you do not sign this permission Head Start & Children's Services will not be able to get your child's health information directly from his/her health care providers and you will be responsible for obtaining and submitting it to the Center. This also means that ABCD Head Start & Children's Services will not share your child's health information with your child's providers and that you will be responsible for providing them with that information directly.***

PARENT/GUARDIAN SIGNATURE: **DATE:**

SUNBLOCK ADMINISTRATION CONSENT:

I give my permission to ABCD staff to administer sun block lotion to my child. I understand this lotion will be used for outdoor activities in summer time. **Check the box below only if you DO NOT want staff to administer sun block.**

☐ **No,** I do not give my permission to ABCD staff to administer sun block.

PARENT/GUARDIAN SIGNATURE: **DATE:**

HAND SANITIZER ADMINISTRATION CONSENT:

I give my permission to ABCD staff to administer hand sanitizer to my child. I understand that hand sanitizer will not be used in lieu of handwashing, and only administered under staff supervision. It will be used only when hand washing is not available. Hand sanitizers will have at least 60 percent ethanol or at least 70 percent isopropanol. Children under age two will not be administered hand sanitizer under any circumstances. **Check the box below only if you DO NOT want staff to administer hand sanitizer.**

☐ **No,** I do not give my permission to ABCD staff to administer hand sanitizer.

PARENT/GUARDIAN SIGNATURE: **DATE:**

ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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FIRST AID/EMERGENCY PERMISSION FORM — School Year 2024-2025

Name of Child:_____ Birth Date:_____
(Please Print)

Name of Parent/Guardian:_____ Daytime Phone:_____
(Please Print)

Address:_____

Emergency Name:_____ Emergency Phone:_____
(Please Print)

As parent/legal guardian, I give my permission to ABCD Head Start and Children's Services staff who has been certified in Pediatric **First Aid** and CPR to provide First Aid treatment to my child as needed and if necessary, to transport my child to

the _____ hospital or nearest medical facility to receive emergency care. In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I give consent for the emergency contact person listed above to act on my behalf until I am available. In the event that no one can be reached, I hereby authorize and request that the physician or trained emergency team of the treatment facility perform proper procedures and medical treatment needed for my child.

I agree to review and update this information whenever a change occurs.

PARENT/GUARDIAN SIGNATURE: **DATE:**

Both copies must have original signature **File: Classroom First Aid Kit**

FIRST AID/EMERGENCY PERMISSION FORM — School Year 2024-2025

Name of Child:_____ Birth Date:_____
(Please Print)

Name of Parent/Guardian:_____ Daytime Phone:_____
(Please Print)

Address:_____

Emergency Name:_____ Emergency Phone:_____
(Please Print)

As parent/legal guardian, I give my permission to ABCD Head Start and Children's Services staff who has been certified in Pediatric First Aid and CPR to provide First Aid treatment to my child as needed and if necessary, to transport my child to

the_____hospital or nearest medical facility to receive emergency care. In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I give consent for the emergency contact person listed above to act on my behalf until I am available. In the event that no one can be reached, I hereby authorize and request that the physician or trained emergency team of the treatment facility perform proper procedures and medical treatment needed for my child.

I agree to review and update this information whenever a change occurs.

PARENT/GUARDIAN SIGNATURE: **DATE:**

Both copies must have original signature **File: Child's File** **8/2024**

ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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CHILD'S MEDICAL INFORMATION

Child's Health Care Provider:_____

Address:_____

Telephone Number:_____

Child's Health Insurance:_____

Child's Special Conditions, Disabilities, Allergies, and Medical Information for Emergency Situations

_____

_____

_____

_____

_____

Child's Picture

CHILD'S MEDICAL INFORMATION

Child's Health Care Provider:_____

Address:_____

Telephone Number:_____

Child's Health Insurance:_____

Child's Special Conditions, Disabilities, Allergies, and Medical Information for Emergency Situations

_____

_____

_____

_____

_____

Child's Picture

ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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MASSACHUSETTS DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION (DESE)
OFFICE FOR FOOD AND NUTRITION PROGRAMS

Child Enrollment Documentation Requirement
Child and Adult Care Food Program – Child Care Centers

Child Care Centers that participate in the Child and Adult Care Food Program (CACFP) are required to annually collect enrollment information from parents and guardians.

Documentation of enrollment must include:
- Each enrolled child's normal days and hours in care and the meal services in which each child normally participates
- Signature of parent or guardian
- Annual updating of the information.

7 CFR 226.15(e)(2) & 226.17(b)(7)

To document enrollment information, child care centers may use the attached CACFP Enrollment Forms or adapt their own form. An adapted form must incorporate the same questions and their intent from the DESE Child Enrollment Form. Sponsors and centers electing to revise the enrollment form must submit a copy to DESE for review and approval prior to use and distribution.

The parent/guardian must complete the form in full with current information, sign, and date the form.

Centers may not claim reimbursement for any participant without a parent/guardian signed enrollment form (new or renewal) on file. Each child enrollment form is effective for a maximum of one year.

Sponsors and centers must perform edit checks for clerical accuracy confirming data entered on all child enrollment forms.

If you have any question about the requirement for collection of enrollment information, please contact DESE Special Nutrition Services at 781-338-6480.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. mail:
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or
2. fax:
(833) 256-1665 or (202) 690-7442; or
3. email:
program.intake@usda.gov

This institution is an equal opportunity provider.

ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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CHILD ENROLLMENT FORM — Child & Adult Care Food Program

Dear Parent/Guardian:

Your child care center_____participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, the child care center has agreed to follow the USDA guidelines. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP.

In an effort to assess that these requirements are being met, the USDA and CACFP requires child care centers to annually collect the enrollment information listed below.

Please complete the form and return it to your child care center. Part 1 and Part 3 need to be completed by all families or guardians. Part 2 is to be completed ONLY if enrolling an infant child (under the age of 12 months).

PART 1: CHILD ENROLLMENT INFORMATION

Child's Name:_____ Child's Date of Birth & Age:_____
(Please Print) *(First Name, Last Name)*

Times Child Normally Attends Hours From: _____ AM to _____ PM Beginning Date of Child Care:_____
(For example 7:30 AM – 5:00 PM)

Check the days your child normally attends: ■ Monday ■ Tuesday ■ Wednesday ■ Thursday ■ Friday

Check the meals you request that your child receives while in care: ■ Breakfast ■ Lunch ■ PM Snack

Second Child *(if applicable)*

Child's Name:_____ Child's Date of Birth & Age:_____
(Please Print) *(First Name, Last Name)*

Times Child Normally Attends Hours From: _____ AM to _____ PM Beginning Date of Child Care:_____
(For example 7:30 AM – 5:00 PM)

Check the days your child normally attends: ■ Monday ■ Tuesday ■ Wednesday ■ Thursday ■ Friday

Check the meals you request that your child receives while in care: ■ Breakfast ■ Lunch ■ PM Snack

Third Child *(if applicable)*

Child's Name:_____ Child's Date of Birth & Age:_____
(Please Print) *(First Name, Last Name)*

Times Child Normally Attends Hours From: _____ AM to _____ PM Beginning Date of Child Care:_____
(For example 7:30 AM – 5:00 PM)

Check the days your child normally attends: ■ Monday ■ Tuesday ■ Wednesday ■ Thursday ■ Friday

Check the meals you request that your child receives while in care: ■ Breakfast ■ Lunch ■ PM Snack

If there are other children in care, please complete additional forms as needed.

FOR SPONSOR OFFICE USE ONLY
Effective Date of this Enrollment Form: August 2024 through August 2025 Fiscal Year: 2024-2025
The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

ABCD HEAD START & CHILDREN'S SERVICES ENROLLMENT FORMS: 2024-2025 PROGRAM YEAR

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PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The child care center must meet the meal component requirements based on age and developmental readiness outlined in the Infant Meal Pattern. **Parents/Guardians may supply not more than one required component per meal in the meal pattern (including breast milk or formula) in order for the meal to be reimbursable in CACFP.**

I understand that this child care center has available the iron fortified formula_____ for my infant while in care.
(Name of Iron Fortified Infant Formula)

To help provide the best nutritional care for your infant, please complete the following information.

PLEASE CHECK ONE OPTION (Breast Milk / Formula):

- ☐ I will supply expressed (pumped) breast milk for my infant child and/or breast feed at center. **OR** I will supply formula for my infant child.
- ☐ I prefer to have the center supply the formula offered.

PLEASE CHECK ONE OPTION (Food Items):

- ☐ I will supply all food items for my infant's meals. I decline food items provided by the provider/center.
- ☐ I have elected to have the provider/center supply the formula and I wish to provide one food item. I will provide the following one creditable food item:_____
- ☐ I would like provider/center to provide all food items for my infant's meals.

PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form.

PARENT/GUARDIAN SIGNATURE: **DATE:**

Name of Parent/Guardian:_____ Home Phone:_____
(Please Print)

Mailing Address:_____ Work Phone:_____

City, State, Zip:_____ Cell Phone:_____

CIVIL RIGHTS: This information is voluntary and will not affect your children's eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander

For questions please contact:
ABCD Head Start & Children's Services
178 Tremont St. Boston, MA 02111
617.348.6272

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In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

This institution is an equal opportunity provider.

COVID-19 AT-HOME TESTING PROGRAM

Child Name:_____
(Please Print)

Through my completion of this form, I opt-in to ABCD's COVID-19 at-home testing program. I understand that, pursuant to this program, if my child attends a class where another student or staff member has tested positive for COVID-19, ABCD will send my child home with antigen COVID-19 tests. In order for my child to continue to attend class at ABCD in the days following the exposure to COVID-19, I must administer the COVID-19 tests to my child at home and report the results on the Parent/Guardian Attestation Form on the 6th day, 8th day, and 10th day after exposure.

I understand that, at any time, I have the option to opt-out of the COVID-19 at-home testing program. However, if I opt-out, my child will still be required to follow all health restriction guidelines provided in the parent handbook.

I acknowledge that by opting into this program, I will only receive COVID-19 tests if my child has been exposed to COVID-19 in an ABCD Head Start & Children Services classroom. If my child is exposed to COVID-19 outside of the ABCD Head Start & Children Services program, I confirm that I will follow CDC guidance on preventing exposure to others.

If my child tests positive or exhibits symptoms of COVID-19, I will keep my child home until symptoms have resolved and they are fever free without the use of fever reducing medication for 24 hours accordance with CDC guidance.

I authorize ABCD to disclose this information to the Massachusetts Department of Public Health, the Massachusetts Executive Office of Health and Human Services, the Massachusetts Department of Early Education and Care and/or any other governmental entity as required by applicable law and governmental guidance.

☐ **No,** I do not plan to test my child at home. If my child attends a class where another student or staff member has tested positive for COVID-19, my child will be asked to use a mask if age appropriate, and will be restricted from attending the program if they show symptoms of COVID-19

PARENT/GUARDIAN PRINTED NAME:

PARENT/GUARDIAN SIGNATURE: **DATE:**

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BOSTON UNIVERSITY GOLDMAN SCHOOL OF DENTAL MEDICINE (GSDM)'S ABCD HEAD/EARLY HEAD START DENTAL HEALTH PROGRAM *Program Coordinator, Kathy Lituri, RDH, MPH, 617.358.6453*

Child Name:_____ ABCD Site:_____
(Please Print)

Child's Date of Birth:_____ Classroom:_____

Child's Gender: ☐ Male ☐ Female ☐ Head Start ☐ Early Head Start

☐ **YES,** I give permission for my child to receive a dental exam, fluoride varnish application and sealants *(if needed). Please complete and return this form.*

OR

☐ **NO,** I do NOT give permission for my child to participate in the program.
***If no,** check the reason and return this form.* ☐ My child has a dentist. ☐ Other:_____

1. What language does *your child* speak best?_____
What language does *parent/guardian* speak at home?_____

2. What is *your child's* race and ethnicity? *(Please select all that apply)*
☐ American Indian/Alaskan Native ☐ Black/African American ☐ Asian ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Brazilian ☐ Hispanic

3. Has your child been to a medical doctor for a checkup in the past year? ☐ YES ☐ NO

4. Has your child been to the dentist for a checkup in the past year? ☐ YES ☐ NO

5. Is your child taking any medication now? ☐ YES ☐ NO
If yes, please list medications:_____

6. Please check any illnesses or conditions your child has EVER had:
☐ ADD/ADHD ☐ Diabetes ☐ Hepatitis ☐ Liver Problems ☐ Anemia
☐ Convulsions/Seizures ☐ Epilepsy ☐ Heart Murmur ☐ Rheumatic Fever ☐ Asthma
☐ Allergies to Medicine ☐ Heart Conditions ☐ Kidney Problems ☐ Tuberculosis ☐ HIV/AIDS

7. Does your child have any other health conditions? ☐ YES ☐ NO
If yes, please explain:_____

8. Does your child take antibiotics before dental treatment? ☐ YES ☐ NO

9. Does your child have any allergies? ☐ YES ☐ NO
If yes, please check all that apply:
☐ Penicillin ☐ Antibiotics ☐ Colophonium ☐ Aspirin ☐ Foods
☐ Latex ☐ Resins ☐ Metals ☐ Other:_____

10. Does your child have any developmental disabilities? ☐ YES ☐ NO

If yes, please explain:_____

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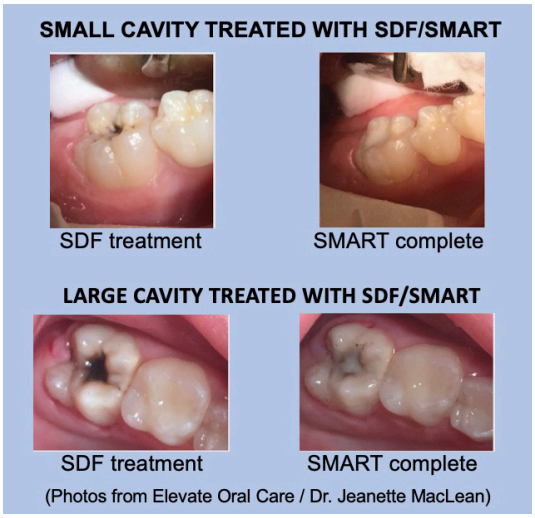
SILVER DIAMINE FLUORIDE (SDF) TREATMENT AND SILVER-MODIFIED ATRAUMATIC RESTORATIVE TREATMENT (SMART)

Silver diamine fluoride (SDF) treatment and **silver-modified atraumatic restorative treatment (SMART)** are now available at your child's school through Boston University's ABCD Head Start/Early Head Start Dental Program. These treatments can be applied to cavities to stop them from growing, stop tooth pain, and give you more time to get your child to the dentist. The treatment is fast and easy – no needles/shots or drilling are needed!

Silver diamine fluoride (SDF) is a liquid that dentists paint on cavities with a brush to stop them from growing. ***The cavity will turn black*** (see photo) and hard – this means it is working. Healthy parts of the tooth do not turn black and should stay tooth colored.

Silver-modified atraumatic restorative treatment (SMART) is when a white colored tooth filling material is placed on top of a cavity that was treated with SDF. This helps repair the tooth and can help cover most or all of the black parts from SDF treatment. Not all cavities treated with SDF can have SMART.



SDF and SMART treatments cannot be used on all cavities or if your child is allergic to silver. If your child cannot receive these treatments, we will provide you with a list of dental clinics that can treat the tooth in a different way.

We are very careful when painting teeth with SDF, but children sometimes move suddenly during treatment and some SDF might get on their gums or skin and could temporarily stain them. This rarely happens, but if it does, the stain should go away in 1-3 weeks.

**** Only back teeth will be treated with SDF and SMART ****

☐ **YES,** I give permission for my child to have SDF and SMART.
Does your child have an **allergy** to **silver or metals?**
☐ YES ☐ NO

OR

☐ **NO,** I do NOT want my child to receive SDF and/or SMART.

Child Name:_____ Child's Date of Birth:_____
(Please Print)

PARENT/GUARDIAN PRINTED NAME:

PARENT/GUARDIAN SIGNATURE: **DATE:**

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11. Does your child have **DENTAL INSURANCE**? ☐ YES ☐ NO

If yes, please check which one and complete below:

☐ Blue Cross/Shield ☐ Delta Dental ☐ Children's Medical (CMSP) ☐ Mass Health/Medicaid

☐ Other:_____

If **MassHealth** please provide number:_____

If **other insurance** please provide:

Subscriber Name:_____ Group/ Policy Number:_____

1) GSDM may use my child's health information for treatment, payment, operations, and program evaluation

2) GSDM's Notice of Privacy Practices is at https://www.bu.edu/dental/files/2017/05/Dental-Notice-of-Privacy-Practices-April-10_2017.pdf

3) If my child has insurance, I authorize GSDM to bill their insurance for services provided. I will not be billed for services provided.

4) Services provided may affect insurance coverage for dental visits.with other dentists

5) My child's dental exam results will be given to appropriate HeadStart staff.

6) I have read and understand the dental program and by signing below, I consent to have my child participate.

CHILD'S PRINTED NAME: **CHILD'S DATE OF BIRTH:**

PARENT/GUARDIAN PRINTED NAME:

PARENT/GUARDIAN SIGNATURE: **DATE:**

Relationship to Child_____ **Daytime Phone**_____

Email_____ **Cell Phone**_____

FOR GSDM PROGRAM STAFF

Reviewed by:_____ Date:_____

Left intentionally blank.

Blue forms to be filed in the family engagement section of the child's file.

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NEIGHBORHOOD AND COMMUNITY TRIPS:

The curriculum in a Head Start classroom involves using community resources such as stores, libraries, police and fire stations, parks, playgrounds, etc. Weather permitting, classes go outside daily to play, walk, or visit in the neighborhood. These activities do not involve any transportation. During these activities, children will be supervised at all times by appropriate Head Start staff. You may receive a list of the community locations that your center visits from the Program Director. Any and all trips, walks or visits to neighborhood playgrounds will occur in compliance with EEC regulations and safety standards.

Please inform staff of any information about your child that they should know when taking them on neighborhood and community trips, such as outdoor allergies, fear of animals, etc.

I give permission for my child to participate in neighborhood trips outside the center as described above.

PARENT/GUARDIAN SIGNATURE: **DATE:**

ABCD MEDIA RELEASE FORM:

ABCD requests your written consent to use your (and/or your children's) image, likeness and voice in various print, electronic and broadcast media. You are not required to give this consent in order to participate in ABCD programs or to receive services or benefits from or through ABCD.

☐ I am 18 years of age or older and am signing this form on my own behalf:

Full Name:_____ Phone Number:_____
(Please Print)

Email Address:_____

☐ I am the parent or legal guardian of the child or children named below, who are under 18, and I am signing this form on behalf of my child or children listed below:

Child's Full Name:_____
(Please Print)

☐ **I DO CONSENT:** I hereby grant permission to Action for Boston Community Development, Inc. (ABCD) to photograph, video or record me (and, if checked above, my child/children) and to use for nonprofit purposes my (and, if checked above, my child/children's) image, likeness, and voice in media of all types, including but not limited to photographs, audio and video recordings, and print and online publications throughout the world in perpetuity without further authorization from, or payment to, me. Media may include but are not limited to: all print media (such as annual reports and publications), all electronic media (such as ABCD's website, ABCD's YouTube channel and ABCD social media [Twitter, Instagram and Facebook]), as well as on all broadcast media (such as television and radio). I expressly release ABCD, its subsidiaries, its affiliates, and their agents, employees, officers, directors, licensees, and assigns from and against any and all claims which I or my child/children may not or at any time have for invasion of privacy, defamation, or any other cause of action arising out of production, distribution, broadcast, or exhibition of my (or my child/children's) name, image, likeness or voice.

☐ **I DO NOT CONSENT:** I do not grant permission to ABCD to photograph, video or record me or my child/children to use the name, image, likeness or voice of me or my child/children in Media of any kind.

I have read this release before signing below, and I fully understand its contents and meaning. I understand that I am free to address any specific questions regarding this release prior to signing it by calling ABCD's General Counsel at 617-348-6587.

PARENT/GUARDIAN SIGNATURE: **DATE:**

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PARENT HANDBOOK RECEIPT:

This ABCD Head Start and Children's Services Parent Handbook contains information about all aspects of our program. According to the Department of Early Education and Care (EEC) policies, written information must be provided to families prior to the enrollment of their child. I have received the Parent Handbook and a staff member has reviewed the information with me.

PARENT/GUARDIAN SIGNATURE: **DATE:**

PARENT LEARNING AND INTEREST SURVEY:

We want to learn about you and your interests. Pick your interest area and include other interests you may have that are not listed. We will use the information to develop family activities and events and offer you information that you find most important and valuable to your family:

Family Well Being

Clothing
- ☐ Adult clothing
- ☐ Child clothing

Housing & Homelessness
- ☐ Affordable housing
- ☐ Furniture
- ☐ Home ownership
- ☐ Services for families experiencing homelessness
- ☐ Tenant's rights
- ☐ Utility assistance

Health & Safety
- ☐ Child abuse & neglect prevention
- ☐ Family dental/oral health
- ☐ Family health/wellness
- ☐ Food assistance resources
- ☐ Health & dental insurance
- ☐ Healthy eating/nutrition
- ☐ Mental health & wellness
- ☐ Safety risks & prevention
- ☐ Stress management
- ☐ Substance abuse prevention/treatment

Family Relationships
- ☐ Domestic violence information
- ☐ Healthy family relationships

Financial & Economic Stability
- ☐ Asset building & management
- ☐ Budgeting
- ☐ Child support information
- ☐ Credit & debt rehabilitation
- ☐ Financial aid for continuing education
- ☐ Public benefit information
- ☐ Saving for emergencies & goals
- ☐ Taxes

Other
- ☐ Legal matters:_____

Positive Parent-Child Relationships
- ☐ Father engagement opportunities
- ☐ First-time parent(s)
- ☐ Parenting program (Parenting Journey, Power of Parenting, Nurturing Families Program, or other)
- ☐ Positive parenting practices
- ☐ Single parenting
- ☐ Step parenting
- ☐ Talking to your child about emotions and difficult topics:_____

_____

Families as Lifelong Educators
- ☐ Activities to do at home to support school readiness
- ☐ Promoting literacy at home
- ☐ Supporting social emotional development
- ☐ Positive guidance & behavior support
- ☐ Media & early childhood development

Families as Learners
- ☐ Computer/technology literacy & training
- ☐ Employment search assistance
- ☐ ESL (English as a second language)
- ☐ First Aid/CPR classes
- ☐ GED/HiSet
- ☐ Resume writing & interviewing skills
- ☐ Vocational & job training programs

Family Engagement in Transitions
- ☐ Child development information
- ☐ Kindergarten registration information
- ☐ School choice information
- ☐ School readiness information
- ☐ Transition information & activities

Family Connections to Peers & Community
- ☐ Community events & activities
- ☐ Family recreation/fitness ideas, events & activities
- ☐ Other support or social group:_____

_____
- ☐ Parent & caregiver support groups
- ☐ Ways to be involved in your community

Families as Advocates & Leaders
- ☐ Advocating for my child and his/her education
- ☐ Citywide Policy Council membership
- ☐ Employment opportunities at Head Start
- ☐ Head Start committee opportunities (local program)
- ☐ Opportunities to advocate at the state & local level

Other – list your interests or other topics you would like to hear more about
- ☐ _____

_____

Volunteering
- ☐ I have _____ hours a week to volunteer in the Head Start program.

I am interested in the following ways to volunteer:
- ☐ Chaperoning on field trips
- ☐ Helping in the classroom
- ☐ Helping in the program
- ☐ Recruiting parents for Head Start
- ☐ Sharing cultural recipes with Head Start food service staff
- ☐ Other:_____

What are the best days for you to attend events at the program?

☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri
☐ Sat ☐ Sun

What are the best times?
- ☐ Mornings (around the time I drop off my child)
- ☐ Afternoons (around the time I pick up my child)
- ☐ Evenings (around 5:30pm after work or school)

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CONFIDENTIALITY POLICY FOR PARENTS:

I understand that:

- All records, communications, and conversations relating to the ABCD Head Start/Early Head Start program that I have received or participated in as a parent volunteer (including as a member of the ABCD Head Start & Children's Services Policy Council, Policy Committee, Parent Committee or any other volunteer activity) must be kept strictly confidential at all times. This confidential information includes, but is not limited to, information about Head Start/Early Head Start children, families, staff, and applicants for Head Start/Early Head Start staff positions, containing agency or staff information (Head Start/Early Head Start staff). However, it does not include information that has been made available by ABCD Head Start to the general public or to Head Start/Early Head Start families.

- The unauthorized possession, use, or copying of such records, and/or the disclosure of information contained in any such records or obtained through communications or conversations to unauthorized persons, including ABCD employees who do not have authorized access to the information within the Head Start/Early Head Start Program, are strictly prohibited.

- The same prohibition applies to any information that I may acquire when serving as a member of any policy groups, serving on committees, or serving as a program volunteer at the local site level or at the ABCD Central level, including but not limited to Administrative/Executive, Personnel, Finance, Health/Nutrition, Education, Self-Assessment, or Advocacy Sub-Committees.

- I may discuss such information, regardless of its source, inside ABCD ONLY with those staff designated by the Vice President of ABCD Head Start & Children's Services, and with no one at all outside ABCD, except as required or permitted by law or regulation or as stated on the "Role of Parents" section on the Parent Handbook. I understand that violation of this confidentiality policy will result in disciplinary action, up to and including termination of policy group membership or of other applicable volunteer activities.

I agree to abide by the above policy for parent confidentiality.

PARENT/GUARDIAN SIGNATURE: **DATE:**

DROP OFF/PICK UP POLICY:

I agree to abide by the policies for drop off/arrival and pick up/departure as listed on pages 38 - 39 of the Parent Handbook.

PARENT/GUARDIAN SIGNATURE: **DATE:**

UNITED WAY'S DRIVE INITIATIVE: Data & Resources Invested in Vital Early Education

PARENT/GUARDIAN CONSENT FORM TO COLLECT AND USE SCREENING DATA:

The goal of United Way's **DRIVE** initiative is to develop a statewide picture of the needs of children ages 0-6. The purpose of the project is to ensure that support is available to families to help their children grow up healthy and ready for school by the time they go to kindergarten. Through the **DRIVE** initiative, United Way works with organizations that serve children and families to screen children between the ages of 0 and 6 using the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire: Social-Emotional (ASQ:SE), analyze this data, and use it to help the organizations identify and support the developmental needs of children they serve.

With your permission, the information about your child from the ASQ and ASQ:SE screening will be shared with United Way and its DRIVE partners.

Any data about your child that is shared with United Way through DRIVE will only be used to 1) create anonymous, aggregate reports about child development in particular organizations and communities and 2) investigate the relationship between screening and other resources, child development, and school readiness.

United Way will not share any personally identifying information about your child with any other third party, organization, or agency nor will your child be identified without your express written consent.

I ALLOW ABCD Head Start & Children's Services to collect and maintain personally identifying information about my child(ren)_____for a period not to exceed six (6) years and to share it with United Way and United Way partners only for the purposes stated above.

I understand that I can contact United Way, either by phone or in writing, at 51 Sleeper Street, Boston, MA. 02210, (617) 624-8105, drive@supportunitedway.org, to cancel this authorization at any time and except for information already given, this authorization form will not be used any further.

☐ **No,** I do not give my permission for ABCD Head Start & Children's Services to share data with the United Way and United Way Partners.

PARENT/GUARDIAN SIGNATURE: **DATE:**

THANK YOU!