Instructional Guide to Enrollment Paper Work

- **Emergency Card-** 1-Fill in your child's classroom. 2-Print your child's name, last name, and Date of Birth. Circle a yes or no answer if there is any custody arrangement and circle a yes or no answer if there are any siblings in enrolled with our program. Fill in the date of the first day of school. 3-Under Name of Parent(s) or Legal Guardian(s) Contact Information, complete all areas. It is important to fill out your email address and your phone numbers. Communication will be done through email, text, and phone calls. Do not forget to circle your choice of yes or no to receive text messages. Please remember if your choice is circled no, it is not okay to receive text, you will not receive text messages from CINHS. 4-Under the Box where it mentions "Persons Authorized to Pick-Up Your Child if You Cannot be Reached Immediately in an Emergency Who Can Assume Responsibility for your Child" please fill out as much of the Emergency Contact information providing the full name, both first name and last name of your Emergency Contact. There must be 2 Emergency Contacts listed on the form and they must be over the age of 16. The emergency contacts cannot be the same as the Legal parents/guardians that is listed in the above boxes. Fill out the Relationship to Child box, emergency contact phone number and place a check mark in the choices of "Emergency" and/or "Routine". 5-Under the Medical Information and Release For Medical Care, please fill out your child's name and mark the box to choose if your child has allergies or not allergies. IF your child has allergies please fill out the box completely. 6-Under the box of Preferred Medical Facility Information, please fill in your child's Physician Name, Physician Phone Number and check which Preferred Hospital you would like your child to go to in the case of an emergency. 7-Under the box, Signature of Parent or Legal Guardian, please print your name, and lastly sign and date.
- **Consent Forms-** 1- Photo Release. Print your name and your child's name and initial the box of choice. 2- Walking Trips and Popcorn Release. Initial the box of your choice. Do not leave any boxes blank. 3- At the bottom of the form print your child's name and Date of Birth. Lastly, sign and date at the bottom of the page.
- **Release of Information-** 1-Print your first and last name on the first line and print your child's first and last name on the second line. 2-Check off any of the programs that pertains to you or your child. 3-And lastly, read the statement of understanding. Print your child's first and last name and date of birth. Sign and date.
- **Attendance/Tardiness Policy-** 1-Print your child's first and last name. Next line box print your child's date of birth. 2- Read the Attendance/Tardiness Policy. 3-Print your first and last name on the first line and print your child's first and last name on the second line. 4-Sign and date. Your Family Advocate will sign and date the last line on the page.
- **Child & Adult Care Food Program Child Enrollment Form for EHS & HS FY 2021-** 1-Fill out the Institution Name and the Facility Name. Please print CINHS for both the Institution and Facility Name. 2-Fill out your child's first name in column 1. Fill out your child's last name in column 2. Fill out your child's birth date in column 3. Fill out the time of your child's class. Circle the typical days your child's class is in session and circle the normal meal times the students would eat. For example, if your child is in the Part-Day Fish

Morning Class, you circle M, T, W, Th and on Fridays there is no class in session. And for the meals, you would circle B-for Breakfast and A M-for Snack. 3-Sign and Date on the first line and Print your first and last name on the next line. Print your phone number. 4-Complete the Infant Formula Selection Box only if you have a student between the ages of 0-3 years old attention our infant/toddler classes.

- **Child Nutrition Programs Medical Statement to Request Special Meals and/or Accommodations-** 1-Please read this page if there is an accommodation needed to substitute you child's food in school.
- **Child Nutrition Programs Medical Statement to Request Special Meals and/or Accommodations Fill-Out Form-** This form is to be completed if there are accommodations needed for your child and a Medical Physician must sign and date. Without your Medical Physician's signature, we cannot make accommodations for your child's meals. 1- Print your School/Agency Name which is CINHS. Print the Site Name which is CINHS. In box 3 fill in your phone number. In Box 4 print the first and last name of your child. In box 5, print the age or date of birth for your child. In Box 6 please print you first and last name. In Box 7 print your telephone number. In Box 8, Please give a description of your child's physical and/or mental impairment, if there is none, mark N/A for not applicable. In box 9, provide an Explanation of Diet Prescription, and/or Accommodation to Ensure Proper Implementation. In Box 10, please list the foods that are to be omitted for your child's meals in column A. and if you have suggestions for substitutions please list them in column B. On Line 11, check off the boxes to indicate the texture of food preferred. In Box 12, if there are any adaptive equipment that must be used please list them. In Box 13, the person who is completing this form must sign and in box 14 the same person who sign, must print their first and last name. In Box 15, print your phone number and date this form in box 16. In Box 17, 18, 19, and 20, this portion must be completed by the Medical Physician.
- **Nutrition and Activity Survey Form-** 1-Print the first and last name of your child on the first line and on the second line fill in your child's birth date. On the third line, print the parent or legal guardian's first and last name. And on the fourth line date when the form is completed. 2-In this section please check the boxes on each column either yes or no answering to the best of your own knowledge. 3- In the Dietary Practices section please read through each column and answer each question the best to your own knowledge.
- **Nutrition and Activity Survey Form Page 2-** Complete this form only if your child has special dietary needs. If there is a need, please complete each statement so we know how to service your child to the best of our abilities.
- **Health History-** 1- Print your child's first and last name. List your child's date of birth on the second line and your child's age on the third line. Under the Medical Coverage area, please check which coverage your family has. 2-In the next listed area, check off a yes or no answer as you read through each question and fill out the comment area if there is an important message you need to let us know about your child regarding the asked questions. 3- The last portion of this page ask if there are additional comments you need to communicate with us, other than what is listed on the top, please print them on the lines provided

- **Release of Protected Health Information/Authorization Form-** 1-In box 1- Print your child's first and last name. Under Date of Birth, please list your child's date of birth. Place N/A in the box that says Medical Record #. In Box 4 please list the child's full address and a phone number in Box 5. Skipping down to section 2 where indicated, under PROGRAM OR LOCATION OF INFORMATION TO BE RELEASED:, please check the box or boxes that indicates each department you are authorizing information to be released from. 3- Skipping down to the end of the document please sign your name and date. And under the signature box, please print your first name and last name and indicate your relationship status next to the signature box.
- **Anchorage School District Tuberculosis (TB) Risk Assessment and Test Consent-** 1- Complete the top portion of this form by printing your child's first and last name. Birth date is required in the 2nd box. In Box 3, Grade will be Pre-school. In Box 4, School is CINHS. In Box 5, please print your first and last name and in Box 6 please print the date. 2-Please read the directions carefully in the coated box. And check off your answer of either yes or no in the circles provided, answering questions 1, 2, and 3 to the best of your knowledge. 3- In this box, if you answered yes to any of the above questions would you need to complete this portion.
- **Alaska Native/American Indian Region XI Head Start Indigenous/Cultural Background Information-** 1-Print your child's first and last name on the first line. On the next line, print your first and last name. 2-Please check as many as appropriate indicating your child's cultural groups. 3- Please check which corporation you and/or your child either are shareholder of or descendants of.
- **CINHS Lead Screening Risk Assessment-** 1-Print your child's first and last name. On line 2 print your child's date of birth. 2- In the next section please read each question carefully and answer each question the best to your knowledge. 3- Please print your first and last name on the line noting who you are to the child and check which box best fits your circumstance. Lastly, please sign and date at the bottom of the page.
- **CINHS Mitigation Plan-** 1-Please Read through the Mitigation Plan. 2-On the last page of the Mitigation Plan, which is page 7, please write in the date on the first line. 3- Lastly, sign and date. Do not fill out the Staff Witness Signature, your Family Advocate will sign the last part and date.

If at all, you have any questions please call or email your Family Advocate. Thank you!

Cook Inlet Native HEAD START

Building Strong Foundations with Alaska Native Families through Alaska Native Cultures and Education

Child's Emergency Record Card

1 Classroom:____________

2

Child's Last Name:	Child's First Name:
Date of Birth:	Any Custody Arrangements? Yes No N/A
Siblings enrolled? YES NO	First Day in School:

Names of Parent(s) or Legal Guardian(s) Contact Information

3

Full Name:	Relationship:	Full Name:	Relationship:
Place of Employment:		Place of Employment:	
Employment Phone Number:		Employment Phone Number:	
Physical Home Address: City: State: ZIP Code:		Physical Home Address: City: State: ZIP Code:	
Cell Phone: OK TO SEND TEXT MESSAGE: YES NO HOME PHONE:		Cell Phone: OK TO SEND TEXT MESSAGE: YES NO HOME PHONE:	
E-MAIL ADDRESS:		E-MAIL ADDRESS:	

PERSONS AUTHORIZED TO PICK UP YOUR CHILD IF YOU CANNOT BE REACHED IMMEDIATELY IN AN EMERGENCY WHO CAN ASSUME RESPONSIBILITY FOR YOUR CHILD. INDIVIDUALS CAN'T BE UNDER THE AGE OF 16

4

FULL NAME:	Relationship to child:	Phone number:	O EMERGENCY O ROUTINE
FULL NAME:	Relationship to child:	Phone number:	O EMERGENCY O ROUTINE
FULL NAME:	Relationship to child:	Phone number:	O EMERGENCY O ROUTINE
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FULL NAME:	Relationship to child:	Phone number:	O EMERGENCY O ROUTINE
FULL NAME:	Relationship to child:	Phone number:	O EMERGENCY O ROUTINE

MEDICAL INFORMATION AND RELEASE FOR MEDICAL CARE

CHILD'S FULL NAME:______________________________ **FACILITY NAME: COOK INLET NATIVE HEADSTART**

5

O My child has NO ongoing health concerns, including allergies or ongoing medication OR

O My child has the following chronic health concerns: O Allergies (list all)

O Asthma O Diabetes O Seizures or Epilepsy O Other (list)

O My child takes the following ongoing medications:____

PREFERRED MEDICAL FACILITY INFORMATION

6

Physician's Name:	Physician's phone (recommended):
Preferred Hospital: O ANMC O Providence O Regional O JBER O Other:	

SIGNATURE OF PARENT OR LEGAL GUARDIAN AND PERIODIC UPDATES REQUIRED EVERY SIX MONTHS.

7

I, the parent or legal guardian of ____________________________, am verifying that this medical information is correct and complete. I hereby give the above named facility permission to seek emergency medical treatment, including necessary emergency paramedic transport for my child. I understand that every effort will be made to locate me or my child's other parent or legal guardian as soon as possible. I understand my obligation is to keep my child's school informed about my whereabouts. I will assume the cost of necessary medical or surgical care and any related medical transportation costs.

______________________________ ______________________________

Signature of Parent or Legal Guardian **Date Signed**

Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial

Building Strong Foundations with Alaska Native Families through Alaska Native Cultures and Education

Consent Forms

1

Photo Release (please initial all that apply):

I, _____, authorize Cook Inlet Native Head Start to videotape/ photograph
(Parent /Guardian Name)

my child _____, for educational or promotional uses only. I understand
(Child Name)
there is no monetary compensation, unless otherwise informed. Usage encompasses, but is not limited to, newsletters, printed publications and other collateral, radio recordings, Internet and web sites, advertising, and video and/or audio presentations. My child's image is okay to use for the following

____Cook Inlet Native Head Start Newsletters, website, and Facebook
____Cook Inlet Native Head Start classroom use

I have the right to: withdraw consent and/or to stop filming or recording; and to rescind consent for use until a reasonable time, before the recording or film is used.

I hereby waive any and all right to inspect or approve the finished product or the advertising text that may be used in connection therewith, or the use to which it may be applied.

I forever release, discharge, and agree to hold CINHS and the AK Native Heritage Center, their affiliates, officers, directors, employees, and agents harmless from any liability by virtue of any use whatsoever of said photographs or images.

Walking Trips (please initial all that apply)

____ I **do** give my child permission to go on walking trips
(Walks will be no further than ¼ mile from the school.)
____ I **do not** give my child permission to go on walking trips

2

Popcorn Release (please initial all that apply)

____ I **do** I give my child permission to have popcorn at Cook Inlet Native Head Start
(During movie/ special days at the school.)
____ I **do not** I give my child permission to have popcorn at Cook Inlet Native Head Start

I am the parent/legal guardian and agree to the terms above.

3

Child's Name _____ DOB _____

Parent/Guardian Signature _____ Date _____

Building Strong Foundations with Alaska Native Families through Alaska Native Cultures and Education

Release of Information

1

I, _____ release and/or exchange any information
(Parent)
regarding my child, _____ to Cook Inlet Native Head Start,
(Child)
6901 E Tudor Rd, Anchorage, AK 99507. The information requested shall be used solely in the administration of CINHS programs, and a reproduction of this release is as valid as the original. Contacts may include, but are not limited to:

- _____ PIC (Programs for Infants and Children
- _____ Alaska Native Medical Center and Southcentral Foundation Clinics
- _____ Anchorage School District
- _____Private clinics and medical providers: _____
  Name Address Phone Number

2

- _____Cook Inlet Tribal Council
- _____Previous infant learning, Head Start or Early intervention programs attended:

  _____
  Name Address Phone Number
- _____ Verbal/electronic exchange between Providers/Agencies:

  _____
  Name Address Phone Number

3

I understand that this information is necessary for the purpose of service coordination, collaboration, continuity of care and case management activities.

I understand that when I revoke this authorization, it is not effective to the extent that the Provider/Agency has already relied on the use of the disclosure of the protected information.

I understand that I have the right to inspect or copy the protected information to be used or disclosed. I have the right to refuse to sign this authorization.

I understand that this release of information is good for one year from the date of signature, or until my child is no longer enrolled at Cook Inlet Native Head Start.

Child's Name _____ *DOB* _____

Parent/Guardian Signature _____ *Date* _____

Building Strong Foundations with Alaska Native Families through Alaska Native Cultures and Education

Attendance/Tardiness Policy

Child's Name:_____ **D.O.B.**_____

1. My child is expected to attend Head Start every day!

2. If my child is unexpectedly absent from Head Start and a parent/guardian has not contacted the program within one hour of program start time, the program must attempt to contact the parent/guardian to ensure the child's well-being.

3. If my child is going to be absent from Head Start, I agree to call daily to the front desk at **907-433-1600**. If my child will be tardy, I agree to notify my family advocate before taking my child to the classroom.

2

4. If my child's absences or tardiness, excused or unexcused, falls below 90% or becomes chromic, I understand my child's enrollment in the current program option may be jeopardized.

5. Within the first 60 days of program operation, and on an ongoing basis thereafter, we use individual child attendance data to identify children with patters of absence that put them at risk of missing 10% of program days per year. We develop appropriate strategies to improve individual attendance among identified children, such as direct contact with parents or intensive case management, as necessary. Both excused and unexcused absences will be counted.

6. If my child will be **30 minutes** late, I understand my child will **not be able** to attend school that day unless I have contacted Family Services to receive clearance into the classroom.

7. When my child is not picked up **30 minutes** after my child's class is dismissed, and every effort has been made to contact everyone on the emergency contact list, management may call **APD or OCS** for child abandonment.

I, _____ have read and understand CINHS' attendance policy. The office of
(Parent/Guardian Name)

3

Head Start requires your child's consistent ad punctual attendance, I understand the importance of attendance for _____
(Child's name)

Parent/Guardian Signature _____ Date_____

4

Advocate Signature _____ Date _____

Child Nutrition Programs
Finance & Support Services
P.O. Box 110500
Juneau, Alaska 99811-0500
Phone (907) 465-8711
Fax (907) 465-8911

Child & Adult Care Food Program
Child Enrollment Form for EHS & HS
FY2021

1

Institution Name: _____

Facility Name: _____

Dear Parent/Guardian,

Your Head Start facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs verification of enrollment for each participant in this facility. Please complete the table below for all children in your household that are enrolled at this facility. The information below should be completed by the parent/guardian. Please use the guides below the table to complete and sign and date the form below.

2

Child's First Name	Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			to	M T W TH F	B A M L PM
			to	M T W TH F	B A M L PM
			to	M T W TH F	B A M L PM

Guide: Normal hours of care: Insert the usual arrival time and the usual departure time. Indicate a.m. or p.m.
Normal days of care: Circle the days of the week the participant(s) are usually in attendance at the facility.
(M=Monday; T=Tuesday; W=Wednesday; TH=Thursday, F=Friday)
Meals Normally Eaten: Circle the meals the participant(s) usually eat at the facility.
(B=Breakfast; AM=AM Snack; L=Lunch; PM=PM Snack)

Parent/Guardian Signature: _____ Date: _____

3

Print Name: _____

Home Telephone Number ( ) _____ Work Telephone Number: ( ) _____

Infant Formula Selection: Complete if any child listed above is an infant under one year of age

This center provides _____ (list brand) iron fortified infant formula.

Check one: ☐ I accept the center provided formula
☐ I decline the center provided formula

I understand that by declining the center provided formula, I agree to provide breast milk or formula for my child. If I provide formula it must be on the approved formula list for the center is to be reimbursed for the meal.

4

For Facility/Provider Use Only:
Signature of Facility Representative: _____ Date: _____
Date the participant withdrew: _____

Updates: (annual at a minimum)	The parent/guardian signing this form certifies that the enrollment information is correct. If information has changed, the parent/guardian has written the appropriate changes on the form and initialed the change. *If there are many changes, please complete a new form.*	
First Update	Parent/Guardian Signature	Date
Second Update	Parent/Guardian Signature	Date

This institution is an equal opportunity provider.

Child Nutrition Programs
Medical Statement to Request Special Meals and/or Accommodations

A recognized Medical Authority must fill out a Medical Statement to Request Special Meals and/or Accommodations form and return it to the school, child or adult care facility/provider. Agencies have an obligation to provide alternate foods to those participants who meet any of the following definitions.

Definitions:

"A person with a disability" is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, specific learning disabilities.

"Major life activities" are defined as "functions such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."

"Major Bodily Functions" have been added to major life activities and include the "functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions."

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

"Recognized Medical Authority" means state recognized medical professional with prescriptive authority such as, licensed physician, physician's assistant, or nurse practitioner.

The medical statement shall identify:

- The participant's disability or medical condition with an explanation of why the disability restricts the participant's diet;
- The major life activity affected by the disability;
- The specific diet or accommodation that has been prescribed by the medical authority. For example: "All foods must be in liquid or pureed form. Participant cannot consume any solid foods."
- The type of texture of food that is required,
- The specific foods that must be omitted and suggested substitutions
- The specific equipment required to assist the participant with dining. Examples might include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS
INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Description of Child's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child's diet.
9. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribe by the state healthcare professional.
10. **A. Foods to Be Omitted:** List specific foods that must be omitted. (e.g., exclude fluid milk.)
    B. Suggested Substitutions: List specific foods to include in the diet. (e.g., calcium fortified juice.)
11. **Indicate Texture:** Check (√) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
12. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the participant with dining. (e.g., a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
13. **Signature of Preparer:** Signature of person completing form.
14. **Printed Name:** Print name of person completing form.
15. **Telephone Number:** Telephone number of person completing form.
16. **Date:** Date preparer signed form.
17. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
18. **Printed Name:** Print name of medical authority.
19. **Telephone Number:** Telephone number of medical authority.
20. **Date:** Date medical authority signed form.

The American with Disabilities Act Amendment Act defines a "disability", in part, as a physical or mental impairment that substantially limits a major bodily function of an individual.

(For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008)

Information regarding the ADAAA, which expanded the definition of disability, can be found at: http://www.law.georgetown.edu/archiveada/documents/comparisonofADAandADAAA.pdf

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

REQUEST for SPECIAL MEALS AND/OR ACCOMMODATIONS

USDA Nondiscrimination Statement

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) online 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.

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3.

Child Nutrition Programs
Medical Statement to Request Special Meals and/or Accommodations

Please fax form to School or Child Care Provider Fax Number: 907-

***Form must be signed by state recognized medical professional with prescriptive authority such as, licensed physician, physician's assistant, or nurse practitioner. Parent/legal guardian signature is acceptable for fluid milk substitution for a child with special medical or dietary needs other than a disability.**

1. School/Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Participant		5. Age or Date of Birth
6. Name of Parent of Guardian		7. Telephone Number
8. Description of Child's Physical or Mental Impairment Affected:		
9. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation: (*please describe in detail to ensure proper implementation-use extra pages as needed*)		
10. Foods to be omitted and substitutions: (*please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed)* **A. Food To Be Omitted:** _____ _____ _____ _____ _____ **B. Suggested Substitutions:** _____ _____ _____ _____ _____		
11. Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed		
12. Adaptive Equipment to be Used:		

13. Signature of Preparer*	14. Printed Name	15. Telephone Number	16. Date
17. Signature of Medical Authority*	18. Printed Name	19. Telephone Number	20. Date

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15b; 7 CFR Sections 210.10(i)(1), 210.23(b);215.14, 220.8(f), 225.16(f)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3. "USDA and the State of Alaska are equal opportunity providers and employers"

Building Strong Foundations with Alaska Native Families through Alaska Native Cultures and Education

Nutrition and Activity Survey Form

1

Child's Name:_____ **Birth Date:**_____

Parent or Legal Guardian Name:_____ **Date Completed:**_____

	Yes	no	
My child eats breakfast 7 days per week			Get off to a great start for the day!
My child eats 5 servings per day of fruits or vegetables			This one is hard to reach; it helps to add a serving at breakfast!
My child has under 2 hours per day of screen time			Discourage all TV for children under 2 and try to limit your whole family to under 2 hours on screens.
My child gets 1 hour or more of active play/exercise per day			Enjoy some fresh air with your child every day!
My child drinks 0 sugary drinks (juice, pop) on a regular day			Juice may be from natural sugars, but they are still sugars and not only increase the risk of cavities but make your child less interested in healthy choices. Treat juice like a cookie!

2

Dietary Practices

			Comments:
How many servings (3/4 cup) of milk does your child usually drink each day?			# of servings:
What type of milk does your child usually drink?			__Skim __1% __2% __whole __soy,rice, etc
How many servings (3/4 cup) of juice or pop does your child usually drink each day?			# of servings of juice: # of servings of pop:
How many glass of water (8 oz) does your child drink each day?			
	Yes	**No**	
Can your child be screened for growth/nutrition at CINCHS?			
Does your child take vitamin/mineral supplements?			
Supplements containing iron?			
Were the supplements prescribed?			
Are any foods not eaten for religious, cultural or personal reasons? If yes, please list.			
Is your child on a special diet for food allergies, lactose intolerance or any other medical issues?			*****If yes, please discuss with the CINHS health team and your child's health care provider will need to submit a medical statement.**
Does your child use a pacifier?			
Does your child take a bottle?			
Does your child use a sippy cup?			
Does your child eat or chew things that aren't food?			If yes, what?
Does your child have difficulty chewing or swallowing?			

3

Are there any comments you would like to make in regards to your child's dietary eating habits?_____

_____

Nutrition and Activity Survey Form
Page 2

Child's Name:_____

Complete this side ONLY if your child has special dietary needs

___ **my child has lactose intolerance and has symptoms when drinking cow's milk**
It is ok to allow my child to eat/drink:
soy milk ___yes ___no
yogurt ___yes ___no
cheese ___yes ___no
cooked foods containing milk ___yes ___no

___ **my child has a food allergy to:**_____
His/her reaction is (circle or add): **Rash**
Lip/tongue/facial swelling
Breathing problems
Vomiting
Other:_____

He/she requires an epi pen : ___yes ___no

Would you like a dietitian to assist you in finding healthy food options?
___yes ___no

___ **my child has other food issues:**_____

Building Strong Foundations with Alaska Native Families through Alaska Native Cultures and Education

Health History

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

1

Information below is required for our Program Information Report to the Office of Head Start.

Medical coverage:

__ **Denali Kid Care/Medicaid**
__ **Tricare/military coverage**
__ **Private Health Insurance**

If you are unable to answer any questions, please ask any staff member for help.

Birth and Pregnancy History	**Yes**	**No**	**Comments:**
Did mother have an abnormal pregnancy? If yes, explain in "comment" section			
Was child exposed to medications, alcohol, or other drugs during the pregnancy?			
Has your child had any issues that would impact learning or development?			
Can he/she be screened for learning/development at CINHS?			
Can he/she be screened for psychological strength/wellness? (previously mental health screening)			
Medical History and Screening Consents:			
VISION			
Does your child have or receive treatment for vision problems (wear glasses, squints, crosses eyes, etc.)			Glasses? Yes __ No __ Last glasses exam?
Is there history of young people in your family having vision problems/needing glasses?			
Can he/she be screened for vision at CINHS? (Head Start requires a screen in the first 45 days of school)			
Hearing			
Does your child have or receive treatment for hearing problems?			
Is there a history of young people in your family having hearing problems?			
Has your child had frequent ear infections (over 4 in 6 months or 6 in a year)			Ear tubes? Yes __ No __
Has your child had prior hearing tests? If so, when?			
Can he/she be screened for hearing at CINHS? (Head Start requires a screen in the first 45 days of school)			
General Health			
Does your child have any other health issues?			
Can he/she be screened for health issues at CINHS? (Head Start requires a screening in the first 90 days of school)			

2

Are there any comments you would like to make in regards to your child's health needs?

3

_____

_____

_____

Southcentral Foundation

Release of Protected Health Information/ Authorization Form

1

Name of customer-owner whose information is to be released:	Date of Birth:	Medical Record #:
Address:	Phone / Contact Number	

I authorize Southcentral Foundation to: (check all that apply) ☑ – **RELEASE** Information To: ☑ – **OBTAIN** Information From:

Organization Name: Cook Inlet Native Head Start	Specify Department, Job Title, or Name of Person to receive information. CMA Health Team
Mailing Address: 6901 E. Tudor Rd	City/State/Zip: Anchorage, Ak 99507
Phone / Contact Number: 907-433-1600	Fax Number: 907-433-1641

2

PROGRAM OR LOCATION OF INFORMATION TO BE RELEASED: (Check each department you are authorizing information to be released from)

☐ Medical Services ☐ Dental ☐ Optometry ☐ Home-Based Services ☐ Behavioral Health ☐ Alcohol/Drug Treatment

INFORMATION TO BE RELEASED: (Check only one)

☑ All Records ☐ Only Specific Dates: From: ____/____/____ To: ____/____/____

☐ Only Information Pertaining to: (Check all that apply)

☐	Laboratory/Radiology Reports	☐	Medication Lists	☐	Mental Health
☐	History/Physical Examinations	☐	HIV/AIDS, Transmittable Diseases	☐	Treatment Plan
☐	Immunization Records	☐	Sexual Assault Info.	☐	Medication Management Notes
☐	Discharge Summary	☐	Assessments	☐	Alcohol/Drug Treatment
☐	Other: (describe)				

PURPOSE FOR THE RELEASE: ☑ Coordination of Care ☐ Personal ☐ Legal ☐ Other: _____

DURATION OF AUTHORIZATION: (Check ONLY one)

☐ This written authorization shall expire (end) immediately after the information has been released.

☐ This written authorization shall remain valid during the dates listed: From: _____/_____/_____ To: _____/_____/_____

☑ This written authorization shall remain valid until an expiration event has been met: Describe expiration event: program disenrollment

I understand that::

- SCF will not condition treatment, payment, enrollment or eligibility for benefits or services if I refuse to sign this form. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, and psychiatric care or other sensitive information.
- I may inspect and receive a copy of this release of information form upon my request;
- I may revoke this release of information at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the SCF Notice of Privacy Practices.
- I understand if the requestor or receiver of the released information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be further disclosed.
- If I am requesting records of a minor child or an incapacitated adult, I must sign this form and include my relationship and authority to sign on their behalf.

I have read the above and voluntarily authorize the release of the protected health information as stated.

3

Signature of Customer-owner/Parent/ Representative	Date Signed
Printed Name of Customer-owner/Parent/Representative	Relationship to Customer-owner if Parent/Representative

ANCHORAGE SCHOOL DISTRICT
TUBERCULOSIS (TB) RISK ASSESSMENT AND TEST CONSENT

1

Student _____ **Birthdate** _____ **Grade** ____ **School** _____

Parent/Guardian filling out form (PRINT): _____ **Date:** _____

Please complete this TB risk assessment on your student who is **New to the School District** in any grade.
TB testing is required if any "YES" answer below.

	YES	NO
1. **Close contact** to someone with infectious TB during the student's lifetime	◯	◯
2. **Birth, travel or residence** in a country with an elevated TB rate for at least 1 month • Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe	◯	◯
3. **Immunosuppression**, current or planned HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids for more than 2 weeks, or other immunosuppressive medication	◯	◯

2

3

Consent for TB Testing ONLY if ANY "YES" answer above.
ANY "YES" Answer means your child **is at risk for TB** and can receive a PPD TB skin test (provided at school for **FREE**)

Parent/Guardian Signature: _____ **Printed Name:** _____ **Date** _____
My Signature gives consent for my child to receive at school the PPD Tuberculin Skin Test required for student with positive TB risk assessment. *(This is an injection just under the skin of tuberculin antigen, PPD, purified protein derivative).*

If you DO NOT want for your child to receive FREE PPD Tuberculin Skin Test at the school, please provide ONE of the following documentation to the school nurse (cost to parent/guardian):

- Interferon Gamma Release Assay (IGRA) no later than 60 days from the start of school.
- Copy or proof or a proof of a negative PPD TB skin test done or negative IGRA blood test within the past initial six months and provide documentation to the nurse within 60 days of enrollment.
- Provide medical information of a previous positive PPD skin test or a positive initial IGRA test to the school nurse within 60 days of enrollment.

Alaska State law requires PPD (purified protein derivative) tuberculin skin testing (TST) **or** Interferon Gamma Release Assay (IGRA) blood test for all students of any age who are new to our school district with positive TB risk assessment. ***Students who have attended then left ASD and returned less than 2 years later are NOT new to district.***

FOR NURSE USE ONLY:
◯ **Negative** Risk Assessment -TB testing is not required at this time (enter in EMR)
◯ **Positive** Risk Assessment -TB testing is required (enter in EMR and TB consent if applicable)

For NURSE Use Only for **YES or Positive TB Risk Assessment**	**PPD Placed:** RT ◯ LT ◯ **Date** _____ **By:** _____	**PPD Read:** _____ **mm** **Date:** _____ **(enter this date in EMR)** **By:** _____

An interval of 4 weeks should be allowed between live virus immunization and administration of the tuberculin skin test because live virus vaccines (Polio-LPV, MMR, and varicella) may temporarily suppress tuberculin reactivity.

Guidance for Students with Prior Positives
http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/TB/TB_Screening_for_Students_with_PriorPositives_April_2018.pdf

Do not repeat TB testing unless there are new risk factors since the last negative test.
Children with a newly positive TB test result should be referred to their healthcare provider for a medical evaluation.

From Alaska.gov:

Alaska Department of Health and Social Services- Tuberculosis: http://dhss.alaska.gov/dph/Epi/id/Pages/tb.aspx

Frequently Asked Questions (FAQs) for School TB Assessment:
http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/TB/TB_schoolscreening_FAQ_April_2018.pdf

Foreign born: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6410a2.htm

Western and Northern European countries: http://unstats.un.org/unsd/methods/m49/m49regin.htm

List of Countries that DO NOT need TB testing:

United States of America	**Northern Europe** includes:	**Western Europe** includes:
Canada	Åland Islands	Austria
Australia	Channel Islands	Belgium
New Zealand	Denmark	France
	Estonia	Germany
	Faeroe Islands	Liechtenstein
	Finland	Luxembourg
	Guernsey	Monaco
	Iceland	Netherlands
	Ireland	Switzerland
	Isle of Man	
	Jersey	
	Latvia	
	Lithuania	
	Norway	
	Sark	
	Svalbard and Jan Mayen Islands	
	Sweden	
	United Kingdom of Great Britain	
	Northern Ireland	

Building Strong Foundations with Alaska Native Families through Alaska Native Cultures and Education

Alaska Native/American Indian
Region XI Head Start
Indigenous/Cultural Background Information

Child's Name _____

Parent(s) Name _____

Please indicate your child's cultural group(s) (Check as many as are appropriate, but please be specific).

This list begins with the colonial name (e.g. Eskimo, Aleut, Indian) as a broad category. If you are unsure of the specific traditional name, please think about where your ancestor(s) came from, and then refer to the language map for the exact tribal group.

Eskimo

___Inupiaq
___St. Lawrence Island Yupik
___Yup'ik
___Cup'ik

Aleut

___Sugpiaq, Alutiiq (Prince William Sound, Lower Kenai Peninsula, Kodiak, Eastern Alaska Peninsula, Bristol Bay)
___Unangax, Aligutax (Western Alaska Peninsula, Shumagin Islands, Aleutian Islands, Pribilof Islands Commander Islands)

Indian

Southeastern

___Tlingit
___Haida
___Tsimshian
___Eyak

Athabascan

___Dena'ina
___Ahtna
___Upper Tanana
___Tanacross
___Han
___Deg Xinag
___Tanana
___Gwich'in
___Koyukon
___Upper Kuskokwim
___Holikachuk

Outside Indian (OSI, Lower 48 Tribes, Canadian First Nation, etc)

___Other(please specify)_____

ANCSA Corporate Information (please indicate which corporation(s) that you and/or your child either are shareholders of or descendants of):

___Arctic Slope Regional Corp.
___Bering Straits Native Corp
___Chugach Alaska Corp.
___Koniag Inc
___Ahtna Inc.
___Bristol Bay Native Corp.
___Cook Inlet Regional Corp.
___NANA Regional Corp.
___Aleut Corp
___Calista Corp.
___Doyon Limited
___Sealaska Corp.

Please list all village corporation(s) that you and/or your child are either shareholders within or descendents of:

_____ _____ _____

Cook Inlet Native Head Start

Lead Screening Risk Assessment

Child's Name: _____ DOB: _____

Lead is a natural metal found in the environment. It is also a very dangerous poison, particularly for children. Rules and regulations prohibit lead in common products like most gasoline and paints, so lead poisoning has dramatically declined in the United States. However, it is still a problem that continues to poison children in the U.S. each year. Some imported products, including toys and candy, have been found to contain lead. Lead is toxic to the brain and can cause learning and behavior problems in children that can last a lifetime.

The Office of Head Start REQUIRES Blood Lead Level testing, and it is a requirement for participation in CINHS Head Start/Early Head Start.

Lead Screening Risk Assessment Questions:

1. Do you suspect your child has been exposed to lead? ☐**Yes** ☐**No**
   Has a health care provider told you your child is at increased risk for lead exposure? ☐**Yes** ☐**No**
2. Is your child a recent immigrant, refugee, or foreign adoptee? ☐**Yes** ☐**No**
3. Has your child ever lived outside of the United States or spent an extended amount of time visiting another country? ☐**Yes** ☐**No** **If yes, where?** _____
4. Has your child ever lived outside of Alaska? ☐**Yes** ☐**No** **If yes, where?** _____
5. Does your family regularly eat foods or use products (for example, cosmetics or pottery) imported from other countries? ☐**Yes** ☐**No**
6. While in your home or around your child, does anyone hand load ammunition or shoot firearms on a regular basis? ☐**Yes** ☐**No**
7. Does your child live with anyone who has a job or hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? ☐**Yes** ☐**No**
8. Has your child ever lived in or regularly visited a home that was built before 1978? ☐**Yes** ☐**No**
9. Do you know if your child has a sibling, playmate, or family member who is known to have elevated blood lead levels? ☐**Yes** ☐**No**

If you answered YES to any of these questions, please explain below:

_____

_____

_____

I, _____, am the parent/legal guardian of the above named child. CINHS has provided me information on lead poisoning. I understand the health risks associated with lead exposure and that any exposure can be detrimental to my child's health. I am aware that blood lead testing is covered by Denali Kid Care, Medicaid and some private insurances and can be arranged by a primary health care provider at Southcentral Foundation (SCF), and that CINHS staff can assist me in arranging testing for my child.

☐ I will ask my child's health care provider to complete blood lead testing on my child and will provide documentation of the results to Cook Inlet Native Head Start & Early Head Start.

☐ I choose to **REFUSE** blood lead level testing on my child for personal or religious reasons.

Parent/Legal Guardian Signature_____ Date_____

Cook Inlet Native Head Start | 2020-2021 CALENDAR

AUGUST '20

S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

3-6; Professional Development Day/ CLOSED
7; Teacher Work Day/ CLOSED
10-12; Professional Development Day/ CLOSED
13; Teacher Work Day/ CLOSED
14-20; Enrollment/Transition
21; Teacher Work Day/ CLOSED
24; First Day of School

SEPTEMBER '20

S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

7; Labor Day/ CLOSED
24; Parent University

OCTOBER '20

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

16; Professional Development Day/ CLOSED
22; Family Night/CLOSED
23; Professional Development Day/ CLOSED

NOVEMBER '20

S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

11; Veterans Day/ CLOSED
19; Parent University
24-25; Parent/Teacher Conferences/NO SCHOOL
26-27;Thanksgiving Day/CLOSED

DECEMBER '20

S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

16; Last Day of Semester
17; Family Night/CLOSED
18; Professional Development Day/CLOSED
21-31; Winter Break/CLOSED

JANUARY '21

S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

1; New Year's Day
4-8; Winter Break/CLOSED
11; Teacher Work Day/ CLOSED
12; First Day of Class
18; M.L. King Day
28; Parent University

FEBRUARY '21

S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

12; Professional Development Day/CLOSED
15; Elizabeth Peratrovich Day/CLOSED

MARCH '21

S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

4; Family Night/CLOSED
5; Professional Development Day/CLOSED
8-12; Spring Break/CLOSED
25; Parent University

APRIL '21

S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

22; Parent University
29-30; Parent/Teacher Conferences/NO SCHOOL

MAY '21

S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

14; Family Night/CLOSED
24; Last Day of School
25; Teacher Work Day/ CLOSED
31; Memorial's Day/ CLOSED

First/Last day of School
Enrollment/Transition
Legal Holiday
Professional Development Day (no school)
Teacher Work Day
Parent-Teacher Conference (no school)
Vacation Day
Family Night (no school)
Parent University

CINHS Mitigation Plan

GENERAL

I. Admittance criteria:

Health Screening

- Staff, children, parents, and visitors who feel ill and/or exhibit signs of illness (coughing, sneezing, fever of 100.4 degrees or higher, chills, muscle pain, shortness of breath/difficulty breathing, sore throat, loss of smell or taste, etc.) will not be allowed to enter or attend classes.
- If a staff member is already at work and begins feeling sick, they should notify their manager and go home immediately.
- Children with underlying medical conditions may be disqualified from attending CINHS until after the emergency orders have been lifted. If a child has a serious medical condition it is highly recommended that the guardians consider the risk of attendance. Attendance in the program will be reviewed on a case by case basis. Medical conditions that prevent attendance may include, but are not limited to the following:

    - Chronic lung disease or moderate to severe asthma
    - Serious heart conditions
    - Individuals who are immunocompromised
        - Many conditions can cause a person to be immunocompromised, including cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
    - Severe obesity (body mass index [BMI] of 40 or higher)
    - Diabetes
    - Chronic kidney disease
    - Liver disease
    - Others:

- We expect all employees to report to work at our business locations unless there is a legitimate reason for continued telework, such as an employee with a compromised immune system or caregiving responsibilities that prevent the employee from returning to the workplace temporarily. Work schedules are established to assist CINHS in meeting required goals and objectives, however, temporary adjustments to regular work schedules for special circumstances may be arranged.
- Upon daily arrival to CINHS **all staff, parental guardians and visitors** will be required to screen before entry is allowed. Screening will include a health survey and temperature check. Individuals (staff, parents, children, guests) with temperatures at or above 100.4 degrees will not be allowed entry. This will be strictly enforced.
- All adults entering CINHS are expected to conduct themselves according to these protocols. Adults who engage in behavior within our schools that could increase the

spread of infection (e.g., spitting, yelling, etc.) will immediately be escorted out, and will not be eligible to return until the emergency order is lifted.

Communication

- ***Communication measures to both families and staff will include the following methods:***
  - Signage at the door and throughout facility.
  - ChildPlus texts and messages to parents
  - Email to staff and parents
  - Direct Contact through Family Services
  - Website

Expectations:

- All employees, parents and visitors will be required to answer questions regarding COVID-19 symptoms before entering our buildings. Individuals who refuse to answer health screening questions will not be permitted entry into the building. Employees will be marked with an unexcused absence in these circumstances and may be subject to disciplinary action.

- Despite all precautionary measures, there is always a risk of workplace exposure to communicable diseases. Should an employee contract COVID-19 and expose others in our workplace, and if the staff member works directly with children, then CINHS will immediately inform all employees and parents of children possibly exposed. Children that are possibly exposed will be sent home immediately and cannot attend program for 14 days. Employees who have been potentially exposed will be sent home and asked to telework for 14 days. A thorough cleaning of the workspace used by the infected individual will be conducted after the area has been closed off for at least 72 hours.
- If a child has been attending CINHS and has a positive COVID 19 test, it is the responsibility of the guardian to contact Family Services immediately and notify them of the situation. All parents of children who were in the same classroom will be notified immediately of a possible exposure. Confidentiality will be kept at all times. Parents will need to immediately remove their child from CINHS. It will be highly recommended that they get tested. Additionally, all who were possibly exposed will not attend CINHS for 14 days. Individuals with positive COVID results must return with a medical provider's note allowing attendance.
- Visitors will be limited, and must follow all CINHS mitigation protocols. Please refer to Operations section. **All parents and visitors entering CINHS must wear a mask and participate in the health screening**.
- Meal prep, service, and clean-up procedures. Meal preparation will be prepared in the kitchen and adjacent space. Meals will be plated, covered, and distributed to each classroom. For those students that have allergies that require food substitutions, the kitchen staff will implement a procedure for identifying the individual students (ie using student photo and name on each plate). Meal Service at ANHC will be dished up by one of the cooks in the classroom. The same protocols for plating will be implemented at this site also. While dining, dividers will be placed on 3 sides of the child to prevent transmission while sitting at large tables. Meals will not be served family or communal

style. Parents and guests will not be allowed to dine in the classroom until the threat of the pandemic is past our community.

- Scrubs, aprons, masks, frontal shields, gloves will be worn by staff at different times to prevent the spread of disease. Children in Head Start will be encouraged to wear a mask. Early Head Start students will not wear masks.

OPERATIONS

- ***Sign-In and Sign-Out procedures.***
- ***In order to protect children and staff, only one EHS parent assigned adult will be allowed to enter the building for pick-up and drop-off. If the assigned individual is not able to pick up/drop off, then upon arrival to the school, they will need to call the front desk or their family advocate to receive the child outside. Pre-established sign-In and sign-out procedures remain in effect.***
- ***In order to protect children and staff, at this time NO HS parent assigned adult will be allowed to enter the building for pick-up and drop off. A CINHS assigned staff member will be utilized for student drop-off and pick-up in order to mitigate the spread of COVID-19.***
- ***Screening protocol for staff and children:***
    - ***Staff, children, parents, and visitors who feel ill and/or exhibit signs of illness (coughing, sneezing, fever of 100.4 degrees or higher, chills, muscle pain, shortness of breath/difficulty breathing, sore throat, loss of smell or taste, etc.) will not be allowed to enter the premises.***
    - ***Individuals exhibiting symptoms may not return until he or she has had no fever for at least three days without taking medication to reduce fever during that time, and any respiratory symptoms (ie cough and shortness of breath) have improved, and at least ten days have passed since symptoms began. They may return earlier if a doctor confirms the cause of the fever or other symptoms is not COVID-19 and provides a written release to return.***
    - ***All individuals who walk in must step in a tray with a minimum of 3% Hydrogen Peroxide solution.***
    - ***They will then pass the threshold and wash hands at hand washing stations.***
    - ***Temperature checks will then take place, followed by the health survey.***
- ***For children, handwashing / hand Sanitizing will take place in the classrooms hourly, and during transitions. For staff, parents and visitors handwashing will take place immediately upon entering the center and/or breaks as well as on an hourly basis (or as needed when appropriate, ie before and after eating or handling food, or feeding children).***

- ***During this emergency order CINHS will not be operating at full capacity. Instead, we will follow the recommendations and guidelines from the CDC. In order to create a safe environment, social distancing and group sizes will be different.***

- Classroom Schedules and Populations

    ** There will be no classes on Friday. This time will be used for disinfecting all spaces and items.*

Early Head Start
Beluga (7:45-3:30 pm) 4 students
Moose (9:15-5:00 pm) 4 students
use the back door nearest Elder Center for EHS
TOTAL: 8 EHS students not to include Home Base Enrollment
We are keeping the same amount of EHS students to support EHS parents/Families by converting a HS classroom to an EHS classroom.

Head Start Full Day 7:45 am-3:30 pm
Ten students attend 2 days a week-Monday and Tuesday, 10 different students attend Wednesday and Thursday)
Eagle: 10 students, Monday-Thursday
Bear: 10 students, Monday-Thursday

Head Start Full Day 9:15 am - 5:00 pm
Wolf: 10 students, Monday-Thursday

Head Start Half Day 7:45 am-11:15 am, 12:15-3:45 pm
Fish AM 10 students, Monday through Thursday
Fish PM 10 students, Monday through Thursday

Head Start Half Day 9:15am -12:45 pm and 1:45 pm -5:15 pm
Raven AM 10 students, Monday through Thursday
Raven PM 10 students, Monday through Thursday

Heritage Center

Head Start Full Day 9:15 am-1:45 pm
Ptarmigan: 5 students, Monday through Thursday

Head Start Full Day 7:45 am - 3:30 pm
Puffin: 10 students, Monday-Thursday

Outdoor CINHS Playground Schedule

Morning Classes
Eagle 8:30 am-9:00 am
Fish am 9:15 am-9:45 am
Bear 10:00 am-10:30 am-use back door for leaving and entering playground
Raven am 11:00 am-11:30 am-use back door for leaving and entering playground
Wolf 11:45-12:15 pm

Afternoon Classes
Fish pm 1:00-1:30 pm
Bear 2:00-2:30 pm
Eagle 2:45-3:15 pm
Raven 3:30-4:00 pm

Wolf 4:15-4:45 pm

**classroom teachers will not be doing small group half in/half out schedule –they will be taking all 10 children out with 2-3 teachers.*

EHS classrooms
Beluga- 9:30-10:00 (outdoor walk) and 2:00-2:30 pm (playground)
Moose- EHS 10:45-11:15 (outdoor walk) and 4:00-4:30 pm (playground).

*These two times allow for playground or stroller use
Times are also staggered with Head Start times so we don't have multiple groups in hallways.

Outdoor Heritage Center Schedule

Ptarmigan 9:00-9:45
Puffin 10:15-10:45
**Allows for more travel/space between classes. Maybe enter and exit at different doors.*

Other

- Gym will remain closed to student use during the emergency order.
- Only 10 in a classroom with 2-3 adults
- Separate times/exits for outdoors
- Activities-rotate centers and rotate clean materials
- Use mats or name plates for exercise in the classroom-keep children spread out all around the class
- Rest time-cots 6 feet apart (cots cleaned after each use, blankets and sheets placed in labeled containers.
- 2-3 ropes for each class for walks (knots placed 6 feet apart)
- Meal times. The delivering cook will stay 30 minutes, at ANHC to serve puffin and ptarmigan children, and wait for late children.
- Safety on walking field trips: Coordinate different times, 2-3 ropes knotted 6 feet apart.
- ***Extra mitigation strategies: The break room will have no more than 2 chairs placed 6 feet apart. No more than two individuals can remain seated in the area. Allow only 4 in the space at any given time (two seated, and two heating preparing food). Staff can choose to eat in their classrooms or outside.***
- ***Routine schedule for cleaning, sanitizing, and disinfecting will be followed by all staff. This must routinely happen in classrooms before and after meals, and between activities. Fridays will be reserved for a deep cleaning and sanitizing of the entire facility and high touch objects.***
- All adults must wear a face covering while in common areas and when interacting with individuals.

OCCURRENCE OF COVID-19 IN THE WORKPLACE

- Should a positive case be confirmed, CINHS will immediately inform all employees and parents of children possibly exposed. Children that are possibly exposed will be sent home immediately and cannot attend program for 14 days. Employees who have been

potentially exposed will be sent home and asked to telework for 14 days. A thorough cleaning of the workspace used by the infected individual will be conducted after the area has been closed off for at least 72 hours.

- ***Plan for staff and children to return to program after testing positive, or how to discontinue home isolation:***

  As directed by the CDC, the decision to discontinue home isolation for persons with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or a test-based strategy. Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

  - ***1). Symptom-based strategy:***
    - ***Persons with COVID-19 who have symptoms and were directed to care for themselves at home may discontinue isolation under the following conditions:***
      - ***At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath) and at least 10 days have passed since symptoms first appeared.***
  - ***2). Test-based strategy Previous recommendations for a test-based strategy remain applicable; however, a test-based strategy is contingent on the availability of ample testing supplies and laboratory capacity as well as convenient access to testing.***
    - ***Persons who have COVID-19 who have symptoms and were directed to care for themselves at home may discontinue isolation under the following conditions:***
      - ***Resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath), and negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens).*** https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html

- Should the entire program close for an extended period then CINHS will resume a limited delivery of service via internet, email, and phone.

- CDC protocols, for Cleaning and Disinfection (will be implemented hourly, daily, and weekly.

OTHER RECOMMENDED SAFETY MEASURES

- CINHS will educate staff, families, and children about signs and symptoms of COVID-19 as well as behaviors that encourage
  - CINHS will address possible stigma related to any infectious disease by providing social support. We can communicate that being of a certain ethnicity does not

increase the chance of getting a disease. Viruses cannot target people from specific populations, ethnicities, and racial backgrounds.
    - Plan will be presented to parents at enrollment, and they will need to sign that they agree to the protocols.
- CINHS will encourage families to consider alternative child care opportunities, if our schedules do not align with their needs.
- If the parents have the ability to stay home with their children, they should.
- Discuss other options for care in their friend and family support network.
- Increase handwashing procedures throughout the day. Only use hand sanitizer if soap and water is not available, and if using hand sanitizer, increase supervision while this product is in use.

Signature Required:

I have read and understood the CINHS Mitigation Plan.

I understand that I am required to follow these protocols from _____ (Date) until after the emergency order is lifted at CINHS. If I do not follow these protocols I understand that I may not be allowed entrance to the program, and it could even jeopardize my child's enrollment.

_____ Parent/Guardian Signature

_____ Date

_____ Staff Witness Signature

_____ Date