the Chickasaw Nation
Department of Education / Chickasaw Education Division
300 Rosedale Road / Ada, OK 74820 / (580) 421-7711 / Fax: (580) 436-7279

Bill Anoatubby
Governor

Parent/Legal Guardian Interview

Interviewer will complete highlighted sections. Enrollment will be completed at the interview.

Student name: _____ Birth date: _____

Enrollment date: _____ Entry date: _____ Dropped date: _____

☐ IE ☐ OI

Years of head start: _____ Center: _____ Classroom: _____

Home school district: _____

Gender: ☐ Male ☐ Female Certificate of Degree of Indian Blood (CDIB): ☐ Yes ☐ No

Tribal affiliation: _____ Degree: _____

Parent/legal guardian name: _____

Mailing address: _____
Street City State ZIP

Physical address: _____
Street City State ZIP

Email address: _____

Home phone no.: (__) _____ Work phone no.: (__) _____ Cell phone no.: (__) _____

Legal guardianship documentation form: **(Bring documentation to enrollment)**

☐ Official birth certificate parent driver's license confirmation
☐ Divorce decree dated: _____
☐ Custody court order dated: _____
☐ Foster care letter dated: _____
☐ Witnessed and notarized parent note dated: _____
☐ Temporary custody order dated: _____

Emergency contact(s):

Name:	Address/town:	Phone no.:	Relationship:
_____	_____	(____) _____	_____
_____	_____	(____) _____	_____

Bus: ☐ a.m. ☐ p.m. ☐ Brought to school ☐ Picked up
☐ Other child care: (List name) _____ Phone no.: (____) _____

Pick-up restriction: _____

Are there any health concerns? ☐ Yes ☐ No If yes, explain: _____

_____

Date of child's last physical exam prior to enrollment: _____

Date of child's last dental exam prior to enrollment: _____

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Date of the interview: _____ Interviewer: _____

Updated on: _____ Updated by staff: _____

Re-enrollment interview date: _____ Interviewer: _____

Established medical provider at enrollment: ☐ Yes ☐ No

Established dental provider at enrollment: ☐ Yes ☐ No

Medical coverage and policy ID no.: _____

Routine medications: (Including prescribed vitamins and supplements)

_____

Allergies: _____

Current Physician	Current Dentist
Place address and phone number label here	Place address and phone number label here
Preferred Clinic	**Preferred Hospital**
Place address and phone number label here	Place address and phone number label here

Describe the child's use of communication/language: _____

_____

Did the mother have any health problems during the pregnancy? ☐ Yes ☐ No
If yes, explain: _____

Baby was born ☐ Full-term ☐ Early by ___ weeks ☐ Late by ___ weeks

What was the child's birth weight and length?

Weight: _____ pounds _____ ounces Length/height: _____ inches

Has the child been diagnosed as having a growth or weight issue? ☐ Yes ☐ No
If yes, explain: _____

_____

Describe any problem(s) at birth:

_____

What non-hospitalized accidents has the child experienced? _____

_____

Expectation ranges for milestones skills to be observed:

- Hearing and speech capacity is fully developed after three months
- Vision capacity is fully developed after seven months
- Crawling six to nine months
- Standing eight to 12 months
- Walking nine to 18 months
- Talking 12 to 24 months
- Feeding self 10 to 18 months
- Dressing self 24 to 36 months
- Scribbling 12 to 36 months
- Potty training 12 to 36 months
- Following simple commands 18 to 24 months

The child's milestones: (Indicate with the number of months of age)

When did child begin to _____?	Age began	Age of mastery	Parent/legal guardian concern
Crawl			
Stand			
Walk			
Talk			
Feed self			
Dress self			
Scribble			
Potty train			
Follow simple instruction			

Does the child have difficulty seeing? ☐ Yes ☐ No

Does the child wear prescription glasses? ☐ Yes ☐ No
If yes, who prescribed the eyewear? _____

How is eyewear to be worn? _____

What ear problems, if any, has the child had? _____

_____

What serious illnesses, if any, has the child had? _____

_____

Has the child ever been seen in the emergency room, been hospitalized, or admitted for surgery?
☐ Yes ☐ No If yes, explain:

_____

Does the child have frequent? (check all that apply)

☐ Cough
☐ Colds
☐ Diarrhea
☐ Toileting accidents
☐ Insect bites
☐ Sore throats
☐ Stomach aches
☐ Constipation
☐ Urinary infections
☐ None at this time
☐ Eye/ear infections
☐ Vomiting
☐ Rash
☐ Bruises

Has the child had any of these? (Check all that apply)

☐ Chickenpox	☐ Eczema	☐ Measles	☐ Mumps
☐ Scarlet fever	☐ Sickle cell	☐ Liver disease	☐ Boils
☐ Whooping cough	☐ Hives	☐ Pin worms	☐ Transfusions
☐ Heart problems	☐ Diabetes	☐ Polio	☐ Bleeding tendencies
☐ Ulcers	☐ Pneumonia	☐ Dental pain	☐ Major injuries
☐ Broken bones	☐ Cancer	☐ Kidney problems	☐ Rheumatoid arthritis
☐ Scoliosis	☐ High fever	☐ Syndrome diagnosis (_____)	

☐ Contagious disease: (Explain, if not listed above) _____

☐ None noted at this time: (Items added after the initial interview will be dated and initialed at the time of the addition)

How often does the child follow directions well? ☐ Most of the time ☐ Sometimes ☐ Not very often

What chores does the child do at home? _____

How does the child react to new environments? _____

Who usually spends time with the child during the day? (Identify the relationship to child) _____

Describe the child's sleep pattern: (Sound, light, restless, etc.) _____

Identify the hours that the child usually sleeps: (A time range) _____

Describe what activities interest the child: _____

Describe the length of the child's attention span: _____

What type of toy does the child prefer? _____

Do you have any specific concerns or questions about the child attending the Early Childhood program at this time? ☐ Yes ☐ No, not at this time

If yes, explain: _____

Rate the following areas by placing a check mark beneath the response that best describes the child's preference or behavior in the situation:

	Areas of Consideration:	Often	At Times	Seldom	Not Observed
1	Listens and follows directions quickly	☐	☐	☐	☐
2	Expresses feelings and mood changes appropriately	☐	☐	☐	☐
3	Expresses affection to familiar people	☐	☐	☐	☐
4	Is friendly and smiles a lot	☐	☐	☐	☐
5	Is happy and carefree	☐	☐	☐	☐
6	Is sad	☐	☐	☐	☐
7	Wants help and gets frustrated without assistance	☐	☐	☐	☐
8	Feels the need to fight or argue	☐	☐	☐	☐
9	Throws tantrums	☐	☐	☐	☐
10	Likes quiet places	☐	☐	☐	☐
11	Likes loud places	☐	☐	☐	☐
12	Likes very warm temperature indoors	☐	☐	☐	☐
13	Likes very cool temperature indoors	☐	☐	☐	☐
14	Likes to play indoors in dark places	☐	☐	☐	☐
15	Likes to play indoors in places with a lot of light	☐	☐	☐	☐
16	Enjoys being with other children	☐	☐	☐	☐

	Areas of Consideration:	Yes	No
1	Is scared easily	☐	☐
2	Is resourceful and independent	☐	☐
3	Is very shy and bashful	☐	☐
4	Has moved more than one time	☐	☐
5	Has had a family pet that ran away or died recently	☐	☐
6	Has had a family member die recently	☐	☐
7	Lives with only one parent now	☐	☐
8	Has close relationship with grandparent	☐	☐
9	Speaks clearly	☐	☐
10	Worries about getting embarrassed	☐	☐
11	Chooses from more than two choices	☐	☐
12	Transitions to new tasks or situations	☐	☐
13	Likes to pretend and has a good imagination	☐	☐
14	Likes to listen to a book	☐	☐
15	Likes to use scissors and glue	☐	☐
16	Takes turns with one person	☐	☐
17	Likes to help others	☐	☐
18	Listens to books at home	☐	☐
19	Likes to talk	☐	☐
20	Likes to tell stories	☐	☐
21	Likes to sing songs	☐	☐
22	Likes to play outdoors with more than one person	☐	☐
23	Likes to draw	☐	☐
24	Is a picky eater	☐	☐
25	Likes to stack blocks	☐	☐

26	Shares with one or more person(s)	☐	☐
27	Answers questions about stories	☐	☐
28	Performs on cue	☐	☐
29	Remains belted during car rides	☐	☐

Dietary Habits:

What foods does your child especially like to eat? _____

_____

Are there any foods your child dislikes or should not eat? _____

_____

Does your child take vitamins and mineral supplements? ☐ Yes ☐ No
Contain iron? ☐ Yes ☐ No Contain fluoride? ☐ Yes ☐ No Prescribed? ☐ Yes ☐ No
Is there any food your child should not eat for medical, religious, or personal reasons? ☐ Yes ☐ No
Is your child on a special diet? ☐ Yes ☐ No
If yes, what kind: _____
Has there been a big change in your child's appetite in the last month? ☐ Yes ☐ No
Does your child take a bottle? ☐ Yes ☐ No
Does your child eat or chew things that are not food? ☐ Yes ☐ No
Does your child have trouble chewing or swallowing? ☐ Yes ☐ No
Does your child often have: Diarrhea ☐ Yes ☐ No
Does your child often have: Constipation ☐ Yes ☐ No
Do you have any concerns about what your child eats? ☐ Yes ☐ No