

UMATILLA-MORROW COUNTY HEAD START, INC.  
PROGRAM FACE SHEET

*Pencil Only Please, and update regularly*

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Family Information** (Fill in information about the adults with whom the child resides)

Mother \_\_\_\_\_ Address \_\_\_\_\_

Father \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Relationship:  Parent/Step-Parent Telephone: Home: \_\_\_\_\_  
 Legal Guardian Message / Cell: \_\_\_\_\_  
 Foster Parents Work: \_\_\_\_\_  
 Other:

Number of Members in Family \_\_\_\_\_

Primary Language Spoken in Home:  English  Spanish  Other: \_\_\_\_\_

Primary Language Spoken by Child  English  Spanish  Other: \_\_\_\_\_

**Documented Disability/Special Needs**

Disability/Special Need \_\_\_\_\_ Last IFSP Date \_\_\_\_\_

Disability/Special Need \_\_\_\_\_ Date of Medical Statement \_\_\_\_\_

**Health Insurance Information**

OHP/Medicaid  
OHP/Medicaid No. \_\_\_\_\_ OHP Re-certification Date \_\_\_\_\_

Private Insurance  
Provider \_\_\_\_\_ Policy No. \_\_\_\_\_

No Insurance

**Emergency Information**

Medical Protocol in Place  Yes  No; If yes, condition \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

Persons to be contacted in case of emergency if unable to reach parent/guardian:

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of physician to be called in an emergency for treatment of illness/injury:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_