



Northwest Montana Head Start
 Kalispell Center
 79 7th Avenue East North
 Kalispell, Montana 59901



406.752.7011 Administration Office

FAX 406.755.1916

an equal opportunity provider and employer

Welcome to Northwest Montana Head Start

We are looking forward to being back to normal which means we can now have volunteers involved with our Head Start Centers again.

Head Start is a 501 C3 school funded by a federal grant, community support, and **In-Kind donations**. Parents and family members play a very important role as volunteers at our centers. Each year we are responsible for raising 20% of our operating funds through In-Kind donations and volunteering at the centers. In-Kind options could be helping out a few hours a week in the classrooms, helping put together take and make projects which can be done at home, reading a book to each class, attending all Parent Center Committee meetings or becoming a Policy Council Board member. These are just a few ways to accomplish meeting our 20% match goal.

We appreciate any time you can offer and welcome you to the 2021-2022 School year. If you have any questions, PLEASE call me.

Sincerely,

Margie Jones
 Volunteer Coordinator
 Phone: 752-7011

All Northwest Montana Head Start (NWMTHS) volunteers must complete this packet. NWMTHS reserves the right to revoke volunteer privileges if any document in this packet is altered or any information provided is found to be false.

Background checks and MMR Immunization verification must be approved **BEFORE** any volunteer is placed. Volunteers are supervised by Head Start staff members at all times and are never left alone with children (unless it is their own child).

REQUIRED FORMS:

_____ State of Montana Release of Information—**must be witnessed by a Notary***

_____ **Must provide Proof of MMR Immunization (unless you were born before 1957)**

_____ Tuberculosis Risk Assessment Form

These forms need to be signed during orientation.

- _____ Declaration Form
- _____ Confidentiality Statement
- _____ Discipline Philosophy
- _____ Volunteer Information Sheet



Northwest Montana Head Start
VOLUNTEER INFORMATION

Name: _____ Center: _____

Child's Name: _____ Teacher: _____

Address: _____

Home Phone: _____ Work Phone: _____

Emergency Contact (Name and Phone): _____

Email Address: _____

What type of volunteer positions are you interested in?

Do you have skills that would be an asset to the classroom ? _____

Do you have any hobbies or cultural background you would be willing to share at Head Start?

Please fill out to help with scheduling your time in the class or for take-home projects.

Best DAY for you: ___ Mon. ___ Tues. ___ Wed. ___ Th. ___ Fri. ___ Sat. ___ Sun. ___ Home projects
Best TIME for you to volunteer: _____AM _____PM _____Other:

Comments: If you have any ideas for volunteer activities, please let us know.

Tuberculosis Risk Assessment Form

The Centers for Disease Control and Prevention and the United States Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at increased risk of tuberculosis as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis.

Please complete the following form completely. Place a mark in the box in front of the section if any item in the section is true for you. IF YOU CHECK ONE OF THE BOXES IN SECTIONS 1 – 4 YOU ARE REQUIRED TO HAVE A TUBERCULOSIS (PPD) SKIN TEST. If you are an employee requiring an employment physical, please take this form to your appointment and review it with your physician. Check the box on the bottom of the page if sections 1-4 do not apply to you. Sign and date the form at the bottom. If you are under eighteen years of age, a parent or guardian must sign the form.

- Section 1: Check this box if you have any of the following **Possible Symptoms of Tuberculosis**:
- Unexplained weight loss
 - Unexplained elevation of temperature for more than one week
 - Unexplained night sweats
 - Unexplained persistent cough for more than 3 weeks
 - Unexplained cough productive of bloody sputum
- Section 2: Check this box if you have any of the following **Risk Factors for Tuberculosis Infection**:
- Close contact with a known case of active tuberculosis
 - Use of illegal injected drugs
 - HIV (Human Immunodeficiency Virus) Infection
 - Health Care Worker
 - Resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility)
- Section 3: Check this box if you have any of the following **Risk Factors for Tuberculosis Disease**:
- Diabetes mellitus
 - Lymphoma, leukemia, or cancer of the head, neck, or lung
 - Chronic kidney failure
 - Silicosis
 - Gastrectomy or jejunio-ileal bypass
 - Long term immunosuppressive therapy
 - Greater than 10% below ideal body weight
- Section 4: Check this box if, in the last five years, you have lived in or traveled for 30 days or more to any of the following **Areas with a High Prevalence of Tuberculosis** as defined by the World Health Organization and the state health department:
- **Africa** – All countries
 - **Asia/Southeast Asia/Pacific Islands** – All countries
 - **North, Central, & South America** – Argentina, Bahamas, Belize, Bolivia, Brazil, Costa Rica, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
 - **Europe** – Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
 - **Middle East** – Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, Yemen
- No, none of the items listed in section 1 – 4 apply to me.

Printed Name _____ Signature _____ Date _____
(Parent Signature if < 18)