

CHILDREN'S TRACKS

Dear Parents

In cooperation with your child's school, the Lead Poisoning Prevention Center is planning to test children for lead poisoning. A child can appear well, showing no symptoms of illness and still have lead poisoning in his body. This test can show if your child has dangerous amounts of lead in his body. This test is free and consists only of a fingerstick blood test which will be analyzed at the Lead Poisoning Prevention Center Laboratory. Your child's school will be notified of the test results and you will be notified if your child needs further tests or treatment. All children should be tested every six months until their sixth birthday.

We hope that you will complete the following permission to test your child and return it to his or her school center within two days.

Thank you for your cooperation.

Ronald Jones
Lead Poisoning

DATE

CHILD'S NAME _____

ADDRESS _____

TELEPHONE # _____

I give my permission to my child tested for lead poisoning.

HAS YOUR CHILD EVER BEEN TESTED FOR LEAD POISONING?

YES NO

If there are other children under six years of age in your home, you are invited to bring them to the Lead Poisoning Prevention Center for testing. The lead poisoning tests will be given on _____ at _____

SCHOOL _____

WAREHOUSE COOPERATIVE SCHOOL

Information on the Student
(to be completed by a parent or guardian together with the student)

Name of the student _____

Date of birth _____

(The next four items should be completed by the student, with the help of the parent or guardian if necessary)

From what you now know of the Warehouse Cooperative School, what questions do you have about it?

What aspects of the school appeal to you?

What interests would you most like to pursue this next year in school?

Which skills or studies do you feel you should engage in this next year to prepare yourself for the future?

Name of student's doctor _____

Address _____

Telephone _____

SOCIAL SECURITY ACCOUNT NUMBER

031-48-5339

HAS BEEN ESTABLISHED FOR

Peter F

SIGNATURE *Peter*

FOR SOCIAL SECURITY AND TAX PURPOSES—NOT FOR IDENTIFICATION

No. 8302

Peter

Trapel


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VISITOR'S PASS



U.S. House of Representatives

WASHINGTON, DC July 30

Michael S

for the Ninety-first Congress


B- 87398 (OVER) M.C.



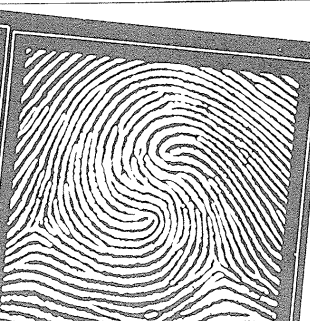
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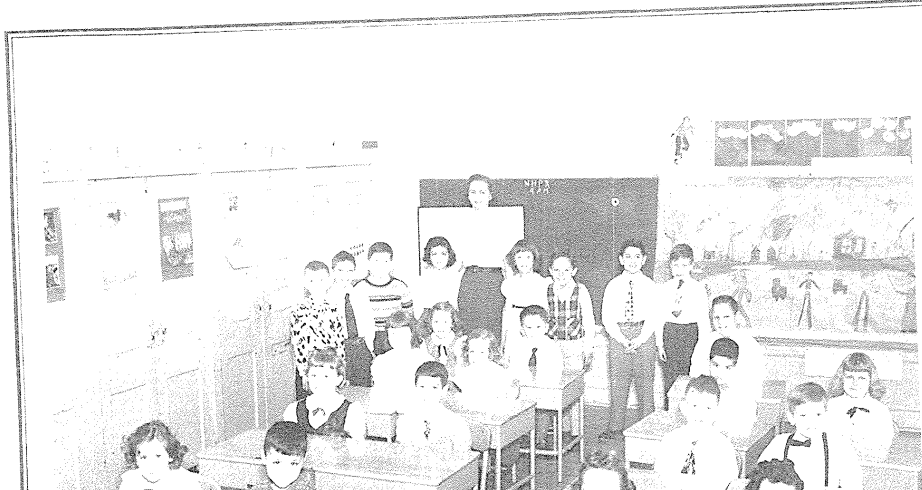
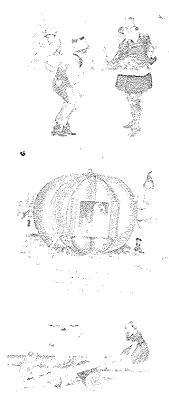



LOOP



DOUBLE LOOP

FINGERPRINTS—VALUABLE CLUES IN SOLVING



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Examination of
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Indicate the teeth
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Before beginning work

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Form CW-32
Plate 1101

Section 15 of
Chapter 500 o

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SPED-12A

The Commonwealth of Massachusetts
DEPARTMENT OF EDUCATION

APPLICATION FOR THE INSTRUCTION OF A BLIND CHILD

To His Excellency the Governor:

I, of in the County
.....
(Name of parent or guardian) (City or Town)
of and Commonwealth of Massachusetts, respectfully represent to
(County)
Your Excellency, that my { son, daughter, }
word, (Name of child)
is blind, and cannot be properly instructed in the regular public school programs of this Common-
wealth.

I therefore respectfully request that Your Excellency will send him (her) to
(Name of School or Class)
..... 19
(Date) (Signature of parent or guardian)

The undersigned believes that the { son, daughter, }
..... (Name of child) (Name of parent or guardian) word,
of (Name of parent or guardian) a resident of this town (city) is incapable of
receiving instruction in our regular public school program by reason of blindness, and is therefore
entitled to be placed in a school or program designated by law for blind children.

QUESTIONS TO BE ANSWERED BY PARENT OR

- Name of parents, Father Mother
- Residence Street City or Town
- Birthplace of parents, Father Mother
- Name of the child
- Birthplace of the child
- Date of birth of the child
- Was the applicant born blind? If not, at what age was the child first
found to be blind?
- Is the blindness total or partial? If partial, how soon apparent is it?
.....
- What is the supposed cause of the blindness?
- Has the applicant any infirmity or disease other than blindness? If
.....
- What serious illnesses has the applicant had? (Measles, mump,
paralysis, scarlet fever, etc.)
- Is the applicant now in good health and free from eruptions and
skin?
- Has the applicant ever been vaccinated?
- Has the child ever been to school? If so, where and how long?
- Occupation of parent or guardian
- Name of employer
- Address of employer
- The weekly charge for residential pupils is \$9.00 per week. Can you
.....

Comments:

(NOTE: If you agree to pay the full amount for the board of your
questions 18, 19, 20 and 21.)

18. Total number of members of family dependent on total income

IMMUNIZATION RECORD

(Your doctor may follow a slightly different schedule)

FIRST YEAR

DPT*

Recommended age Date given to your child

1½ to 2 months
3 months
5 months

Polio vaccine

5-8 months

Measles vaccine

6-12 months

Smallpox vaccine

Before 12 months

SECOND YEAR

Give any injections not started or completed in first year.

Additional injection of DPT. 12-18 months

Polio and measles vaccine may be recommended by your doctor.

BEFORE GOING TO SCHOOL

DPT and polio vaccine

4 years

Smallpox vaccine

5-6 years

THEREAFTER

Booster doses of DT (whooping cough no longer needed) and polio vaccine. At intervals recommended by your doctor.

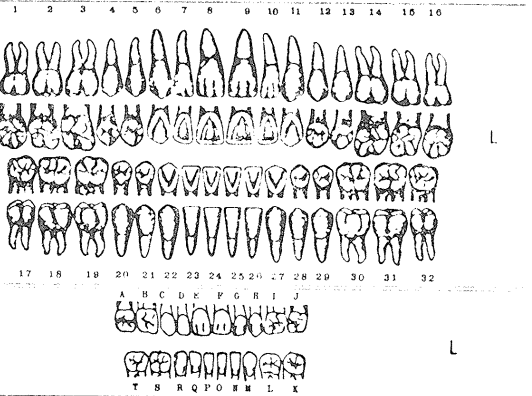
Smallpox vaccine every 5 years, before the child leaves the United States or if there is an epidemic.

*DPT stands for diphtheria, pertussis (whooping cough), and tetanus.

DEPARTMENT OF PUBLIC WELFARE - DIVISION OF CHILD GUARDIANSHIP REPORT ON DENTAL EXAMINATION

Date _____ 19__

Name of _____
Birth _____



the teeth requiring attention and itemize the treatment and the cost.

Beginning work kindly return this report for approval to _____, Visitor

Dr. _____

Section 15 of Chapter 76 of the General Laws, as most recently amended by Chapter 590 of the Acts of 1967, is hereby further amended...

"In the absence of an emergency or epidemic of disease declared by the department of public health, no child whose parent or guardian states in writing that vaccination or immunization conflicts with his sincere religious beliefs shall be required to present said physician's certificate in order to be admitted to school."

Chapter 285 of the Acts of 1971
General Laws of Massachusetts

Deaths From Diphtheria, Measles,
Polomyelitis and Pertussis: U. S. 1958-1967

Signs of eye trouble in children

BEHAVIOR

- Rubs eyes excessively.
- Shuts or covers one eye, tilts head or thrusts head forward.
- Has difficulty in reading or in other work requiring close use of the eyes.
- Blinks more than usual or is irritable when doing close work.
- Stumbles over small objects.
- Holds books close to eyes.
- Is unable to see distant things clearly.
- Squints eyelids together or frowns.

APPEARANCE

- Crossed eyes.
- Red-rimmed, encrusted, or swollen eyelids

**SPECIAL SCHOOLTIME ACCIDENT INSURANCE AVAILABLE TO PUPILS AND EMPLOYEES
BOSTON PUBLIC SCHOOLS**

Underwritten By:
NORTH CENTRAL LIFE INSURANCE COMPANY
St. Paul, Minnesota

UNDER THE SCHOOLTIME PLAN your child is insured while:

ATTENDING SCHOOL during the hours and on the days when school is in session. . . **PARTICIPATING** in or attending sponsored activities, except as otherwise provided in the Policy, including school supervised travel directly and uninterruptedly and from such activities, during the school term. . . **TRAVELING** directly and uninterruptedly to or from the Insured's home as defined in the Policy, and the school for regular school sessions, for such travel time as is required, but not to exceed one hour before school begins and not more than one hour after school is dismissed, or if additional travel time beyond one hour by school bus or a common carrier is required, coverage hereunder shall extend for such time that might be necessary. . . **PARTICIPATING** in play or practice of school-sponsored and supervised sports except interscholastic football at the Senior High School.

STUDENT ACCIDENT INSURANCE PAYS . . . necessary expenses, commencing within 60 days, and incurred within 90 days from date of accidental injury, up to a maximum benefit of \$3,000 for:

HOSPITAL CARE — All usual and customary charges for necessary in-hospital services commencing within 60 days after the accident;

NURSE — All customary charges for a licensed registered nurse, if nursing is recommended by doctor;

PHYSICIAN'S FEES — Usual, customary fees charged in the area where treatment is administered by a licensed physician, surgeon, or osteopath (M.D., D.O., or D.M.D.);

DENTAL — Usual, customary fees for dental treatment administered to injured sound, natural teeth;

X-RAY — All necessary X-rays;

PHYSIOTHERAPY — Pays for physiotherapy, diathermy,

heat treatment in any form, manipulation, or massage;

PRIVATE OR COMMUNITY AMBULANCE.

DEATH OR DISMEMBERMENT — If injury results in any of the following specific losses within 180 days of the accident, the Company will pay the amount shown in the table below, the greatest, shall be paid for any one loss and is payable IN ADDITION TO benefits payable for medical expenses.

PAYS FOR LOSS OF —

| | |
|-------------------------------|-------|
| Life | |
| Double Dismemberment | |
| Single Dismemberment | |
| Entire Sight of One Eye | |

THE POLICY DOES NOT COVER:

Senior High School Interscholastic football, including the practice or play thereof; ptomaine or bacterial infections (except venereal diseases) which shall occur with or through a wound effected by accidental bodily injuries; any damage or treatment for the replacement and repair of injury sustained to sound, natural teeth; private air travel; self-inflicted injury; war or any act of war; damage or replacement of eye glasses or prescriptions therefor; illness or injury of any kind, including blisters, insect bites, heat or fatigue exhaustion, frostbite or sunstroke, fainting, warts or ingrown nails, or any other condition of any form, however caused and regardless of anatomical location; injury for which compensation is payable under any workers' compensation law, or any aggravation of a pre-existing condition.

PROMPT CLAIM PAYMENT. . . All claims are handled efficiently, promptly and courteously. When your child is hurt or injured, the injury is reported to the school, which will supply a claim form to be filled in. Many years of experience in the service to schools of every kind assures each parent of excellent service.

NOTICE OF CLAIM AND PROOF OF LOSS. . . Written notice of claim must be given to the Company within 30 days of the date of the accident. Claims must be filed within 90 days from the date of the accident.

TO INSURE YOUR CHILD. . . Simply fill in the application-envelope completely, enclose \$1.40 and have your boy or girl bring the envelope to school. The insurance cannot become effective until the application and premium are received by the school. Urge all parents to participate in this program which is written at a nominal cost. The policy is extremely broad with many exclusions.

53-86-7

Application to
NORTH CENTRAL LIFE INSURANCE COMPANY
SCHOOL STUDENT ACCIDENT INSURANCE

Student's Name

Age..... Birth Date.....

Home Address

EMPLOYEES OF

or attending school-
d uninterruptedly to
e Insured's residence
t to exceed one hour
and one hour on the
cessary. PARTICI-
or High School level.

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injury results in one
n 180 days after the
ount shown. Only
for any one accident
benefits for medical

-\$2,000
-\$7,500
-\$3,500
-\$3,500

ions (except pyogenic
or treatment to or re-
r any act of war; aller-
giness or disease in any
ngrown nails; hernia in
under any Workmen's

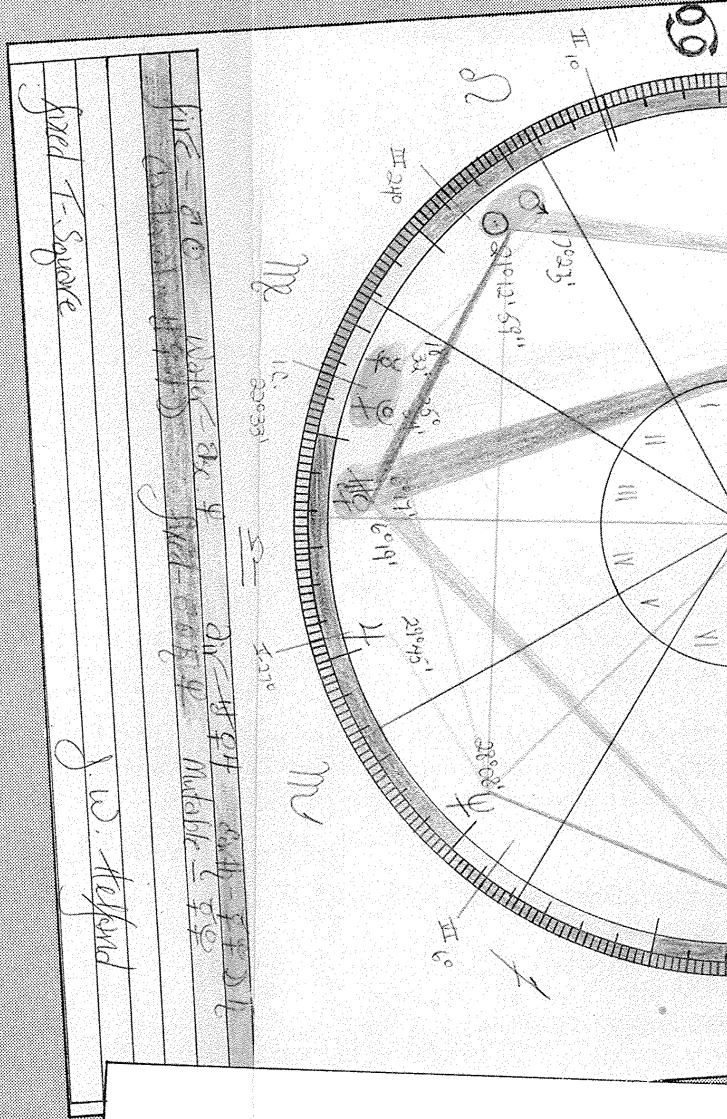
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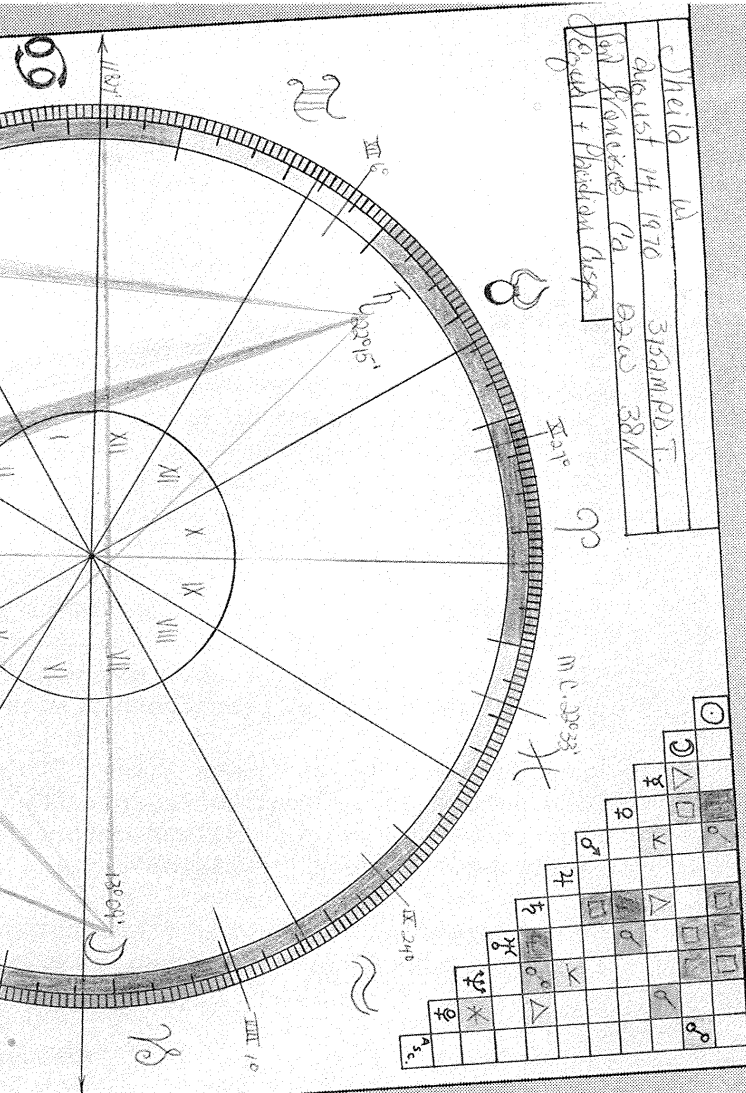
your boy or girl return
ved by the school. We
broad with few excep-

COMPANY
ANCE

Grade.....



powerful position which could ma-
career woman. She could be a
recovered respectable person. She
to wander the physical sciences and
Power. She should guard against &
There is an ability to materialize good
The general placement of planets
marked for an irate, objective
ASC, Cancer ascending makes
with the past. She will become a creative
emotion. There is a need for production



Sheila W.
August 14, 1970

O Sun in Leo generally indicates energetic individual & somewhat unlikely to be quite direct and sincere in and communication. Leo are often of leadership. While their aggression usually springs from a warm some may be regarded as over-ventured. The Leo child has a center of attention.

M Moon in Capricorn often in powerful position which could make career woman. She could be a



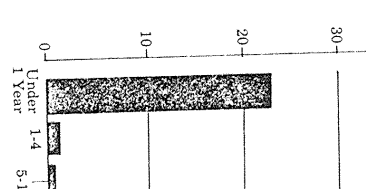
The Commonwealth
Department of
600 Washington Street

PATRICK A. TOMPKINS
COMMISSIONER

Will you kindly verify the following information:

Name _____
 Date and Place of death _____
 Cause of Death _____
 Married to or widowed or divorced from _____
 Age: Years _____ Months _____
 Birthplace _____
 Father _____
 Mother _____
 Place of burial _____
 Name of undertaker _____
 As no certified copy is necessary we will accept with any corrections or additional information _____
 Town or City Clerk _____
 Death record. Case No. _____

GW-120c
295



Commonwealth of Massachusetts

Department of Public Welfare

600 Washington Street, Boston 11

_____ 19_____

Following record:

DEATH

Sex _____ Color _____

Deceased from _____
 Months _____ Days _____

Occupation _____

His birthplace _____

Her birthplace _____

It is necessary we would appreciate the checking of this form
 if additional information your records may afford.

 Supervisor

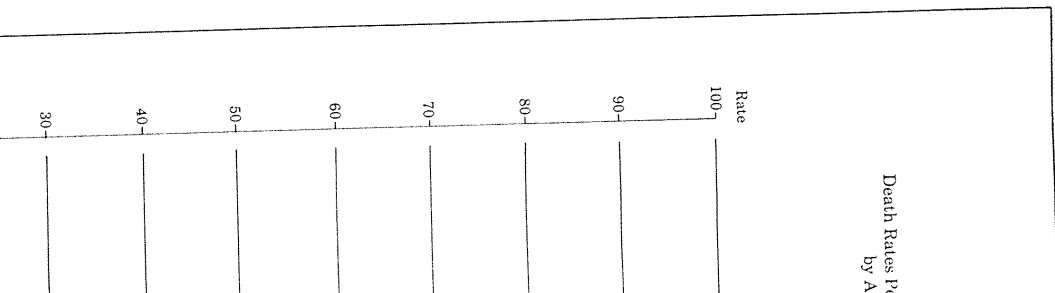
Table 50.
 Deaths in Children
 Aged 1 to 4
 by 6 Leading Causes:
 United States, 1967
 (Chart 110) (Adapted)

| Cause of Death | Deaths per 100,000 Population | |
|---|-------------------------------|-----------------|
| | Total | Specified Group |
| Accidents | 32.4 | |
| Congenital malformations | 9.7 | |
| Influenza and pneumonia | 9.2 | |
| Cancer | 8.2 | |
| Measles | 2.0 | |
| Menigitis | | |
| Castroitis, duodenitis, enteritis, and colitis except diarrhea of newborn | 1.9 | |

U.S. Department of Health, Education, and Welfare
 Division of Health Services and Mental Health Administration
 National Center for Health Statistics

Fill in 1970.
 L.I. Girl, 2, Burned to Death
 HEMPSTEAD, L.I., March 28
 (UPI) — A 2-year-old girl was
 burned to death today while
 playing with matches while
 sitting in the back seat of an aban-
 doned car parked in an alley
 in Hempstead. Capt. William
 Or Meddis, commander of the
 Nassau County police homicide
 squad, said an effort to
 rescue the girl, Latisha R. ,
 had failed because "the interior
 of the car was completely en-
 gulfed in flames." She had
 lived at 96 Mason Street.

The risk of death in the
 first year is higher than
 that for any other year
 under sixty-five.
 Premature births,
 congenital
 malformations, and
 postnatal asphyxia
 account for more than
 fifty percent of all
 infant deaths.



EXPLORING CHILDHOOD / FAMILY AND SOCIETY

Experimental Edition

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Print
in ink
or type

APPLICATION FOR LICENSE TO CONDUCT A DAY CARE SERVICE

The undersigned hereby applies for a license to conduct the following day care service for _____ children, ages _____ to _____ years:

Name of day care service Tel. No.

Street address of premises City or town Zip Code

7. I agree to assume complete responsibility for all business to be carried on in the premises for which I am making this application for a license and I further agree that all of said business conducted in said premises will be carried on at all times in full compliance with all Federal, State, and city or town laws, rules, and ordinances pertaining to licensing of day care services.

Signature of applicant or authorized officer(s) Title Date

Title Date

9. School year: from _____ to _____ Summer program: from _____ to _____

| Session | Days | Hours | Fee per period covered | No. of groups | No. of children | Age range | Number transported |
|---------|------|-------|------------------------|---------------|-----------------|-----------|--------------------|
| A.M. | | | | | | | |
| P.M. | | | | | | | |
| All day | | | | | | | |

Additional fees: Registration \$ _____ Transportation \$ _____ Other \$ _____

10. Number of children under 3 years _____
 Children 6 years of age and over on premises:
 Elementary or secondary grades: No. of children _____ Ages _____ to _____
 After school program: No. of children _____ Ages _____ to _____

11. Number of handicapped children _____

ADMISSION POLICIES AND PARENT COUNSELING

12. Attach copy of your application form (enrollment form) for admission of a child to this day care service

13. Give statement of procedure followed in admitting a child to care:

14. Describe plan for counseling with parents:

INDOOR AND OUTDOOR PROGRAM FOR THE CHILDREN

15. Is there a planned daily schedule of activity? Yes _____ No _____

16. Is this schedule planned in advance for a Year _____ Month _____ Other (Specify) _____

17. Describe schedule of indoor activity

ETY



PEDIATRIC HISTORY FORM

PLEASE BRING THIS AND IMMUNIZATION RECORD AT TIME OF FIRST PEDIATRIC APPOINTMENT: . . .

Name of child: Donald Mitchell
Date of birth: March 7, 1972
Your relation to this child: Mother

INSTRUCTIONS: Please fill in the blanks or check the correct answers as thoughtfully as you can and return to us in the enclosed self-addressed envelope. This will help your doctor to understand your child. It is regarded as a confidential, privileged communication, so please be frank with your answers.

newborn history:
Where was this child born? Newton-Wellesley Hospital Newton, Mass.
City & State
Was the child born: Early by 1 week or more, at 9 months. Overdue 1 week or more
Was the child born by: a. Normal birth: b. Breech feet first: c. Caesarian section
Was labor induced with this child's birth? Yes No
Was the mother in labor with this child for over 24 hours? Yes No
Did the mother's water break over 24 hours before the child was delivered? Yes No
Were there any problems or complications during this pregnancy or delivery? Yes No
The child's weight at birth was 9 lbs. and 13 1/2 oz.
At what age did this child first leave the hospital? 7 days

During the first week of life did this child have any of the following - check off any of the following problems which this child had during the first week of life:

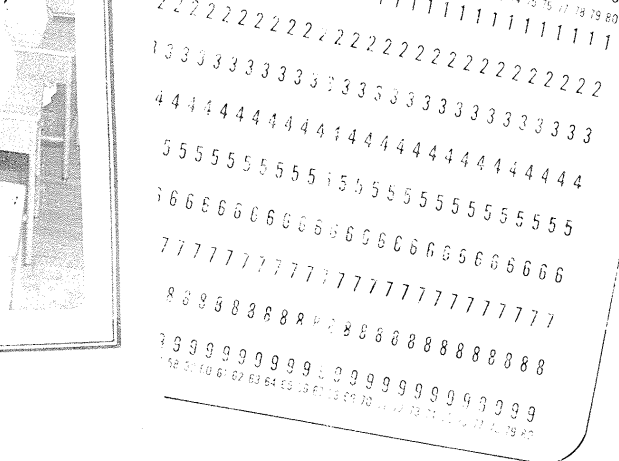
- a. Feeding trouble
- b. Excess vomiting
- c. Blueness - Cyanosis
- d. Need of oxygen
- e. Yellow jaundice
- f. Diarrhea
- g. Seizures - convulsions
- h. Breathing trouble
- i. Fever
- j. Other: _____

Yes No
 Yes No
 Yes No
 Yes No

Yes No
 Yes No
 Yes No

average
age

fever



a. Vomiting b. Diarrhea c. Constipation
 d. Colic e. Ear infections f. Fever
 g. Slow weight gain h. Other: _____

Does the child now take vitamins? Yes No
 Does the child now take flourides? Yes No
 Does your community have flouridated water? Yes No
 Do you have speckle in the house? Yes No

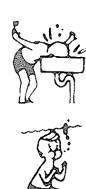
Feeding history:
 What kind of milk was the child started on? a. Breast b. Formula
 How old was the child when taken off the bottle? 9 Months
 How many bottles or glasses of milk does the child have a day? 2-3
 Did the child have any of the following during the first 6 months of life?

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Norms Used: First half of year Second half of year
 (Check one)

| | | | |
|----------------------------------|--------------------------|--------------------------|--------------------------|
| Index of Learning Potential Rank | Chronological Age | YRS. | MOS. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| PERFORMANCE BY AGE | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Stanine | Percentile Rank | TOTAL | Percentile Rank |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



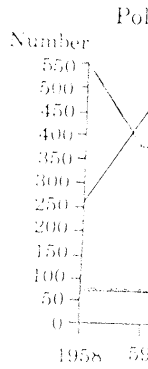
Breath Holding

Rhythmic Breathing

Appropriate dates, and sign on specified lines write "unknown", "unavailable", and complete in every detail.

Name of parent or guardian: _____

of your child, you need not answer: _____



APP ANALYSIS OF LEARNING POTENTIAL

PRIMARY I BATTERY



Fill in these blanks:

NAME _____ LAST _____ FIRST _____ INITIAL _____ BOY GIRL
 TEACHER _____ DATE OF TEST _____ YR. MO. DAY _____
 SCHOOL _____ GRADE _____ DATE OF BIRTH _____ YR. MO. DAY _____
 CITY _____ STATE _____ AGE _____ YRS. MOS. DAYS _____

TEST SCORE SUMMARY

PERFORMANCE BY GRADE

| TEST | RAW SCORE | GENERAL COMPOSITE STANDARD SCORE | PERFORMANCE BY GRADE | | | | | |
|-----------------------------|--------------------------|----------------------------------|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | OPTIONAL COMPOSITE PROGNOSTIC SCORES | | | | | |
| 1. Quantitative Language | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. General Information | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Word-Picture Association | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Listening Comprehension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Picture Vocabulary | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Figure Perception | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Story Sequence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TOTAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Percentile | | | | | | | | |

✓ Combined Stroke front



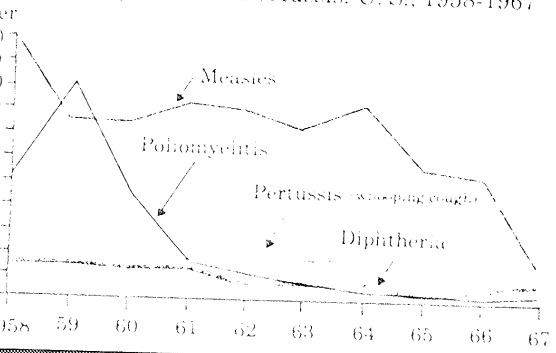
Combined Stroke



Procedures:

Items 1 and

Deaths From Diphtheria, Measles, Polomyelitis and Pertussis: U. S., 1958-1967



- Crossed eyes.
- Red-rimmed, encrusted, or swollen eyelids
- Inflamed or watery eyes.
- Recurring styes.

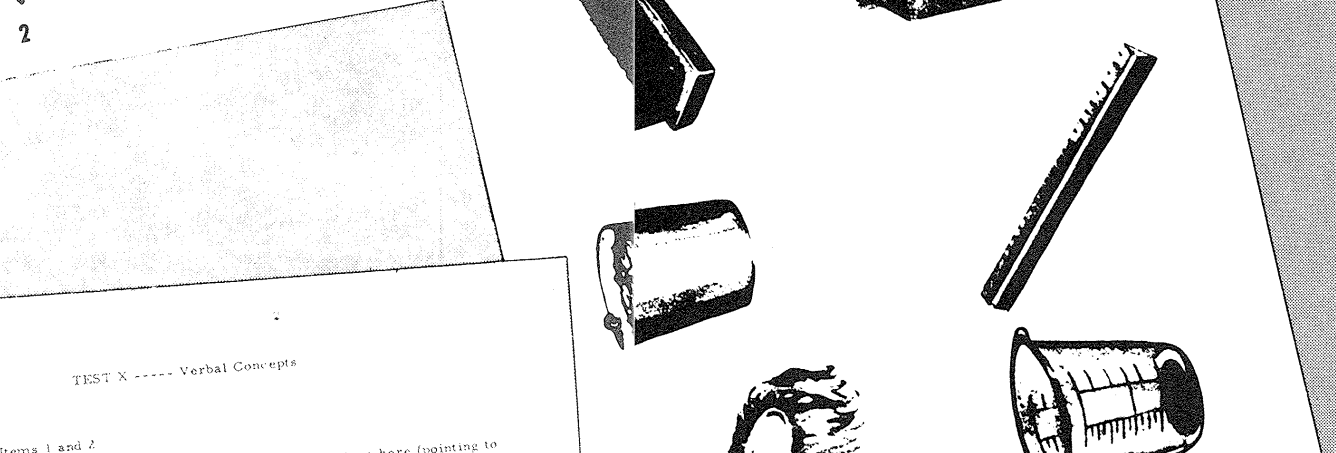
COMPLAINTS

- Eyes itch, burn or feel scratchy.
- Cannot see well.
- Dizziness, headaches, or nausea following close eye work.
- Blurred or double vision.

Tab. G-102



Developed by the Pittsburgh Public Schools, and used with their permission.



TEST X ----- Verbal Concepts

Items 1 and 2

here (pointing to

Age..... Birth Date.....

Home Address

School..... Room Num.....

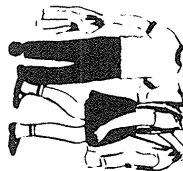
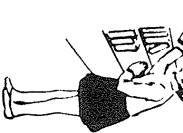

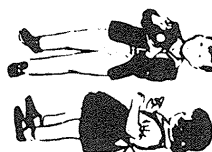
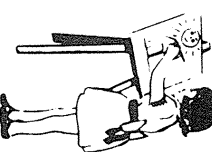
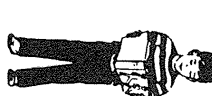
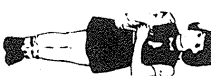


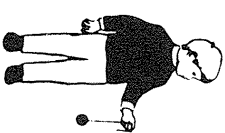
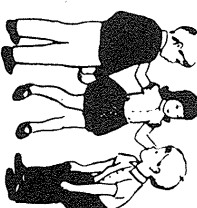
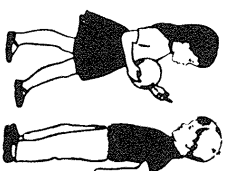
SIGNATURE OF PARENT OR

Please cooperate with your school officials by returning the Room Teacher promptly with the premium of \$1.40 enclosed.

If you do not wish to insure your child, please sign below.

..... Parent

BOSTON PUBLIC SCHOOLS

| | | |
|---|---|---|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

| | |
|--------------------------------|-------|
| COMPLETES WORK ASSIGNMENTS | _____ |
| LISTENS WHEN OTHERS SPEAK | _____ |
| OBEYS QUICKLY AND CHEERFULLY | _____ |
| ACCEPTS RESPONSIBILITIES | _____ |
| IS COURTEOUS | _____ |
| RELAXES DURING RECREATION TIME | _____ |
| ATTENDANCE | _____ |
| DAYS ABSENT | _____ |
| TIMES TARDY | _____ |

Grade
Number
Parent or Guardian
ing this to the Home
nclosed.
low.
Parent or Guardian

make for dedicated
a prudent, sensitive
there is a tendency
and a capacity for
at thinking comparisons.
goals.
plants in the chart
ative personality.
shers for a preoccupation
tween and shelter.
I



Progress Report

KINDERGARTEN

PUPILS
TEACHER
PRINCIPAL

COMPLETES WORK

Spanish-speaking pupils 'neglected'

The Civil Rights Commission said today teachers in Southwestern schools pay far more attention to Anglo students than chicanos, reinforcing and mirroring educational neglect of the Spanish-speaking minority.

"There are gross disparities in favor of Anglos," the commission said in releasing a report on teacher-pupil interaction in the classrooms.

Child Care

New York child-care facilities discriminate against black children, according to a federal lawsuit filed on behalf of 10,000 children by the New York City and the Legal Aid Society. In New York City, child-care services are provided by 77 voluntary agencies, organized by religion. They are ostensibly private agencies; however, they get up to 100 percent of their funds from government. "The voluntary agencies can pick the children they want and refuse those they don't want," the lawsuit says. "The overflow ends up in children's shelters or state training schools where services are inadequate and conditions brutal." The "overflow" tend overwhelmingly to be black and Protestant, the lawsuit alleges. The suit asks the court to order the city and state to formulate a child-care plan free of racial and religious discrimination.

COPY FOR JUVENILE

The Commonwealth of Massachusetts

JUVENILE SESSION

SUFFOLK, ss:

COMPLAINT — DELINQUENT CHILD
(General Laws Chapter 119 Sections 54-55 As Amended)

TO THE HONORABLE PAUL MURPHY, Justice of the Municipal Court of the West Roxbury District.

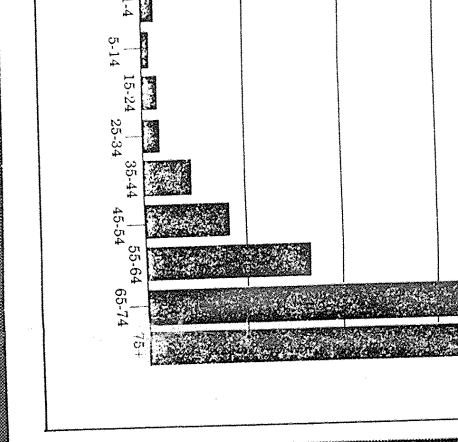
RESPECTFULLY represents your complainant Laurence J. Sullivan
of Boston, in said County of Suffolk, in behalf of said Commonwealth, on oath complains that

of Boston in said County of Suffolk, being between the ages of seventeen and seventeen is considered a Delinquent Child in that on the February day of February in the year of our Lord one thousand nine hundred and seventy four, at said Boston

in said County of Suffolk, said , was a disorderly person, in that the said did use abusive and obscene language, and did create a hazardous and physically offensive condition by an act which served no legitimate purpose of the actor, to wit: throwing missiles in a public way, said abusive and obscene language being directed at Laurence Sullivan, said offence taking place in Clare Avenue, then and there a public way in said City:

4, 1970 3:15 AM PDT

indicates an outgoing
 authority. She will
 be in matters of love
 often seen in positions
 receive self expression
 from her nature,
 overbearing and
 a desire to be the
 then produces persons
 This is a very
 make for dedicated



LEGAL ASSISTANCE INTAKE SHEET

CLIENT (Last) (First) (Middle) DATE / / FILE NO. _____

ADDRESS _____ INTERVIEWER _____

APT. _____ TELEPHONE NO. _____ TRANSFERRED TO _____

MARRIED: Yes _____ No _____ DATE _____

NO. OF CHILDREN AT HOME _____ ADDRESS _____

NO. OTHER PERSON SUPPORTED BY _____ TEL. _____

FAMILY INCOME _____

EMPLOYED: Yes _____ No _____ ATTORNEY _____

EMPLOYER'S NAME AND ADDRESS: _____ ADDRESS _____

_____ TEL. _____

PRESENT NET INCOME/WK _____ RETURN DAY / / CT. DOCKET _____

NO. MOS. EMPLOYED _____ REFERRED HERE BY _____

DATE LAST EMPLOYED _____ CONSULTED OTHER ATTORNEY _____

NAME AND ADDRESS OF _____

LEGAL PROBLEM BY TYPE

- | | |
|--|--|
| <p>FAMILY PROBLEMS</p> <p>Wills and Estates _____</p> <p>Divorce _____</p> <p>Separation _____</p> <p>Non-Support _____</p> <p>Custody & Guardianship _____</p> <p>Paternity _____</p> <p>Adoption _____</p> <p>Property _____</p> <p>Other _____</p> <p>ADMINISTRATIVE PROBLEMS</p> <p>State and Local Welfare _____</p> <p>Denial/Resignation/Redemption _____</p> <p>Workman's Compensation for _____</p> <p>Veteran's Administration _____</p> <p>Benefits _____</p> <p>Unemployment Insurance _____</p> <p>Other _____</p> <p>HOUSING PROBLEMS</p> <p>Private Landlord and Tenant _____</p> <p>Housing Code Violations _____</p> <p>Public Housing _____</p> <p>Non-Consent Proceedings _____</p> <p>Eviction _____</p> <p>Rent Withholding _____</p> <p>Rent Increases _____</p> <p>Other _____</p> | <p>CONSUMER AND EMPLOYMENT PROBLEMS</p> <p>Sales Contracts _____</p> <p>Garnishment & Attachment _____</p> <p>Wage Claims _____</p> <p>Bankruptcy _____</p> <p>Discrimination _____</p> <p>Other _____</p> <p>MISCELLANEOUS PROBLEMS</p> <p>Commitment Procedures _____</p> <p>Incorporation _____</p> <p>Profit _____</p> <p>Unprofit _____</p> <p>Income Tax _____</p> <p>Other _____</p> <p>SCHOOL PROBLEMS</p> <p>Truancy _____</p> <p>Teacher/Student _____</p> <p>Curriculum _____</p> <p>Special Needs _____</p> <p>Discrimination _____</p> <p>Other _____</p> <p>TORT PROBLEMS</p> <p>Slander/Libel _____</p> <p>Automobile Injury _____</p> <p>Assault & Battery _____</p> <p>Trespass _____</p> <p>Fraud & Deceit _____</p> |
|--|--|

DOCUMENTS FILED _____ COURT DOCKET _____ HEARING DATE _____ COURT _____ RESULT _____

FOR INFANTS AND CHILDREN THROUGH SIX YEARS OLD

EATING:

Fed by: _____ Bottle: _____ Cup: _____ Glass: _____

Feeds self: _____ Needs help: _____ Likes help: _____

Food consists of: _____ Strained _____ Junior _____ Regular _____

Comments or requests: _____

Special food and drink likes: _____

your child
 furnish
 l at home.
 I leave it

Special food and drink likes:

Food dislikes: Allergy to foods:

SLEEPING:

| | | |
|------------------------------|---------------------------------|-------|
| Sleeps on back: | Stomach: | Side: |
| Takes toy to bed with him: | What? | |
| Are you leaving it with him? | Be sure everything is labelled. | |
| Goes to sleep quickly: | Plays awhile? | |
| Sleeps in room alone: | With someone: | |
| Wakes at night: | Sleeps through: | |

BATHING:

| | | |
|----------------------|-------------|-------------|
| Washes self: | Needs help: | Likes help: |
| Brushes teeth alone: | Needs help: | Likes help: |

TOILET HABITS:

| | |
|--|-----------------|
| Has toilet training started? | Been completed? |
| Accustomed to nursery chair: | Potty: Toilet: |
| Terms used to refer to bowel movement: | Urination: |

REMARKS:

How long?

How many times a week?

How long a week?

e)
 bar)
 emony)
 please give



Certificate of Recognition

Awarded to *Samy*
 in recognition of satisfactory
 completion of course
 in the *Teacher Education Program*

Developmental history:

- Did the child first sit without help between the ages of 4 to 8 months?
- Did this child first walk without holding on between 10 and 18 months?
- Did the child first start speaking between the ages of 12 and 18 months?
- Did this child first learn to tie shoes between 4 and 6 years old?

Give the approximate age when this child became toilet-trained
 Does the child now wet the bed?
 What grade is the child presently in?

Are the child's school marks: a. Average
 b. Above average
 c. Below average

Name of child's school:

- Has this child repeated any grades?
- Does this child play well with other children?
- Has the child had a vision or hearing test within the past year?
- Age of menstruation, if a girl?
- Any problems?

Childhood Illnesses:

Check off any of the following illnesses which this child has had:

- a. Measles
- b. Mumps
- c. Chicken pox
- d. German measles
- e. Whooping cough
- f. Pneumonia
- g. Asthma
- h. Rheumatic fever
- i. Blood in urine
- j. Broken bones
- k. Urine or kidney infection
- l. Skin problems
- m. Head injury
- n. Trouble seeing
- o. Been unconscious
- p. Blood transfusion
- q. Anemia, low blood
- r. Easy bruising
- s. Worms
- t. High blood pressure
- u. Nightmares
- v. Exposure to tuberculosis
- w. Poisoning (lead, dye etc.)
- x. Blindness, cyanosis
- y. Fainting spells
- z. Turning easily
- Seizures, with or without fever
- Ear infections
- Mouth breathing

m. Head injury _____
 n. Trouble seeing _____
 o. Been unconscious _____










Seizures (with or without fever) _____
 Ear infections _____
 Mouth breathing _____
 Snoring _____
 Trouble with hearing _____
 Hoarseness or choking when swallowing _____

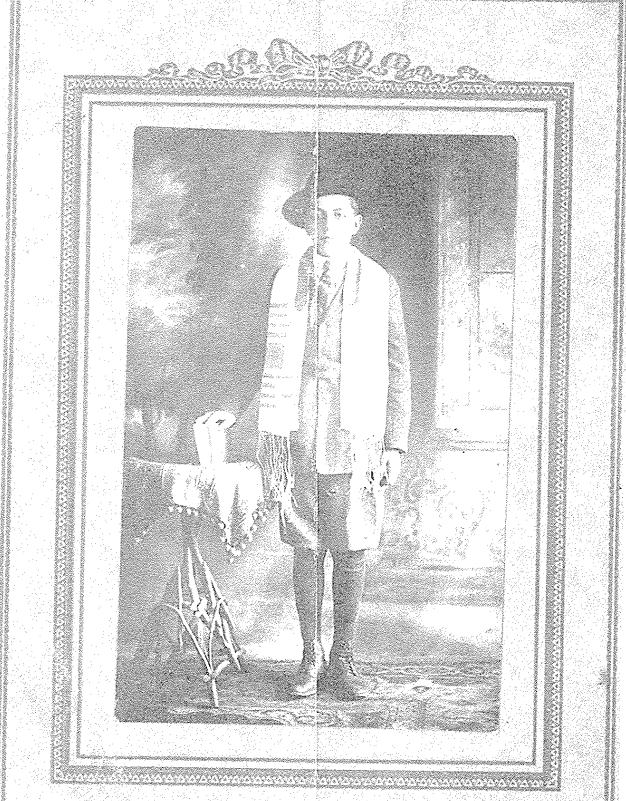
Does the child crave or eat non-food substances (paint chips, hair, plaster, etc.) _____
 Is the child allergic to anything? _____
 If so, what? too much orange juice

Has the child been hospitalized at any time? _____
 If yes, please give the age, year, hospital, and reason for hospitalization:

| Child's age | Year | Hospital | Reason |
|-------------|------|----------|--------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Has the child any other problems you would like to mention?

-  Rhythmic Breathing
-  Prone Float
-  Prone Glide
-  Back Float
-  Back Glide
-  Kick Glide-front
-  Kick Glide-back
-  Arm Stroke
-  Flinning



Coedu

TREEHAVEN
TUCSON, ARIZONA

Florence H. Schneider
 William I. Schneider
 Co-Directors

Treehaven is a co-ed and day primary and day primary and day primary situated on a beautiful campus surrounded by majestic desert, 15 miles from the Nursery through eight acres.

program keyed to the best in education. The school's inception in 1949, its many alumni merit in academic and extra-curricular areas.

The pre-school and grades one through eight are on a separate campus and have a Spanish is an integral part of the curriculum. Curricular activities for all are geared to the interest age groups and the natural advantages.

Swimming is in Treehaven's own two beautiful pools is on its own horses. There is a strong interscholastic athletic program. Constructive use is emphasized at all times. A summer session is offered.

Careful attention is paid to health and safety. Facilities are provided for the care of some of the children in the broader program. Family life, physical and educational activities are emphasized.

AMERICAN NATIONAL
RED CROSS

GREATER BOSTON REGION

ACHIEVEMENT RECORD FOR
BEGINNING SWIMMERS

Name: Joshua C.

Class conducted under
the auspices...

of: Brown and Nichols Day Camp

at:

by: Susan C.

date: 8-16

 Combined Stroke
back



 Change of Direction



 Turning Over



 Leveling Off



 Jump-waist deep



 Jump-deep water



 Plain front dive



 1st. Combined test



 2nd. Combined test



Procedures:

PAGE 1 ----- Items 1 and

Item 1: Say, "Listen
rowl that tell
a police man."

Item 2: Repeat direc
money, and
go is

PAGE 2 ----- Items

Item 3: Repeat dir
water and

Item 4: Repeat di
a ruler,
the best

Acceptable respons

Item 1:
Item 2:
Item 3:
Item 4:

Coeducational Schools—1144

AVEN SCHOOL
ARIZONA

Schneider, Ph.D.
Schneider, B.A.
ors

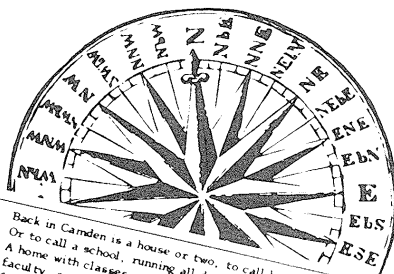
is a coeducational boarding
primary and junior high school
beautiful 65-acre ranch, sur-
majestic mountains and
les from downtown Tucson.
ugh eighth grade is attended
nd abroad; they are offered a
eation and living. Since the
alumni have performed with
areas.

rough four have their own
sroom. Grades five through
ave a departmental program.
riculum in all classes. Extra-
o the interests of the differ-
antages of the Southwest.
beautiful pools; desert rid-
strong intramural and inter-
ective use of leisure time is
sion is conducted.

and safety and excellent
ome delicate children with-
physical care, recreational

er Sargent, 1971), p. 1144.

The Sea School



Back in Camden is a house or two, to call home.
Or to call a school, running all day, every day.
A home with classes. A school with local
faculty, or such resource people as boatbuilders,
fishermen, journalists, artists and clam-
diggers.
The surrounding communities of Rockland,
Rockport and Vinalhaven provide additional
resources and comparisons to the Camden
experience.
The staff are counselors, facilitators, and
Friends, a few people who live in and who
coordinate the freedoms with the responsibilities.
After Redington Pond the Sea School is a
counterpoint to the social pressure of a larger
group, to the simplicity of a non-electric
to the limits of a demanding em-
is a preparation for wh-
schooling; it is
A ch-



Spea

Part II: How do
about children?

1. I am the mother of
father of

Ages

For the purposes
suggest you choos
tween the ages of
swer the following
can then repeat th
children, using diffe
it you want to.

2. The following ans
child aged

3. How many hours
child watch each w
through Friday) o
How about Saturd
How about Sunday

4. a) Do you think t
programs in yo
specifically for c
Yes

b) How often do

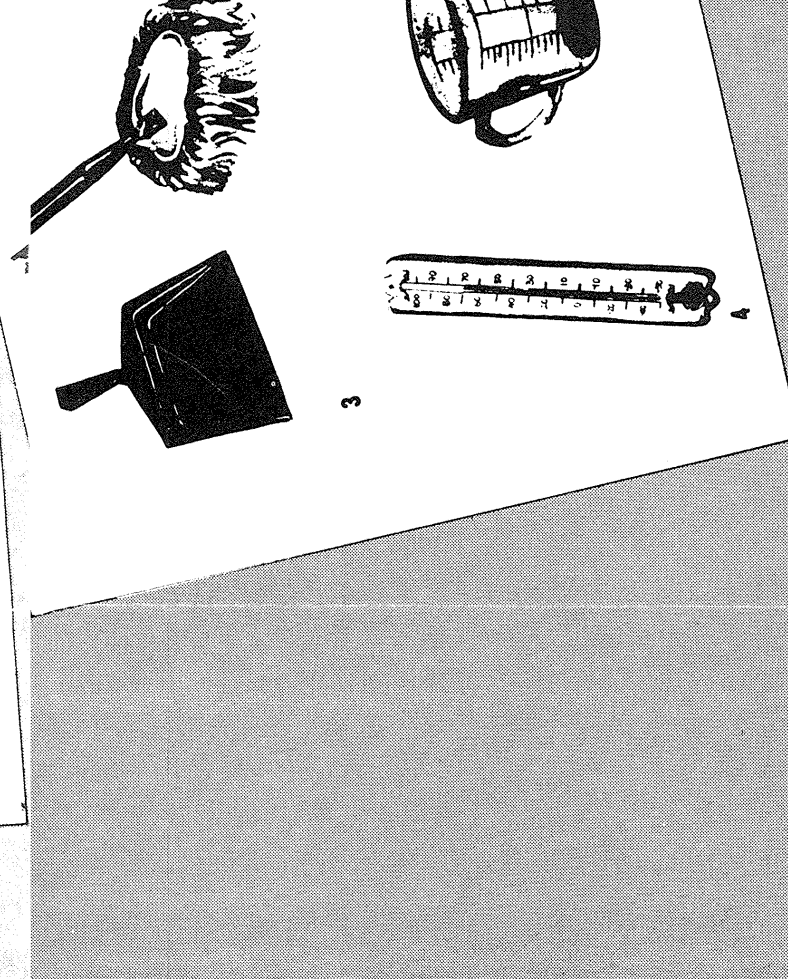
Items 1 and 2
 "Listen to what I say. Then show me the picture here (pointing to
 w) that tells the answer. Here is a fireman, a dentist, a little boy, and
 policeman. If someone is lost, the best person to go to for help is
 _____".

Repeat directions substituting. "Here is a supermarket, a library, some
 library, and a museum. If someone wants to buy meat, the best place to
 go is _____".

Items 3 and 4
 Repeat directions substituting. "Here is a dust pan, a dust mop, a bucket of
 water and a scrub brush. The best thing to use for dusting the floor is
 _____".

Repeat directions substituting. "Here is a thermometer, a measuring cup,
 a ruler, and a thermostat. If we need to find out how long something is,
 the best thing to use is _____".

Item responses:
 Item 1: policeman
 Item 2: supermarket
 Item 3: dust mop
 Item 4: ruler



Action for Children's Television

46 Austin Street, Newtonville, Massachusetts 02160 617-244-5941

Speak Out on Children's TV—Mail This Quiz

How do you feel about children's TV?

Other _____ of _____ children
 other _____ (how many)

Purposes of the test, we
 you choose one child be-
 ages of 2 and 11 and an-
 following questions. You
 repeat the test for other
 using different colored ink.
 t to:
 iving answers refer to my

How many hours of TV does your
 child watch each weekday (Monday
 through Friday) on the average _____
 on Saturday? _____
 on Sunday? _____
 Do you think there are enough
 programs in your area designed
 especially for children?
 Yes No
 How often do you watch TV pro-

Occasionally Almost always
 5. Which programs does your child
 watch most often? (LIST UP TO
 FIVE)

6. In general, how would you rate the
 programs you have listed above?
 Excellent Fair
 Good Poor
 Comments _____

7. There are commercials on children's
 TV programs at present. Would you
 prefer children's TV to have

ning and end of program?
 d) No change in the present
 system?
 How often has your child asked you
 to buy a TV-advertised toy?
 a) Never (If you check this, skip
 to next question)
 b) Occasionally
 c) Frequently
 d) If he has, did you buy the toy?
 Yes No
 e) If you bought the toy, were you
 satisfied?
 Yes No
 f) If no, why not? _____

a) Television may have both good
 and bad influences on children.
 Do you think TV watching has in-
 fluenced or affected your child in

10. We know that a short questionnaire
 can't cover everything of interest
 to you. What are your concerns about
 children and TV?

(Completed questionnaire should
 be placed in an envelope and mailed to Action

| | | | |
|------------------------|--|----------------|--|
| WORK KNOWS | | KNOWS NAME | |
| KNOWS OTHERS | | KNOWS AGE | |
| KNOWS BIRTHDAY | | KNOWS BIRTHDAY | |
| KNOWS RESPONSIBILITIES | | COUNTS TO 10 | |
| KNOWS COLORS | | KNOWS STANDARD | |
| KNOWS QUIETLY | | KNOWS QUIETLY | |

EXPLANATION OF MARKS

| | | | | | |
|----------------|--|--|--|--|--|
| KNOWS NAME | | | | | |
| KNOWS AGE | | | | | |
| KNOWS BIRTHDAY | | | | | |
| COUNTS TO 10 | | | | | |
| KNOWS STANDARD | | | | | |
| KNOWS QUIETLY | | | | | |

Footprint
 of
 Baby Girl Wood
 Born in the Samuel Merritt Hospital
 Oakland, California
 On 1/27/32 at 6:16 A.M.



Certificate of



Church of

This is to Certify

That
 Child of _____
 and _____
 born in _____ (CITY)
 on the _____ day of _____
 was _____ Baptized
 on the _____ day of _____
 According to the Rite of the Roman
 Catholic Church
 by the Rev. _____

WORK

KNOWS NAME

OTHER GOALS TO BE ATTAINED

TEACHER _____

PRINCIPAL _____

SCHOOL YEAR _____

UPILS NAME _____

Louise J. Sullivan Complainant

SUFFOLK, ss: Received and sworn to this _____^{5th} day of February in the year of our Lord one thousand nine hundred and _____^{seventy four} Clerk

[Signature]

APPROVED BY THE CHIEF JUSTICE OF THE DISTRICT COURTS

FORM 2000

- CHILDREN'S LOBBY PRIORITY BILLS
State Legislature 1974
- S190 *McKinnon-Rights for Unwed Fathers*
Unwed fathers will receive notice that the mother of his child has surrendered the child for adoption where the unwed father has requested such prior notice to the surrender.
 - S985 *Backman-Newborn's Children Insurance*
This bill would require health insurance policies which provide coverage for a family member of the insured, shall also provide benefits applicable to a newly born child of the insured from the moment of birth.
 - H.3997 *Pines-Tax deduction for Child Care*
This bill provides working parents with a tax deduction for child care expenses and other work related expenses on state income tax returns.
 - H1612 *Gray-To Create a Family Court*
This bill would establish a Family Court to hear all cases, excepting juvenile felonies that involve children. The Court would transform the present Probate Court, lessen the workload of the juvenile court and focus attention more directly to the needs of children. Family courts exist now in Rhode Island, New York, and other states.
 - S.1259 *Backman-Children's and Family's Rights*
This bill would create a commission on Children's and Family's rights that would evaluate the status of children in the Commonwealth with the concept that all children are entitled to basic human rights.

Certificate of Baptism

Church of _____

to Certify _____

(STATE) _____ 19____

ptized _____ 19____

the Roman Catholic Church

REGISTRATION FORM

DATE OF BIRTH _____

PHONE _____

PHONE _____

NOTIFY: _____

IONS, IF ANY: _____

TYPE OF MEMBERSHIP

() \$1.00 INDIVIDUAL CHILD () 50¢ TEEN () \$1.00 CHILDREN UNDER 13 () \$2.00 If family membership,

of people in family _____

the Docket

February 1971

Civil Liberties Union of Massachusetts

Volume 1, Number 1

Worcester Mother Sues For Child

The Worcester chapter of CLUM is challenging as vague and overbroad the law that allows the state to declare a mother unfit to care for her children.

Mel Greenberg, attorney for the Worcester chapter, states that the procedure whereby the Commonwealth petitions a court to make a judicial determination of a mother's unfitness to care for her children is "usually taken against welfare mothers or mothers of illegitimate children. The standards under which children can be removed from their natural mother go well beyond questions

of physical abuse. The statute is so broad that it covers such things as moral character and environment, which are defined in so vague and overbroad a way as to be a denial of 14th Amendment rights. Often it's not a problem of a mother's character and fitness, but of her not having enough money to rent a decent place to live in."

In the Worcester case, Commonwealth v. Janet Butler, the Department of Public Welfare required that the youngest of a woman's three illegitimate children be placed in a foster home.

YOU CHILD AT HOME

A Description by the Parent

Your answers to these questions will help in the care of your child during his hospital visit. Please answer any questions or furnish any information which will help us to make your child feel at home.

When you come to the hospital bring this form with you and leave it at the desk on the floor where your child will be staying.

INTRODUCTION:

Name of Patient:

Nickname:

Town:

State:

RULES AND REGULATIONS OF THE BROMLEY HEALTH COMMUNITY CENTER (BROMLEY HALL)

1. Everyone must come to scheduled activities at least 15 minutes before activity is to begin.
2. You must bring your membership card when coming to the Center.
3. Periodic field trips will be given and a minimal cost for transportation will be requested; permission slips must be filled out and returned to the Center.
4. No drugs are permitted in the Centers.
5. No abusive language will be allowed in the centers.

Failure to follow the above rules will lead to suspension of Membership Cards and use of the Centers facilities.

Cave Restaurant serves sandwiches, hot dogs, hot meals, ice cream, french fries, tonic, etc., hours 8 A.M. - 7 P.M.

Peer entitle you to participate in all activities.

Original Day Camp for Boys and Girls Ages 4-12 Est. 1951

Known for its informal and relaxed atmosphere and mature staff — 40 acres of rolling fields enhance a creative program for tiny tots to teens.

"Neverland" for children up to 12 has its own camp site and counseling program filled with fun and laughter. Regular camping activities based on "Neverland" campers may enroll depending upon readiness.

DISCOVERING MUSIC THROUGH THE ARTS

THIS COURSE IS DESIGNED FOR INDIVIDUAL STUDENTS THROUGH THE ARTS THROUGH THE ARTS

LOWL:

Nickname: _____ State: _____
 Grade in School: _____ Age: _____ Birthday: _____
 Language spoken at home if not English: _____
 First names or nicknames and ages of brothers and sisters:
 1) _____ Age: 3)
 2) _____ Age: 4)
 Names of household pets: _____
 Names and relation of other people at home important to your child:
 1) _____
 2) _____
 Shy with new people: _____
 Likes sociable times: _____
 Favorite toys or activities: _____
 Does he have a special belonging (such as a blanket, or toy) that is important to him?
 If so, what does he call it?
 Be sure to label all important belongings.

Accustomed to baby sitters: _____
 Likes quiet times: _____
 Favorite foods: _____

EXPERIENCE OUTSIDE YOUR HOME:
 Is this the first experience away from home? _____
 In hospital before? _____ When? _____ Age at time: _____ How long? _____
 Does he talk about the previous hospital experience? _____
 How long has he known about this trip to the hospital? _____
 Surprise visit: _____ Several days: _____ One week: _____ Several weeks: _____

WHEN YOUR FAMILY WILL BE ABLE TO VISIT:
 Twice a day: _____ Once a day: _____ 3-5 times a week: _____ Once a week: _____
 Comment: _____
 We can plan to help when you have to be away.

03894

THE CHILDREN'S HOSPITAL MEDICAL CENTER, BOSTON, MASS.

mp
 4-12
 and relaxed program
 s of woodland an
 ve and varied pro
 up to first grade
 ounselors and a pro-
 daughter, as well as
 sed on their abilities.
 nroll half or full day,
 MUSIC WORKSHOP
 VIDUAL CREATIVE EXPRESSION

My name Age
 Grade School
 Parents' Name Phone
 Address
 Town Zip
 Transportation to, from school

Cut here

Camp Fire Blue Birds are the youngest (6-8) members in Camp Fire Girls, Inc., a national, non-sectarian, interracial organization. Camp Fire is a laboratory for living which encourages a girl to grow, to appreciate and enjoy her role in life. It is a rare setting which joins the generations and unites girls and adults in common concern and shared undertakings.

CAMP THOREAU DAY CAMP
 1973 APPLICATION

Name of Child: _____ Nickname: _____
 Birth Date: _____ Age in Camp: _____
 School: _____ Grade next Fall: _____
 Home Address: _____ Zip: _____ Phone: _____
 Father's Name: _____ Occupation: _____
 Business Address: _____ Phone: _____
 Child's Physician: _____ Phone: _____
 Address: _____

Please register my (son)(daughter) for:

Religion and Race

National Descent

| Date | Place | Previous Marriages | Date | Place |
|------|-------|-------------------------|------|-------|
| Date | Place | Termination of Marriage | Date | Place |

Names of Parents

Occupation

Name of Employer

Address of Employer

Date of Employment

Type of Employment

Annual Salary

Other Income

Savings

Amount of Personal Insurance

Number of Years Grade

School

Number of Years High

School

Other education

Specify Degree

Military Service - State

Branch and Dates

State fully any illness, injury,
or nervous disorder

Please request the V. A. to
forward a report of any service
disability

Do you own your home _____ or rent _____ or live in with relatives _____ Please

check whether your home is a single house _____ or a duplex _____ or an apartment _____

Purchase price of home _____, cost of mortgage? _____ Monthly rent _____

or mortgage? _____ how many rooms have you including bathroom? _____

Bedrooms _____

Why do you feel you would like to adopt? _____

What are your expectations and plans for the child you would like to adopt? _____

What experiences have you had in your own families which you think would help
ad adoptive parents? Describe briefly family background and relationships.

Place

Place

Please

ment

ent

pt?

and help you
tips.

in the *Companion of Justice* school that
 of *St. Joseph's* school
 at *St. Joseph's*
 near *St. Joseph's*
 Mrs. *Constance*, Mrs. *Pauline*
 the *Legal* *Authority*

Date *July 10, 1911*
E. August



The Father and the Son
 by the Spirit in the world
 of the Holy Spirit



Good Shepherd, Fort Defiance, Ariz., provides special care for children. This baby is being brought for baptism

Year of Arrival in the United States _____

Languages Spoken _____

Please briefly describe the quality of the father's or guardian's relationship with your child. _____

Mother or Guardian's Age _____ Educational Level _____

Occupation _____ Place of Birth _____

Year of Arrival in the United States _____

Languages Spoken _____

Please briefly describe the quality of the mother or guardian's relationship with your child. _____

Names of all brothers, sisters, and _____

U.S. CONSUMER PRO

If you know
 you believe
 The followi



S. Baumgarten
184 E. 114th St.,
Cor. 3rd Ave., N. Y.



Careful attention is paid to health and safety facilities are provided for the care of some de in the broader program. Family life, physical and educational activities are supervised persons. The boarding facilities are limited in warmth and security of family living.



WAREHOUSE COOPERATIVE SCHOOL

Information on the Student

(to be completed by a parent or guardian together with the student)

Name of the student _____

Date of birth _____

(The next four items should be completed by the student, with the help of the parent or guardian if necessary)

From what you now know of the Warehouse Cooperative School, what questions do you have about it?

What aspects of the school appeal to you?

What interests would you most like to pursue this next year in school?

Which skills or studies do you feel you should engage in this next year to prepare yourself for the future?

Name of student's doctor _____

Address _____

Telephone _____

Information on the Student

Describe any history of physical difficulties experienced by the student

Describe any history of emotional difficulties experienced by the student

Previous education (include complete address of the school from which you may obtain the student's cumulative record):

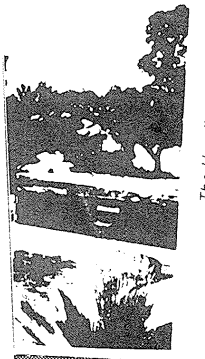
| Name of school | Address | Dates attended | Grade |
|----------------|---------|----------------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Describe any history of learning difficulties experienced by the student

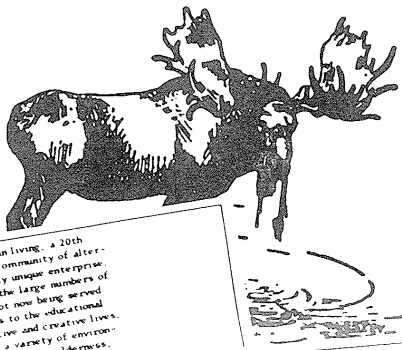
Signature of _____

...is conducted.
 and safety and excellent
 some delicate children with-
 physical care, recreational
 ted personally by the direc-
 ted in size to provide the

The Handbook of Private Schools, (Boston: Porter Sargent



Academix Inc.



Academix is an experiment in living, a 20th-century survival school, a community enterprise, alternative school - a completely unique enterprise. Its function is to restore the large numbers of children and adolescents not being served by schools and institutions to the educational mainstream or to provide fine and creative living. Academix schools provide a variety of environments for living and learning: the wilderness, the sea, cities, and farms. (Redington Pond, The Sea Ranch)

A student lives in each for moves to another. In this adolescent years may be in each place a student is supporting in a suitable way rely on inner resources, and existing connections. The longer one remains the more life experience. When students leave to environment - college - will be prepared to adapt to live in the new situ self-assurance. Through it all, they w with change. Redington Pond, the was built in 1970 in the backwoods farm and c convenience. It is b Natural env They have curative of

*Forty people in
 three logging camps isn't
 easy living but it is
 easy learning.*

Bob North

programs in yo
 specifically for c
 Yes
 b) How often do y
 grams for chi
 child?
 Never

Reprinted by permission of A

student)

h the help

what ques-

in school?

is next year

page 2

by the student.

by the student.

from which we

Grade

the student.

St. Francis of Assisi
 5100 Dabney
 Houston, Texas 77026

Pupil _____ Boy _____ Girl _____ Grade _____
 Address _____ Zip Code _____
 Phone _____ Religion _____
 Age _____ Date of Birth _____ Place of Birth _____
 Father's name _____
 Father's occupation _____ Business Address _____
 _____ Business Phone _____
 Father's religion _____ Living _____ Deceased _____ Remarried _____
 Mother's Maiden Name _____
 Mother's Occupation _____ Business Address _____
 _____ Business Phone _____
 Mother's religion _____ Living _____ Deceased _____ Remarried _____
 Baptism _____ First Communion _____ Confirmation _____

VI. En algunos casos
 comidas gratis s
 favor marque ac
 frecuencia.
 Yo por esto certifi

in your area designed
ally for children?
s No
often do you watch TV pro-
for children with your
... Quite often ...

7. There are commercials on children's
TV programs at present. Would you
prefer children's TV to have
a) No commercials?
b) Fewer commercials?
c) Commercials only at the begin-

and bad influences on children.
Do you think TV watching has in-
fluenced or affected your child in
any way?
Yes No Not sure
b) Can you give an example? _____

(Completed questionnaire should
be clipped out and mailed to Action
Children's Television, 46 Austin
Newtonville, Mass. 02160.)

ision of Action for Children's Television, Inc., Newtonville, Mass. To be published in *The Family Guide to Children's Television* by Evelyn Kaye, Pantheon Books, summer 1974.



- III. Número total de
- IV. Salario total de f
seguro social, y to
- LEENE UNO:
- V. Si su salario fam
condiciones espe
apuro aquí: (ES
GUIA DE SALVA
- VI. En algunos caso
comidas gratis ;
lavor marque ac

II. Ponga nombres, e
gratis.

NOMBRE DE NIÑOS A

NOMBRE DE ESCUELA

Si usted está interesado
elegibles para almuerzo
Programa Desayuno de E
COMPLETE SOLO UN
Esté seguro de firmar es

I. Nombre y dirección

A. Padre
B. Madre
C. Custodio



by the Reb.
 the Spousers being
 as appears from the Baptismal Regi
 Dated _____

NO. 314 - T. J. ARNEY CO. INC. - WINDY, ILL.

| CLIN/DEPT | DAY | DATE | TIME | DOCTOR |
|-----------|-----|------|------|--------|
| | | | | |
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REMOVE THIS STICKER BEFORE APPLYING NEW ONE

COMO GUARDAR LA SA
 How to keep you



SI SU CRIATURA SE ENFERMA O SI NECESITA
 If your baby is sick or you need advice

CONSEJO PARA SU CRIATURA, LLAME O INFORME
 about your baby, call or see:

NOMBRE
 Name _____

DOMICILIO
 Address _____

NOMERO DE TELEFONO
 Phone Number _____

PERSONA O AGENCIA LOCAL
 Person or Local Agency _____

INTRODUCTORY REPORT - Preschool and Infant

Name of Child _____
 Address _____

Introductory Report - Preschool and In

FAMILY HISTORY: (Note any exceptional home conditions, relatives, background household.)

Roman Catholic Church
 Pastor
 Register of this Church

PAR LA SALUD DE SU CRIATURA
 Keep your baby healthy



NECESITA
 IE O INFORME:
 ONO
 IA LOCAL

ool and Infant
 ceptional or significant facts in regard to parents,
 ackground.) Please state any additional members of

today's date _____
 date of testing _____

2:15 PLAYHOUSE & PUPPET SHOW
 1:40 LUNCH
 1:40 AQUARIUM-BEHIND-THE-SCENES-TOUR
 12:00 LUNCH
 1:00 LAWSON'S FARM AND TOUR OF CIDER MILL

TEAR HERE

MAIL TO: KIDS TRIPS
 C/O POLYARTS Box 1974 CAMBRIDGE, Mass 02139

NAME: _____ Age: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: _____
 NAME OF PARENT OR GUARDIAN: _____
 WHICH DATES (INCLUDE ALTERNATIVE DATES): _____
 NAME OF PARENT OR GUARDIAN ACCOMPANYING CHILD (IF ANY): _____
 REGISTRATION MUST BE ACCOMPANIED BY FULL TUITION. ONCE REGISTRATION IS ACCEPTED, TUITION CANNOT BE RETURNED.
 AMOUNT ENCLOSED (\$1/4 PER CHILD, \$5 PER ADULT): _____
 I RELEASE POLYARTS FROM ANY LIABILITY INCURRED DURING THESE TRIPS.
 DATE _____ SIGNATURE _____

list names, ages of pe
 FAMILY ADULTS, CHILDRE
 INDIVIDUAL ADULT ()
 HEALTH RESTRICTIONS,
 ADDRESS:
 IN EMERGENCY, NOTIFY:
 PARENT/GUARDIAN:
 ADDRESS:
 NAME:
 Please print (

...s, ice cream, french fries, tonic, etc., hours 8 A.M. - 7 P.M.

Fees entitle you to participate in all activities at the Centers. The money will be used for Programs and parties for Members.

THIS COURSE IS DESIGNED FOR INDIVIDUAL THROUGH THE ARTS. THROUGH PERSONAL INVOLVEMENT THE CHILD WILL DEVELOP MUSICAL SKILLS AND HIS UNDERSTANDING OF MUSIC AS A MEANS OF SELF-EXPRESSION. THE CHILD WILL EXPLORE "SOUND" THROUGH THE USE OF INSTRUMENTS, LISTENING, AND CREATIVE COMPOSITION. THE COURSES, ONE FOR 5-7 YEAR OLDS, AND ONE FOR 8-10 YEAR OLDS. THE COURSE WILL BEGIN SATURDAY, MARCH 2, 10:00 - 12:00, FOR TEN WEEKS.

PLEASE SEND FORM TO POLYARTS,

NAME _____ AGE _____
 ADDRESS _____ STATE _____
 I WOULD LIKE TO ENROLL _____ CHILDREN, AND _____ CHILDREN, IN THE CHILDREN'S POTTERY COURSE.
 I WOULD LIKE TO ENROLL _____ CHILDREN, AND _____ CHILDREN, IN THE MUSIC WORKSHOP.

POLYARTS, BOX 1974, CAMBRIDGE, MASS, 02139 617-492-2900

KIDS TRIPS

POLYARTS CONTINUES ITS UNIQUE SERIES OF SATURDAY EXCURSIONS FOR CHILDREN AND THEIR PARENTS IN AND AROUND BOSTON. THESE TRIPS ARE DESIGNED TO INCREASE EACH CHILD'S AWARENESS OF HIS OR HER ENVIRONMENT. THE TRIPS WILL PROVIDE AN ENJOYABLE LEARNING EXPERIENCE AS WELL AS AN ADVENTURE IN EXPLORING THE COMMUNITY.

GENERAL INFORMATION

AGES: CHILDREN OF ALL AGES WILL BENEFIT FROM THESE TRIPS. PARENTS: PARENTS ARE WELCOME TO ACCOMPANY THEIR CHILDREN. LIABILITY: PARENTS MUST SIGN A WAIVER EXEMPTING POLYARTS FROM ANY LIABILITY WHATSOEVER. TIME: EACH SATURDAY WE WILL MEET AT POLYARTS AT 9:30 AM. MOST TRIPS WILL END AROUND 3:30 PM. COST: THE OVERALL COST INCLUDES TRANSPORTATION AND ADMISSION PRICES. CHILDREN: \$4.00 ADULTS: \$5.00 (LUNCH IS NOT INCLUDED.)

FEBRUARY 9
 9:30 MEET AT POLYARTS
 11:00 HOUSE OF SEVEN GABLES, SALEM
 12:15 LUNCH
 1:30 PEABODY MUSEUM AND TOUR OF OLD SALEM HOMES

FEBRUARY 23
 9:30 MEET AT POLYARTS
 10:00 ICE SKATING AT THE PRU
 12:00 SKY WALK AT THE PRU
 2:00 LUNCH
 2:00 PROPOSITION THEATER CHILDREN'S MATINEE

FEBRUARY 16
 9:30 MEET AT POLYARTS
 10:00 TOUR OF POLYARTS, PUPPET PLAYHOUSE & PUPPET SHOW
 2:15 LUNCH
 1:30 AQUARIUM-BEHIND-THE-SCENES-TOUR

MARCH 2
 9:30 MEET AT POLYARTS
 10:00 DECOROVA MUSEUM TOUR
 12:00 LUNCH
 1:00 LAWSON'S FARM AND TOUR OF CIDER MILL

AT THE DAY CARE CENTER

26 Wales Street, Dorchester
 Come into the child's world. Salvation Army Day Care Centers have been in existence since 1891. Our programs are in constant changing and upgrading of programs and methods. Our staff's skills are widely used, involving case work and medical, hearing, and vision evaluation and treatment.



Captain Erich Hamm, a dedicated professional, wholesome with a deg... our existence, and communicate with parents, home and school environment, we know who resource. We're really Educational aspect co... important here. The "We try to give them how to play. It's tim

Dear Parents:

I HEREBY CERTIFY that this record was prepared in accordance with the provisions of the Births and Deaths Registration Act, 1953.
 DATE: _____
 AT: _____
 VS & R 101 D

INDIVIDUAL CREATIVE EXPRESSION
 SOCIAL INVOLVEMENT WITH MUSIC,
 SKILLS AS WELL AS INCREASE
 MEANS OF COMMUNICATION AND
 EXPLORE THE "WORLD OF
 ARTS, SINGING, MOVEMENT,
 AND GAMES. THERE WILL BE TWO
 SESSIONS, ONE FOR 8-11 YEAR OLDS.
 STARTING MARCH 2, AND WILL BE FROM

POLYARTS, 861 MAIN ST. CAMBRIDGE

PHONE _____
 ZIP _____

CHILDREN, AT \$30.00 A PIECE,
 SUB-TOTAL \$ _____
 CHILDREN, AT \$25.00 A PIECE,
 SUB-TOTAL \$ _____
 TOTAL \$ _____

Address: _____ Phone: _____

Please register my (son)(daughter) for:
 _____ Eight weeks: June 25 to August 17, 1973
 _____ Four weeks: June 25 to July 20, 1973
 _____ Four weeks: July 23 to August 17, 1973

Tuition: Eight weeks - \$375. Four weeks - \$225.
 Neverland full day - same as above.
 Neverland mornings only: Four weeks - \$160.
 Eight weeks - \$320.

NEVERLAND ONLY:
 A.M. _____
 Full Day _____

A \$50.00 registration fee (deductible from tuition) must accompany this application.
 Balance of tuition must be paid by May 1, 1973 to guarantee a place for your child.
 Make checks payable to Camp Thoreau. It is understood and agreed that no refunds
 can be made for any cause.

Date: _____ Signature: _____ (Parent)

On reverse side please give directions to your home for camp transportation.

(for office use only)

Received _____ Tuition \$ _____ Transportation _____ wks. at \$ _____
 Accepted _____ Deposit \$ _____ Amt. due \$ _____
 New _____ Bal. due \$ _____ Paid _____
 Returning _____ Paid _____

CENTER

has been in existence since 1896, but there
 are many programs and facilities. Professional
 staff work and medical services with speech,
 hearing and dental treatment.
 Hamm notes, "The atmosphere is
 warm and with a degree of flexibility for both
 parents. Solving problems makes for
 growth, and communication is the key. We
 work with parents to try to strengthen
 the school environments. If we can't help
 a school who can. Parents use us as a
 Family Care center. The
 We're really a Family Care center. The
 child aspect combined with child care is very
 important here. The children are pre-school age and come primarily from surrounding neighborhoods."
 to give them a good feeling about themselves, then their friends and neighbors."
 play. It's time to share."



CPS Children's Protective Services, the Massachusetts Society for the Prevention of Cruelty to Children, is a private, state-wide, nonsectarian agency. Founded in 1878, it is the only state-wide agency whose primary function is to work with families in which neglect and/or abuse of children exist.

Each year the agency provides protective services to some 9,000 children in its twelve districts throughout the Commonwealth.

1. PLACE
 County of _____ Co.
 City of _____

2. RESIDENCE OF MOTHER (usual place of abode)
 (a) _____
 (b) Township _____

3. FULL NAME OF CHILD

4. Sex of Child _____
 male or female

5. Full name _____

6. Date of birth _____

7. Color or race _____

8. Birthplace (city or town) (State or country)

9. Trade, profession, occupation, business, or service (State or country)

10. Industry or business work was done (State or country)

11. (a) Including this date, how long has this child been in the custody of this mother, her father, or other person?

12. (a) How many were there at the time of this child's birth?

13. (a) How many were there at the time of this child's birth?

14. (a) How many were there at the time of this child's birth?

15. (a) How many were there at the time of this child's birth?

16. (a) How many were there at the time of this child's birth?

17. (a) How many were there at the time of this child's birth?

18. (a) How many were there at the time of this child's birth?

19. (a) How many were there at the time of this child's birth?

20. (a) How many were there at the time of this child's birth?

21. (a) How many were there at the time of this child's birth?

22. (a) How many were there at the time of this child's birth?

23. (a) How many were there at the time of this child's birth?

24. (a) How many were there at the time of this child's birth?

25. (a) How many were there at the time of this child's birth?

Date signed _____

Date filed _____

Post Office Address _____

1970

APPLICATION FORM
FAMILY HEALTH SERVICES - DAY CARE PROJECT

Castle Square Center
436 Tremont Street, Boston, Massachusetts
Hawthorne Center
c/o Highland Park Free School
Hawthorne Street, Roxbury, Massachusetts

Identifying Data:

Name of Child _____ Date _____
Last First Middle Sex
Birthplace _____
City State Birth Date _____ Mo. Day Yr.
Home Address _____ Telephone _____

Family Data:

Father or Guardian's Name _____
Address _____ Telephone _____
Business Address _____
Hours of Work _____ Business Phone _____
Mother or Guardian's Name _____
Address _____ Telephone _____
Business Address _____
Hours of Work _____ Business Phone _____
Caseworker's Name _____ Center _____ Phone _____
Whom should we contact in case of emergency?
Name _____ Relationship _____
Address _____ Telephone _____
What is the name of your doctor or clinic? _____
Address _____

We are interested in your conception of day care. What do you expect this day care program to do for your child? Have you had any previous experience with day care? Do you have any complaints about, or suggestions for this program? Any questions? Ideas?

Child's Behavior Patterns and Habits:

Please briefly describe an ordinary day in the life of your child, from his rising in the morning to going to bed. _____

What is your child's favorite toy? _____ Book? _____
Pet? _____ Person? _____

Does your child have any particular habits or mannerisms, such as thumb sucking, nail biting? Please describe. _____

Does your child have any particular fears, such as of dogs, or sirens; does he have nightmares? Please describe. _____

Does your child use any peculiar words or expressions (such as "wee-wee" for urine) that may not be understood by an outsider? Please describe. _____

In general, how does your child react to anxiety or a stressful situation?

Languages Spoken _____
Please briefly describe the quality of the mother of _____
relationship with your child. _____
Please list the names, relationship, and ages of all brothers, sisters, and
other members of your child's usual household. _____

Does he cry, withdraw, throw tantrums? _____
Has your child had any previous school or play-group experience? Please
describe. _____
Does your child relate well to other children? Does he seek friendships;
or is he a "loner"? _____
How does your child relate to adults? _____
Has your child had the experience of being cared for by adults other
than members of your family? Please describe. _____
What is your accustomed mode of reassuring and rewarding your child?

What is your accustomed mode of disciplining your child? What is your
"philosophy" of discipline? _____
Does your child speak English? _____ Any other languages? _____
Is he talkative, quiet, average? _____
To the best of your knowledge, does your child have any language prob-
lems, or learning disabilities? _____
Does your child have any emotional disturbances, or physical handicaps?

How well do you anticipate your child will adjust to this day care pro-
gram? _____
Are there additional circumstances regarding your child's physical or
emotional status that you would like us to be aware of? _____

How do you describe your child's role in your family? Is the child
"the sister," "the black sheep," etc. _____
Are there any alliances and frictions in the family that you think
we are aware of? _____
Have there been any major changes in the family constellation such as
death? _____
Have you seen any difficulties or crises in your family — such as, acci-
dents, problems with the law, medical problems — that may have
affected the emotional well-being of your child? _____
What is the language predominantly spoken in your home? _____

Family Background:

Father or Guardian's Age _____ Educational Level _____
Occupation _____ Place of Birth _____

If you know
you believe
The following

NAME OF THE _____
STOCK OR CODE _____
COUNTRY OF ORIGIN _____
MANUFACTURER _____
WHERE AND WHEN MADE _____
WHAT IS HAZARDOUS _____
DO YOU KNOW OF ANY OTHER HAZARDOUS MATERIALS?
SO PLEASE TELL US _____

YOUR NAME, _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

Please send _____

If you know of an article intended for use by children or adults which believe to present an unreasonable hazard, please let us know. The following information will enable us to take the appropriate action.

TITLE OF THE ARTICLE OR A BRIEF DESCRIPTION _____

CHECK OR CODE NUMBERS ON ARTICLE PACKAGE _____

COUNTRY OF ORIGIN (IF IMPORTED) _____

MANUFACTURER OR IMPORTER (IF KNOWN) _____

WHERE AND WHEN WAS THE ARTICLE PURCHASED? _____

WHAT IS HAZARDOUS ABOUT THIS PRODUCT? _____

DO YOU KNOW OF ANY INJURIES INVOLVING THIS ITEM? ANY CLOSE CALLS? IF PLEASE TELL US THE CIRCUMSTANCES. _____

YOUR NAME, ADDRESS AND TELEPHONE NUMBER _____

Please send this form to: U.S. Consumer Product Safety Commission
Washington, D.C. 20207

Signature of the student _____
Signature of the parent _____
Date _____

WAREHOUSE COOPERATIVE SCHOOL

Time Contribution
(to be completed by each parent involved)

Name of parent or guardian _____
I believe I can provide, as a (tutor, assistant, instructor), the following learning experiences to students (including academic, social, physical experiences):

I can provide the following services or skills to the school:

I can make the following facilities available to the students and/or the school (both within and outside the metropolitan area):

I (am, am not) willing to serve as a coordinator of other parents' contributions, particularly in the area of:

I am available: daily, during the hours _____
(on, not on) weekends, particularly _____
during the months _____

I am not available _____

I understand that if our family is accepted as a member of the Warehouse School Cooperative, I will be obliged to provide up to ninety hours (during the period 1 July 1973 through 30 June 1974).

Signature _____
Date _____

NOTE: Please do not feel restricted to the spaces provided above.

Business Phone _____
 Mother's religion _____ Living _____ Decenseu _____ Remarried _____
Baptism First Communion Confirmation
 Date _____
 Church _____
 City & State _____
 School last attended _____
 Complete address of school last attended _____
 Family physician _____ Address _____
 Phone of physician _____
 Please give below the names of two responsible people to be contacted in case
 of an emergency if unable to locate parents:
 Name _____ Address _____ Phone _____
 Name _____ Address _____ Phone _____

DEBERRY ACADEMY
Bdg — Boys Ages 5-14
Bloomington Springs, Tenn. 38545. 615-526-4211.

Established by Col. Laban Lacy Rice as the junior school of Castle Heights
 Military Academy, and since 1923 independent under the direction of Maj.
 DeBerry, this school offers year-round supervision through its Camp Whoop-
 pec.
The Handbook of Private Schools, (Boston: Porter Sargent, 1971), p. 566.

MID-CITY BAPTIST SCHOOL
Day — Coed Ages 4-18
New Orleans, La. 70118. 8829 Airline Highway. 504-486-5318.

This program offers general and vocational as well as preparatory courses.
 Non-sectarian in enrollment, although affiliated with Mid-City Baptist
 Church, the school occupies a modern plant. Most graduates attend neigh-
 boring universities.
The Handbook of Private Schools, (Boston: Porter Sargent 1971), p. 592.

FIRMA DE MIEMBRO FAMILIAR ADULTO

certifico que toda la informacion de arriba es cierta y correcta para lo mejor de mi informacion y
 en que aqui
 nos casos niños sin hogares, que fueron traídos a su casa por sus padres
 gratis a pesar de su salario familiar. Si usted tiene tal niños viviendo con usted y desea aplicar, por

**DISTRITO ESCOLAR INDEPENDIENTE
DEPARTAMENTO DE ASISTENCIA ESTUDIANTIL
APLICACION PARA ALMUERZO GRATIS
PARA EL AÑO ESCOLAR 1973-74**

(DEJE ESTE ESPACIO EN BLANCO)
APROBADO: _____
DESAPROBADO: _____
POR: _____
Deplo. de Asistencia Estudiantil

FECHA

ESCUELA
 Presentado en almuerzo gratis para sus hijos, conteste las preguntas en esta forma. Estudiantes que son
 almuerzo gratis tambien seran elegibles para desayuno gratis en esas escuelas que particippan en el
 almuerzo de Escuela. Otra aplicacion no es necesaria.

¿CÓMO UNA APLICACION PARA CADA ESCUELA DONDE ESTE DIENTE NINOS ATENDIDO.
 Determinar esta aplicacion y devolverla a la escuela donde usted ha escrito arriba.

Direccion de padres o custodio: _____
 Direccion: _____ Zona: _____ Telefono: _____
 Direccion: _____ Zona: _____ Telefono: _____
 Direccion: _____ Zona: _____ Telefono: _____

Nombre, edades, y grados de sus niños que atienden ESTA escuela y para quien usted pide almuerzo

| NINOS ATENDIENDO ESTA ESCUELA | INDIQUE CON UNA X PARA QUIEN PIDE EL ALMUERZO | EDAD | GRADO |
|-------------------------------|--|------|-------|
| | | | |
| | | | |
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| | | | |

total de personas (niños y adultos) que están viviendo en su casa _____
 total de familia antes de deducir (incluyendo pagos de wellfare, salario de todos trabajando, pensiones,
 fiscal, y todo otro salario). _____

ANUAL \$ _____ Mensual \$ _____ Semanal \$ _____
 ¿El ingreso familiar excede la cantidad en la escala de salario familiar, y usted desea aplicar bajo cualquiera de
 las categorías especiales citadas en esta carta, por favor complete la aplicación y también describa la razón de su
 ingreso? (ESTE ARTICULO ES PARA COMPLETAR SOLAMENTE SI SU SALARIO ES SOBRE DEL
 SALARIO). _____

En los casos de niños sin hogares, que fueron traídos a su casa por una agencia de wellfare, son elegibles para
 almuerzo gratis a pesar de su salario familiar. Si usted tiene tal niño viviendo con usted y desea aplicar, por
 favor indique aquí: _____

FAMILY HISTORY: (Note any exceptional home conditions, relatives, background household.)

FOSTER HOME: Has child been in foster (Give details including names of foster

SOCIAL HISTORY: (Home and foster home tunities for play with other children s

CHILD'S BEHAVIOR CHARACTERISTICS: (Moch child's outstanding personality traits.)

Are there any problems with regard to fe

BEHAVIOR DAY: (Time of sleeping feeding

When, during the day, does the child's lo

Has there been a previous psychological e

Report

Name of Child _____
Address _____ Phone _____

Height _____ Weight _____ Present date _____

Name _____ Birth date _____ Education _____

Father _____
Mother _____

Nationality _____ Religious Affiliation _____ Occupation _____

Father _____
Mother _____

Brothers and Sisters
Name _____ Birth date _____ School _____ Grade _____

BIRTH HISTORY: Date _____ Age: _____ Yrs. _____ Mos. _____

Birth weight: _____ Term: premature _____ wks.; postmature _____ wks.; full _____

Complications during pregnancy _____ German measles? _____

Delivery: Physician (name, address) _____
Home or Hospital (name, address) _____

Duration of labor _____
(details: normal, precipitate, difficult, version, instrumental): _____

Condition at birth (cried immediately, cyanotic, resuscitated, etc.): _____

Condition during first month (feeding difficulties, convulsions, crying, etc.): _____

HEALTH HISTORY: (List illnesses with dates. Give date and summary of last physical examination.) Visual difficulties and results of examination if given.

DEVELOPMENTAL HISTORY: Sat unsupported at _____ mos.; walked alone at _____ mos.; began to name objects (ball, etc.) at _____ mos.; trained to toilet at _____ mos.; held own cup at _____ mos.; fed self with spoon at _____ mos. Further details: _____

Reason for Requesting Evaluation: _____

DEFE ESTE ESPACIO EN BLANCO

SUMMARY FOR DEVELOPMENTAL EVALUATION OR OTHER TESTING

(Exceptional or significant facts in regard to parents, background.) Please state any additional members of

today's date _____
date of testing _____

child's name: _____ group: _____ teacher: _____

birth date: _____ age now: _____ years, _____ months.

Testing initiated by: Parent _____; School _____.

Reason for requesting: routine _____; other: (explain)

In foster home? _____ In an institution? _____
(of foster parents and dates of placements.)

Home conditions treatment of child oppor-
tunities for children same age etc.)

Comments: (Mother or foster mother's description of
child's traits.)

Comments regarding feeding, sleeping, play, etc.?

(e.g. feeding playing bathing toilet etc.)

When does child's longest and happiest play period occur?

Medical examination? _____ By whom? _____

Report filled out by _____

1. Child's outstanding characteristics, preferred and avoided play activities:

2. Possible reaction to testing situation; degree of cooperation or resistance:

3. Tone of previous parent-teacher contact:

4. Particular areas of interest or concern to teacher and/or parent:

5. Does parent have any particular expectation about outcome of evaluation, or
what we will be able to tell them?

Attach another page if necessary.

EBY CERTIFY THAT the foregoing is a true and correct copy of the birth record for the child named at item 3 and that record was established and filed in my office in accordance with the provisions of the Illinois statutes relating to the registra-
births, stillbirths and deaths.

August 21, 1957

SIGNED

M. R. Tucker, M.D.

Evanston

Illinois

OFFICIAL TITLE

Local Registrar

R 101 DEPARTMENT OF PUBLIC HEALTH—Bureau of Statistics. Printed by the Authority of the State of Illinois.
(Use this form for certifying birth records filed prior to 1950)

Final record of this birth is permanently filed with the ILLINOIS DEPARTMENT OF PUBLIC HEALTH at Springfield. County clerks and local registrars are authorized to furnish copies of this record to persons entitled to them. The Illinois statutes provide that the certification of a birth record by the Department of Public Health or the local registrar is prima facie evidence in all courts and places of the facts therein stated.

Dear Parents:

In cooperation with your child's school, the Lead Poisoning Prevention Center is planning to test children for lead poisoning. A child can appear well, showing no symptoms of illness and still have lead poisoning. A simple blood test can show if your child has dangerous amounts of lead in his body. This test is free and consists only of a fingerstick blood test which will be analyzed at the Lead Poisoning Prevention Center Laboratory. Your child's school will be notified of the test results and you will be notified if your child needs further tests or treatment. All children should be tested every six months until their sixth birthday.

We hope that you will complete the following permission slip giving us permission to test your child and return it to his or her school or day care center within two days.

Thank you for your cooperation.

Ronald Jones
Lead Poisoning Prevention Center

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ APT. # _____

TELEPHONE # _____ MOTHER'S NAME _____

I give my permission to have my child tested for lead poisoning:

PARENT SIGNATURE

HAS YOUR CHILD EVER BEEN TESTED FOR LEAD POISONING BEFORE? _____

If there are other children under six years of age in your home, we urge you to bring them to school for this test, too. If this is not convenient, it is very important to have your children tested at a neighborhood health center, or at the Lead Poisoning Prevention Center at Boston City Hospital.

The lead poisoning tests will be given at your child's school

_____ on _____ DATE _____ at _____ TIME _____
SCHOOL NAME

