

Pueblo of Laguna
Department of Education
Division of Early Childhood

May 26, 2023

Parents/Guardians:

Attached is the application packet for PY 2023-2024.

ALL documents will need to be turned in before an application is considered complete and your child is placed in a classroom. Documents needed for **NEW** students:

- Parent's Income (W-2 or 1040 tax form for 2022)
- Birth Certificate
- Immunization Record
- Well Child Check-Up (for current age at time of enrollment)

Returning students will receive an application/letter stating what documents will be needed to complete their application.

Please fill out the attached survey for child care services.

If you have any questions, I can be reached at 505-552-6544 ext. 5004 or 505-235-9286. I can also be reached thru email at: p.charlie@lagunaed.net

Thank You,
Patricia Charlie
DEC ERSEA Coordinator/Childcare Manager

P.O. Box 798
Laguna, New Mexico 87026
140 West—Exit 114

Preschool Head Start
Phone: (505) 552-6544
Fax: (505) 552-7533

Early Head Start
Phone: (505) 552-6544
Fax: (505) 552-7533



APPLICATION Program Year 2023-2024

General			
Child's Name			
Last	First	Middle	Date of Birth
			Gender: Please circle
Clans:	Big Clan:	Male	
	Little Clan:	Female	
Tribal Affiliation:		Race / Ethnicity:	
Address			
Mailing Address			
City		State	Zip
Physical Address:			
Village Residence:			
Phone Numbers of Parents/Guardian			
Name / Relationship to child		Phone Number	Phone type Cell, work, message, text only
		()	
		()	
		()	
General			
Do you have other children in a DEC program?		If yes, which program? <input type="checkbox"/> PHS <input type="checkbox"/> EHS	
Number of people in family? (Child's parents/siblings?)			
Does child live with both parents?		Which parent does child live with?	
Is your child receiving disability services (Early Intervention/IEP/IFSP)?			
Are you currently receiving WIC?			
Primary Language of Child/Family			
English	Keres	Other(please specify)	

Certification: I certify that this information is true, if any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I also understand that the information in this application will be held in strict confidence within the agency and is accessible to me during school hours

Verifying DEC Staff Member: _____

Date: _____



APPLICATION Program Year 2023-2024

Parent/Legal Guardian				
Adult Name				
Last	First	Middle	Date of Birth	
Relationship to Child?	Do both parents have legal custody		Yes	No
	Name of parent who has legal custody			
Supporting legal documents/court documents			Yes	No
Address				
Mailing Address/Physical Address if Different from Applicant				
Highest Grade Completed: High school diploma/GED/Higher Education, etc..				
Teen Parent? (Currently 18 years old or younger)			Yes	No
Parent/Legal Guardian				
Adult Name				
Last	First	Middle	Date of Birth	
Relationship to Child?	Do both parents have legal custody		Yes	No
	Name of parent who has legal custody			
Supporting legal documents/court documents			Yes	No
Address				
Mailing Address/Physical Address if Different from Applicant				
Highest Grade Completed: High school diploma/GED/Higher Education, etc..				
Teen Parent? (Currently 18 years old or younger)			Yes	No

Parent/Guardian Signature _____ Date: _____

Child's Name: _____

Reviewing DEC Staff Member's Initials: _____ Date: _____



EMERGENCY CONTACTS/RELEASE FORM Program Year 2023-2024

The Laguna Division of Early Childhood requests that each child have a minimum of two current emergency contact numbers on file. Please be certain that numbers listed are currently in service.

Child Release from Program or Preschool Head Start Bus Check-out Information: We are unable to release a child to any unauthorized person or to an individual appearing to be under the influence of alcohol or drugs. We cannot release a child to any person under the age of 18, from the center or from program activities such as field trips, unless that person is the parent. Identification (picture ID or driver's license) may be required before a child is released. We cannot release a child to a person who does not have an approved car seat. **Please note, it is DEC Policy that a person who is listed on the sex offender registry cannot be named as an emergency contact, pick up a child from the program, take a child off the bus, or participate in any DEC activity.**

ONLY ONE PERSON PER BLOCK PLEASE / REMEMBER ANY CHANGES OR UPDATES MUST BE MADE IN PERSON

Emergency Contacts / Program Check-outs / Head Start Bus Check-outs					
Parent/Legal Guardian Primary Contact 1	Name of Individual	Phone Type		Phone Number	Relationship to Child
		Home		()	
		Work		()	
		Cell		()	
	Release To?	Yes	No	()	
Parent/Legal Guardian Primary Contact 2	Name of Individual	Phone Type		Phone Number	Relationship to Child
		Home		()	
		Work		()	
		Cell		()	
	Release To?	Yes	No	()	
Contact 3	Name of Individual	Phone Type		Phone Number	Relationship to Child
		Home		()	
		Work		()	
		Cell		()	
	Release To?	Yes	No	()	
Contact 4	Name of Individual	Phone Type		Phone Number	Relationship to Child
		Home		()	
		Work		()	
		Cell		()	
	Release To?	Yes	No	()	
Contact 5	Name of Individual	Phone Type		Phone Number	Relationship to Child
		Home		()	
		Work		()	
		Cell		()	
	Release To?	Yes	No	()	

Child's Name: _____

Reviewing Staff Initials: _____

Date: _____

CLASSROOM EMERGENCY MEDICAL CONSENT

(This form is taken on field trips and kept in the child's classroom and the bus.)

In presenting my child, _____, in case of an **emergency**, I hereby consent to diagnosis and/or treatment (diagnostic procedures, surgical and medical treatment, and blood transfusion) by authorized members of the hospital staff which in their professional judgment is deemed necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of the child's condition.

I hereby give my consent for the child named above to be transported for **emergency** medical procedures or emergency dental care necessary to preserve the health and life of my child for program year: **2022-2023**. I acknowledge that I am responsible for all reasonable charges in connection with such **emergency** care and treatment.

Printed Name of Parent/Guardian:	Family Doctor or Pediatrician:
Address:	Dentist:
Telephone: Home Cell or Message phone:	Current Medications:
Does your child have medical insurance: Yes/No	Does your child have any significant or chronic health problem? (i.e. asthma, severe food allergy, heart condition, etc.)
Private Insurance Name & Policy or Group Number:	Special Care Plan required: YES NO
Medicaid Number:	Previous Surgeries:
<div style="display: flex; justify-content: space-between;"> Parent or Guardian Signature: _____ Date Signed: _____ </div>	

Child's Name _____ Date of Birth _____

Reviewing Staff Initials _____ Date _____

PERMISSION TO PHOTOGRAPH AND/OR VIDEO RECORDING

I grant permission for my child _____ to have his/her photograph taken by the staff of the Division of Early Childhood. I understand that these photographs are for the promotion of self-esteem, self-identity, and for tracking each child's developmental progress and other classroom use.

I understand that this permission form is valid for program year: 2023-2024

Parent/Guardian Signature

Date

Division of Early Childhood Staff Signature

Date

**PERMISSION TO POST PICTURES OF CHILD ON
FACEBOOK AND LDOE WEB PAGE**

I **DO/DO NOT** give permission to Division of Early Childhood to post pictures of my child on the LDOE Facebook page and the LDOE web site.

Parent / Guardian Signature: _____

DEC Staff Signature: _____

**PERMISSION TO INCLUDE PICTURES OF CHILD ON EHS/PHS BULLETIN
BOARDS AND NEWSLETTER**

I **DO/DO NOT** give permission to Division of Early Childhood to post pictures of my child on bulletin boards and newsletters.

Parent/Guardian Signature: _____

DEC Staff Signature: _____

CONSENT FOR SCREENING/ASSESSMENT

I understand that for PY 2023-2024 my child, _____, to have screenings and assessments completed in order to gain information about his/her development and progress. I understand the office of Head Start requires child and family data for reporting purposes, including required reporting from the office of Head Start. All information will be kept confidential.

I understand that this permission form is valid for program year: 2023-2024

Child will receive the following screenings:

◆ Developmental Screening, Ages and Stages Questionnaire (ASQ)	◆ Health Screenings: audio, vision, dental, height and weights
◆ Ages and Stages Questionnaire-Social Emotional (ASQ-SE)	

Statement to Parents/Guardians:

1. Health and developmental screenings noted in the paragraph above are part of Headstart requirements.
2. You will be informed of the results and may request copies of any screenings & assessments & other records.
3. All screening, assessment, and other records in your child's name will be kept confidential.
4. I understand that Head Start programs are required to conduct developmental screenings and have evidence of completion of a physical examination and health screenings within 45 days of the child's enrollment.

☐ **I approve the use of my child's/family records for program improvement and Head Start grant-related purposes, including reporting. All information will be kept confidential.**

Parent/Guardian's Signature

Date

Reviewing DEC Staff Member's Initials: _____ Date: _____

Interview completed by _____ **Date:** _____

Pueblo of Laguna
Division of Early Childhood
Preschool Head Start
Program Year 2023-2024

Parents:

The Preschool Head Start Program is requesting permission to administer topical solutions to your child during DEC program hours. Topical solutions are sprays, ointments, or creams that can be applied directly to skin. Please check the topical solution(s) of which you give permission to be used for your child while here in the program and return the form.

Child's Name: _____ DOB: _____

I, _____, authorize the DEC staff to use the following on my child when needed.

_____ Insect Repellent with DEET

_____ Lotion

_____ Sunscreen

Parent's signature: _____ Date: _____

Reviewing DEC staff's Initials: _____ Date: _____

Physical Residency Questionnaire

McKinney-Vento Act

NAME OF CHILD: _____
First Middle Initial Last

Date of Birth: _____ Age: _____
Month Day Year

Section 1

The answers to the following questions can help determine the physical residency of the child.

- | | | |
|--|------------------------------|-----------------------------|
| a) Is this child's physical address a temporary living arrangement? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Is this a temporary living arrangement due to a loss of housing or economic hardship? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Is this child in a temporary foster care placement or awaiting foster care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) Is the child living with someone other than the parent or legal guardian? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If the family answered **YES** to any of the above questions, please answer the following:

Would you describe the child's nighttime residence as fixed, regular, and adequate? _____

If the family answered **NO** to questions a, b, c, and d please skip section 2 and go to section 3

Section 2

Where is the child currently living? *(Check the box that best describes the child's circumstance)*

- ☐ In a motel
 - ☐ In a shelter
 - ☐ Transitional housing
 - ☐ In another family's home
 - ☐ With more than one family in a house or apartment
 - ☐ Moving from place to place
 - ☐ In a location not designed for sleeping accommodations such as a car, park or campsite
-

Section 3

Print name of Parent(s)/Legal Guardian(s): _____

Signature of Parent(s)/Legal Guardian(s): _____ Date: _____

DEC STAFF SIGNATURE: _____ Date: _____

School Screening, Fluoride Varnish, Dental Sealant Consent

Dear Parent or Guardian,

Indian Health Service Dental Program will be offering free dental screenings, fluoride varnish and sealants at your child's school.

Fluoride Varnish

Procedure: Fluoride varnish is applied directly onto the teeth.

Benefits: Fluoride Varnish coats the outside of the tooth and makes it resistant to a cavity.

Risks: Used in the proper amount, fluoride varnish is safe and effective.

Dental Sealants

Procedure: A Plastic coating is applied on the chewing surface of the back teeth.

Benefits: Sealants help prevent cavity-causing germs from getting stuck in the deep groves in the back teeth.

Risks: There are no known commonly occurring adverse effects or hazards associated with dental sealants.

Preventive Services provided by Indian Health Service at your Child's school DO NOT replace a regular dental checkup. We will send a notice home with your child of all retreatment they received in school.

Please list any medical conditions that the school should be aware of (asthma, allergies, chronic illness, etc.): _____

Student Name: _____

Date of Birth: _____

Grade & Teacher _____

Parents Name and Phone Number _____

Parental Permission

I give permission to have a screening, fluoride varnish and dental sealants placed.

Signature of Parent or Guardian

Date

Please check if you DO NOT want your child to participate in all or part of the prevention services:

____ **I DO NOT** want my child to participate in the program.

____ **I DO NOT** want my child to have a fluoride varnish application.

____ **I DO NOT** want my child to have sealants placed.

Note: All procedures rendered at these visits are billable to Medicaid and third party insurance as authorized in the Indian Health Care Improvement Act

Pueblo of Laguna-Department of Education-Division of Early Childhood
P.O. Box 798 Laguna, NM 87026

Laguna Head Start

(505) 552-6544

FAX (505) 552-7533

AUTHORIZATION TO RELEASE OR RECEIVE INFORMATION

- I. The purpose or need for this disclosure is for program enrollment and ongoing health and developmental information.

Child's Name (Last, First, MI)	
Address	
City/State/Zip	Date of Birth

- II. The information to be disclosed from my child's record may include:

- | | | |
|---|--|---|
| <input type="checkbox"/> Well Child Check/
Physical Exam | <input type="checkbox"/> Audio Screenings | <input type="checkbox"/> Lead Screening Results |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Vision Screenings | <input type="checkbox"/> Social Emotional
Screenings |
| <input type="checkbox"/> School Records | <input type="checkbox"/> IFSP/IEP | |
| <input type="checkbox"/> Dental Records | <input type="checkbox"/> Developmental
Screenings | |

Information can be disclosed by:

Name of program/organization/facility
Address
City/State/Zip

And shall be provided to:

- Pueblo of Laguna-Division of Early Childhood, P.O. Box 798, Laguna, NM 87026
- Fax Number: _____

- III. By checking and signing below, I hereby authorize the sharing of information regarding my child.

- ☐ I understand that I may revoke this authorization in writing submitted at any time to the program/organization/facility. If this authorization has not been revoked, it will terminate on June 30th of the program: _____
- ☐ I understand that I have the right to withdraw this authorization at any time.
- ☐ I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that I can inspect or copy the information that is disclosed. I understand that authorizing this release of information is voluntary.
- ☐ I understand that the Laguna Division of Early Childhood will share information between the programs of Preschool Head Start, Early Head Start and Child Care as appropriate in order to enroll or transition my child into a DEC program and to ensure coordinated program services.
- ☐ I do **NOT** consent to releasing information listed above and understand that this may effect my child's placement in Head Start programs

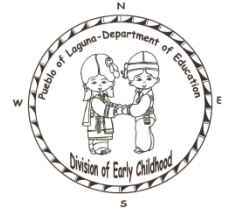
Signature Parent/Guardian

Date

Print Name

Laguna DEC Staff Signature

Date



Pueblo of Laguna
Department of Education
Division of Early Childhood

May 26, 2023

Dear Parents/Guardians,

We would like your feedback regarding child care services!

We are planning on offering child care services for children enrolled within the Division of Early Childhood. Parents **MUST** be working and/or in school. Documents that will need to be submitted will be 2 current check stubs and/or class schedule (if taking classes) and a DEC child care application. Childcare rates are based on family's income/family size. Please answer the following questions regarding child care:

I plan to utilize child care services: _____ morning childcare only (7:30 – 8:45/9:00)

_____ afternoon childcare only (3:30-5:00 or 2:00-5:00)

_____ morning & afternoon childcare

I do not need child care services at this time _____

Child's/Children's names: _____

Please return the forms back to Patricia Charlie as soon as possible.

If you have any questions, I can be reached at 505-552-6544 ext. 5004 or 505-235-9286.

Thank You,
Patricia Charlie
DEC Childcare Manager

P.O. Box 798
Laguna, New Mexico 87026

Preschool Head Start
Phone: (505) 552-6544
Fax: (505) 552-7533

Early Head Start
Phone: (505) 552-6544
Fax: (505) 552-7533