



May 1, 2026

Parents/Guardians,

For school year 2026\_2027, the Laguna Division of Early Childhood school hours:

- Early Head Start school hours will be Monday – Friday 7:30 a.m. – 3:00 p.m.
- Preschool Head Start school hours will be Monday – Friday 7:30 a.m. – 3:00 p.m.

Childcare hours will be:

- Early Head Start 3:00 p.m. – 5:00 p.m. (Monday-Friday)
- Preschool Head Start 3:00 p.m. - 5:00 p.m. (Monday – Friday)
- **NO** Child Care on Staff Professional Development days.

All new and returning children must have a completed application for school year 2026\_2027.

All supporting documents will need to be turned in within 45 days of enrollment. Missing documents could affect the status of your child in the program. DEC staff can assist you, if necessary.

Documents needed for NEW students:

- Immunization record
- Birth certificate
- Well child check-up (for current age at time of enrollment)
- Legal guardian **MUST** provide current legal documentation (i.e., court order verifying custody of the child being enrolled)
- Dental Exam (current)

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

Thank you,

Patricia Charlie  
ERSEA Manager  
p.charlie @lagunaed.net  
505-552-6544, ext. 5004  
505-235-9286 (program cell)



**APPLICATION**  
**Program Year 2026-2027**

General			
<b>Child's Name</b>			
Last	First	Middle	Date of Birth
			Gender: Please circle
Big Clan:			Male      Female
Little Clan:			
Tribal Affiliation:	Race/Ethnicity:	Email:	
Address			
Mailing Address:			
City:	State:	Zip:	
Physical Address:			
Village Residence:			
Phone Numbers of Parent/Guardians			
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 individuals in family?(Child's parents/siblings)			
Does child live with both parents?		If not, which parent does child live with?	
Is your child receiving disability services? <input type="checkbox"/> IEP <input type="checkbox"/> IFSP <input type="checkbox"/> None			
Are you currently receiving WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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 2026-2027**

<b>Primary Parent/Legal Guardian</b>			
Adult Name			
Last	First	Middle	Date of Birth
Relationship to Child	Do both parents have legal custody?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Name of parent who has legal custody:		
	Supporting legal documents/court orders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Address</b>			
Mailing Address/Physical Address if different from applicant:			
Highest Grade Completed: (High school diploma/GED/Higher Education)			
Teen Parent? (Currently 18 years old or younger)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Secondary Parent/Legal Guardian</b>			
Adult Name			
Last	First	Middle	Date of Birth
Relationship to Child	Do both parents have legal custody?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Name of parent who has legal custody:		
	Supporting legal documents/court orders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Address</b>			
Mailing Address/Physical Address if different from applicant:			
Highest Grade Completed: (High school diploma/GED/Higher Education)			
Teen Parent? (Currently 18 years old or younger)		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Reviewing DEC Staff Member's Initials: \_\_\_\_\_ Date: \_\_\_\_\_



**EMERGENCY CONTACTS/RELEASE FORM**  
**Program Year 2026-2027**

The Laguna Division of Early Childhood requests that each child has 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 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 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					
Primary Contact 1  Parent/Legal Guardian	Name of Individual	Phone Type		Phone Number	Relationship to Child
		Home		( )	
		Work		( )	
		Cell		( )	
	Release To?	Yes	No	( )	
Primary Contact 2  Parent/Legal Guardian	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: \_\_\_\_\_

Pueblo of Laguna – Department of Education – Division of Early Childhood

**CLASSROOM EMERGENCY MEDICAL CONSENT**

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

In case of an **emergency**, I hereby consent for my child, \_\_\_\_\_ to receive diagnosis and/or treatment (diagnostic procedure, surgical and medical treatment, and blood transfusion) by authorized members of the hospital staff which, in their professional judgement 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 to transport the above named child, for **emergency** medical procedures or emergency dental care necessary to preserve the health and life of my child for program year **2026-2027**. I acknowledge that I am responsible for all reasonable charges in connection with such **emergency** care and treatment.

**All boxes must be completed.**

Printed Name of Parent/Guardian:	Family Doctor or Pediatrician:
Address:	Dentist:
Home Telephone:	Current Medications:
Cell or Message Phone:	
Does your child have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child have any significant or chronic health problem? (i.e. asthma, food allergy, heart condition, etc.)
Private Insurance Name & Policy or Group Number:	Special Care Plan required: <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid Number:	Previous Surgeries:
Parent or Guardian Signature:	Date Signed:

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, for tracking each child's developmental progress and other classroom use.

**I understand that this permission form is valid for program year 2026-2027.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Division of Early Childhood Staff Signature

\_\_\_\_\_  
Date

**PERMISSION TO POST PICTURES OF CHILD ON LDOE FACEBOOK AND 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 page.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

DEC Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PERMISSION TO INCLUDE PICTURES OF CHILD IN NEWSLETTER  
(Newsletter is posted to the LDoE web page)**

I **DO/DO NOT** give permission to Division of Early Childhood to post pictures of my child in newsletters.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

DEC Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PERMISSION TO INCLUDE PICTURES OF CHILD ON BULLETIN BOARDS**

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

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

DEC Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CONSENT FOR SCREENING/ASSESSMENT**

I give consent to the Division of Early Childhood for my child, \_\_\_\_\_, to have for SY 26-27, 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 requiring reporting from the Office of Head Start. All information will be kept confidential.

**I understand that this permission is valid for program year 2026-2027.**

**Child will receive the following screenings:**

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

**Statement to Parents/Guardians:**

1. Health and developmental screenings noted in the paragraph above are part of Head Start requirements.
2. You will be informed of the results and may request copies of any screenings, assessments & other records.
3. All screenings, 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 to 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 involvement and Head Start grant related purposes, including reporting. All information will be kept confidential.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewing DEC Staff Member’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Pueblo of Laguna  
Division of Early Childhood  
Program Year 2026-2027

Parents:

The Division of Early Childhood 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), 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: \_\_\_\_\_



**School Screening, Flouride 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.

**Flouride Varnish**

**Procedure:** Flouride varnish is applied directly onto the teeth.

**Benefits:** Flouride 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 Services 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: \_\_\_\_\_

Parent 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 service:

- 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 207 Laguna, NM 87026



Laguna Preschool Head Start  
Laguna Early Head Start  
(505) 552-6544  
Fax: (505) 796-6909

**AUTHORIZATION TO RELEASE OR RECEIVE INFORMATION**

I. The purpose or need for this disclosure is for program enrollment and ongoing health and development 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"/> Dental Records    | <input type="checkbox"/> Developmental Screenings    |
| <input type="checkbox"/> Immunization Records           | <input type="checkbox"/> Audio Screenings  | <input type="checkbox"/> Lead Screening Results      |
| <input type="checkbox"/> School Records                 | <input type="checkbox"/> Vision Screenings | <input type="checkbox"/> Social Emotional Screenings |
| <input type="checkbox"/> IFSP/IEP                       |  |  |

Information can be disclosed by:

Name of program/organization/facility	
Address	Fax Number
City/State/Zip	Phone Number

And shall be provided to:

- Pueblo of Laguna-Division of Early Childhood, P.O. Box 207, Laguna, NM 87026
- Fax Number: (505)796-6909

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 30<sup>th</sup> of the current program year: 2026-2027
- 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 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 affect my child's placement in Head Start programs.

\_\_\_\_\_  
Signature Parent/Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Laguna DEC Staff Signature

\_\_\_\_\_  
Date



May 1, 2026

Dear Parents/Guardians,

For school year 2026\_2027, the Laguna Division of Early Childhood school hours:

- Early Head Start school hours will be Monday – Friday 7:30 a.m. – 3:00 p.m.
- Preschool Head Start school hours will be Monday – Friday 8:00 a.m. – 3:00 p.m.

Childcare hours will be:

- Early Head Start 3:00 p.m. – 5:00 p.m. (Monday-Friday)
- Preschool Head Start 3:00 p.m. - 5:00 p.m. (Monday – Thursday)
- **NO** Child Care on Staff Professional Development Days

In order to qualify for child care services, parents must be working and/or in school.

Please provide:

- 2 current check stubs and/or class schedule (if taking classes) **and**
- DEC child care application. Childcare rates are based on family's income/family size.

Please indicate which childcare services you will need:

\_\_\_\_\_Afternoon childcare Early Head Start

\_\_\_\_\_Afternoon childcare Preschool Head Start

Child's/Children's names: \_\_\_\_\_

Please return the forms back to Patricia Charlie.

Thank you.

Patricia Charlie,  
DEC Childcare  
505-552-6544 ext. 5004  
505-235-9286 (program cell)