April 1, 2025

Parents/Guardians,

For school year 2025_2026, the Laguna Division of Early Childhood school hours:

- Early Head Start school hours will be Monday – Thursday 7:30 a.m. – 3:00 p.m. and Friday 7:30 a.m. – 12:00 p.m.
- Preschool Head Start school hours will be Monday – Thursday 8:00 a.m. – 2:00 p.m. and Friday 8:00 a.m. – 12:00 p.m.

Childcare hours will be:

- Early Head Start 3:00 p.m. – 5:00 p.m. (Monday-Thursday) and 12:00 p.m. – 4:30 p.m. (on Fridays)
- Preschool Head Start 2:00 p.m. - 5:00 p.m. (Monday – Thursday) and 12:00 p.m. – 4:30 p.m. (on Fridays)

All new and returning children must have a completed application for school year 2025_2026.

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:

- Parent's income (W-2 or 1040 tax form for 2024)
- 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)

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

Thank you,

Melanie Sarracino
ERSEA Manager
me.sarracino@lagunaed.net
505-552-6544, ext. 5004
505-235-9286 (program cell)

Pueblo of Laguna
Department of Education
Division of Early Childhood

Preschool Head Start & Early Head Start
P.O. Box 207, Laguna, NM 87026
Phone: (505) 552-6544
Fax: (505)796-6909

APPLICATION
Program Year 2025-2026

General			
Child's Name			
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? ☐ PHS ☐ 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? ☐ IEP ☐ IFSP ☐ None			
Are you currently receiving WIC? ☐ Yes ☐ 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: _____

Pueblo of Laguna
Department of Education
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APPLICATION
Program Year 2025-2026

Primary 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 orders		☐ Yes	☐ No
Address				
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)			☐ Yes	☐ No
Secondary 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 orders		☐ Yes	☐ No
Address				
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)			☐ Yes	☐ No

Parent/Guardian Signature: _____ Date: _____

Child's Name: _____

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

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Department of Education
Division of Early Childhood

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EMERGENCY CONTACTS/RELEASE FORM
Program Year 2025-2026

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	Name of Individual	Phone Type	Phone Number	Relationship to Child
Parent/Legal Guardian		Home	( )	
		Work	( )	
		Cell	( )	
	Release To?	Yes / No	( )	
Primary Contact 2	Name of Individual	Phone Type	Phone Number	Relationship to Child
Parent/Legal Guardian		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 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 **2025-2026**. 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: 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, food allergy, heart condition, etc.)
Private Insurance Name & Policy or Group Number:	Special Care Plan required: □ Yes □ 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 2025-2026.

_____ _____
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 25-26, 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 2025-2026.

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 2025-2026

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: _____

Pueblo of Laguna – Department of Education – Division of Earl Childhood
P.O. Box 207
Laguna, New Mexico 87026

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? ☐ Yes ☐ No
b) Is this a temporary living arrangement due to a loss of housing or economic hardship? ☐ Yes ☐ No
c) Is this child in a temporary foster care placement or awaiting foster care? ☐ Yes ☐ No
d) Is the child living with someone other than the parent or legal guardian? ☐ Yes ☐ No

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

If the family answered **YES** to any of the above question, please answer the following:
Would you describe the child's nighttime residence as fixed, regular, and adequate? _____

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 one place to another
☐ In a location not designated for sleeping accommodations such as a car, park or campsite

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Section 3

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

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

DEC Staff Signature: _____ Date: _____

HIS-972 {8/2016}

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:

- ☐ Well Child Check/Physical Exam
- ☐ Immunization Records
- ☐ School Records
- ☐ IFSP/IEP
- ☐ Dental Records
- ☐ Audio Screenings
- ☐ Vision Screenings
- ☐ Developmental Screenings
- ☐ Lead Screening Results
- ☐ Social Emotional Screenings

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 30th of the current program year: 2025-2026
- ☐ 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

April, 2025

Dear Parents/Guardians,

For school year 2025_2026, the Laguna Division of Early Childhood school hours:

- Early Head Start school hours will be Monday – Thursday 7:30 a.m. – 3:00 p.m. and Friday 7:30 a.m. – 12:00 p.m.
- Preschool Head Start school hours will be Monday – Thursday 8:00 a.m. – 2:00 p.m. and Friday 8:00 a.m. – 12:00 p.m.

Childcare hours will be:

- Early Head Start 3:00 p.m. – 5:00 p.m. (Monday-Thursday) and 12:00 p.m. – 4:30 p.m. (on Fridays)
- Preschool Head Start 2:00 p.m. - 5:00 p.m. (Monday – Thursday) and 12:00 p.m. – 4:30 p.m. (on Fridays)

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 Madalynne Francis.

Thank you.

Madalynne Francis,
DEC Childcare
505-552-6544 ext. 5000
505-280-3656 (program cell)