Pueblo of Laguna
Department of Education
Division of Early Childhood

May 23, 2022

Parents/Guardians:
Attached is the application packet for PY 2022-2023.
Listed below are some changes for the upcoming school year:

1. Preschool Headstart will be in-person learning – virtual instruction will NOT be available
2. Early Headstart will have 4 slots open for virtual learners
3. 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 for 2021), birth certificate, immunization record, Covid immunization cards for persons listed on the emergency contact list, Covid immunization card for child if child is 5 years old, Covid immunization cards for household, well child check up (for current age at time of enrollment)
4. Dental sealant consent has been added to the application
5. Consent for Covid-19 diagnostic testing – for children 2 years and older
6. Returning students will receive a letter stating what documents will be needed to complete their application
7. Child care will NOT be offered at this time

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
I-40 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

Pueblo of Laguna
Department of Education
Division of Early Childhood

Head Start-552-6544
P.O Box 798, Laguna, NM 87026

APPLICATION
Program Year 2022-2023

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? □PHS □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: _____

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APPLICATION
Program Year 2022-2023

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: _____

Pueblo of Laguna
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P O Box 798
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ENROLLMENT
EMERGENCY CONTACTS/RELEASE FORM
Program Year 2022-2023

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				
	Name of Individual	Phone Type	Phone Number	Relationship to Child
Parent/Legal Guardian Primary Contact 1		Home	( )	
		Work	( )	
		Cell	( )	
	Release To?	Yes ◯ No ◯	( )	
	Name of Individual	Phone Type	Phone Number	Relationship to Child
Parent/Legal Guardian Primary Contact 2		Home	( )	
		Work	( )	
		Cell	( )	
	Release To?	Yes ◯ No ◯	( )	
	Name of Individual	Phone Type	Phone Number	Relationship to Child
		Home	( )	
		Work	( )	
		Cell	( )	
Contact 3	Release To?	Yes ◯ No ◯	( )	
	Name of Individual	Phone Type	Phone Number	Relationship to Child
		Home	( )	
		Work	( )	
		Cell	( )	
Contact 4	Release To?	Yes ◯ No ◯	( )	
	Name of Individual	Phone Type	Phone Number	Relationship to Child
		Home	( )	
		Work	( )	
		Cell	( )	
Contact 5	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:**
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, and for tracking each child's developmental progress and other classroom use.

I understand that this permission form is valid for program year: 2022-2023

_____ _____
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 2022-2023 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: 2022-2023

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 2022-2023

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: _____

Pueblo of Laguna-Department of Education-Division of Early Childhood
P.O. Box 798
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 **YES** to **<u>any</u>** 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

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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:** _____

IHS-972 {8/2016)

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:

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

LAGUNA DIVISION OF EARLY CHILDHOOD
INFORMED CONSENT FOR COVID-19 DIAGNOSTIC TESTING

1. Authorization and Consent for Covid-19 Diagnostic Testing:

I, _____, voluntarily consent and authorize Laguna EOC personnel to conduct collection, testing and analysis for the purposes of a COVID-19 diagnostic test on my child, _____, date of birth: _____, last 4 digits of Social Security #: _____. I acknowledge and understand that the COVID-19 diagnostic test will require the collection of an appropriate sample by a trained Laguna EOC personnel through a nasal swab collection procedure. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19. I assume complete and full responsibility to take appropriate action with regards to my child's test results. Should I have questions or concerns regarding my results, I shall promptly seek advice and treatment from an appropriate medical provider.

2. Release

By signing this permission form

I acknowledge and agree that my child's COVID-19 results may be disclosed to the Laguna Department of Education, appropriate Tribal, county, state, or other governmental and regulatory entities as may be permitted by law.

I to the fullest extent permitted by law, I hereby release, discharge and hold harmless, LDOE and Laguna EOC, including, without limitation, any respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.

Printed Name: _____ Signature: _____

Date: _____ Physical Address: _____

Parent/Legal Guardian Phone #: _____