Dear Parent/Guardian,

Thank you for placing your confidence in the Saint Regis Mohawk Tribe Head Start Early Learning Center for your child's educational needs. We are pleased that you have chosen to enroll your child with us and we will make every effort to earn your trust and maintain your ongoing interest in our program.

We are confident that you will enjoy working with our knowledgeable and friendly staff and will be fully satisfied with the service we provide.

As the Family Service Coordinator for Head Start, I am here to answer any questions or assist you with your application at any time.

Nia:wen,

Rhonda King
Head Start Family Service Coordinator
Saint Regis Mohawk Tribe
Early Learning Center

Phone: 518-358-2988
Fax: 518-358-3585
Email: Rhonda.king@srmt-nsn.gov

Saint Regis Mohawk Tribe
Early Learning Center
25 Library Road
Akwesasne, NY 13655
Phone: 518-358-2988 or Fax: 518-358-3585

Checklist for Documents Needed for Eligibility: ***Must have all documents***

_____ Application

_____ Due Process

_____ Birth Certificate

_____ Income Statement for all parents supporting household (wages, letter, from employer, check stub, school allowance, mother's allowance, unemployment, SNAP award letter, social assistance documentation.) Any means of supporting your family.

_____ Tribal Enrollment Cards: **Child** and **Parents** (This may include Tribal, MCA or Haudenosaunee identification card.

_____ Health Insurance Card (American or Canadian)

_____ Record of NYS Required Immunizations (will accept Canadian record)

_____ Physical Form

_____ Dental Form

For more information, please contact Rhonda King or Peighton Laffin

Rhonda King
Family Service Coordinator
Saint Regis Mohawk Tribe
Early Learning Center
Phone: 518-358-2988 ext. 3106
Email: Rhonda.king@srmt-nsn.gov

Peighton Laffin
Family Advocate
Saint Regis Mohawk Tribe
Early Learning Center
Phone 518-358-2988 ext. 3108
Email: Peightonlaffin@srmt-nsn.gov

Application# _____

Saint Regis Mohawk Tribe Head Start

Early Learning Center Application

Registration Date:_____ Selection Date:_____

Enrollment Date:_____ Date Withdrawn:_____

Client (Confidential)

Childs name:_____

First MI Last

DOB:_____ M:_____ F:_____

American Mailing Address:_____

Physical Address:_____

Home Phone:_____ Cell Phone:_____

Tribal Affiliation:_____ Tribal Membership Number:_____

Primary Language Spoken:_____ Copy of Card_____ Tribal Letter_____

Household Information:

Parent/Guardian:_____

Relation to Child:_____

DOB:_____

Tribal Affiliation:_____

Tribal Membership Number:_____

Cell Phone:_____

Email:_____

In the home? Y N

Parent/Guardian:_____

Relation to Child:_____

DOB:_____

Tribal Affiliation:_____

Tribal Membership Number:_____

Cell Phone:_____

Email:_____

In the home? Y N

If a parent is NOT allowed to pick up the child, court documents are required

Household Information on Education:

Parent/Guardian	***Parent/Guardian***
Attending School:_____	Attending School:_____
School Attending:_____	School Attending:_____
School Phone Number:_____	School Phone Number:_____
Days/Hours Attending:_____	Days/Hours Attending:_____
Not Employed or School:_____	Not Employed or School:_____

Household Information on Employment:

Parent/Guardian	***Parent/Guardian***
Place of Work:_____	Place of Work:_____
Occupation:_____	Occupation:_____
Work Phone:_____	Work Phone:_____
Days/Hours Worked:_____	Days/Hours Worked:_____
Highest Level of Education:_____	Highest Level of Education:_____

Emergency Contact Information (Person other than the Parents/Guardians)

Name:_____ Relationship:_____

Phone Number:_____

Name:_____ Relationship:_____

Phone Number:_____

Name:_____ Relationship:_____

Phone Number:_____

Household Size:

Number of Adults living in the household:_____

Number of Children living in the household:_____

List the names and birth dates of children in the household:

Name of Children:	Birth Date:	Gender:

Family Type:

_____ Two Parent Family

_____ Single Parent (Mother)

_____ Single Parent (Father)

_____ Foster Family

_____ Other Relative

_____ Other:_____

Disability/ Special Needs:

Individualized Education Plan (IEP) _____ Yes _____ No

Parent Concern _____ Yes _____ No

Documentation _____ Yes _____ No

Child Care Services:

Is Child Care used for child? _____ Yes _____ No

If yes, is Child Care subsidized? _____ Yes _____No

*If Child Care is used for child, please complete information about provider(s), mark all that apply:

_____ Child Care Center _____ Other

_____ Relative

Name of Center/Provider: _____

Does anyone in the family receive Women, Infant, and Children (WIC):
____Y____N

Does your family receive SNAP benefits? ____Y____N

Does your family receive TANF benefits? ____Y____N

Does your family receive SSI benefits? ____Y____N

Health Information:

Dentist Name: _____ Doctor's Name: _____

I certify that the information provided in this application is accurate and truthful to the best of my knowledge. I give Head Start permission to verify any/all information on this form.

Parent/Guardian Print Name:
_____

Parent/Guardian
Signature:_____
Date:_____

Parent/Guardian Print Name:
_____

Parent/Guardian
Signature:_____
Date:_____

Application# _____

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Notice of Parent's Rights and Due Process

Due process consists of all the procedures written into law to safeguard your rights and the rights of your children. An important provision of the due process procedure is your right to receive and provide notification, information and consent written in the language you understand best. Be sure to obtain and keep all pertinent notices, information and consents.

The following is a summary of the due process procedure:

- You have the right to a full evaluation of your child's individual educational needs, and to be notified of and participate in planning your child's assessment.
- Specialized testing and exchange of confidential information used in the assessment process may only take place if you give your consent.
- You have the right to see relevant school records of your child, and to request the school to change any information you feel is incorrect or misleading.
- You have the right to be notified of, and participate in team meetings to develop an individual educational program for your child.

If you disagree with any decisions made about your child, you are urged to meet with the appropriate Early Childhood Development Program staff and Parent Policy Council to resolve these differences. If you cannot come to a satisfactory decision as a result of this meeting, you may initiate the following due process procedure:

- You have the right to an impartial hearing to clarify disagreements concerning identification, assessment and/or placement decision. You may file for this impartial hearing with the State Superintendent of Public Instruction.
- You may bring representative to the hearing to help you advocate for your child.
- If satisfactory decision cannot be reached at the fair hearing, you may initiate a civil legal action.

NOTE: For more explanation of the above summary of the law and your rights, contact the Early Learning Center office at 518-358-2988.

NOTIFICATION OF PARENT'S RIGHT AND DUE PROCESS PROCEDURES

The law requires that we have a signed copy of this notice in each pupil's file. If you would like to discuss further any of the above items before signing, please contact the Early Childhood Development Program office.

I have read and/or had the above information explained to me, and I understand its meaning as it relates to my rights and those of my child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

Updated (7/26/2021)

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Weight, Height and BMI

Weight:	Date / /	**Child's BMI:** _____
Height	Date / /	Are there any concerns? Please include recommendation below ☐ Yes ☐ No

Summary of Physical Exam

Include special recommendations to child day care providers

_____

_____

_____

_____

_____

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

_____ Signature of Examiner

_____ Address

_____ Please Print Name

_____ City, State, Zip

_____ Title

( ) - _____ Phone

/ / _____ Date

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Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

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