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:

____ 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)

Will be given time for the following:

____ Health Insurance Card (American or Canadian)

____ Record of NYS Required Immunizations

____ Physical (will be given time)

____ Dental (will be given time)

For more information, please contact Rhonda King

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

Phone: 518-358-2988 ext.# 3106
Fax: 518-358-3585

Email: Rhonda.king@srmt-nsn.gov

Application #_____

Saint Regis Mohawk Tribe
Early Learning Center

NOTICE OF PARENTS RIGHTS AND DUE PROCESS

Dear Parent/Guardian:

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 all 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 Education Supervisor for support and 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 decisions. 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 RIGHTS 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 Learning Center 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.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Witness Signature Date

Saint Regis Mohawk Tribe
Early Learning Center
25 Library Road
Akwesasne, NY 13655
518-358-2988

Application# _____

DENTAL HEALTH ASSESSMENT FORM

Child's Name: _____ Date: _____

Date of Birth: _____

Has your child visited the dentist before? Yes or No

If yes, what was the date of your child's last dental visit? _____

Does your child have any problems with his/her teeth, gums or mouth? Yes or No

If yes, please explain: _____

Tooth Number or Letter	Surfaces	Description of Work	Treatment	Date Services Performed mo/day/yr	A.D.A Procedure Number

Dental Needs: (Check all that apply)

_____ Treatment (extraction, pulp therapy….)

_____ Cleaning _____ Fluoride _____ Baby Bottle Tooth Decay

_____ Other (please explain) _____

_____ No Problems

Child oral health summary:

All planned treatment is complete: Yes or No

If no, please explain: _____

_____

Next Appointment Date (or 6-month Follow-up Visit): _____

_____ _____

Dentist Signature Date

ECDP 2019

Application# _____

Saint Regis Mohawk Tribe Head Start
Early Learning Center Application

Registration Date:_____ Selection Date: _____

Enrollment Date: _____ Date withdrawn:_____

Client (confidential)

Child's 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:_____ Parent/Guardian: _____

Relation to Child:_____ Relation to Child: _____

DOB:_____ DOB: _____

Tribal Affiliation:_____ Tribal Affiliation: _____

Tribal Membership Number:_____ Tribal Membership Number: _____

Cell Phone #:_____ Cell Phone #:_____

Email: _____ **Email:** _____

In the home? Y N 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 worked: _____
Not Employed or School_____	Not Employed or School _____

Household Information on Employment:

Parent/Guardian	***Parent/Guardian***
Place of Work:_____	Place of Work_____
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: _____

Application# _____

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:

Family Type:

_____ Two Parent Family _____ Foster Family

_____ Single Parent (Father) _____ Other Relative

_____ Single Parent (Mother) _____ 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

Does anyone in the family receive Women, Infant, and Children (WIC) supplement? ___Y____N

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: _____

Verifying Staff Name Print:_____

Verifying Staff Signature:_____ Date: _____

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	

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