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
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.

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
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: ______________________________________________________

<table>
<thead>
<tr>
<th>Tooth Number or Letter</th>
<th>Surfaces</th>
<th>Description of Work</th>
<th>Treatment</th>
<th>Date Services Performed mo/day/yr</th>
<th>A.D.A Procedure Number</th>
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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:_________________
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:

<table>
<thead>
<tr>
<th>Name of Children</th>
<th>Birth Date</th>
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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: ____________

Application# __________
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).

<table>
<thead>
<tr>
<th>Immunization</th>
<th>1st Date</th>
<th>2nd Date</th>
<th>3rd Date</th>
<th>4th Date</th>
<th>5th Date</th>
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<tr>
<td>Diphtheria, Tetanus and Pertussis (DPT)</td>
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<td>Polio (IPV or OPV)</td>
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<tr>
<td>Haemophilus influenzae type B (Hib)</td>
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<tr>
<td>Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>Measles, Mumps and Rubella (MMR)</td>
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<tr>
<td>Varicella (also known as Chicken Pox)</td>
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</table>

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

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<tr>
<th>Type of Immunization</th>
<th>Date: / /</th>
<th>Type of Immunization</th>
<th>Date: / /</th>
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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)
**Health Specifics**

<table>
<thead>
<tr>
<th>Are there allergies? (Specify)</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Is medication regularly taken?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>(Specify drug and condition)</td>
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<tr>
<td>Is a special diet required?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>(Specify diet and condition)</td>
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<tr>
<td>Are there any hearing, visual or dental</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>conditions requiring special attention?</td>
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<tr>
<td>Are there any medical or developmental</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>conditions requiring special attention?</td>
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**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.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

Signature of Examiner

Address

Please Print Name

City, State, Zip

( ) - / / Phone

Title

Date