Sicangu Lakota Oyate

Early Childhood Program

725 Hospital Drive

Box 836, Rosebud, SD 57570

P. (605) 747-2391 \* Fax (605) 747-2590

**ENROLLMENT CHECKLIST**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: Latino/Hispanic (Y) (N)

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For ERSEA Manager Only**

**^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **HEATLH:** |  | **MENTAL HEALTH:** |  | **FAMILY SERVICES:** |  |
| Dental Screen: |  | ASQSE Questionnaire |  | Enrollment Checklist |  |
| Physical Exam |  | **EDUCATION:** |  | Family Information |  |
| Release of Info. |  | JOM |  | Parent Consent |  |
|  |  | **DISABILITIES:** |  | Family Assessment Rel. |  |
| **NUTRITION:** |  | IFSP/IEP |  | Income Eligibility Form |  |
| Nutrition Assessment |  |  |  | Video Surveillance Policy |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Birth Certificate |  | Medicaid Card |  | Income Verification |  |
| Tribal Abstract |  | Immunization |  | No Income Form |  |
|  |  | Guardianship/Custody |  |  |  |

**DOCUMENTS NEEDED:**

**ELIGIBILITY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total Points |  | New Student |  | Foster Child |  |
| Returning |  | Eligibility Points |  | Homeless |  |

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**PARENT CONSENT FORM**

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby give the Rosebud Sioux Tribe Head Start/Early Head Start Program Personnel the authorization to: (check the following)**

**EDUCATION/FAMILY SERVICES**

1. Release my name, telephone number and/or address to other parents for the purpose of communicating about specific

program activities. Yes\_\_\_\_\_\_No\_\_\_\_\_\_

2. Income my child on local field trips (fire department, post office, library, Elementary Schools, day care, Park, Halloween

Activities) Child must be supervised by the parent, guardian, or other responsible adult during home visits, field trips,

and socialization activities. Yes\_\_\_\_\_\_No\_\_\_\_\_\_

3. Transport my child for all program purposes. HS/EHS will ensure that children are safely secured in their seats and

assist them with buckling seat belts. Yes\_\_\_\_\_\_No\_\_\_\_\_\_

4. Include information about my child/family in the program newsletter. I understand the newsletter is distributed to

program staff and enrolled families. This information may include but not limited to child/family name, family

photographs, child/family achievements or successes, birthdays and participation in the program activities. Yes\_\_\_\_\_No\_\_\_\_

5. Observe my child in the classroom in relation to behavioral or developmental concerns, and when needed to have an

affiliated professional conduct observation. Yes\_\_\_\_\_No\_\_\_\_\_\_

6. Share developmental screen results & birth certificate with local Education agencies (LEA) Yes\_\_\_\_No\_\_\_\_\_\_\_

**PUBLIC RELATIONS**

7. Take photographs/Videos of my child for RST Head Start Facebook/Web Site, newsletter, newspaper, etc. Yes\_\_\_\_\_No\_\_\_\_\_\_

8. Photograph or film me and my family, I understand the photographs and footages may be used for the purpose of

publicity, illustration, and advertising for Head Start/Early Head Start. Yes\_\_\_\_\_No\_\_\_\_\_\_

**HEALTH AND SAFETY**

9. Provide first aide/CPR and emergency medical care to my child as needed. Yes\_\_\_\_\_No\_\_\_\_\_\_

10.Conduct a health screening on my child; I understand this screening may include, height, weight, vision, Hearing.

Yes\_\_\_\_\_No\_\_\_\_\_\_

11. Indian Health Service Dental Dept. Delta Dental, ROST HS/EHS Health & Safety staff may apply fluoride varnish to my

child. Yes\_\_\_\_\_\_No\_\_\_\_\_

12. Any immunization updates needed or found by Public Health Nurse. Yes\_\_\_\_\_\_\_No\_\_\_\_

**NON-DISCRIMINATION CLAUSE**: It is the policy of the RST Head Start/EHS to not discriminate on the basis of race, sex, age, color, national origin, or disabilities in the provision of service and employment.

**CONFIDENTIALITY STATEMENT**: Information shared with the RST HS/EHS will be kept confidential unless a parent release is authorized in writing. These forms will be maintained in locked files. I hereby release RST HS/EHS from all legal responsibilities or liabilities that may arise from acts I have authorized above. I would like a copy of this consent form.

**Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERMISSION IS VOLUNTARY, IT IS THE PARENTS RIGHT TO CHANGE CONSENT FORM AT ANY TIME**

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**FAMILY INFORMATION**

|  |
| --- |
| **CHILD INFORMATION** |
| **First MI Last Suffix DOB Gender** |
|  |
| **Child’s Race Child’s Ethnicity Child’s Primary Language Child’s Secondary Language** |
| ( ) Native American Hispanic ( ) English ( ) Spanish ( )English ( )Spanish  ( ) White ( ) Yes ( ) Other \_\_\_\_\_\_\_\_\_ ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ( ) Other\_\_\_\_\_\_\_\_ ( ) No |
| **Child’s Medical Provider Child’s Dental Provider Child’s Insurance** |
| ( ) Medicaid ( ) I.H.S.  ( ) Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**ADDRESS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Physical Address: P.O. Box City State Zip Code | | | | | | | |
|  | | | | | | | |
| Phone Numbers Home: Work: Cell: | | | | | | | |
|  | | | | | | | |
| **Parental Status** | **Receiving TANF** | **Homeless Family** | **Active Duty Military** | **Military Veteran** | **Referred by Welfare Agency** | **Receiving SNAP** | **WIC** |
| [ ] 1 parent  [ ] 2 parent | [ ] Yes  [ ] No | [ ] Yes  [ ] No | [ ] Yes  [ ] No | [ ] Yes  [ ] No | [ ] Yes  [ ] No | [ ] Yes  [ ] No | [ ] Yes  [ ] No |

**CUSTODIAL INFORMATION**

|  |
| --- |
| **Child’s Relationship**: [ ] Biological/Adopted/Step [ ] Foster Parent [ ] Grandparent [ ] Other Relative  [ ] Legal Guardian [ ] Custody [ ] Lives with family [ ] Provides financial support [ ] Teen parent  Is there a current order of protection or no contact order which concerns this child? [ ] Yes [ ] No |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have any concerns with your child’s behavior? | Would you like to speak to our Mental Health Consultant about the behavior? | Have you or your family experienced Trauma/Crisis? | Has your child been exposed to domestic violence? |
| [ ] Yes  [ ] No | [ ] Yes  [ ] No | [ ] Yes  [ ] No | [ ] Yes  [ ] No |

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**FAMILY INFORMATION CONT.**

|  |  |  |
| --- | --- | --- |
| **PRIMARY ADULT** | | |
| **FIRST NAME: MI LAST NAME: SUFFIX: BIRTHDAY: GENDER:** | | |
|  | | |
| **RACE: HISPANIC LANGUAGE SPOKEN** | | |
| [ ] Native American  [ ] Other | [ ] Yes  [ ] No |  |
| **EDUCATION EMPLOYMENT STATUS** | | |
| [ ] An advanced degree or baccalaureate degree [ ] Employed where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] An Associates degree, or some college [ ] Unemployed  [ ] High School graduate or GED  [ ] Did not finish  **Are you currently in school?**  [ ] No [ ] Yes, Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Full Time [ ] Part Time | | |
| **SECONDARY ADULT** | | |
| **FIRST NAME: MI LAST NAME: SUFFIX: BIRTHDAY: GENDER:** | | |
|  | | |
| **RACE: HISPANIC LANGUAGE SPOKEN** | | |
| [ ] Native American  [ ] Other | [ ] Yes  [ ] No |  |
| **EDUCATION EMPLOYMENT STATUS** | | |
| [ ] An advanced degree or baccalaureate degree [ ] Employed where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] An Associates degree, or some college [ ] Unemployed  [ ] High School graduate or GED  [ ] Did not finish  **Are you currently in school?**  [ ] No [ ] Yes, Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Full Time [ ] Part Time | | |

**ADDITIONAL FAMILY MEMBERS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FIRST NAME** | **MI** | **LAST NAME** | **BIRTHDAY** | **GENDER** | **GRADE** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

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**PARENT CONSENT FORM**

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give the Sicangu Lakota Oyate Early Childhood Program the authorization to:

(check the following)

**EDUCATIONAL/FAMILY SERVICES**

1. Release my name, telephone number and/or address to other parents for the purpose of communicating about specific program

activities. [ ] Yes [ ] No

2. Include my child on local field trips (fire dept. post office, library, Elementary schools, day care, park, Halloween activities)

[ ]Yes [ ] No

3. Transport my child for program purposes. Sicangu Lakota Oyate Early Childhood Program will ensure that children are safely

secured in their seats and assist them with buckling seat belts. [ ] Yes [ ] No

4. Include information about my child/family in the program website. I understand the website is to keep program staff and

enrolled families informed. This information may include but not limited to child/family name, family photographs, child/

family achievements or successes, birthdays and participation in the program activities. [ ] Yes [ ] No

5. Observe child in the classroom in relation to behavioral or developmental concerns, and when needed to have affliated

professionals conduct observations. [ ] Yes [ ] No

6. Share developmental screen results & birth certificates with Local Education Agencies (LEA). [ ] Yes [ ] No

PUBLIC RELATIONS

7. Take photographs/Videos of my child for Sicangu Lakota Oyate Early Childhood Program Facebook/Web site, newspaper

etc. [ ] Yes [ ]No

8. Photograph of film me and my family, I understand the photographs and footages may used for the purpose of publicity,

illustration, and advertising for the Sicangu Lakota Oyate Early Childhood Program. [ ] Yes [ ] No

HEALTH AND SAFETY

9. Provide first aide/CPR and emergency medical care to my child as needed. [ ] Yes [ ] No

10. Conduct health screenings on my child, I understand these screenings may include, height, weight, vision, hearing.

[ ] Yes [ ] No

11. Indian Health Service Dental Dept. Sicangu Lakota Oyate Early Childhood Program may apply fluoride varnish to my child.

[ ] Yes [ ] No

12. Any immunization updates needed or found by Public Health Nurse. ` [ ] Yes [ ] No

**NON-DISCRIMINATION CLAUSE**: It is the policy of the Sicangu Lakota Oyate Early Childhood Program to not discriminate

on the basis of race, sex, color, national origin, or disabilities in the provision of service and employment.

**CONFIDENTIALITY STATEMENT**: Information shared with the Sicangu Lakota Oyate Childhood Program will be kept

confidential unless a parent release is authorized in writing. I hereby release Sicangu Lakota Oyate Early Childhood Program

from all legal responsibilities or liabilities that may arise from acts I have authorized above. I would like a copy of this consent form.

Signature of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERMISSION IS VOLUNTARY, IT IS THE PARENTS RIGHT TO CHANGE CONSENT FORM AT ANY TIME.**

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**SICANGU LAKOTA OYATE EARLY CHILDHOOD PROGRAM**

**VIDEO CAMERA SURVEILLANCE POLICY**

Our Video Camera Surveillance Policy is to ensure our children and employees safety is maintained at all times. The following steps must be followed.

1. All employees and parents must sign a release authorizing video recordings for the limited purpose of

classroom surveillance. This signed consent will authorize release to Law Enforcement agencies (RST

PD, RST Criminal Investigations, Prosecutors Office, or the FBI) by court order ONLY.

2. If a child is injured on the Sicangu Lakota Oyate Early Childhood Program property, the program will

archive the video of the incident (if it exists) for three (3) consecutive school years.

3. Parents/Guardians of the child may view the video in question upon setting up an appointment with the

Director or Authorized Representative. The video may not be released to the parent/Guardian under

any circumstances absent a court order. The parent may not record the video utilizing any means of

recording.

4. If there are any accusations of abuse or neglect, the video shall be forwarded to Law Enforcement

services.

5. The Sicangu Lakota Oyate Early Childhood Program Staff members are mandatory reporters as

defined by Rosebud Sioux Tribe Law & Order Code (RSTLOC) § 5-8-6 and subject to RSTLOC

§ 5-8-7 and RSTLOC § 5-8-8.

I, Parent/Guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby agree to the above

Video Camera Surveillance Policy and I release the Sicangu Lakota Oyate Early Childhood Program from any liability related to the

above Policy.

Signature of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CERTIFICATION OF DEGREE OF INDIAN BLOOD**

**JOHNSON O’MALLEY FUNDING**

In order for the Sicangu Lakota Oyate Early Childhood Program to receive supplemental Johnson O’Malley funding to those identified as Indian students, the following information must be submitted by the Parent or Guardian for certification to authorized personnel.

**PLEASE COMPLETE THE ENTIRE FORM**

Students Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Name (s) Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tribe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Degree of Indian Blood: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrollment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pending: Yes: \_\_\_\_\_\_\_No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Name (s) Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tribe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Degree of Indian Blood: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrollment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pending: Yes:\_\_\_\_\_\_\_No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Name (s) Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tribe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Degree of Indian Blood: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enrollment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pending: Yes:\_\_\_\_\_\_\_\_No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If this child is enrolled, please attach a copy of their abstract,**

**If this child is not enrolled, please attach the mothers abstract.**

**PERMISSION FOR RELEASE OF INFORMATION**

I agree to release my child’s abstract from his/her file for information to be used for entrance into the Public School System and Johnson O’Malley Program.

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS SECTION IS TO BE COMPLETED BY THE RST ENROLLMENT OFFICE**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

I hereby certify that I have reviewed the appropriate records available and do further certify that the degree of Indian blood of the individuals as listed on this certification form is correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature and Title of Certifying Official: Date:

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Early Childhood Program

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**Sicangu Lakota Oyate Early Childhood Program**

**Eligibility Verification Form**

1. Family Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Child’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Size:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Family is eligible to participate in the Program: [ ] Yes [ ] No

4. Type of eligibility interview conducted: [ ] In-person [ ] Telephone

5. Check the applicable category of eligibility for this family/Child:

[ ] SSI [ ] Income Eligible

[ ] Homeless [ ] Between 100-130% of federal poverty guidelines

[ ] Foster Care [ ] (no more that 35% of enrolled children may fall into this category)

[ ] Public Assistance

6. Check the applicable determination for Over-Income Children/Families:

[ ] Counted as part of 10% maximum for non-AI/AN programs

[ ] Counted as part of the 49% maximum for AI/AN programs

7. What documentation was used to determine eligibility?

[ ] Income Tax Form 1040 [ ] Written statement from employers

[ ] W-2 [ ] Foster Care reimbursement

[ ] TANF Documentation [ ] SSI documentation

[ ] Pay Stub or pay envelopes [ ] Other

[ ] Unemployment if other, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Documentation of No Income:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of eligibility verification: \_\_\_\_\_\_\_\_\_\_\_

9. Staff Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SICANGU LAKOTA OYATE EARLY CHILDHOOD PROGRAM**

**RELEASE OF INFORMATION 2019-2020**

I/We\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_give Sicangu Lakota Oyate Early Child hood Program permission to release and/or obtain information with the understanding that the information will be used to assist our families in receiving services regarding the Family NEEDS ASSESSMENT activities and IEP/IFSP process. This information will be given to the following agencies.

* RST Community Services
* RST Child Care Program
* Crazy Horse School
* Department of Social Services (TANF, SNAP)
* Department of Disabilities Services
* I.H.S Environmental Health
* I.H.S. Behavioral Health
* Low Income Housing Energy Program (LIHEAP)
* Maternal Child Health Program
* Mni Wiconi Water Conservation
* Lakota Tiwahe Center Program
* RST Court House
* Rosebud Casino
* RST Personnel Dept.
* RST Vice Presidents Office
* RST Diabetes Prevention Program
* RST Commodity Food Program
* Sicangu Nation Employment & Training Program
* Southern Plains Behavioral Health
* St. Francis Indian School
* Sinte Gleska University Registers Program
* Sunrise Apartments Maintenance
* SWA Occupancy Modernization Program
* Tiwahe Glu Kini Pi
* Tree of Life Ministries
* Todd County School District
* Winner School District
* White River School Disctict
* Colombe Consolidated School/Wood District

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date:

Sicangu Lakota Oyate

Early Childhood Program

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**RELEASE OF HEALTH INFORMATION**

I hereby authorize the Sicangu Lakota Oyate Early Childhood Program to receive/send the following information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Copy of Health Records

[ ] Dental Exam or Treatment Plan

[ ] Lead/Hemoglobin Screening Results

[ ] Immunization Record

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(must be specific)

^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^^

Authorization is given this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Sicangu Lakota Oyate

Early Childhood Program

725 Hospital Drive

Box 836, Rosebud, SD 57570

P. (605) 747-2391 \* Fax (605) 747-2590

NUTRITION ASSESSMENT

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Food Items: | Yes | No | Comments |
| 1. | Does your child drink 100% fruit juice? (Orange, Grape, Apple, Etc.)  How Often? |  |  |  |
| 2. | Does your child drink sugar base drinks? (pop, Sports drinks, Kool-Aid, Flavored milk, Etc) How often? |  |  |  |
| 3. | Does your child eat fresh/canned vegetables? how often? |  |  |  |
| 4. | Does your child eat potatoes of any kind? |  |  |  |
| 5. | Does your child eat beans of any kind? |  |  |  |
| 6. | Does your child eat cereal (hot or cold)? How often? |  |  |  |
| 7. | Does your child eat beef? (Hamburger, Roast, etc)? how often? |  |  |  |
| 8. | Does your child eat poultry (Turkey or Chicken)? How often? |  |  |  |
| 9. | Does your child eat pork? (Sausage, Bacon, etc)? how often? |  |  |  |
| 10. | Do you cook with butter or margarine? |  |  |  |
| 11. | Does your child drink milk? if so what type? 1%, 2%, Whole, Skim, Breast Milk, or formula? |  |  |  |
| 12. | Does your child eat Eggs, Cheese, or peanut butter? how often? |  |  |  |
| 13. | Does your child eat chips, popcorn, or crackers? how often? |  |  |  |
| 14. | Does your child eat pastries? (cake, cookies etc)? how often? |  |  |  |
| 15. | Are there any foods your child is not allowed to eat due to religious or personal reasons? Please list foods in the comments. |  |  |  |

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NUTRITION ASSESSMENT CONT.

Child’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Food Items: | Yes | No | Comments: |
| 16. | Does your family eat together at the dinner table during meals? How often? |  |  |  |
| 17. | Do you have any concerns with your child being underweight or overweight? |  |  |  |
| 18. | Do you have any concerns regarding your child’s diet? if yes, please comment. |  |  |  |
| 19. | Is your child on a special diet? If yes you must provide a Dr. Statement. |  |  |  |
| 20. | Does your child have any diagnosed food or milk allergies? If yes, you must provide a Dr. Statement, List allergies in the comments section. |  |  |  |
| 21. | Would you like to set up an appointment with a Nutritionist to discuss any of your Child’s Nutrition concerns? |  |  |  |
| 22. | Would you like more information on preparing healthy meals for your family? |  |  |  |

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nutrition Manager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_