



Oglala Lakota College
Head Start/Early Head Start Program
P.O. Box 490
Kyle, SD 57752
Phone (605) 455-6117
Fax (605) 455-6116



Renewal Application for Returning Students Only

What is Head Start/Early Head Start?

Head Start and Early Head Start are comprehensive child development programs which serve children from birth to age 5, pregnant women, and their families. They are child-focused programs, and have the overall goal of increasing the social competence of young children in low-income families. By “social competence” is meant the child’s everyday effectiveness in dealing with either his or her present environment and later responsibilities in school and life. Social competence takes into account the interrelatedness of social, emotional, cognitive, and physical development.

What is Oglala Lakota College Head Start Program?

Our goal is to provide a full range of services to meet the needs of Lakota children from 0-5 and their families addressing cognitive, emotional, physical, nutritional, mental health, and Lakota language and culture development of the children and the development needs of families.

What Happens Next?

When we receive your renewal application, it will be reviewed and you will be contacted if any other information is needed.

Checklist

These documents must be submitted with the attached renewal application.

- Completed Renewal Application (required for determining eligibility)
- Family’s Proof of Income (required for determining eligibility)
- Immunization Record (*current for age as required by SD school immunization law 13-28-7.1*) **(Updated Only)**
- Family Survey





**Oglala Lakota College
Head Start/Early Head Start
Program**



Application Date: _____
(Office Use Only)

Renewal Application

Center Applying for: _____

ABOUT YOUR CHILD:

Child's Legal Name (First, MI, Last) _____

Date of Birth: _____ Social Security # _____ Male/Female _____

Race/Ethnicity _____ Primary Language: English Lakota Spanish Other: _____

Does your child have medical coverage? Yes No If Yes, What Kind (Please Attach)? _____

Has your child been to Head Start/Early Head Start before? Yes No If so, this is his/her year # 2 3

Where previously attended? _____ Receiving WIC? Yes No

Is your child in childcare now? Yes No If so, where? _____ What hours? _____

Is your child participating in any type of special services (IEP, IFSP): Yes No

If so, please list: _____

ABOUT YOUR FAMILY:

Languages Spoken: _____

Number in Family: _____ Parents need interpreter? Yes No

Number in Household: _____ One Parent Family Two Parent Family

Number of children 0-3 years old? _____ Number of children 4-5 years old? _____

Is anyone in your family Pregnant? Yes or No If so, due date? _____

Was your family referred to Head Start? Yes or No If so, by whom? _____

PARENT/GUARDIAN #1 _____ Child lives w/ this parent? Yes or No

Living address: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Message Phone: _____

Does this Parent: Attend School Work Attend a Training Program

Highest Grade completed in school: _____ Parent Birthdate: _____

PARENT/GUARDIAN #2 _____ Child lives w/ this parent? Yes or No

Living address: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Message Phone: _____

Does this Parent: Attend School Work Attend a Training Program

Highest Grade completed in school: _____ Parent Birthdate: _____



Oglala Lakota College
Head Start/Early Head Start Program



Child Emergency Contact Sheet
Renewal

Emergency Contact/Authorized Persons				
Person(s) listed below must be 13 years of age. Each person you list will be granted unrestricted access to your child to include visitation, pick-up and drop off from your OLC-Head Start/Early Head Start Center. Person(s) listed will be utilized as an alternate point of contact in case of an EMERGENCY .				
Contact Name:	Relationship to Child:	Phone #:	Address:	Primary Language Spoken:
		Work:		
		Home:		
		Cell/Message:		
		Work:		
		Home:		
		Cell/Message:		
		Work:		
		Home:		
		Cell/Message:		
Parent/Guardian Signature: _____ Date: _____				



Oglala Lakota College
Head Start/Early Head Start Program

Allergy Form
Renewal

Child's Name: _____

1. Do you know your child has allergies? YES / NO

If YES:

To what are they allergic? _____

What symptoms does your child have when they have allergies? _____

❖ **Please provide a doctor's statement stating what they are specifically allergic to.**

2. Are there any changes to your child's health in the last year? YES/NO

Explain: _____

3. Has a physician ever told you your child has allergies? YES / NO

4. Has your child ever had a skin test for allergies? YES / NO

If your child was skin tested, to what were they allergic? _____

5. Has your child ever had allergy shots? YES / NO

6. Has your child ever taken medications for allergies? YES / NO

If YES:

What medications? _____

How often? _____

7. Has a physician ever told you your child has asthma? YES / NO

8. Has your child ever had an attack of wheezing that made them short of breath? YES / NO

If YES:

Are they currently taking medications for these attacks? YES / NO

How often do these attacks occur and for how long? _____

9. Is your child allergic or sensitive to things that causes skin rashes?

If YES: What causes rashes? _____

Parent/ Guardian Signature: _____

Date: _____



Oglala Lakota College
Head Start/Early Head Start Program
Attendance Policy for Children
Renewal
School Year: 2009-2010



In accordance with the Head Start Performance Standard 1305.8, pg. 246 – When the monthly average daily attendance rate in a center-based program falls below 85 percent, a Head Start/Early Head Start program must analyze the causes of absenteeism. The analysis must include a study of the pattern of absences for each child, including the reasons for absences as well as the number of absences that occur on consecutive days.

Please help your child to be in school every day. If your child is absent or will be absent, please contact your child's classroom teacher and/or Family Helper.

Procedure for Child absenteeism:

- **First Contact:** The teacher is required to contact the parent/guardian after three (3) consecutive days of absenteeism, by phone or in person (when phone is not an option) and will be documented with the use of the **Family Contact Form**. It will be the responsibility of the teacher/ teacher aid to keep track of absences.
- **Absentees due to illnesses;** If the child is absent 3 days or more due to an illness or health concerns the staff will need to obtain what symptoms the child is experiencing or if the child been seen by a medical provider. The staff will notify the Health Coordinator of any children absent due to an illness or health concern. The staff and Health Coordinator will discuss the information provided by the family and the Health Coordinator will determine if a physician statement is required to excuse the absence and when the child should return to the center. The Health Coordinator will help the staff to determine unexcused or excused absences due to illnesses or health concerns.
- **Second Contact:** Following the first attempt to contact the parent/guardian of an absent child and child does not return to school, the Teacher completes an **Incident Report Form** and submits it to the Family Helper on the 4th day. The Family Helper will document (on the same **Incident Report Form** and inform the teacher of the outcome of the contact made with the family. If there is no Family Helpers- the attendance needs to be reported to the Family Development Coordinator.
- **Third Contact:** The Family Helper will make the third contact, if the child is not in attendance on the 8th consecutively day or 5th cumulative days per month and will try to encourage the family to keep the child enrolled. If not the Family Helper completes an **Enrollment Inactive Form**.
- To be considered inactive the child will be absent for 9 days consecutively without family contact or 6 cumulative days per month. Staff will need to notify Admin staff to clarify.
- The Family Helper notifies the appropriate staff of the child withdrawing from the program and the vacancies will be filled immediately.
- Whenever any documentation, whether it is a **Family Contact Form** or **Incident Report** is completed it must be immediately faxed to the Admin office.

Please sign below to indicate you have read and understand the Attendance Policy.

Parent/Guardian Signature _____ Date _____



Oglala Lakota College
Head Start/Early Head Start Program



Renewal
Authorization for Request for Confidential Information

I _____ (Printed Name of Parent Guardian)
hereby give permission for OLC Early Head Start /Head Start Program to obtain the
following information:

- Developmental Screenings (including speech and language)
- Medical Records (including immunizations, vision, hearing, dental and physicals)
- Educational records (including Individual Family Service Plans or Individual Education Plans)
- Professional Diagnosis (including behavioral/psychological)
- Other

From one or all of the following agencies:

- Shannon County Birth to Three Connections (Batesland, South Dakota)
- Oglala Sioux Tribe Early Intervention (Pine Ridge, South Dakota)
- Local Education Agencies (including Shannon School District, Loneman School, Red Cloud School, Pine Ridge School, Wounded Knee School, Porcupine School, Our Lady of Lourdes School, Little Wound School, American Horse School, Bennett County School District, Crazy Horse School, Jackson County School District, and Custer School District)
- Other

Regarding My Child: _____

DOB: _____ **Male** _____ **Female**

Attending OLC EHS/HS Center: _____

Classroom: _____

Parent/Guardian Signature: _____

Relationship to OLC EHS/HS Student: _____

Date Signed: _____

****This consent is valid for one year from the Date Signed, unless otherwise noted by the parent/guardian. ****



Oglala Lakota College
Head Start/Early Head Start Program



Renewal
Parental Permission to Participate

I _____ (Printed Name of Parent/Guardian) give

permission for my child _____

DOB: _____ / enrolled at the _____

EHS/HS Center in the _____ classroom to participate in

the following:

Yes / No	I authorize my child to accompany his/her class on field trips or other socialization activities. All children will be supervised by the staff, parents/guardians.
Yes / No	I authorize OLC EHS/HS to transport my child for all program purposes. Staff will ensure that children are safely secured in their seats and assist them in buckling seat belts.
Yes / No	I authorize the OLC EHS/HS to release my telephone number and/or address to other parents for the purpose of communicating to me about specific program activities.
Yes / No	I authorize OLC EHS/HS to take and use pictures of my child or my family to be used by the program for newspaper articles, or for promotional use.
Yes / No	I give permission for OLC EHS/HS Staff to use lotion, sunscreen, bath soap, and diaper ointment on my child when needed. (If answer is no, items will only be used if supplied by parent.)
Yes / No	I give permission for OLC EHS/HS or affiliated agencies to conduct a developmental screening on my child. I understand that this screening is a tool used to determine my child's current level of performance in areas of concept, language, and motor development.
Yes / No	I authorize OLC EHS/HS personnel/professional and/or affiliated professionals to observe my child informally in the classroom in relation to developmental or behavioral concerns.
Yes / No	In the event of an emergency, I give permission to OLC EHS/HS Staff to provide CPR/First Aid treatment and/or transportation to a health care facility. This may include examinations and any tests, which in the opinion of the physician or dentist is deemed necessary or advisable. This <u>does not</u> include the right to perform surgical operations without my further consent unless the OLC EHS/HS has exhausted all means of contacting.
Yes / No	I give permission for my child to participate in all OLC EHS/HS programs and activities including but not limited to: diabetes, dental, hearing and vision screenings

Parent/Guardian Signature: _____

Relationship to OLC EHS/HS Students: _____

Date Signed: _____

**This consent is valid for one year from the Date Signed, unless otherwise noted by the parent/guardian. **



Oglala Lakota College
 Head Start/Early Head Start Program
Authorization for Release of Confidential Information



I _____ (Printed Name of Parent Guardian)

hereby give permission for OLC Early Head Start/Head Start Program to release the following information:

- Developmental Screenings (including speech and language)
- Medical Records (including immunizations, vision, hearing, dental)
- Educational records (including Individual Family Service Plans or Individual Education Plans)
- Professional Diagnosis (including behavioral/psychological)
- Other _____

To one or all of the following agencies:

- Shannon County Birth to Three Connections (Batesland, South Dakota)
- Oglala Sioux Tribe Early Intervention (Pine Ridge, South Dakota)
- Local Education Agencies (including Shannon School District, Loneman School, Red Cloud School, Pine Ridge School, Wounded Knee School, Porcupine School, Our Lady of Lourdes School, Little Wound School, American Horse School, Bennett County School District, Crazy Horse School, Jackson County School District, and Custer School District)
- Other _____

Regarding My Child: _____

DOB: _____ **Male** _____ **Female**

Attending OLC EHS/HS Center: _____

Classroom: _____

Parent/Guardian Signature: _____

Relationship to OLC EHS/HS Student: _____

Date Signed: _____

****This consent is valid for one year from the Date Signed, unless otherwise noted by the parent/guardian. ****



Oglala Lakota College
 Head Start/Early Head Start Program
Family Survey
Renewal



Date Completed	Parent Completing Assessment
If there was a pre-existing/agreement; what agency/phone number?	
Family Goals	
3. Do you have any unanswered questions about the Head Start/Early Head Start Program?	
4. In what ways would you like to participate in the Head Start Program? <input type="checkbox"/> Classroom Officers <input type="checkbox"/> Event Planning <input type="checkbox"/> Workshops <input type="checkbox"/> Policy Council	
5. Are interested in being a member of the Policy Council? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Would you like information, training or both in the areas below? <input type="checkbox"/> Food Handlers <input type="checkbox"/> Male Involvement Program <input type="checkbox"/> Computer Training <input type="checkbox"/> Diabetes Prevention <input type="checkbox"/> Child w/ Special Needs <input type="checkbox"/> Resume Writing <input type="checkbox"/> Health Lifestyles <input type="checkbox"/> Job Application Assistance <input type="checkbox"/> Responsible Parenting Classes <input type="checkbox"/> Traditional Parenting <input type="checkbox"/> CPR/First Aid <input type="checkbox"/> Child Development/CDA <input type="checkbox"/> Substance Abuse Prevention <input type="checkbox"/> Prenatal/Postpartum Care <input type="checkbox"/> GED Preparation <input type="checkbox"/> CDL Training <input type="checkbox"/> Full Day, Full Year Child Care	
Part of the services offered to Head Start/Early Head Start is the opportunity to identify goals for yourself or your family that you can work on throughout the year with Head Start staff. Please fill out the form below to the best of your ability	
My family's greatest strengths are:	
My family 's hopes and dreams for the future are:	

 Signature of Parent/Guardian

 Date

 Signature of Head Start/Early Head Start Staff

 Date

(Give To Parent)

SD Department of Health – WIC Program

WIC is a supplemental nutrition program for eligible women, infants and children, funded by the U.S. Department of Agriculture and administered by the South Dakota Department of Health. WIC's goal is to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. WIC is available for all counties in the state and is an equal opportunity program. WIC provides nutrition education and counseling, breast-feeding support (information & breast pumps), healthy foods, referral to doctors, nurses, health and social service agencies, and immunizations, if needed.

WIC serves eligible women and teens (who are pregnant or have been pregnant in the last six months, are breast-feeding up to 12 months after delivery, or have had a baby in the last six months), infants and children up to age five. To be eligible, an applicant must meet income guidelines, residency requirements and have a nutrition or health risk.

For the number of the local WIC office, **call toll free 1-800-738-2301** (in South Dakota only). At the WIC appointment you will be asked to provide family income information, identity and residency information, information about foods eaten, answer questions about past and current health, have height and weight taken, have a finger blood test taken, visit with health professional about nutrition education and health needs, and if eligible, get food "checks" to buy foods at authorized grocery store. Benefits will be received monthly. Come to the local WIC office to receive nutrition education and food "checks." WIC food can be purchased at any grocery store that has signed an agreement with the WIC Program to comply with program policies. These stores are referred to as "authorized" WIC retailers. A list of "authorized" stores in your area is provided when you are determined eligible for WIC.

2009 - 2010 Income Guidelines

Size of Family Unit	Total Annual Income cannot exceed..
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530
7	\$33,270
8	\$37,010

For family units with more than 8 members, add \$3,740 for each addition member

(Give To Parent)



Building For the Future

This Head Start facility participates in the Child and Adult Care Food Program (CACFP), a Federal program that provides healthy meals and snacks to children.

Each day more than 2.6 million children participate in CACFP Head Start centers across the country. Centers are reimbursed for serving nutritious meals which meet USDA requirements. The program plays a vital role in improving the quality of Head Start and making affordable for low-income families.

Meals CACFP centers follow meal requirements established by USDA.

Breakfast	Lunch	Snacks (Two of the four groups :)
Milk Fruit or Vegetable Grains or Bread	Milk Meat or meat alternate Grains or bread Two different servings of fruits or vegetables	Milk Meat or meat alternate Grains or bread Fruit or vegetable

Participating Facilities

Many different homes and Head Start centers operate CACFP and share the common goal of bringing nutritious meals and snacks to participants. Participating facilities include:

- Child Care Centers: Licensed or approved public or private nonprofit child care centers, Head Start programs, and some for-profit centers.
- Family Day Care Homes: Licensed or approved private homes.
- After school Care Programs: Centers in low-income areas provide free snacks to school-age children and youth.
- Homeless Shelters: Emergency shelters provide food services to homeless children.

Eligibility

State agencies reimburse facilities that offer non-residential day care to the following children:

- Children age 12 and under.
- Migrant children age 15 and younger.
- Youth through age 18 in after school care programs in needy areas.

Contact

Information If you have questions about CACFP, please contact one of the following:

Sponsoring Organization/Center

Oglala Lakota College Head Start
P.O. Box 490
Kyle, SD 57752
Ph.(605)455-6000/Fx.(605)455-2787

State Agency:

Child and Nutrition Services
Department of Education and Cultural Affairs
800 Governors Drive
Pierre, SD 57501
Phone: (605)773-3413

Or



Oglala Lakota College
 Head Start/Early Head Start Program
Administration for Children
Fluoride Varnish Consent Form
Renewal

PARENT or GUARDIAN: Please complete and sign the Parental Permission for fluoride varnish (*Paint to Prevent*) Program treatment below.

Parental Permission

I give my son or daughter, _____, permission to have fluoride varnish placed on his or her teeth at least 4 times in a year by a trained staff or provider with prescription or standing orders. I have read the participation flyers and understand the procedure. The staff may refer to the medical history and contact list if any problems arise. I understand the **Paint to Prevent** program is a preventive program and the product is safe and effective.

Preventive Dental Treatment Authorization

I hereby authorize trained staff or providers to apply the varnish product to prevent dental caries and arrest incipient decay. I understand that the consent and authorization herein granted do not include major procedures. I also read the flyers and information on the product and consider it safe. This is considered a high risk area for oral diseases and participation in this preventive program will help reduce the rampant caries rate in the area. Please list any physical conditions that the school should be aware of (allergies, recurring illnesses, disabilities, chronic illnesses, etc.):

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me.

I have read the general information and hereby agree to all policies of the Head Start/ Early Head Start center concerning medical/dental and preventive treatment including the above authorization for the dental preventive program.

I DO _____ give my consent to have fluoride varnish applied.

I DO NOT _____ give my consent to have fluoride varnish applied.

Parent or guardian's name (please print): _____

Parent or guardian's signature: _____ ***Date:*** _____

Dentist Name and phone number _____



Oglala Lakota College
Head Start/Early Head Start Program
Xylitol Gum Consent Form
Renewal



Xylitol is a “tooth friendly” sugar. It is a naturally occurring sweetener found in the fibers of many fruits and vegetables, including various berries and corn husks, oats and mushrooms.

It does not encourage tooth decay (cavities) and may aid in repairing minor cavities. Xylitol has a plaque reducing effect and will “starve” the harmful bacteria that cause cavities. This can allow the mouth to “remineralize” the damaged tooth surfaces.

Xylitol products are allowed by the U.S. Food and Drug administration to make the medical claim that they do not promote dental decay.

Your child will chew three pieces of gum during the duration of the day to get the maximum benefit of this product.

Other Xylitol gum products sold in the United States are “Carefree Koolerz”; “Ice Breakers” brand Ice Cubes gum and “Orbit Complete” gum.

I DO _____ give my consent for my child to receive the benefits of the Xylitol and participate in the school Xylitol gum program.

I DO NOT _____ give my consent to participate.

Student’s Name: _____

Center: _____

Classroom & Teacher: _____

Signature of Parent or Guardian & Date