Oglala Lakota College
Early/Head Start Program
P.O Box 490 Kyle S.D 57752
(Phone) 605-455-6125
(Fax) 605-455-6116

Student Application 2025-2026

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 either low-income and homeless families or both. Social competence means the child's everyday school and life. Social competence considers the interrelatedness of social, emotional, cognitive, and physical development.

What is Oglala Lakota Head Start/Early Head Start?

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

Who is eligible to participate?

All prenatal mothers and children from birth to age five, whose families meet federal requirements for eligibility, are encouraged to apply for the Wounspe Oaye Takohe Program.

How does my family apply?

Please read this eligibility application carefully and fill out completely. It contains important information that is used to determine if your child is eligible for Head Start/Early Head Start services based on federal requirements. OLC selection criteria is located on Page 3 of the attached eligibility application.

Checklist (These documents must be submitted with the attached eligibility application)

- [ ] **Completed Enrollment Packet**
- [ ] **Immunization Record**
- [ ] **Guardianship/Custody Papers (If Appliable)**
- [ ] **IFSP/IEP Documentation (if applicable)**
- [ ] **Medicaid Card/Insurance**
- [ ] **Physical exam w/Lead & Hemoglobin**
- [ ] **Tribal Enrollment or Pending Letter**

Centers:

Allen Center (605) 455-2852 - ***Kyle Center*** (605) 455-2466 - ***Manderson*** (605) 867-1805 - ***Martin Center*** (605) 685-6651 - ***Oglala EHS Center*** (605) 867-5716 & ***Oglala HS Center*** (605) 867-1760 - ***Pine Ridge Center*** (605) 867-5649 &(605) 867-5460 - ***Porcupine Center*** (605) 867-5783 - ***Wakpamni EHS Center*** (605) 288-0032 - ***Wanblee HS Center*** (605) 462-6215 - ***Wounded Knee Center*** (605) 867-5464

CENTER APPLYING FOR:				
Applicant **Child's Name**	**First Name MI Last Name Date of Birth** **[ ] Female [ ] Male**			
Race	**Ethnicity Hispanic**	**Primary Language**		
[ ] Native American **[ ] White** **[ ] Other**	**[ ] Yes** **[ ] No**	**[ ] English** **[ ] Spanish** **[ ] Other**		
Medicaid [ ]yes [ ] No	**Dental Insurance**	**Primary Health Care Provider**		**Private Health Insurance**
Number:	**[ ] Yes [ ] No**			**[ ] Yes [ ] No**
Diagnosed Disability	**IEP**	**IFSP**	**Food Allergy**	**Explain food allergy**
[ ] Yes [ ] No **Explain:**	**[ ] Yes [ ] No**	**[ ] Yes [ ]No**	**[ ] Yes [ ]No**	

Please Note: If child has a food allergy then a Doctor's Note is required

Primary Adult	**First Name Last Name Date of Birth** **[ ] Female [ ] Male**		
Race	**Ethnicity Hispanic**	**English Proficiency**	**Lakota Language spoken**
[ ] Native American **[ ] White** **[ ] Other**	**[ ] Yes** **[ ] No**	**[ ] None [ ] Moderate** **[ ] Little [ ] Proficient**	**[ ] None** **[ ] Basic** **[ ] Fluent**

Highest grade completed	**Employment Status**	**Child's Relationship**
[ ] Associates [ ] Grade 10 **[ ] Bachelor's [ ] Grade 11** **[ ] Master's [ ] HS Diploma** **[ ] Some college [ ] Grade 9** **[ ] GED [ ] Did not finish**	**[ ] Full -time** **[ ] Part-time** **[ ] Seasonal** **[ ] Unemployed** **[ ] Retired or Disabled** **[ ] In school.**	**[ ] Biological/Adopted/Step** **[ ] Grandchild** **[ ] Other Relative** **[ ] Foster** **[ ] Other**

Custody	**Check all that apply**	**Email address**
[ ] Yes **[ ] No**	**[ ] Lives with Family** **[ ] Provides financial Support**	

Please Note: If there is Custody and/or Protections Orders we will need a copy of the Court Order for our file.

Secondary Adult	**First Name Last Name Date of Birth** **[ ] Female [ ] Male**		
Race	**Ethnicity Hispanic**	**English Proficiency**	**Lakota Language Spoken**
[ ] Native American **[ ] White** **[ ] Other**	**[ ] Yes** **[ ] No**	**[ ] None [ ] Moderate** **[ ] Little [ ] Proficient**	**[ ] None** **[ ] Basic** **[ ] Fluent**

Highest grade completed	**Employment Status**	**Child's Relationship**
[ ] Associates [ ] Grade 10 **[ ] Bachelors [ ] Grade 11** **[ ] Master's [ ] HS Diploma** **[ ] Some College [ ] Grade 9** **[ ] GED [ ] Did not finish**	**[ ] Full-time** **[ ] Part–time** **[ ] Seasonal** **[ ] Unemployed** **[ ] Retired or disabled** **[ ] In school**	**[ ] Biological/Adopted/Step** **[ ] Grandchild** **[ ] Other Relative** **[ ] Foster** **[ ] Other**
Custody **[ ] Yes** **[ ] No**	**Check all that apply** **[ ] Lives with Family** **[ ] Provides financial support**	**Email Address**

FAMILY CONTACT INFORMATION				
Physical Address	**City**	**State**	**Zip Code**	**County**
Mailing Address (If different)	**City**	**State**	**Zip Code**	**County**

Phone Numbers	Opt in for text messages	Primary Phone #	Secondary Phone #	Notes
Cell #	[ ] Yes [ ] No	[ ]	[ ]	Message #
Cell #	[ ] Yes [ ] No	[ ]	[ ]	Message #
Home #				
Work #				Work place:

Parental Status		Active Duty Military	Veteran	WIC	TANF	SNAP	SSI	Referred By DSS
[ ] 1 parent [ ] 2 parent		[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No

OTHER HOUSEHOLD MEMBERS					
Adult/Child	First	MI	Last	DOB	Gender
					[ ] Female [ ] Male
					[ ] Female [ ] Male
					[ ] Female [ ] Male
					[ ] Female [ ] Male
					[ ] Female [ ] Male
					[ ] Female [ ] Male
					[ ] Female [ ] Male
					[ ] Female [ ] Male

How did you hear about our Program?

[ ] Friend or Relative [ ] Health Care Provider [ ] WIC Office
[ ] Personal Contact [ ] Newspaper [ ] HS/EHS Face Book
[ ] Recruitment [ ] Other Specify_____

1. I declare under penalty of perjury that the information provided is true and correct to the best of my knowledge.
2. I will notify the agency immediately if there is any change in my income, family size, residence, employment, or reason for needing child development services.
3. I understand that the information about my eligibility may be reviewed by representatives of the State of South Dakota, The Federal Government, independent auditors, or others as necessary for the administration of the program.
4. I understand that I will receive a notice of approval or disapproval of my eligibility application.
5. I understand that there is additional paperwork for me to fill out if my child is approved for Head Start/Early Head Start.
6. I understand there is additional paperwork for me to fill out if my child is approved for Had Start/Early Head Start.
7. Under the South Dakota Privacy Act (Section 504 of the Rehabilitation Act, 29 U.S.C & 794d), you have the right to know that information you provide on your application for agency programming is classified and cannot be disclosed without your permission. The information you provide on this application is used to determine eligibility, and to provide program assistance, if applicable.
8. I give permission to Wounspe Oaye Tokahe Oglala Lakota College Head Start/Early Head Start Program to verify my income and any materials related to my eligibility and supply a copy of this application to other Human Service programs that require this information. To the best of my knowledge the information I have given is accurate and true.

_____ ____/____/____

Parent/Guardian Signature Date

_____ ____/____/____

Oglala Lakota College HS/EHS Staff Signature Date

CACFP Enrollment Form

Please complete and/or update and sign this form and return it to _____ no later than _____.

Our agency participates in the Child and Adult Care Food Program (CACFP) and receives Federal reimbursement for the meals served to your child(ren). The Federal regulations for the CACFP require us to collect and update this information on an annual basis for all of our enrolled children. This information is used to confirm your child(ren)'s current enrollment in the center and thus in the CACFP. All information is confidential and will be shared with appropriate personnel and state/federal staff as needed. **Note:** The indication of racial and ethnic background is optional and will not affect eligibility for the Program. This information is used for reporting purposes only. By providing this information you will assist us in assuring that this program is administered in a nondiscriminatory manner. If racial/ethnic background is not reported, a visual identification of the child's race and ethnicity will be made.

(Please circle all that apply)

Full Name(s) of Enrolled Child(ren)	*Race/ Ethnicity	Date of Birth	Normal Hours in Care	Normal Days of Care	Meals Normally Eaten While at the Facility**
			____ to ____	M T W T F S S	B AM L PM Su Ev
			____ to ____	M T W T F S S	B AM L PM Su Ev
			____ to ____	M T W T F S S	B AM L PM Su Ev

***Race:** Hispanic or Latino **Ethnicity:** American Indian or Alaskan Native/Asian/Black or African American/ Native Hawaiian or other Pacific Islander/White

****B=Breakfast AM=AM Snack L=Lunch PM=PM Snack Su=Supper Ev=Evening Snack**

List any holidays that may require care:_____

Special needs or instructions (i.e. allergies):_____

Parent/Guardian's Name:_____ Phone Number:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Mother's Employer:_____ Phone Number:_____

Father's Employer:_____ Phone Number:_____

Family Doctor:_____ In Emergency Call:_____

Parent Signature:_____ **Date:**_____

Annual Update (to be completed on an annual basis after initial enrollment):

1st Annual Update

I have reviewed the enrollment information for my child(ren) and (check one): ☐ found it to be accurate at the present time ☐ made changes as needed

Parent Signature:_____ Date:_____

2nd Annual Update

I have reviewed the enrollment information for my child(ren) and (check one): ☐ found it to be accurate at the present time ☐ made changes as needed

Parent Signature:_____ Date:_____

3rd Annual Update

I have reviewed the enrollment information for my child(ren) and (check one): ☐ found it to be accurate at the present time ☐ made changes as needed

Parent Signature:_____ Date:_____

"In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, dolor, national origin, sec, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is a equal opportunity provider and employer."

Office use Only: Enrollment Date:_____ Update Date:_____ Dismissal Date:_____

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WIC
Release of Information

Is your child currently on WIC? **Yes** ☐ **No** ☐

Regarding: _____ _____
(Name of Head Start Student) (Date of Birth)

I hereby give written authorization for the Oglala Lakota College Head Start/ Early Head Start Program to obtain and release information to:

Name of Agency: **WIC- Women, Infant, Child Program**

Mailing Agency: **PO Box 1988**

Pine Ridge, SD 57770

INFORMATION REQUESTED: (Head Start Staff will fill in what is requested below)

( ) Heights and Weights (current certification)
( ) Ages & Stages Developmental Screening (Delay Notes)
( ) Nutrition Counseling Documentation
( ) Hemoglobin Results
( ) Other (Please specify): _____
( ) Head Circumference (Under 2 years of age)
( ) BMI
( ) Diet Recall and Recommendations
( ) Immunization Record

This consent expires 16 months from the date signed. I understand that I may revoke this authorization upon written request at any time. The information obtained will not be disclosed to other people or organizations.

_____ _____ _____
Signature Relationship to Child Date

_____ _____
Authorized WIC Staff Signature Date

Child Health History

Name of Child: _____ Parent/Guardian name: _____

MEDICATION:
Is your child currently taking any medication? ☐Yes ☐ No If yes, please explain? _____

GENERAL HEALTH HISTORY - *Does your child have any of the following health conditions:*

☐ Anemia or Sickle Cell Anemia ☐ Chronic or Periodic Asthma ☐ Diabetes ☐ Seizure Disorders

Allergies To: ☐ Bee Stings ☐ Food, If So Please List:_____ ☐ Insect Bites ☐ Medication, What:_____

☐ Poison Oak Ivy ☐Sunscreen ☐Other:_____ Last Dental Exam and Where:_____

Sinus / Problems: ☐ Hay fever ☐ Seasonal Allergies ☐ Sinus trouble ☐ Frequent runny nose

Bowel / Urinary Track Problems: ☐ Diarrhea ☐ Frequent urination ☐ Wears diapers ☐ Bed wetting

☐ Daytime wetting ☐ Frequent constipation ☐ Painful urination

Vision Problems: ☐ Wears glasses ☐ Squints frequently ☐ Rubs eyes frequently

Hearing Problems: ☐ Difficulty hearing ☐ Frequent earaches or infections ☐ Tubes in ears

Digestion Problems: ☐ Frequent indigestion ☐ Frequent stomachaches ☐ Frequent vomiting

Other concerns or conditions: ☐ Bites when frustrated/angry ☐ Fainting spells ☐ Hyperactivity ☐ Thumb sucking
☐ Frequent Fevers ☐ Lack of energy/tired ☐ Trouble sleeping ☐ Frequent Sore throat
☐ Bone, joint or muscle disease or injury ☐ Eczema, hives, skin problems ☐ Born more than 6 weeks premature

Other (please explain) _____

SOCIAL / EMOTIONAL DEVELOPMENT - These questions will help us understand your child better and to know what is usual for him/her and what might not be usual that we should be concerned about:

Can you tell me one or two things your child is interested in or does especially well?_____

Does your child take a nap? ☐Yes ☐ No If YES, Describe when and how long?_____

Does your child sleep less than 8 hours a day or have trouble sleeping (such as being fretful, having nightmares, wanting to stay up late)?
☐Yes ☐ No If YES Describe arrangements (own room, own bed, and so forth)_____

How does your child tell you he/she has to go the toilet?_____

Does your child need help in going to the toilet during the day or night, or does your child wet his/her pants? ☐Yes ☐ No
If YES, Please Describe _____

How does your child act with adults that he/she doesn't know? _____

How does your child act with children his/her own age?_____

How does your child act when playing with a group of other children?_____

Is your child afraid of anything? ☐Yes ☐ No
If YES, what things seem to cause him or her to worry or to be afraid?_____
Does your child take a bottle? _____ _____

THANK YOU FOR TAKING TIME TO COMPLETE THIS INFORMATION

PARENT CONSENT FORM

Child's Name:_____

I hereby give the Oglala Lakota College Head Start Program Staff the authorization to: (circle one)

EDUCATION 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 field trips. Child must be supervised by the parent, guardian, and other responsible adults 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 on our Program Facebook page and Program website. This includes photographs, child/family achievements or successes, birthdays, perfect attendance, and all participation in 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 for educational development.	**Yes / No**
6. Share developmental screen results with local education agencies (LEA)	**Yes / No**

PUBLIC RELATIONS

7. Photograph my child 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

8. Indian Health Service Dental Dept., Delta Dental, Staff may apply fluoride varnish to my child.	**Yes / No**
9. Administer medication (Baby Wipes, Sunscreen, Antibiotic Ointment, Wound Cleaner, Diaper Rash Ointment, Burn Gel, Anti-Itch Cream, etc.) to my child on an as needed basis for medical purposes only. I understand that prescribed meds will need a standing order from the doctor to administer.	**Yes / No**
10. In the event of a medical emergency, permission for OLC EHS/HS Staff to provide first-aid treatment and/or transportation to health care facility.	**Yes / No**

Please check the OLC EHS/HS Programs and activities that you give permission for your child to participate in:

[ ]Dental Screening [ ]Hearing Screening [ ]Lead Test [ ]Hemoglobin Test

[ ]Vision Screening [ ] Fluoride Test [ ]Physical

Signature of Parent/Guardian_____

PARENT CONSENT FORM CONT.

ERSEA
McKinney-Vento Act: Definition of Homeless

A homeless child or youth lacks as fixed, regular, and adequate nighttime residence, sharing the housing Of others due to the loss of housing, economic hardship, or similar reason (doubled up). Living in motels, Hotels, trailer parks. Campgrounds, due to the lack of adequate alternative accommodations, living in Emergency or transitional shelters or awaiting foster care placement. Living in a public place not designed For humans to live. Living in cars, parks, abandoned buildings, substantial housing, bus or train stations. Etc.

After reading the McKinney-Vento Act, do you consider yourself homeless? Circle Yes/No

Do you own/rent your own home? Yes/No Do you pay utilities? Yes/No

Are you living with multiple families? Yes/No

Please read each section then initial that you have read and understand.

ATTENDANCE CONTRACT

I understand that full participation is encouraged in the Oglala Lakota College Head Start/Early Head Start Program and will maximize my child's opportunities for growth. I am aware that if my child's attendance becomes sporadic, My Family Center Service Provider will work with me to improve my child's attendance and that an "Attendance Contract" may be a part of the process. If at any time, my child's attendance becomes an issue my child may be put back on the waiting list.	Initial
I understand that participation in parent meetings/socializations are important growth experiences for my child. If I have trouble attending meetings/socializations my Family Center Service Provider will work with me to identify and remove any barriers.	Initial

NON-DISCRIMINATION CLAUSE
It is the policy of the Oglala Lakota College Head Start Program not to discriminate based on race, sex, age, color, national origin, or disabilities in the provision of service and employment.

CONFIDENTIALITY STATEMENT
Information shared with the Oglala Lakota College Head Start Program will be kept confidential unless a parent release is authorized in writing. These forms will be maintained in locked files. I hereby release Oglala Lakota College Head Start Program from all legal responsibilities or liabilities that may arise from acts that I have authorized above.

Signature of Parent/Legal Guardian_____

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

HEAD START IS NOT A BABYSITTING SERVICE

Oglala Lakota College
Head Start/Early-Head Start Program

Parent Bus Rules

1. Head Start/Early Head Start children will be picked up, daily. If there is to be a change in pick-up or delivery, then a Written Notice must be given to the driver (1) day in advance.
2. Parents need to notify the center staff when a child is not going to attend class.
3. Parents need to notify the Head Start/ Early Head Start center a week in advance of moving.
4. HS/EHS children need to be dressed and ready when the bus arrives. The driver will not wait more than three (3) minutes at each stop. If the child misses the bust, it is the parents' responsibility to take the child to school.
5. HS/EHS staff will not leave children unattended, and an authorized person must come to the bus to get the child.
6. Only individuals authorized by the legal parent or guardian will be allowed to take children off the bus or pick them up from school.
7. Siblings that are responsible for getting a child off the bus must be at least 13 years old.
8. If you are not at home and the driver cannot reach you or your emergency contacts by cell phone, the child will be returned to the center. It is the responsibility of the parents/guardians to see that he/she is taken home. The child will not be picked up again until the parent confers with the center staff.
9. If a child must cross the street to get on or off the bus, he/she must be accompanied by an adult. The child must cross in front of the bus.
10. Only Head Start/Early Head Start children and volunteers will ride the bus to and from the enter.
11. There is no food, drink, or smoking on the bus.
12. Personal toys and any other items (candy,etc.) should not be sent with the child while attending school.
13. There will be a Head Start/Early Head Start staff member (Bus Monitor) on the bus at all times.
14. All bus passengers are to be seated and to wear seat belts while the vehicle is in motion.

Parent/Guardian Signature: _____ Date: _____

Oglala Lakota College
Early/Head Start Program

Authorization for Request/Release of Confidential Information

I _____ hereby give permission
(Printed Name of Parent Guardian)

for the OLC Early Head Start/Head Start Program to request/release the following information: _____

- Developmental Screenings (including speech and language)
- Medical Records (including immunizations, vision, hearing, dental, physicals and lab results)
- 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: _____/_____/_____ **Gender (Circle): Male / Female**

Attending OLC EHS/HS Center: _____

Classroom: _____

Parent/Guardian Signature: _____

Relationship to OLC EHS/HS Student: _____

Date Signed: _____/_____/_____

****This request 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

Attendance Policy

Date form completed: _____/_____/_____ ☐ **Head Start** ☐ **Early Head Start**

Name of Child: _____ Parent/Guardian name: _____

Staff in both Head Start and Early Head Start centers will document daily attendance to ensure all children and families are receiving ongoing educational services.
After four consecutive days of absence with no parent/guardian contact, an enrolled child will be dropped from the program.

PROCEDURE

If absences are a result of illness or if they are well documented absences for other reasons, no special action is required. If however, the absences result from other factors, including temporary family problems that affect a child's regular attendance, the program must initiate appropriate family support procedure for all children with four or more consecutive unexcused absences.

Consecutive Absenteeism:

1. First day of absence: The teacher/teacher assistant will attempt to contact the parent/guardian.
2. Second day of absence: The teacher/teacher assistant will attempt to make contact with the parent/guardian.
3. Third day of absence: Family Service Worker will attempt to make contact with the parent/guardian.
4. Fourth day of absence: Family Service Worker will be required to do a home visit to contact the parent/guardian. If no contact has been made with the parent/guardian a letter will be sent home and the child will be placed on the waiting list and the child's slot will be considered open.

Chronic Absenteeism:

1. After the fourth day of unexcused absence, Family Service Workers will begin working with the family and emphasize the benefits of regular attendance, while at the same time being sensitive to any special family circumstances influencing their attendance pattern.
2. In cases of chronic absenteeism, where a child has more than 5 unexcused absences in one month, the child will be placed on the waiting list and the child's slot will be considered open.

In order for a child to be reinstated into the classroom after being placed on the waiting list for absenteeism, the parent/guardian and the Family Service Worker will have a conference to discuss and complete an attendance contract.

_____ _____/_____/_____
Parent/Guardian Signature Date

CHILD HEALTH RECORD

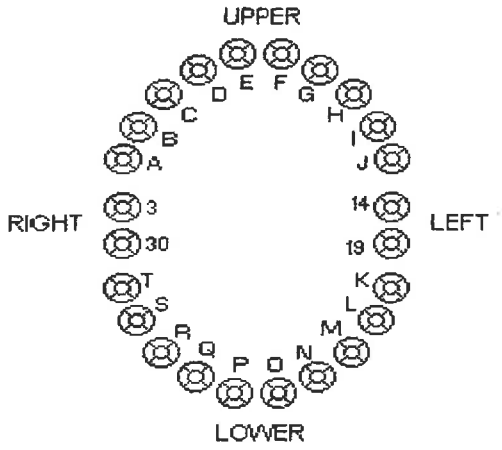
CHILD'S NAME: _____ BIRTHDATE: _____

Dental Provider: _____

Type: ☐ Screening ☐ Examination ☐ Treatment

# of times per day child flosses: _____

1. Teeth Condition



Key

Missing (X) **Crown (#)**
Decayed (=) **Sealants (s)**
Filled (+)

Brushing Frequency

- ☐ N/A
- ☐ Never
- ☐ Daily
- ☐ Weekly
- ☐ Occasionally

Oral Condition

- ☐ Normal
- ☐ Gingivitis
- ☐ Plaque
- ☐ Dental abscess

Referral for:

_____

Date

_____

MM DD YYYY

Clinic Name

_____

Follow Up for:

_____

Date

_____

MM DD YYYY

Clinic Name

_____

Comments: _____

2. DENTAL NEEDS (Check one or more)

- ☐ A. TREATMENT (extraction, pulp therapy, restoration)
- ☐ B. CLEANING
- ☐ C. FLUORIDE VARNISH
- ☐ D. ORAL HYGIENE INSTRUCTION
- ☐ E. DENTAL SEALANTS
- ☐ F. NO NEEDS
- ☐ G. OTHER _____

3. DENTAL ENCOUNTER: ☐ Received Dental Encounter Treatment DATE: _____

Services Received:

☐ Fluoride Varnish ☐ Cleaning ☐ Oral Hygiene Instructions ☐ Dental Sealants ☐ Other: _____

4. TREATMENT: ☐ Received Treatment DATE: _____

Services Received:

☐ Pulp Therapy ☐ Extraction ☐ Restoration ☐ Other: _____

5. CHILD ORAL HEALTH SUMMARY

All planned treatment (_____ is, _____ is not) complete.
If not, check the following items

- ☐ a. Routine recall visits
- ☐ b. Special home emphasis oral hygiene
- ☐ c. Dietary problem(s)
- ☐ d. Developmental problems
- ☐ e. Harmful oral habits
- ☐ f. Needs fluoride supplement

Signature _____ Date _____

Child Medical Provider Information

Name of child: _____ Parent/Guardian Name: _____

[ ] Head Start [ ] Early Head Start

[ ] Title 19/Medicaid [ ] Indian Health Service [ ] Private Insurance [ ] No Medical Coverage

Policy Number: _____ Insurance Effective Date: __/__/____

Doctor Provider: _____ [ ] Indian Health Service

Street Address: _____ Town/City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Dentist Provider: _____ [ ] Indian Health Service

Street Address: _____ Town/City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

A medication authorization form will need to be filled out for any medication given at OLC EHS/HS Program. **No medication will be given without a Doctor's Order, including over the counter medications.**

Child Evaluation/Disabilities Information

Has your child ever received Early Intervention Services from an outside agency?	Yes / No	If yes, please state where:
Has your child ever received an evaluation because of overall health and development delay?	Yes / No	If yes, please explain and state where the evaluation was completed at:
Is your child currently receiving services to address any special needs or disabilities that they might have?	Yes / No	If yes, please state where:
Is your child currently on an IEP or IFSP?	Yes / No	If yes, please provide a copy of the IEP or IFSP:

Custody/Protection Order Information

Please note: If you answer YES to these questions below then we will need a copy of the court order for our file.

Who has legal custody of the child: _____

Are there any special visitation orders we should be aware of? **Yes or No**

Is there currently a protection or restraining order in effect that concerns the child? **Yes or No**

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P.O. Box 490 Kyle, SD 57752
605-455-6125 (Phone) 605-455-6116 (Fax)

EMERGENCY CONTACT FORM

Please take the time to fill this form out completely. This is very important information for the following reasons: 1) In an emergency situation we need to contact someone if we cannot locate you (the parent) 2) emergencies can occur at any given time, contacts are important.

CHILD'S NAME: _____ **DATE COMPLETED:** _____

Mother's Name: _____
Address: _____
Home/Cell Phone: _____
Work Phone: _____
e-mail: _____

Father's Name: _____
Address: _____
Home/Cell Phone: _____
Work Phone: _____
e-mail: _____

The Following Phone Numbers need to be working and Inservice. The emergency contacts are used in case we can not contact the Parent/Guardian. If no one answers any of the contact numbers, we will proceed with the process and the Police Department will be Notified.

CONTACT 1

NAME: _____
RELATION: _____
ADDRESS: _____
_____
HM PHONE: _____
WK. PHONE: _____
CELL PHONE: _____

CONTACT 2

NAME: _____
RELATION: _____
ADDRESS: _____
_____
HM PHONE: _____
WK. PHONE: _____
CELL PHONE: _____

CONTACT 3

NAME: _____
RELATION: _____
ADDRESS: _____
_____
HM PHONE: _____
WK. PHONE: _____
CELL PHONE: _____

We will contact you by Phone, Facebook, or Messenger with upcoming school events and closures.

Oglala Lakota College
Head Start/Early-Head Start Program
P.O. Box 490Kyle, SD 57752
605-455-6125 (Phone) 605-455-6116 (Fax)

Child: _____ Sex: _____ Date of Birth: ___/___/____
Parent/Guardian: _____ Phone Number: _____
Address: _____ City: _____ State: _____

PHYSICAL ASSESSMENT	NORMAL	ABNORMAL	COMMENT/TREATMENT PLAN
GENERAL APPEARANCE			
SKIN			
LYMPH NODES			
HEAD			
NECK			
EYES			
EARS			
NOSE			
MOUTH AND THROAT			
CHEST			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
BACK AND EXTREMIT.			
NEUROLOGICAL			
ALLERGIES			

LAB RESULTS:

Hgb/Hct: _____
Lead Screen: _____
Date:_____
REQUIRED

VITALS:

Height: _____
Weight: _____
B/P: _____
H/C: _____ under the age of 2.

DIAGNOSIS:

PROVIDER:

_____
(Signature)

Name: _____
(PLEASE PRINT)

Address: _____

Date:

_____

Age-appropriate immunizations are required for Head Start programs. "Give Booster Immunizations if age 4 or older"

Please provide Oglala Lakota College Early/Head Start with a current copy of Immunizations.
Thank You.

MENTAL HEALTH: (Physicians need to ask the following questions and fill in)

Do you have concerns with your child's separation from you? YES NO If yes, please explain: _____

Do you have concerns with your child's attachment with significant adults? YES NO If yes, please explain:

_____

Oglala Lakota College
Head Start/Early Head Start Program

Child Routing & Information Form

Date form completed: ___/___/___ ☐Original ☐ Modified ☐Head Start ☐ Early Head Start

Name of Center:	**Teacher & Class:**
Name of Child:	**Nickname:**
Parent/Guardian Name:	
Primary Phone:	**Secondary Phone:**

Address and Directions for Drop-off & Pick-up

Home:

Alternative (Please include a phone number for alt. route):

Has a copy of emergency procedures (while on route) been given to parents of this child? Yes☐ No☐

Child Authorization

Please list the names of those authorized to sign-out your child

-
-
-

For Office Use Only

Assigned Bus Route & Driver(s):

Have copies been provided to the Teacher and Assigned Bus Driver(s): Yes☐ No☐

P.O. Box 490, Kyle, So. Dak. 57752
Phone: (605) 455-6125 Fax: (605) 455-6116

Oglala Lakota College
Head Start/Early-Head Start Program
P.O. Box 490 Kyle, SD 57752

Family Partnership Assessment

Child's Name: _____ **Date:** _____

Parent's Name(s): _____

Please mark any of the services that your family is currently receiving

☐ Medicaid, Medicare, CHIPS	☐ Supplemental Security Income (SSI)/(SSDI)	☐ LEIP-Energy Assistance
☐ Food Stamps	☐ Foster Care/Adoption Subsidy	☐ Child Support
☐ TANF	☐ Public Housing Assistance	☐ Alimony
☐ WIC		☐ Child Care Assistance
☐ Cornerstone		☐ Behavior Management Services
☐ Unemployment		

Do you have any existing plans with any of the above listed agencies? Yes No

If yes list agency: _____

Would you be willing to share a copy of this plan with our staff so that we may assist you with pre-existing goals? Yes No

Please mark the following items as the following:
S= Strength, N=Need or U= urgent need

Emergency		**Job Training**	
Crisis Assistance		**Substance Abuse Prevention**	
Food		**Substance Abuse Treatment**	
Clothing		**Child Abuse & Neglect Services**	
Transportation		**Child Support Assistance**	
Housing Assistance		**Health Education (Including Prenatal)**	
Mental Health Services		**Assistance to Families of Incarcerated**	
Literacy or Education		**Parenting Education**	
English as a 2nd Language		**Marriage Education**	
Adult Education		**Asset Building Services**	

Please explain any needs or urgent needs so we can gather all available community resources for your family:

_____

_____

_____

This form is used during the first intake visit with the family. Information from this form is then used to develop the Family Partnership Agreement, goal development and community resource referrals