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CHEROKEE NATION®
Early Childhood Unit

2021-2022 Public School Enrollment Application

P.O. Box 948 • Tahlequah, OK 74465 • (918) 453-5757 • 1-888-458-4393 • FAX (918) 458-5799 • headstart@cherokee.org

PLEASE ATTACH A COPY OF THE FOLLOWING INFORMATION TO THE APPLICATION:

1. Income Verification for Family *(Must show the Gross amount - Tax Return, W2, Pay Stub, Employer Statement, TANF or Supplemental Security Income (SSI) Documentation. Check stubs must be dated for month previous of the date of the application)*
2. Child's Birth Record *(Birth Certificate, Birth Card, Letter of Live Birth)*
3. Current Immunization Record
4. Tribal Membership Card for child and/or parent

Application Date _____ **Public School District in which child resides** _____

Child's First Name _____ **Middle** _____ **Last Name** _____

Date of Birth _____ **Gender** ☐ Male ☐ Female

Ethnicity/Race *(circle one)*: American Indian/Alaska Native, Asian, Black or African American, Multi-racial/Biracial, Native Hawaiian/Other Pacific Islander, Hispanic, Other, Unspecified, White

Language *(circle one)*: English, Cherokee, Spanish, Asian, Native North American, Caribbean, Indic, Western European, Pacific Island, African Languages, Other

Has your child been diagnosed for special needs services? ☐ Yes ☐ No *If yes, please provide documentation.*
Has your child received services for special needs? ☐ Yes ☐ No *If yes, please provide documentation.*
Are there other siblings in the household ages 0-4? ☐ Yes ☐ No
Are the parents employed by Cherokee Nation? ☐ Yes ☐ No
Did your child attend a Cherokee Nation Early Head Start Classroom? ☐ Yes ☐ No *If yes, where?* _____
Does your child have a primary physician? ☐ Yes ☐ No *If yes, where?* _____
Does your child have a primary dental home? ☐ Yes ☐ No *If yes, where?* _____

CONTACT INFORMATION:

Mailing Address _____ **City** _____ **State** ____ **Zip Code** _____

Physical Address _____ **City** _____ **State** ____ **Zip Code** _____

Home Phone _____ **Cell** _____ **Message or Work Phone** _____

Email address _____

FAMILY INFORMATION:
PLEASE LIST ALL HOUSEHOLD MEMBERS INCLUDING THE APPLICANT.

Relationship	First Name	Middle Name	Last Name	Date of Birth	Gender – M/F
Applying Child					

PRIMARY PARENT/GUARDIAN'S INFORMATION:

First Name _____ **Middle** _____ **Last Name** _____

Date of Birth _____ **Gender** ___ Male ___ Female **Relationship to Child**: _____

Opt in for Text Messages Y / N **Cell Number:** _____ **not from public school message system*

Ethnicity *(circle one)*: American Indian/Alaska Native, Asian, Black or African American, Multi-racial/Biracial, Native Hawaiian/Other Pacific Islander, Hispanic, Other, Unspecified, White

Language *(circle one)*: English, Cherokee, Spanish, Asian, Native North American, Caribbean, Indic, Western European, Pacific Island, African Languages, Other

Do any of the following apply *(Please circle)*: Lives with Family / Provides Financial Support / Teen Parent

Highest Grade Completed *(circle one)*: Master's, Bachelor's, Associate's, College Degree/Training, Advance Training, Grade 10, Grade 11, Grade 12, < Grade 9, HS Graduate, GED, Currently Enrolled in College

Employment Status *(circle one)*: Full Time, Part Time, Seasonal, Unemployed, Full Time & Training, Part Time & Training, Training or School, Retired or Disabled

SECONDARY PARENT/GUARDIAN'S INFORMATION:

First Name _____ **Middle** _____ **Last Name** _____

Date of Birth _____ **Gender** ___ Male ___ Female **Relationship to Child**: _____

Opt in for Text Messages Y / N **Cell Number:** _____ **not from public school message system*

Ethnicity *(circle one)*: American Indian/Alaska Native, Asian, Black or African American, Multi-racial/Biracial, Native Hawaiian/Other Pacific Islander, Hispanic, Other, Unspecified, White

Language *(circle one)*: English, Cherokee, Spanish, Asian, Native North American, Caribbean, Indic, Western European, Pacific Island, African Languages, Other

Do any of the following apply *(Please circle)*: Lives with Family / Provides Financial Support / Teen Parent

Highest Grade Completed *(circle one)*: Master's, Bachelor's, Associate's, College Degree/Training, Advance Training, Grade 10, Grade 11, Grade 12, < Grade 9, HS Graduate, GED, Currently Enrolled in College

Employment Status *(circle one)*: Full Time, Part Time, Seasonal, Unemployed, Full Time & Training, Part Time & Training, Training or School, Retired or Disabled

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOUR FAMILY:

1. Foster Child *(Provide Documentation)*
2. Protective Service Referral *(DHS / ICW)*
3. Single Parent or Single Guardian Household
4. Family Crisis *(Please explain)* _____
5. Homeless *(Complete Homeless Questionnaire)*
6. Siblings Currently Enrolled
7. Receiving Public Assistance TANF or SSI *(Provide Documentation)*
8. Receiving SNAP / WIC. *(please circle which)* WIC ID#: _____
9. Active Military Family
10. Military Veteran Family
11. Child receives services from the following programs *(please circle which)*: *Sooner Start, HERO Project, Bair Foundation, CREOKS, Evolve Professional Counseling, Cherokee Parents*
12. Family is acquiring/learning another language in addition to English.

HANG ON TO THESE FORMS:

You will need them to take to your child's health provider.

1. CHILD PHYSICAL EXAMINATION
2. CHILD ORAL HEALTH RECORD

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CHILD ORAL HEALTH RECORD

Child: _____ **DOB:** _____

Center: _____ **Classroom:** _____

Parent's Name : _____ **Phone:** _____

Address: _____

Do you have Sooner Care / Medicaid? Yes or No – Member ID Number: _____

Do you have Medical Insurance? Yes or No – Policy Number: _____

Company Name: _____ **- Phone Number:** _____

Do you have Dental Insurance? Yes or No - Policy Number: _____

Company Name: **- Phone Number:**

MUST BE COMPLETED BY PARENT:

Is the Child Now Receiving?

Topical Fluoride Application	**Yes** ____	**No** ____
Fluoridated Water	**Yes** ____	**No** ____
Fluoride Supplement Diet	**Yes** ____	**No** ____

(Tablets Liquid)

Screening: __ Examination: __

EXAMINATION/TREATMENT RECORD

(List recommended services in order)

Tooth # or Letter	Surfaces	Description of Work	Date Service Performed Mo.	Day	Yr.
		Dental Screening			

PRIORITY

_____ 1. Extractions

_____ 2. Pulpotomy or Pulpectomy

_____ 3. Space maintainer

_____ 4. Routine treatment: □Fillings □Crowns □Sealants

□Recommendations: _____

_____ 5. No Treatment Needed

_____ 6. Comments _____

_____

Dentist (Print) **Signature** **Date**

_____

Clinic (Print) **Phone**

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CHILD PHYSICAL EXAMINATION

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

1. CHILD HEALTH HISTORY

a.	Has your child had a complete physical/well child check?	YES / NO	Where: _____
b.	Has your child ever been to the dentist?	YES / NO	Where: _____
c.	Does your child have any known allergies?	YES / NO	What is it? _____
d.	Other than delivery, has your child ever been hospitalized?	YES / NO	If yes, when? _____
e.	Does your child take medication on a daily basis?	YES / NO	If yes, please explain: _____
f.	Is there anything that has caused concern about your child's health & development?	YES / NO	If yes, please explain: _____
g.	Would you describe your child as physically active?	YES / NO	

2. SCREENING TESTS

*When recording results, use at a minimum "N", "S", or "S" for NORMAL, SUSPECT, or ATYPICAL/ABNORMAL, respectively. *Head Start Requirement*

	TEST	DATE	RESULTS
a.	PRESENT AGE *		_____ YRS _____ MTHS
b.	HEIGHT (No shoes, to nearest 1/8 in.) *		
c.	WEIGHT (light clothing to nearest 1/4 lb.) *		
d.	BLOOD PRESSURE (ages 3 years & up)		Result: _____ / _____
e.	HEMATOCRIT OR HEMOGLOBIN *		Result: _____
f.	LEAD *		Reading : _____ ☐ Not Recommended
g.	HEARING *		Type of Test: _____ Result: _____
h.	VISION *		Type of Test: _____ Result: _____

3. PHYSICAL EXAMINATION/ASSESSMENT

		Normal	Abnormal	Not Eval.	Comments *(Use additional sheet if necessary)*
a.	GENERAL APPEARANCE				
b.	POSTURE, GAIT				
c.	HEAD				
d.	SKIN				
e.	EYES: (1.) External				
	(2.) Internal				
f.	EARS: (1.) External & Canals				
	(2.) Tympanic Membranes				
g.	ALLERGIES				
h.	NOSE, MOUTH, PHARYNX				
i.	HEART				
j.	LUNGS				
k.	ABDOMEN				
l.	GENITALIA				
m.	GLANDS (Lymphatic/Thyroid)				
n.	MUSCULAR COORDINATION				
o.	BONES				
p.	JOINTS				
q.	MUSCLES				
r.	GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:				

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

	ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS (Initial when complete)	DATE
a.				
b.				

Health Professional Signature: _____ **Date:** _____

Health Care Facility: _____ **Phone:** _____

AUTHORIZATIONS:

I, _____, hereby authorize the Oklahoma Immunization Service to release my child's Immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS") to the Cherokee Nation Early Childhood Unit for the purpose of completing my child's school records file to ensure that my child meets Oklahoma eligibility requirements for schools/day cares as outlined in Title 70 O.S. § 1210.191 and Oklahoma Administrative Code ("OAC") 310:535-1-2 and OAC 310: 535-1-3. Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon my child dropping or completing the Early Head Start/Head Start program at the Cherokee Nation Early Childhood Unit.

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information and revoke this authorization at any time in writing. If I choose to withdraw my permission, I will be responsible for providing updated Immunization records to my child's classroom for the purpose of completing my child's records.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand I may change this authorization at any time in writing. However, I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Regulations.

Parent/Guardian Signature _____ **Date** _____

INCOME VERIFICATION:

This public school collaborates with Cherokee Nation Early Childhood Unit to provide Head Start services to the children in our care. Working together provides our Pre-K students access to free lunches, classroom equipment, materials & supplies, playground equipment, teacher training, and ensures that your child is safe & healthy. In return, CNECU benefits from community partnerships, compliance with Federal Performance Standards, enrollment, and community awareness of the work that the Cherokee Nation Early Childhood Unit provides for families.

Because Head Start is an income based program, we must verify income for the families that we serve. The following is a list of the acceptable documents.

- ☐ Check stub (Must be dated for the month previous of the date of the application and show the GROSS amount of pay).
- ☐ W2 or Tax Documentation (Must be dated for the previous year of the date of the application).
- ☐ Employer Statement on Business Letterhead
- ☐ TANF Letter
- ☐ Supplemental Security Income (SSI) Award Letter
- ☐ Foster Care Documentation
- ☐ ECU Income Declaration Letter (Can be obtained from the CNECU Family Advocate).

Application Comments: _____

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that providing false documentation may disqualify me from receiving services.

Parent/Guardian Signature _____ **Date** _____

FAMILY INTERVIEW - ECU Staff Complete

☐ In-Person ☐ Telephone *(Document Reason Why Not In-Person)* _____

Please verify the following with the family:

1. Childs Name: _____
2. Parent(s)/Guardian(s) Name _____
3. Age Verification _____ 4. Income Verification _____ 5.Family Size _____
6. Household Members _____
7. Child Information _____
8. Family Strengths _____
9. Does the child receive special services from any program: _____
10. Do any of the following apply?: Homeless, Foster, SSI, TANF

Completing Staff Signature: _____ **Date:** _____

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Homeless Questionnaire

Student Name: _____ Center: _____

This form is intended to address the McKinney-Vento Act. Your answers will help determine residency requirements and certain needs for the student.

Presently where is the student living? (Check one)

SECTION A

_____ Rent/own my own home or apartment

STOP: If you checked the box that you rent/own your own home or apartment skip to the bottom of the page, sign the form and then submit to school personnel.

SECTION B

_____ In an Emergency or Transitional Shelter. Shelter name: _____

_____ Temporarily with another family member or friend due to loss of a job, loss of housing or until we can locate affordable housing.

_____ In a vehicle, park, campground, or on the streets.

_____ In a house, building, or trailer *WITHOUT* running water or electricity.

_____ In a hotel or motel until we can locate affordable housing.

_____ With an adult that is *NOT* a parent or legal guardian.

_____ Alone or in different location, without an adult serving as a caregiver.

_____ Wherever I can find a place to stay at night.

_____ Other - Please explain: _____

_____ _____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature Date

Present Address: _____

ERSEA: 5/1/17 CC