LKSD Early Learning Programs

ENROLLMENT APPLICATION FORM

LKSD Staff use only Date:

The following forms are required for a completed enrollment

- Emergency Information Card (yellow form)
- Preschool Enrollment Form (for Student Records Dept.)
- Immunizations record or certified Exemption Form
- Payment/Discipline policy signed
- Copy of birth certificate
- Title VII Form and copy of Tribal Card (if apply)

Services: ☐ Full Time Preschool ☐ Half Time Preschool ☐ Migrant Ed. Program ☐ Free Program

Notes:

INSTRUCTIONS

This form can be filled on your computer and then printed, please only type on the gray spaces, when finish sign on the required spaces. Otherwise please print clearly, using black ink or typewriter.
Remit your filled application to LKSD Early Childhood Department to the address below, or bring it to 1004 Ron Edward St. (green building), you can set up a visit of the facility as your desire.

General Information

Child Information:

Name: Nickname:

Gender: ☐ Male ☐ Female SSN:

Ethnicity (Please mark all that apply):

☐ Alaska Native ☐ American Indian ☐ White ☐ African ☐ Asian ☐ Hispanic

☐ Pacific/Hawaiian ☐ Multi-Ethnic ☐ Other:

Date of Birth:

Primary Sponsor:

Name: Relationship:

Mailing Address: Home Phone:

Physical Address: Work Phone:

Employer: Cell Phone:

Email Address:

Secondary Sponsor:

Name: Relationship:

Mailing Address: Home Phone:

Physical Address: Work Phone:

Employer: Cell Phone:

Email Address:

Contacts (Person to be called in case of an EMERGENCY when parents cannot be reached)		
Name:	Relationship:	
Address:	Phone:	
Authorized Persons to take child from Child Care:	☐ yes	☐ No
Name:	Relationship:	
Address:	Phone:	
Authorized Persons to take child from Child Care:	☐ yes	☐ No
Name:	Relationship:	
Address:	Phone:	
Authorized Persons to take child from Child Care:	☐ yes	☐ No

Household Income

If you are applying for the State Grant program we need the following information, acceptance is income based.
Please report for all member of the household

Type of Income	Job 1	Job 2	No Income
1. Gross Monthly Earnings: wages, salary, commissions			☐
2. Monthly Welfare Payments, Child Support, Alimony			☐
3. Monthly Payments from Pensions, Retirement, Social Security			☐
4. Monthly Dividends or Interest on Savings			☐
5. Monthly Worker's Compensation , Unemployment, Strike			☐
6. Other Monthly (SSI, VA, Disability, Farm, other)			☐
Totals for Columns Job 1 and Job 2			

Family Type:

☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Other:

Number of Children Ages 0-4: Number of Children Ages K-12 grade :

Parental Status: ☐ One ☐ Two Total Number in Family:

Does your child have an IEP: ☐ No ☐ Yes FIT Services: ☐ No ☐ Yes

Do you have any other school-aged children receiving free or reduced-price lunch?: ☐ No ☐ Yes

This section must be completed by a school official

Please check all that apply:		
☐	Free Lunch	(2 points)
☐	Reduce Lunch	(1 point)
☐	English Language Learner	(1 point)
☐	IEP or FSP	(1 point)
☐	Single Parent Household	(1 point)
	Total Rank:	

Child History

Do you receive assistance with the payment of your bill? ☐ yes ☐ No
If yes, which program assist you?

Adopted/Foster/Step Children:
If the child is adopted, foster child, step child or if the parents are divorced please provide any information regarding the child's past history or custody arrangements that will be helpful to our staff.

Languages spoken at home:

Nap/Quiet Time **(All children will participate in quiet time)**
Does the child take an afternoon nap? ☐ yes ☐ No

If so, approximate length:

Potty Training **(child must be potty trained at 3yrs old)**

Is the child fully responsible for his/her own toileting? ☐ yes ☐ No

If not, is your child in the potty training process? ☐ yes ☐ No

Medical Care

Child's usual source of medical care:

Dr.'s Name: Phone:

Medication/Medical Treatment:

Is there any medication/medical treatment required by your child? ☐ yes ☐ No

If yes, explain:

Allergies **(if your child have allergies, please contact the preschool leader for more information)**

Does your child have allergies? ☐ Yes ☐ No If yes, explain

Severity: ☐ Mild ☐ Moderate ☐ Severe Treatment:

Child's Special Needs **(Chronic Illness, bottle using, pacifier, fears, etc.)**

Does your child have special needs? ☐ yes ☐ No

Please explain:

Previous Child Care Information: **(Please include home care, family day care, preschools, etc.)**
Has your child had previous childcare? ☐ yes ☐ No

How many children is the child accustomed to being around?

Has the child been asked to leave another center or home day care? ☐ yes ☐ No

If so, why?

Please tell us about your Child **(likes, dislikes or any information that will by helpful to our staff)**

Acknowledgement

This is to verify that we _____ and _____ parent/guardian of _____ have received, read, and fully understand the LKSD Preschool Parent Handbook and agree to comply with the policies and procedures stated.

Name (please print) _____ Relationship: _____

Name (please print) _____ Relationship: _____

Signatures: _____ Date: _____

Photo Release

I certify that I am the parent and/or guardian of _____, a student of the Lower Kuskokwim School District (LKSD). I give my permission as parent or guardian, for both LKSD to publish photographic pictures of the above named student, to be used for educational purposes in the LKSD newsletters, posters, or any other material that will represent the district in a positive and beneficial way.

Parent Signature: _____ Date: _____

State of Alaska
Department of Health and Social Services
Office of the Privacy Official
PO Box 110650
Juneau, AK 99811-0650

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

SSN: _____ Record # or Other ID: _____ Date of Birth: _____

Other Names Under Which Records Might Be Filed: _____

Person/Organization Releasing Information: Public Health Nursing - Bethel

Person/Organization Receiving Information: (*include address if needed*) _____

LKSD Preschool Programs Fax 907-543-4902

Description of Information To Be Released: *(If substance abuse information is to be released from a federally assisted substance abuse treatment center, then this information must be included in the description)*

Immunizations

The purpose of the release of this information is: Preschool Enrollment

I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any affect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event: _____

_____ _____
Signature of Client or Personal Representative (Or Witness if signature is by mark) | Date

_____ _____
Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

NOTE: This authorization was revoked on: _____ *(see attached revocation)*
Date

RECIPIENT INFORMATION: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains or as otherwise permitted by CFR 42 Part 2. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS:

The elements of this form described below (1-5) and marked with an asterisk (*) MUST BE COMPLETED. There are NO exceptions. Incomplete authorization forms are invalid and WILL NOT BE PROCESSED!

1. **Client Information** *: Enter the Name, SSN, Case # or Client ID, and Date of Birth (if known) of the individual whose information (PHI) is being released or requested. At least one identifier other than name must be present – e.g. SSN or DOB or Case # or Client ID

2. **Organization Releasing and Receiving Information** *: Enter "DHSS" and/or "Division Name" or "Program Name" ONLY on either the Releasing line or Receiving line depending on whether the Department or Division is receiving information or releasing information. ***DO NOT enter specific DHSS employee names!*** The client or client's representative should indicate a specific name (and address, if known) of the individual(s) or organization(s) receiving or releasing the information. Multiple individuals/organizations may be specified on a single authorization if they are ALL receiving the same information and are clearly specified. Use additional authorizations if individuals/organizations are receiving different information or if there is not enough room on a single authorization to clearly specify multiple individuals/organizations on the Receiving Information lines.

3. **Description of Information to be Released** *: A specific description of the information that is being requested or released should be indicated. Detail is not required, but is preferred. For example, *"Medical and mental health records"* rather than *"All information you have"*. If alcohol or other substance abuse information is being released or requested, this must be explicitly stated in the description. For example, *"Medical and mental health records, including alcohol or substance abuse records"*.

4. **Expiration Date/Event** *: Enter a date or event that is reasonable and acceptable to the client or client's representative. For instance, *"One year from the date of this authorization"* is generally accepted as a reasonable expiration date.

5. **Signatures & Dates** *: The individual whose PHI is being released or requested should sign and date the form. If the individual is a minor, or is otherwise not able to sign the form, the individual's authorized representative or witness should sign and date it. If an authorized representative is signing the form on behalf of the client, the representative's "legal authority" to act on the part of the individual must be verified first and then described in the appropriate space. Legal authority includes but is not limited to a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released or requested.

6. **Revocation Date**: The revocation date on the reverse side of this form does NOT need to be completed UNLESS the individual has revoked this authorization using form 06-5872 Revocation of Authorization. If revoked, a copy of the revocation should be attached to this form & the date of revocation noted of the front of this form.

7. **ALL authorization forms MUST be retained for SIX (6) YEARS from the date of signature.** This form should be stored in the client file, if one is maintained. Some programs have procedures requiring the form, or a copy of the form be retained solely or additionally by the Division Privacy Official. Please refer to the appropriate Division or Program specific procedures or inquire with your Division Privacy Official regarding any additional retention requirements of authorization forms.

8. If requested, provide a copy of this authorization to the client or client's representative.

QUESTIONS?
Contact the DHSS Privacy Official at (907) 465-2150 with any concerns you may have.

FOR DHSS & BUSINESS ASSOCIATE USE ONLY

Use this section to document ALL disclosures made by DHSS or business associates based on this authorization. Please supply the information below detailing information about the disclosures that may not be adequately described the front of this authorization. For instance, if Description of Information To Be Released on the front states *"All information you have on me"* – then completely describe the data that was actually disclosed, such as *"Medicaid eligibility and disability information from 1993 - 2001"* or *"Immunization data from 2001 - 2003"*. Indicate the actual date(s) of disclosure(s) and the name and division of the employee(s) releasing the data. Attach additional documentation if necessary.

Disclosure Date	Disclosed By (Name/Division)	Detailed Description of Information Disclosed

Lower Kuskokwim School District

PRESCHOOL ENROLLMENT CARD

SCHOOL: LKSD Early Learning Center ENROLLMENT DATE:

1. STUDENT LEGAL NAME LAST FIRST MIDDLE	2. SOCIAL SECURITY NUMBER	3. SEX M or F	4. BIRTH DATE MONTH / DAY / YEAR

5. ETHNIC ORIGIN ESK ☐ IND ☐ ALEUT ☐ ASIAN ☐ BLACK ☐ WHITE ☐ HISPANIC ☐ MIXED ☐	6. MAILING ADDRESS (PO BOX)	7. ZIP CODE	8. HOUSE AND STREET ADDRESS

9. MALE PARENT GUARDIAN	10. FEMALE PARENT GUARDIAN	11. MOTHER'S MAIDEN NAME

12. FATHER'S EMPLOYER	13. MOTHER'S EMPLOYER	14. P.S. 0 (BIRTH) Before August 15

15. FATHER'S BUSINESS PHONE NO.	16. MOTHER'S BUSINESS PHONE NO.	P.S 1 (Yr) ☐
		P.S 2 (Yr) ☐

17. FATHER'S EMAIL ADDRESS	18. MOTHER'S EMAIL ADDRESS	P.S 3 (Yr) ☐
		P.S 4 (Yr) ☐

OMB Control No. 1810-0021 (Exp. 01/31/2024)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

LKSD MIGRANT EDUCATION PROGRAM

Coordinator: Delilah Hodge -delilah_hodge@lksd.org (543-4854)
Jazzmin LaVale -jazzmin_lavalle@lksd.org Rachel DeHaan -rachel_dehaan@lksd.org (543-4869)

The primary goal of the Alaska Migrant Education Program is to ensure that all migrant students reach challenging academic standards & graduate with a high school diploma that prepares them for responsible citizenship, further learning, & productive employment, while supporting a subsistence lifestyle.

Please fill out the survey on the back of this sheet & return to your child's school office.

Your child(ren) may qualify for the Migrant Education Program if they:

*-**Travelled more than 20 miles** to a fish camp or berry camp or for commercial logging*
*- Stayed at camp for a total of **7 nights** or more within a year (doesn't have to be consecutive)*
*-**Relies on subsistence** fish &/or berries to get through the year*

After returning this survey, you may be called by recruiter for a short interview for details about your children's trips.

**** Children do not have to be in school to qualify.***

Some of the services we can provide include (after school or weekends):

- ***Tutoring***
- ***Credit Recovery***
- ***Family Nights***
- ***Book & School Supply Distributions***
- ***Summer Camps***
- ***First Aide/CPR Training***
- ***Hunter Safety Training***
- ***Swimming Lessons + pool access***
- ***Enrichment Activities***
- ***Safety Gear***

PLEASE FILL OUT THIS SURVEY
& RETURN IT TO YOUR CHILD'S SCHOOL

Migrant Education Application **School** _____ Date _____, 2023/2024

TO SEE IF YOU QUALIFY. COMPLETE ONE SURVEY PER FAMILY.
DO include kids not in school yet & those at Mt. Edgecumbe/GILA/dropped out (label).

Child's Full Name (list youngest 1st) ***Children do not have to be in school to qualify.***	**Birthdate**	**Grade**	**Twin?**

Parent Names	**Phone Number**	**Physical** Address (not PO box)	e-mail please

REQUIREMENTS TO APPLY

- **Children must travel <u>over 20 miles from home</u> & <u>stay at least one night per trip</u>.**
- ***A total of 7 nights or more. (They can take several trips to total the 7+ nights.)***

Please list specific location names & dates. If you can provide a map, that's great!

- **<u>Fishing & berry picking trips only.</u> <u>Commercial logging counts also.</u>**
- **<u>NO HUNTING please, unless</u> they picked berries, plants, &/or fished <u>as well</u>. (state rule, not LKSD's)**

**EXAMPLE*

Location of Fishing/Picking Trip	*Tunt. Fish Camp, upriver from Tunt.*
Dates of Overnight Trips	*06/05/23 - 07/01/23 … … We <u>DO</u> need the month <u>& days</u> or a good guess.*
Type of Gear/Activity and Type of Catch	*Drift Net-Salmon (reds, chum, silvers) + salmon berries (5 gal.)*
Guardian for Fishing/Picking Trip	*Grandma Sally*

Location of Fishing/Picking Trip	
Dates of Overnight Trips	/ / *Only DAY trips?*
Type of **Gear/Activity** and Type of **Catch**	
Guardian for Fishing/Picking Trip	

Location of Fishing/Picking Trip	
Dates of Overnight Trips	/ / *Only DAY trips?*
Type of **Gear/Activity** and Type of **Catch**	
Guardian for Fishing/Picking Trip	

1. Are fish and berries a financial necessity for your family? YES / NO (circle one)
2. What will happen if your family does not gather fish or berries?_____
_____
3. How do you use the food? How often do you eat fish &/or berries?_____
4. How much food do you store for the winter?_____
_____

*<u>RETURN TO:</u> Rachel (Swiggum) DeHaan <u>rachel_dehaan@lksd.org</u> or **fax 543-4902** or your school secretary*

ALREADY in Migrant Ed.? __yes_____ no_____not sure__ (circle one)

Updated 07-25-23 dmh