ROSEBUD SIOUX TRIBE
EARLY HEAD START/
HEAD START PROGRAM

P.O. Box 836, Rosebud, SD 57570
(605) 747-2391 • Fax (605) 747-2590

2025-2026 SCHOOL YEAR

The Sicangu Lakota Oyate Head Start/Early Head Start Program provides a comprehensive program which includes Early childhood education, Nutrition, Family Partnerships, Mental Health and Disability advocacy for enrolled families.

The Sicangu Lakota Oyate Head Start/Early Head Start Program recognizes parents as the primary educator of their child and with your engagement in the program, you will have many opportunities to learn and grow with your child. We look forward to sharing the Head Start/Early Head Start journey with you and your family.

To complete the enrollment packet you will need to provide the following information:

[ ] Complete the enrollment packet
[ ] Dental Screening
[ ] Physical exam
[ ] Lead screening
[ ] Child's Birth Certificate
[ ] Degree of Indian blood
[ ] Medicaid Card
[ ] IEP or IFSP (if available)
[ ] Medicaid or Insurance card
[ ] Current immunization

FOR FURTHER INFORMATION REGARDING SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START ENROLLMENT PLEASE CONTACT ONE OF THE FOLLOWING ADVOCATES AT:

Cheyenne D. Marshall- Long Warrior/Dunham, Billy Mills, Woksape Woihanble Classrooms, ext. 201
April Martinez – Nellie Menard, Wilma Whipple Classrooms, (605) 747-2364
Natasa Larvie – Arrow, Kate Omaha Boy, Owl Bonnet Classrooms, ext. 227
Feri Veloz – Antelope, Stephan Fallis, Neola Spotted Tail Classrooms, (605) 856-4724
Rikki Spotted Tail – Mercy Poorman, Yellow Hawk, Lame Deer Classrooms, (605) 856-4724
Elizabeth Castro – Keya, Sungmanitu Tanka, Pahin, Sungmantu Cika, Mato Tatanka Classrooms, (605) 747-2364
Amber Elk Looks Back – Sungh'Pala, Tusweca, Wanbli, Kimimila, Sunka Wakan Classrooms, Ext. 225

Debb M. LeRoy – ERSEA Manager, (605) 747-2391 ext. 215
Victoria Burnette – ERSEA Assistant, (605) 747-2391 ext. 209

SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START

ENROLLMENT APPLICATION
2025-2026 SCHOOL YEAR
ENROLLMENT CHECKLIST

FAMILY INFORMATION

Applicant First Name:	MI	Last Name	Date of Birth	Gender F /M

Ethnicity	Hispanic	Primary Language
[ ] Native American [ ] Non Native [ ] Other	[ ] No [ ] Yes	[ ] English [ ] Spanish [ ] Other

Medicaid	Dental Insurance	Primary Health Care Provider	Private Health Insurance
[ ] Yes [ ] No	[ ] Yes [ ] No		[ ] Yes [ ] No

Diagnosed disability	IEP	IFSP	Food Allergy	Explain Food Allergy
[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	

FAMILY CONTACT INFORMATION

Mailing Address	City	State	Zip Code	County
P.O.				
Physical Address	City	State	Zip Code	County

Phone Numbers	Opt in for messages	Primary Phone #	Secondary Phone #	Notes
Cell #	[ ] Yes [ ] No	Home #	Work #	Message #
Cell #	[ ] Yes [ ] No			
Parental Status	Active Duty Military	Veteran	WIC	TANF
[ ] 1 parent [ ] 2 parent	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
SSI	SNAP	Referred by DSS		
[ ] Yes [ ] NO	[ ] Yes [ ] NO	[ ] Yes [ ] NO		

ERSEA AREA ONLY

FAMILY SERVICES		DISABILITIES		HEALTH	
Enrollment Checklist		IEP/IFSP		Physical	
Family Information		EDUCATION		Dental	
Parent Consent		JOM			
Video Surveillance Policy					
Family Assessment Release					

DOCUMENTS NEEDED

Birth Certificate		Medicaid		Signed Eligibility Form	
Tribal Abstract		Immunization		Income Verification	
Guardianship/Custody					

FAMILY MEMBER INFORMATION

PRIMARY ADULT

First Name	MI	Last Name	Suffix	Birthday	Gender

Ethnicity	Hispanic	English Proficiency	Lakota Language spoken
[ ] Native American [ ] Non Native [ ] Other	[ ] Yes [ ] No	[ ] None [ ] Moderate [ ] Some [ ] Proficient	[ ] None [ ] Basic [ ] Fluent

Highest grade completed	Employment Status	Child's Relationship
[ ] Associates [ ] Grade 10 [ ] Bachelors [ ] Grade 11 [ ] Master's [ ] HS grad [ ] 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
[ ] Yes [ ] No	[ ] Lives with Family [ ] Provides financial support

Email Address

SECONDARY ADULT

First Name	MI	Last Name	Suffix	Birthday	Gender

Ethnicity	Hispanic	English Proficiency	Lakota Language Spoken

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

Custody	Check all that apply
[ ] Yes [ ] No	[ ] Lives with Family [ ] Provides financial support

Email Address

How did you hear about our Program?

[ ] Friend/Relative
[ ] WIC Office
[ ] Program Brochure
[ ] SLO HS/EHS Face Book
[ ] Heath Care Provider
[ ] Personal Contact
[ ] Other Specify_____
[ ] Channel 93
[ ] Newspaper

FAMILY MEMBERS CON'T

OTHER HOUSEHOLD					
Adult/Child	First Name	MI	Last Name	DOB	Gender
					[ ]F [ ]M
					[ ]F [ ]M
					[ ]F [ ]M
					[ ]F [ ]M
					[ ]F [ ]M
					[ ]F [ ]M
					[ ]F [ ]M
					[ ]F [ ]M

EMERGENCY CONTACT			
Name	Relationship	Emergency Contact Y/N	Release to Y/N
Physical Address	City	Zip	
Phone # 1	Phone # 2	Message Phone #	

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Phone # 1	Phone # 2	Message Phone #	

ERSEA

McKinney-Vento Act: Definition of Homeless

A homeless child or youth lacks a fixed, regular, and adequate night-time 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 accommodation, 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, abandoned buildings, substantial housing, bus or train stations. ETC.

- After reading 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

PARENT CONSENT FORM

CHILD'S NAME:_____

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 local field trips (fire department, post office, library, elementary schools, day care, Halloween activities). 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 Face book 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 activities'. In the event I request mental health services for myself, student or family, referrals will be made to outside agencies on my behalf.	Yes/No
6. Share Developmental screen results and birth certificates with local education agencies (LEA)	Yes/No

PUBLIC RELATIONS

7. Photograph my child and 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, Sicangu Lakota Oyate HS/EHS Health & Safety Staff may apply fluoride varnish to my child.	Yes/No

Signature of Parent/Guardian_____

ATTENDANCE CONTRACT

I understand that full participation is encouraged in the Sicangu Lakota Oyate/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 Advocate 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 wait 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 Advocate will work with me to identify and remove any barriers.	Initial

CONFIDENTIALITY STATEMENT Information shared with the Sicangu Lakota Oyate Head Start/Early 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 Sicangu Lakota Oyate Head Start/Early Head Start from all legal responsibilities or liabilities that may arise from acts that I have authorized above. I would like a copy of this form.

Signature of Parent/Legal Guardian_____

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

HEAD START IS NOT A BABYSITTING SERVICE

CERTIFICATION OF DEGREE OF INDIAN BLOOD

JOHNSON O'MALLEY FUNDING

In order for the Sicangu Lakota Oyate Head Start/Early Head Start Program to received supplemental Johnson O'Malley funding to those individuals as Indian Students, the following information must be submitted by the Parent or legal guardian for certification to authorized personnel.

PLEASE COMPLETE THE ENTIRE FORM

Students Name_____ Date of Birth:_____

Other Name (s) used:_____

Tribe:_____ Degree of Indian Blood:_____

Enrollment Number:_____ Pending: Yes_____ No_____

Father's Name_____ Date Of Birth_____

Other Name (s) used_____

Tribe_____ Degree of Indian Blood_____

Enrollment number_____ Pending: Yes_____ No_____

Mother's Name_____ Date Of Birth_____

Other Name (s) used_____

Tribe_____ Degree of Indian Blood_____

Enrollment number_____ Pending: Yes_____ No_____

If this child is enrolled, please attach a copy of their abstract
If this child is not enrolled, please attach the mother's abstract

PERMISSION FOR RELEASE OF INFORMATION

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

Parent/Legal Guardian_____

THIS SECTION IS TO BE COMPLETED BY THE RST ENROLLMENT OFFICE

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

Signature and Title of Certifying Official_____ Date_____

SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START PROGRAM
VIDEO CAMERA SURVEILLANCE POLICY

Policy

The Video Camera Surveillance policy of the Sicangu Lakota Oyate Head Start/Early Head Start Program is to ensure our children and employee's safety is maintained at all times. All employees and parents must sign a release authorizing video recordings for the limited purpose of classroom surveillance. This form will authorize the release to law enforcement agencies RST Police Department, RST Criminal Investigations, Prosecutor's office, or the FBI by court order only.

Procedures

1. If a child is injured on Sicangu Lakota Oyate Head Start/Early Head Start program property. The Program will archive the video of the incident (if one exists) for three (3) consecutive school years.

2. Parent/Guardians of the child may view the video in question upon setting up an appointment with the Director or authorized representative. The video may not be released to the parent/guardians under any circumstances absent a court order. The parent may not record the video utilizing any means of copying.

3. If there are any accusations of abuse or neglect, the video will be forwarded to Law Enforcement Agencies.

4. Sicangu Lakota Oyate Head Start/Early Head Start Program Employees are mandatory reporters as defined by Rosebud Sioux Tribe law and order code (RSTLOC) §5-8-7 and RST §5-8-8.

5. No parent will video or record or photograph any child who they do not have legal custody of.

6. SLOHS/EHS staff members are mandatory reporters as defined by Rosebud Sioux Tribe Law & order Code (RSTLOC) §5-8-6 and subject to RSTLOC §5-8-7 and RSTLOC §5-8-8.

7. No emailing clips to Program staff.

8. Any child incident must be reported to the Systems Admin/P.R. Manager and/or IT Specialist within an 8 hr. Workday period for a video clip request.

I_____Parent/Guardian of_____

Have read and hereby agree to the above Video Surveillance Policy and I release the Sicangu Lakota Oyate Head/Early Head Start Program from any liability to the above policy.

Signature of Parent/Legal Guardian_____

SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START PROGRAM

RELEASE OF INFORMATION 2025-2026 SCHOOL YEAR

I_____Parent/Legal Guardian of_____

Give Sicangu Lakota Oyate Head Start/Early Head Start Program permission to release or obtain information with the understanding that the information will be used to assist our families in receiving services regarding the Family Needs Assessment activities and IEP/IFSP Process. This information will be given to the following agencies:

- Crazy Horse School
- Department of Disabilities Services
- I.H.S. Environmental Health
- I.H.S. Behavioral Health
- Lakota Tiwahe Center Program
- Low Income Housing Energy Program (LIHEAP)
- Maternal Child Health Program
- MNI Wiconi Water Conservation
- RST Child Care Program
- RST Commodity Food Program
- RST Community Services
- RST Court House
- RST Diabetes Prevention Program
- RST Personnel Dept.
- RST Vice Presidents Office
- Sicangu Nation Employment & Training Program
- Sinte Gleska University Registars Program/GED Dept.
- Tiwahe Glu Kini Pi
- Todd County School District
- Tree of Life Ministries
- White River School District
- Winner School District
- Horizon Health (Mission, White River, Martin)
- Colombe School District
- St. Francis Indian School
- Sicangu Wicoti Awanyakapi

Signature of Parent/Guardian_____

Parent/Legal Guardian
Contact Information _____

_____

SICANGU LAKOTA OYATE HEAD START/EARLY HEAD START
ELIGIBILITY VERIFICATION FORM
25-26 SCHOOL YEAR

1. Parent/Legal Guardian Name_____
2. Is person eligible to participate in the Program? [ ] Yes [ ] No
3. Type of Interview conducted [ ] In person [ ] Audio or Video Call

ELIGIBILITY CRITERIA

Eligibility Question	Category	Points
Child's age by September 1st	4 years old by September 1st	50
	3 years old by September 1st	25
Native American	Rosebud Sioux Tribal Member	200
	Native American (Non tribal)	175
	Non Native	100
Parental/Family Status	Foster Parent	75
	Military Parent	50
	Teen Parent	50
	Prenatal	50
	Guardian (non-parent, other)	50
	Two parent household	25
	One parent household	25
Disability	None	0
	In Progress	150
	Existing IEP	200
	Existing IFSP	200
Income	Categorically Eligible (TANF,SNAP,SSI)	200
	0-100 Income Eligible	75
	101-130 Income Eligible	50
	130-Above	25
Other Factors	DSS Referral	100
	Homeless	200
	Domestic Violence	100
	Child of SLOHS/EHS Employee	75
	SLOHS/EHS returning student	75
Returning Student	Yes	100
	No	0

I have carefully reviewed the documents and information I have provided with the ERSEA Staff. and, by signing this form, certify to the best of my knowledge and belief that all information regarding eligibility by me is true and accurate.

Parent/Legal Guardian signature_____ Date_____

ERSEA Staff signature _____ Date_____

SICANGU LAKOTA OYATE
HEAD START/ EARLY HEAD START PROGRAM
PHYSICAL EXAMINATION 2025 - 2026

Student's Legal Name: _____ **Date of Birth:** _____

Sex: □ M □ F

Parent or Legal Guardian: _____ **Phone:** _____

PLEASE ADDRESS ALL AREAS

BLOOD PRESSURE:	PULSE:	HEIGHT:	WEIGHT:	HEAD CIRCUMFERENCE:
LEAD:(Ages 1-5) Results: _____ Date Completed: _____	HEMOGLOBIN: _____ and/or HEMATOCRIT: _____	MEDICATIONS:		IMMUNIZATIONS: Up to date: □ Yes □ No List any given today:

PHYSICAL ASSESSMENT

	Normal	Abnormal	Fully describe any abnormal findings.
Abdomen :			
Behavior Concerns:			
Developmental Screening:			
Ears (Canal, Tympanic Membrane)			
Extremities, feet, hands:			
Eye (Extraocular Movements)			
General Appearance, Posture, Gait:			
Heart:			
Lungs:			
Neurological findings:			
Nose, Mouth, Pharynx:			
Nutrition/Growth:			
Oral/Teeth:			
Skin-(Mongolian Spots or Birth Marks)			
Throat, Tonsils, Glands:			
Other:			

HEALTH CONDITIONS- NEEDING A HEALTH CARE PLAN

ALLERGIES	□ Yes □ No	
ANEMIA	□ Yes □ No	
ASTHMA	□ Yes □ No	
SEIZURES	□ Yes □ No	
IFSP - IEP	□ Yes □ No	

Child Health Status: □ Healthy Child □ Follow-up w/PCP □ Child needs a referral to specialist

Recommendation/Restrictions: _____

Examination Date: _____

Provider Signature: _____

Print Name & Title: _____

Medical Clinic: _____ **Phone:** _____

Address: _____

REVISED: May 2025

SICANGU LAKOTA OYATE
HEAD START/EARLY HEAD START PROGRAM
DENTAL EXAM
2025-2026

Childs Name: _____ **Date of Birth:** _____

Exam Completed by ☐ Dentist ☐ Pediatrician ☐ Hygienist ☐ Other _____

Provider Setting: ☐ Dental Clinic ☐ School ☐ Other _____

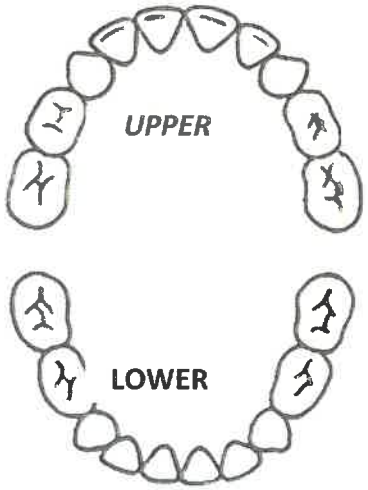
Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Times Per Day Child Brushes Teeth: ☐ Once ☐ Twice ☐ Occasionally ☐ Never

Uses Fluoride Toothpaste: ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily

Today's Visit:	**Treatment:**
Visual Screening ☐	No Treatment Needed ☐
Fluoride ☐	Treatment Needed ☐
Oral Hygiene Instruction ☐	Referral Needed ☐
	Next Appt. Date: ___/___/_____
Other (specify):	**Treatment Plan:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



KEY: Missing ⬡ **Decayed** ⬡ **Filled** ⬡

Additional Comments:

_____

_____

Today's Date: _____

Dental Follow-up needed: _____

Provider Signature Name & Title: _____

Print Name: _____

Dental Clinic: _____ **Phone:** _____

Address: _____

Revised: *May 2025*