NEW STUDENT

2021-2022

Fort McDowell Yavapai Nation
'Hmañ 'shawa Early Childhood Development Center
P.O. Box 17779 Fountain Hills, AZ 85269-7779
Phone (480) 789-7227 FAX(480) 789-7289

Entry Date
Grade
Office use only rev2021

A. STUDENT INFORMATION

Child's Name _____ ☐ ☐ M / F

Name to be called at school _____ Date of Birth _____

Street Address _____ **Best Contact Phone Number** _____

City _____ State _____ Zip _____

Is Birth Certificate attached YES/NO
Is Immunization attached YES/NO
****student will not be added to the 2021/2022 official ECDC roster until both documents are received****

B. PARENT/GUARDIAN INFORMATION

Mother/Guardian _____

Home Address _____

Workplace _____

Cell/Home Phone _____ Work Phone _____

Personal and/or Work Email _____
Please provide an email you will see on weekends in case information needs to be communicated outside of work hours

Father/Guardian _____

Home Address _____

Workplace _____

Cell/Home Phone _____ Work Phone _____

Personal and/or Work Email _____
Please provide an email you will see on weekends in case information needs to be communicated outside of work hours

C. EMERGENCY CONTACT INFORMATION

The contacts listed below may assume responsibility for your child if the parent/guardian cannot be reached. A **minimum of two (2)** emergency contacts must be listed. **Emergency contacts must be at least 18 years of age.**

	EMERGENCY CONTACT #1	EMERGENCY CONTACT #2	EMERGENCY CONTACT #3	EMERGENCY CONTACT #4
Name (First & Last)				
Relationship to Child				
Phone	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Alt. Phone	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work

D. UNAUTHORIZED PERSONS

Persons that are **NOT** permitted to pick up my child _____

_____

Parent/Guardian Signature _____ Date _____

Education Division
Fort McDowell Yavapai Nation
P.O. Box 17779
Fountain Hills, AZ 85269-7779
(480) 789-7105 FAX (480) 816-0479

AUTHORIZATION FOR DISCLOSURE OF INFORMATION
2021-2022 SCHOOL YEAR

RE: _____ _____ _____
(Complete Name of Student) (Date of Birth) (Grade Level)

TO:

I HEREBY AUTHORIZE AND DIRECT THE FORT MCDOWELL EDUCATION DIVISION TO OBTAIN THE FOLLOWING:

All academic, special education, attendance, disciplinary, enrollment, and health records relating to the education of the above-named child. (Article V. Truancy Section 11- 54a 1-2, 11-56G require academic, attendance, and enrollment records – all other records are optional) Other:_____

A copy of this ***Authorization for Disclosure of Information*** shall be treated as an original. This authorization is made under all applicable Federal and State Privacy Acts, and all applicable laws and/or regulations restricting access to information. This authorization remains on file in the Fort McDowell Yavapai Nation Education Division and remains in effect for twelve months from the date of signature (Parents/Guardians, see reverse side for additional conditions).

☐ **Please check this box if you do not want the Education Division to share any information received under this disclosure form, including, but not limited to, Tribal Council, the Events Department, and Tribal Committees.**

MAIL TO: **Education Division**
Fort McDowell Yavapai Nation
P.O. Box 17779
Fountain Hills, AZ 85269-7779

OR FAX TO: (480) 816-0479

OR SCAN AND EMAIL TO: lkthompson@fmyn.org

Authorization By:

_____
(Please PRINT Parent/Legal Guardian's Name) Relationship Mother, Father, Guardian, Other

_____ _____
(Parent/Legal Guardian SIGNATURE) (Date)

_____
(Mailing Address) (City/State/Zip)

_____
(Physical Address) (City/State/Zip)

_____
(Home Phone Number) (Work Phone Number) (e-mail)

E. TRIBAL AFFILATION

Is student an enrolled member of the Ft. McDowell Yavapai Nation Yes/No/Pending ☐☐ ☐

If Yes; Enrollment Number _____

If student is not an enrolled member of Fort McDowell Yavapai Nation, please check the appropriate description:

☐ Child of a Tribal Member ☐ Grand child of a Tribal Member ☐ Native American living in FMYN
☐ Non-Native living in community ☐ Native Child of an Employee ☐ Non-Native Child of an Employee

F. TRANSPORTATION INFORMATION

My child will get on the bus at:_____
Home,Day Care, Other

My child will get off the bus at:_____
Home,Day Care, Other

G. STUDENT LEGAL CONSIDERATIONS

Please mark any items below that apply to this student and provide the school with copies of the related documents.

☐ **No** legal considerations exist for this student

☐ Student is in foster care

☐ Court Appointed Custody

☐ Power of Attorney

☐ Student Not Living with Biological Parents

☐ Student has an injunction Against Harassment (Please list unauthorized persons in Section D. on page 1)

☐ Student has an Order of Protection (Please list unauthorized persons in Section D. on page 1)

☐ Student is covered by a Court Order Regarding School

H. FAMILY HISTORY

Have there been any changes in your family during the past year, such as:

Separation, divorce, or remarriage? ☐ No ☐ Yes

Death or serious illness? ☐ No ☐ Yes

Any other situation, which may affect the student? ☐ No ☐ Yes

If yes, please explain:

_____

MISCELLANEOUS

Please list any condition and/or restrictions that your child may have which might limit the students' activities in school. Please include any comments that you think might be helpful:

_____

_____

Parent/Guardian: _____ Date: _____

'Hmañ 'shawa Early Childhood Development Center

P.O. Box 17779, Fountain Hills, AZ 85269
Phone (480)789-7227 Fax (480)789-7289

Dear Parent/Guardian

Our Enrichment/Resource Room exists to help children in a number of ways. Some students just seem to benefit from a little extra attention. Your child may visit the Resource Room individually, in small groups, or the Resource Teachers may visit the classroom. Your child may receive help with math, reading, speech and language, motor skills, class projects, etc.

Please give your permission for your child to participate in Resource activities.

Sincerely, The Resource Staff

Your Child's Name_____ Date_____

Parent/Guardian Signature_____

I. MEDICAL AND HEALTH HISTORY

Child's Name _____ Date of Birth _____
Address _____ Best Contact Phone: _____
City/State _____ Zip Code _____
Does the child live with both parents? _____ Who are the caregivers of the child?
_____

Mother's Name _____ Father's Name _____
Family Doctor _____ Pediatrician _____
Hospital _____ Pediatrician Phone _____
Brothers/Ages _____ Sisters/Ages _____
_____ _____

Prenatal and Birth History: Was your baby **Full Term**☐**/ Pre-Mature**☐**?** Child's Birth Weight? _____
How long was your baby in the hospital after birth? _____
What type of delivery? **Vaginal**☐**/ C-Section**☐
Were there any complications with your baby at birth?_____
Was your newborn screened at birth for hearing loss? ☐**Unknown** ☐**Pass**☐**Fail**

Has your child had, or been diagnosed with any of the following ?
Asthma _____ Chicken Pox_____ Convulsions _____ Croup _____ Colds _____ Broken bones _____
Eczema _____ Mumps _____ Pneumonia _____ Tonsillitis _____ Failure to thrive _____
Ear Infections _____ How many? _____ Tubes? _____ Ringing in the ears _____
Draining Ear _____ Sinusitis _____ Dizziness _____ Measles _____ Headaches _____
High Fever _____ Encephalitis _____ Flu _____ Mastoiditis _____ Meningitis _____
Other _____
Has your child had any surgeries or been hospitalized in the past year? **YES**☐**/NO**☐
If yes, please list type and when _____
Does your child have any medical or physical conditions we should be aware of? **YES**☐**/NO**☐
If yes, what precautions should be taken?_____

***Is your child allergic to any food or other substance? YES/NO? If yes, name food(s)or substances to be avoided? Is Epi-Pen required? Procedure if reaction occurs?**_____
_____
Is your child unusualy susceptible to infections **Yes**☐**/ No**☐ Is yes, what percautions need to be taken?
_____
_____
Is your child subject to seizures?_____If so, What should be our procedure if one occurs?
_____

Has your child?

been to the dentist? YES☐/NO☐ When ? _____ Who? _____
had their eyes (vision) checked? YES☐/NO☐ When ? _____ Who?

had their hearing checked? YES☐/NO☐ When ? _____ Who?

J. PERMISSION

FIELD TRIP / PHOTO RELEASE

This field trip permission form, when signed, will allow your child to be transported to and from regularly scheduled field trips that whole or part of the school is participating in, such as, The FMD Gym, The FMD Library, Fountain Hills, etc, this will include any local trips **within the boundaries of Ft. McDowell or Fountain Hills**.

You will receive another permission form for any other field trips outside the Ft. McDowell or Fountain Hills Boundaries. A separate permission form will be required for each of these trips.

This form **MUST BE SIGNED** by a parent/guardian before any child can participate in a school-sponsored field trip. **NO EXCEPTIONS.**

All reasonable and necessary precautions for safeguarding the school children during the trip will be taken. Beyond this, we will not hold the school or those supervising the trip responsible.

During the school year, photographs/videos of the students may be taken. These photos may be reprinted in the local newspapers, the school annual, brochures, ECDC web-page and ECDC social media profile. We are requesting your permission to photograph/video your child and print his/her name in connection with any school activities, there is no charge for these services.

Please sign the form to indicate permission for the following:

1. Field Trips within the boundaries of Fort McDowell and Fountain Hills
2. Photograph/Video Release
3. Release to print name of student.

PHYSICAL EDUCATION

Physical Education is one of the required subjects in which your child will participate. Since physical examinations are not required, we are asking your help in determining limitations of participation. Please list below any limitations or special instructions regarding your child's health that will apply.

If your child cannot actively participate for a long period of time, **a note from your physician is required**. Illness should be identified, and limitations noted with an approximate duration of limitations. If your child has been excused with a physicians note, **an additional note stating the child can safely resume physical activity is required,** before he/she can return to normal activities.

If there is a temporary illness for a short period of time, a note from the parent is required, stating the approximate length of time the child will not be participating in physical activity. A note will then be required to resume activity.

Student Name_____

Parent/Guardian Signature_____Date_____

PLEASE NOTE

***This form will remain on file and in force until your child no longer attends this school.

STUDENT NAME _____

Has your child ever been hospitalized for any reason? When and What for?

_____

_____

_____

Is there any medicines your child takes on a regular basis?_____

Is your child toilet trained? _____Toilet training started at age____ Completed at age____
Problems with bed wetting_____
Does your child need help in going to the bathroom? If yes, please specify

_____
Does your child have occasional potty accidents?_____

Please describe your child's eating habits and attitudes towards eating

_____

_____

Does your child have repetitive habits? (thumb sucking, twirling of hair, rocking)
If yes, please specify _____

Has your child ever been diagnosed and/or treated for hyperactivity?

_____

Is there any other information you feel would be helpful in understanding your child more fully?

_____

_____

_____

In case of injury or sudden illness call _____first. In the event that they can not be reached, I, the undersigned parent or guardian of the child named above, do hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said child as, in the judgement of said doctor or hospital may be required on an emergency basis, in the event said child should be injured or stricken ill while participating in an activity sponsored by 'Hmañ 'shawa Early Childhood Development Center.
It is understood that any expenses incurred will be paid for by the parent/legal guardian of the student and their insurance carrier. Payment of the expense is not a school/day care center responsibility.

Parent/Guardian Signature Date

Participation Form

Waiver of Liability and Indemnification, Assumption of Risk

PLEASE READ THIS PARTICIPATION FORM THOROUGHLY AND CAREFULLLY BEFORE SIGNING. THIS PARTICIPATION FORM WAIVES LEGAL RIGHTS AND WILL ELIMINATE YOUR ABILITY TO PURSUE FUTURE LEGAL ACTIONS.

I, the undersigned, in consideration of my participation and/or my minor child's participation (if applicable) in the 2021-2022 school year 'Hmañ 'shawa Early Childhood Development Center monthly field trips ("Activity"), hereby take action for myself and/or my minor child, my and/or my minor child's executors, administrators, heirs, next of kin, successors, assigns or anyone else who might claim or sue om my and/or my minor child behalf as follows:

- I understand and acknowledge that participating in a field trip with transportation to and from has dangers that no amount of care, caution, instruction, prevention or expertise can eliminate; therefore, I hereby agree to freely, voluntarily, and expressly assume and accept any and all risks of personal injury, including death, or property damage from my and/or my minor child's (if applicable) participation in the Activity,
- I understand that all claims whatsoever arising from all damages to property which may occur as a result of me and/or my minor child's (if applicable) participation during the Activity, will be my sole responsibility.
- I agree to hold harmless, defend and indemnify the Nation and the Nation's employees, officers, departments, committees, enterprises, and/or affiliates from any and all claims, losses, suits, damages, liabilities and expenses of whatever kind of nature, including reasonable attorney fees, arising out of or resulting in any what from any negligent, reckless or intention al act, error, omission or mistake arising from injury or loss due to my and/or my minor child's (if applicable) participation in the Activity.
- I hereby consent to receive medical treatment for myself and/or my minor child (if applicable) which may be deemed advisable in the event of injury, accident, and/or illness during this Activity. All medical expenses, including medial transportation expenses, which may occur as a result of my and/or my minor child (if applicable) participation in the Activity, will be my sole responsibility.
- I assert that I and/or my minor child (if applicable) are in good health and in proper physical condition to safely participate in the Activity. I and/or my minor child (if applicable) have no known or knowable physical or mental condition that would affect my and/or my minor child (if applicable) ability to safely participate in the Activity or that would result in my participation creating a rist of danger to myself or to other participants.
- I acknowledge that there are rules for the protection of all participants. I and/or my minor child (if applicable) agree to review those rules and follow them throughout the Activity. I recognize that me and/or my minor child (if applicable) failure to abide by all rules may result in discontinued participation.

I understand and agree that this Participation Form is intended to be as broad and inclusive as is permitted by law and that if any term shall be found to be unlawful, void or for any reason unenforceable then this Participation Form, including all the remaining terms, will remain in full force and effect as if such unlawful, void or unenforceable term had never been included. The laws of the Fort McDowell Yavapai Nation shall govern this Participation Form. Any dispute or legal action arising from this Participation Form will be filed with the Tribal Court of the Fort McDowell Yavapai Nation.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS FORM AND UNDERSTAND ITS CONTENTS. I UNDERSTAND THAT MY VOLUNTARY SIGNATURE BELOW EXPRESSLY WAIVES LEGAL RIGHTS AND ELIMINATES THE ABILITY TO PURSUE FUTURE LEGAL ACTIONS.

_____ _____

Please **Print** - Parent/Guardian Name Please Print - **Students Name**

_____

Parent/Guardian **Signature** Date

Rev 2017

Book Exchange

The Book Exchange Program is a take-home book bag program that encourages families to fall in love with books and celebrate reading together.

Books are rotated on a weekly basis among your child's classmates. Book bags should be returned every Monday,and your child will be given 2-4 new books every week.
We encourage you to have fun with books! Sharing books together and reading is an enjoyable time that you can spend with your children.
As a mandatory part of the program, we ask that all participating parents report each week how many times their child was read to. This is a free program, and in order to keep it free we must be able to show that parents are reading to their children.
Below is an enrollment form you can fill out and return to your child's teacher.
If you have any questions, please contact:
Liela Williams (480) 789-7215 **Monica Thompson (480)789-7212**
lwilliams@fmyn.org **mthompson@fmyn.org**

Registration

Are you interested in having your child participate in the Book Exchange Program? Yes_____ No _____

If yes, complete the information below

Child's Name _____

Date of Birth_____ Age _____

Teacher _____

Parents Name(s) _____

Phone Number _____

Email Address _____

Welcome to the Book Exchange Program ages 3-5. We will be sending home a form for you to track how many times you and your child read and tell stories together each week. We ask that you track and complete this sheet each week and return it with your students bag.

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'J[man 'shawa P.ar[y Childhood<Devefopment Center
P.O. <Bo 17779, Pountain :Jfil{s, f l Z 85269
(}'hone (480)789-7227 P (480)789-7289
:M.ichae[<Brown, (J'rincipa[

Medication Protocol

The Medication Authorization Form must be completed and signed by the parent/guardian before medication will administered by ECDC staff.

1. All medication must be in their original containers and must include:
   a. Child's name clearly displayed on the medication
   b. The name of the medication and prescription number (if available)
   c. Specific instruction for administering the medication including; dosage, method medication should be administered, dates, and times.
   d. Reason medication is being given.
   e. Signature of Parent or guardian and date
2. Medications which are no longer to be given, or those that have expired dates, or expired authorization forms will be returned to the parent/guardian.
3. All medication will be kept in a locked area or leak-proof lockable storage container. Those that need to be refrigerated will be in a locked container in the refrigerator.
4. All medication, excluding diapering medications, will be removed from diaper bags and removed from the classroom. Those medications will be given to parents at pick-up time.
5. No medication will be given to a child in his/her milk/formula bottle or cup.
6. No over-the-counter medication will be given to a child if the medication advises on the label that it not be given.
7. Completed medication forms and medications should be dropped off at the front desk.

Arizona Department of Health Services
Bureau of Child Care Licensing

MEDICATION CONSENT FORM

First & Last Name of CHILD:			
Type/Name of Medication:	Prescription #:	Dosage:	Route (method)*:
Start date:	End Date:	Times & frequency:	
REASON:			
I give permission for the administration of the medication, according to the instructions listed, to the child listed above.			
Date of authorization:	Signature (parenUguardian):		

POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION:

_____

_____

*** Injections: Attach health care provider's written authorization.**

****

FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:	YES	NO
Is the medication consent form complete?	☐	☐
Is the original prescription label on the medication container or prepackaged and labeled for use by manufacturer?	☐	☐
Is the full name of the child on the container?	☐	☐
Is the prescription or over-the-counter medication current?	☐	☐
Is the dose, name of drug, frequency of administration given on label consistent with instructions above?	☐	☐

Staff initials: - - - - -

Please use the second page to document administration of the medication.

I Name of Child:

DATE	NAME OF MEDICATION	RX#	DOSE	TIME	FULL SIGNATURE of AUTHORIZED STAFF PERSON