Required Documents for Registration

- **Your child must be 2 years of age by September 1st**
- **Your child must be 3 years of age by September 1st**
- **Your child must be 4 years of age by September 1st**
- **Please fill in & return forms to:**

Preschool@miccosukeetribe.com

New students:

- **Child Health Examination Form, original**
- **Child Certification of Immunization, original**
- **Copy of Birth Certificate**

All forms and documents required for enrollment must be turn in before the child start attending the program.

*****SHONAABESHA*****

Miccosukee Tribe of Indians of Florida
Preschool Program Registration Form

Entrance Day: _____

STUDENT ENROLLMENT INFORMATION:		
Last Name:	First Name:	Middle Initial:
Address:		
Date of Birth: _____/_____/_____	Age:	Sex: F ☐ M ☐
Clan:		
Did your child attend the program last year? ☐ Yes ☐ No	Has your child attended another school before? ☐ Yes ☐ No	

BIRTHDAY VERIFICATION/HOW IS DATE OF BIRTH DOCUMENTED (CHECK WHICH APPLY):		
☐ Birth Certificate	☐ Tribal Affidavit	☐ Miccosukee Clinic Records
☐ Doctor's Certificate	☐ Parental Affidavit	☐ Others

PARENT/GUARDIAN INFORMATION:	
Mother/Legal Guardian's Name:	
Address:	
Home Phone #:	Cell Phone #:
Office Phone #:	Email:
Father/Legal Guardian's Name:	
Address:	
Home Phone #:	Cell Phone #:
Office Phone #:	Email:

EMERGENCY CONTACTS

(persons other than the legal parents/guardians authorized to sign out/pick up the child from the program)

	NAME	RELATIONSHIP	PHONE NUMBER
Names and phone numbers of persons who can **ONLY** be contacted in case of an emergency:			

PERSON(S) NOT AUTHORIZED TO SIGN OUT/PICK UP CHILD FROM THE PRESCHOOL PROGRAM:

NAME	RELATIONSHIP	PHONE NUMBER

MEDICAL INFORMATION:

If your child has any food restrictions and/or allergies please list them below:

Is your child allergic to the following:

Yes	No	
☐	☐	Penicillin
☐	☐	Aspirin
☐	☐	Iodine
☐	☐	Antibiotic

Other (Please be specific):

Has your child been prescribed an EPI Pen? ☐ Yes ☐ No

If **Yes**, please provide the EPI Pen to the school nurse to be kept at the school in case of an emergency

Does your child have, has had, or has been treated for the following medical condition:

Yes	No	Condition:	Yes	No	Condition:
☐	☐	Asthma/Hay Fever	☐	☐	Congenital Heart Lesions
☐	☐	Diabetes	☐	☐	Epilepsy
☐	☐	Heart Murmur	☐	☐	Hepatitis
☐	☐	Hives/Skin Rash	☐	☐	Rheumatic Fever
☐	☐	Tuberculosis	☐	☐	Cancer/Leukemia

Any other condition(s):

Is your child currently taking any medication? ☐Yes ☐No

If yes, please list below:

Is your child currently on Indian medicine? ☐Yes ☐No

If yes, please list the restrictions and for how long? :

PARENTAL/GUARDIAN AUTHORIZATION FOR EMERGENCY MEDICAL CARE:

To facilitate health care for my child, I hereby authorize the Program to send my child to the Miccosukee Tribe Health Clinic on an emergency basis if my child becomes sick or has an accident. I also authorize the Miccosukee Health Clinic to attend to my child at these times and provide whatever health care is considered reasonable, including permission for a physical.

☐Yes

☐No,

Initials_____

I would like to permit my child to participate in the dental screening, fluoride treatment as well and varnish treatment performed by the Miccosukee Tribe Dental Clinic personnel.

☐Yes

☐No,

Initials_____

Any Comments or Special Notes:

To the best of my ability and knowledge, the information on this form is correct.

I understand that it is my responsibility to report any changes to this information immediately.

_____ _____

Signature of Parent/Legal Guardian ***Signature of Preschool Staff***

Date:_____ Date_____

MEDIA RELEASE PARENTAL CONSENT FORM

_____
Date

Dear Parent/Guardian:

Please be advice that during the school year your child may be photographed, videotaped, or interviewed at various school sponsored events. With your consent, the photograph, video or interview may be reproduced and released for use in the media, i.e., newspapers, flyers, brochures, videos, television, and internet.

Please indicate your preference below.

Student's Name:_____

☐ Yes — My child's photograph/video/interview **may** be reproduced and released for use in the media

☐ No — My child's photograph/video/interview **may not** be reproduced and released for use in the media

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Miccosukee Tribe Pre-School Program

Request for Food Substitutions for Children with Special Dietary Needs

Child's Name: _____ Date: _____

Dear Parent/Guardian and Recognized Medical Authority:

Request for food substitutions may be made for children with special dietary needs (related or unrelated to a disability, cultural/religions). Please have this form completed by a physician, physician's assistant, nurse practitioner (ARNP), or registered dietitian and return it to our office as soon as possible. If you have any questions, please contact the program at **(305) 894-2376**.

Thank you,

Miccosukee Head Start Program

1. Does your child have special dietary need? A special dietary need is defined as sensitively to certain foods or food allergies, but do not have life-threatening reactions when exposed to the food(s) to which they have problems.

☐ **Yes** ☐ **No, parent/guardian initials**_____

If Yes:

State and describe special dietary needs: _____

_____

2. List any food(s) to be omitted from the child's diet.

_____

3. List any food(s) to be substituted.

_____

4. Describe any textural modification required.

_____

5. Additional Comments: _____

_____

_____ _____

Signature of Physician or Recognized Medical Authority ***Date***

_____

Physician Printed Name

Lice Policy

Recently M.I.S and the Preschool-Program noticed an increment of students with lice. Once students have head lice for over several months, they begin to scratch their heads often, which leads to the development of crust scalp. If these crust become infected, they may suffer a bacterial infection called impetigo of the skin which is caused by streptococcus (strep) of staphylococcus (staph) bacteria. In order to address this serious concern, M.I.S and the Pre-School program has established a new policy, after approved by the Tribal Business Council, which will be strictly enforced:

- All students will participate in monthly lice checks by assigned staff members.
- In the case of the Pre-School students, if they are identified with lice or nits, the school nurse will send home a notification regarding the result of the screening. Parent/ guardians will be responsible for treating the lice/nits at home.
- If the same child is identified with lice or nits during the remainder of the school year, they will be sent home. At this point, it will be the parent's/family's responsibility to ensure that lice and nits are properly removed. The school nurse will provide the parent/ family member with different alternatives on treating lice (near by lice treatment clinics, product recommendation, combing and treatment procedures, cleaning of sheets, towels and pillowcases, etc…). Any student that is sent home as a result of having lice/nits must be cleared by the school nurse prior to returning to class.

I, _____, understand that the M.I.S and the Pre-School Program Lice Policy will be strictly enforce for the well-being of all students

Student (s) Name (s):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date:_____

Miccosukee Health Department

DENTAL CLINIC

Fluoride Varnish, Dental Sealant, & Temporary Filling Permission Form

Dear Parent or Guardian,

Over half of American Indian and Alaska Native children have dental cavities. However, cavities can be prevented through the use of fluoride and dental sealants, and early cavities can be treated with temporary fillings.

We will provide fluoride varnish, sealants, and temporary fillings to children the Miccosukee Indian School this year. Because your child is a minor, your consent is needed to allow your child to receive these preventive services.

Fluoride Varnish

Procedure: A high concentration fluoride varnish is painted directly onto the teeth.
Benefits: Fluoride Varnish coats the outside of the tooth and can provide some cavity-fighting power for up to 3 months.

Dental Sealant

Procedure: A plastic coating is painted on the chewing surface of the back teeth.
Benefits: Sealants help prevent food and cavity-causing germs from getting stuck in the deep grooves in back teeth.

Temporary Filling

Procedure: A small cavity is scooped out without anesthesia, and a plastic filling material is put in the hole.
Benefits: The temporary filling may last several years and prevents the cavity from getting bigger.

Parental Permission

I give my CHILD, _____, permission to have fluoride varnish, dental sealants, and temporary fillings placed on his or her teeth during the year by a trained staff or provider with prescription or standing orders. I understand that this is a preventive program and the product is safe and effective.

Please list any physical conditions that the school should be aware of (asthma, allergies, recurring illnesses, disabilities, chronic illnesses, etc.):_____

Fluoride Varnish:

☐ I **DO NOT** want my child to have fluoride varnish, sealants, or temporary fillings.
☐ I **DO** want my child to have fluoride varnish, sealants, or temporary fillings.

Parent or Guardian Name (print) _____

Signature _____ Date _____

Telephone Number _____