Lukachukai Community Board of Education, Inc.
"Commitment to Children, Commitment to Progress"

SY 2023-2024

RESIDENTIAL PROGRAM

ENROLLMENT APPLICATION

Required Documents

- ☐ **Residential Application**
- ☐ **Birth Certificate**
- ☐ **Certificate of Indian (CIB)**
- ☐ **Current, Updated Immunization**
- ☐ **Court Order (Power of Attorney, Legal Guardianship Decree)**
- ☐ **Student/Parent(s)/Guardian Agreement Form**

Navajo Route 12 * P. O. Box 230 * Lukachukai, Az. 86507
Phone: (928)787-4405/4406 * Fax: (928)787-4419
http://www.lukaeagles.org

RESIDENTIAL PROGRAM ENROLLMENT APPLICATION

Student Name: _____ Gender: ☐ Male ☐ Female

Grade: _____ ☐ New ☐ Returning

Date of Birth: _____ Census#: _____

Address: _____ City: _____ Zip Code: _____

Location of Resident: _____

Primary Phone Number: _____ Cell/Other: _____

Mother's Name: _____ Father's Name: _____

1st Clan: _____ 1st Clan: _____

2nd Clan: _____ 2nd Clan: _____

Legal Guardian 1 Legal Guardian 2

Name: _____ Name: _____

1st Clan: _____ 1st Clan: _____

2nd Clan: _____ 2nd Clan: _____

LCBE, Inc., Residential Program will offer various activities. Please list your child's hobbies and interests:

1. _____ 2. _____

3._____ 4. _____

I verify, that I have provided true information on my child for enrollment at Mountain Hall Residential Program for the school year 2023-2024. I verify that I will transport my child to the LCS Residential/dormitory on Sundays and my child may ride the bus from school every Friday afternoon.

_____ _____

*(Parent/Legal Guardian **Print**)* *(Parent/Legal Guardian **Signature**)*

_____

(Date)

PARENT AUTHORIZATION RELEASE

Dear Parent(s)/Guardians: Please indicate all authorized Persons including yourself:

Students will not be allowed to leave campus at anytime; unless they are checked out by a person, who is 18 years old or older, whom are authorized on this form. Photo I.D. verification with proof of age maybe required during check out. **Residential will not accept any additional names once you have turned in this application. Please inform Residential staff of any changes in writing.**

Student's Name: _____

NAMES (Print)	RELATIONSHP	ADDRESS	PHONE NUMBERS

Emergency Contact #1

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Emergency Contact #2

Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

_____
(Legal Parent/Guardian **Print***)*

_____
(Legal Parent/Guardian ***Signature****)*

_____
(Date)

STUDENT/PARENT/GUARDIAN MEDICAL INFORMATION AND CONSENT FORM

(Consent to Emergency Medical Treatment)

ALL INFORMATION WILL BE KEPT <u>CONFIDENTIAL</u> AND WILL ONLY BE USED FOR PROGRAM PURPOSES.

Student's Name: _____
(Last Name) *(First Name)* *(MI)*

Parent/Guardian: _____
(Last Name) *(First Name)* *(MI)*

Parent/Guardian: _____
(Last Name) *(First Name)* *(MI)*

Address: _____
(P.O. Box/Street Address) *(City, State)* *(Zip)*

Home Number: _____ Cell Number: _____

Student Birthdate: _____ Current Age: _____

Location of Resident: _____

<u>CONSENT TO EMERGENCY MEDICAL TREATMENT</u>

I hereby state that I/We am/are responsible for the above named minor student. I/We grant permission for my child(ren) to receive emergency treatment and/or hospital services or minor medical help which a health provider and/or the Lukachukai Community School Board, Inc. employee(s) may agree is necessary for the welfare of my child(ren). I/We understand that neither Lukachukai Community Board of Education, Inc., nor its employee(s) will not be liable for any medical emergencies or treatment incidences.

I/We understand that any medical (both minor and major) expenses that may be incurred by my child(ren) is/are not covered by the program is/are the primary responsibility of the student's legal parent(s)/guardian(s).

_____ _____
(Legal Parent/Guardian **Print***)* *(Legal Parent/Guardian* ***Signature****)*

_____
(Date)

(CON'T) STUDENT/PARENT/GUARDIAN MEDICAL INFORMATION AND CONSENT FORM

MEDICAL CONDITIONS

Check off any medical conditions:

_____ allergy(ies) type of allergy_____

_____ asthma	_____ urine infection	_____ anxiety
_____ epilepsy	_____ diabetes	_____ arthritis
_____ seizures	_____ high blood pressure	_____ headaches
_____ sinusitis	_____ pregnancy	_____ stomach issues

List prescribed medications that your child(ren) is/are taking daily:

_____

Please list any additional health information that a health care provider or Lukachukai Community School Board of Education, In., should be aware of;

_____

_____

I/We, _____ and _____
have *(**Print** Parent/Guardian Name)* *(**Print** Student Name)*

completed the information to the best of our knowledge. I/We, the parent(s)/guardian(s) and the student, have provided all of the information of which we are aware concerning my child(ren)'s medical health. It is also understood that this report of any medical conditions are the only background information a health care provider will have when treating my child(ren).

WE ARE AWARE THAT WITHHOLDING INFORMATION COULD BE GROUNDS FOR DISMISSAL FROM THE PROGRAM.

_____ _____ _____

(Signature of Parent/Guardian) *(Signature of Student)* *(Date)*

CHINLE COMPREHENSIVE HEALTH CARE FACILITY P. O. Drawer PH Chinle, Arizona 86503 (928)674-7001		**FORT DEFIANCE PHS INDIAN HOSPITAL** P. O. Drawer 649 Fort Defiance, Arizona 86504 (928)729-8000
GALLUP INDIAN MEDICAL CENTER P. O. Box 1337 Gallup, New Mexico 87305 (505)722-1000		**NORTHERN NAVAJO NEW MEX. MEDICAL CENTER** P. O. Box 160 Shiprock, New Mexico 87420 (505)368-6001
TSAILE PHS INDIAN HEALTH CENTER P. O. Box 467 Tsaile, Arizona 86556 (928)724-3600		**FOUR CORNERS REGIONAL HEALTH CENTER** HCR 6100 – Box 30 Teec Nos Pos, Arizona 86514 (928)656-5000