

STANDING ROCK SCHOOL ENROLLMENT INFORMATION

The following information **MUST** be provided to the school **BEFORE** students will be allowed to attend school. If not supplied the student **WILL NOT** be allowed to attend school until the necessary documentation is provided. **ALL STUDENTS REQUIRED TO BRING THIS INFORMATION IN EVEN IF IN ATTENDANCE PREVIOUS YEARS.**

1. Enrollment packet filled out. Including:

____ Certificate of Indian Blood (parents CIB if student not enrolled)

____ Certified Birth Certificate (not crib card)

____ Up to date immunization record

____ Current custody papers/official court documents (if it pertains to student)

____ All forms in enrollment packet filled out completely

ALL DOCUMENTATION MUST BE TURNED IN BEFORE STUDENT MAY ATTEND

2. Transfer students only: Has student been involved in a Special Education Program in another school? If yes, please sign a release form.

Please fill out this enrollment packet completely. This information is very important for your student. Please return packet to the Business Office – **DO NOT TURN IN AT THE SCHOOLS.**

Thank you!

Mission Statement: Standing Rock-Fort Yates Community School will provide students with opportunities to excel academically, physically, spiritually and socially by expanding curriculum and activities, increasing community involvement and integrating culture in the school environment

Vision Statement: We envision a world-wide community that is free from prejudice and in which each individual and culture is valued for unique abilities, traditions, and strengths while students fulfill their responsibility as a member of society.

****Please note this information will be kept on file the entire time your student is enrolled at Standing Rock Schools. You will need to contact the school if any information changes.**

Email to send records: c.archambault@k12.nd.us



RESTISTRATION FORM 2022-2023
Standing Rock Community School
 9189 Hwy 24
 Fort Yates, ND 58538
 Registrar 701-854-9009
 SRES 701-854-3865
 SRJH/HS 701-854-3461

Office Use Only	
Immunizations: <input type="checkbox"/> Yes <input type="checkbox"/> No	CIB: <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Entry Date:
State ID#:	Student ID:
Teacher:	NASIS ID:
Received:	Sent for Records:
	Transfer from:

STUDENT INFORMATION

Student Name: Last: _____ First: _____ MI: _____		Have you ever attended SRCS: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what grade _____	
Preferred Name: _____		Date of Birth: _____	Age: _____ Gender: _____ M / F
		Primary Phone Number () _____	
Language Spoken at Home: _____		Has your child ever received EL services? <input type="checkbox"/> Yes <input type="checkbox"/> No Where: _____	
Student Lives With (Please Check Only One): <input type="checkbox"/> Both Parents <input type="checkbox"/> Parents Share Custody <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Mother & Stepfather <input type="checkbox"/> Father & Stepmother <input type="checkbox"/> Other Guardian/ CPS: _____			
Student is Oldest in this School: <input type="checkbox"/> Yes <input type="checkbox"/> No		Student is Oldest in District: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a Single Parent Household: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Child's Race: <input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Pacific Islander			
Tribe Enrolled: _____		Home Agency: _____	
Street Address: _____		Mailing Address (PO Box): _____	
City, State, Zip: _____		City, State, Zip: _____	
Does this student have a current Individual Education Plan (IEP) through Special Education? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes Primary Disability: _____			
Does this student have a 504 Accommodation Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this student currently expelled or suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PARENT/GUARDIAN INFORMATION

Father	Mother	Other Guardian
Relationship: <input type="checkbox"/> Legal Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Custodian <input type="checkbox"/> Other: _____	Relationship: <input type="checkbox"/> Legal Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Custodian <input type="checkbox"/> Other: _____	Relationship: _____
Name _____	Name _____	Name _____
Street Address _____	Street Address _____	Street Address _____
Mailing Address (PO Box) _____	Mailing Address (PO Box) _____	Mailing Address (PO Box) _____
City, State Zip _____	City, State Zip _____	City, State Zip _____
Home Phone Number () _____	Home Phone Number () _____	Home Phone Number () _____
Cell Phone Number () _____	Cell Phone Number () _____	Cell Phone Number () _____
Work Phone Number () _____	Work Phone Number () _____	Work Phone Number () _____
Email: _____	Email: _____	Email: _____
Employer: _____	Employer: _____	Employer: _____

EMERGENCY INFORMATION (Other Than Parent)

Emergency Contact #1	Relationship to Student:	Daytime Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell () _____
Emergency Contact #2	Relationship to Student:	Daytime Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell () _____
Emergency Contact #3	Relationship to Student:	Daytime Phone Number: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell () _____

Continued on Other Side



TRANSPORTATION INFORMATION

Transportation Needs:

- Both AM/PM
 AM Only
 PM Only
 No Busing Needed

AM Pick-Up Address: _____

PM Drop-Off Address: _____

Special Needs/Instructions/Directions:

OTHER INFORMATION

No Contact/Allowed to check out or see student:

Name: _____

Court Ordered: Yes No

Please provide court documentation if possible

*See Attachment

STANDING ROCK COMMUNITY SCHOOL

Authorization for Release of Confidential Information

Enrollment Release:

I hereby give permission for the Standing Rock Community School to obtain enrollment information from the Standing Rock Tribal Enrollment Office or any other Tribal Enrollment office that you or your child maybe in enrolled. This information is to be used as verification for our ISEP count.

Name of Child: _____ Birth date: _____

Parent/Legal Guardian: _____

Father's Name: _____ Birth date: _____

Agency Where Enrolled: _____

Mother's Maiden Name: _____ Birth date: _____

Agency Where Enrolled: _____

RELEASE OF INFORMATION

I hereby grant permission to the Standing Rock Community School to receive information concerning my child if the information is not provided to the school by the parent/guardian at the time of registration. This information would consist of immunizations from Public Health, the Public Health Nurse, WIC, Certificate of Indian Blood from the Bureau of Indian Affairs, and Income Verification from Social Services or Commodities.

Signature of
Parent/Guardian _____

Date: _____

STANDING ROCK COMMUNITY SCHOOL
FIELD TRIP CONSENT FORM
2022-2023 SCHOOL YEAR

I, Legal Guardian of _____, hereby give consent to the Standing Rock School to provide him/her with the following services:

1. Local trips on the reservation
2. Off reservation trips
3. Overnight trips
4. Extended trips-for two or more days
5. Emergency Medical Care

I also give my permission to transport my child to and from locations or localities where travel services are provided. I understand that my child will be chaperoned and all precautions taken to insure his/her safety will be taken.

This consent will cover all school trips and no other consent form will be sent out during the school year.

Custodial Parent/Guardian Signature

Media Consent:

I hereby allow Standing Rock Community School to use my student picture as needed. (Example: Classroom photos, Activity participation photos, Student-of-the-Month.)

(Student Name)

Custodial Parent/Guardian Signature

Standing Rock Community School Internet and E-Mail Rules

Staff and students are responsible for implementing good behavior on school computer networks just as they are in a classroom or a school hallway. Communication on the network is often public in nature. General school rules for behavior and communication apply. The network is provided for staff and students to conduct research and communicate with other via email for school-related activities and assignments. Use of school technology for personal business is deemed unacceptable and will not be supported by the school. Access to network services is given to staff and students who agree to act in a considerate and responsible manner.

***Access is a privilege-not a right ** Access entails responsibility *** Permission is Required**

Individual users of the school's computer networks are responsible for their behavior and communication over those networks. It is presumed that users will comply with the SRCS standard and will honor the agreements they have signed. Beyond the clarification of such standards, the school is not responsible for restricting, monitoring or controlling the communication of individuals utilizing the network, however, school personnel **will professionally monitor** all users' communication and structure and guide proper usages. Network storage areas may be treated like school lockers. Network administrator may review files and communication to maintain system integrity and insure the users are using system responsibly. Users should not expect that files stored on the school's server will be private.

Within reason, freedom of speech and access to information will be honored. During school, a teacher will guide students toward appropriate materials.

As outlined in Board Policy and Procedures on staff and students right and responsibilities, copies of which are available in school offices, the following are not permitted for staff and/or students:

***** Inappropriate use includes, but is not limited to:**

*Social Media, * Sending or displaying offensive messages or pictures, * Use of personal technology devices, * Using obscene language , * Harassing, insulting or attacking others, * Damaging or tampering with any technology or communication tools, * Violating copyright laws, * Attempting to discover or use another's login name or password, or sharing passwords, * Trespassing in another's folders, work, or files, * Intentionally wasting limited resources (Streaming non-educational movies, music), * Employing the network for commercial purposes, * Bypassing school Internet filters without authorization, * Storing of movies or music, * Allowing students to use a staff computer, * Storing of software used primarily for hacking, eavesdropping, or network administration.

Violations may result in loss of access as well as other disciplinary action

Staff/Student Signature

Date

STUDENT USER AGREEMENT:

As a user of the SRCS computer network, I hereby agree to comply with the above stated rules-communicating over the network in a reliable fashion while honoring all relevant laws and restrictions. As a parent/ legal guardian of the minor student by signing the student handbook. I grant permission for my daughter/son to access networked computer service, and agree to the rules and regulation stated in the Computer/Internet Acceptable Use Policy.

Parent/Legal Guardian

Date

U.S. Department of Education
Office of Indian Education
Washington, DC 20202
TITLE VI ED 506 INDIAN STUDENT ELIGIBILITY CERTIFICATION FORM

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count. You are not required to complete or submit this form. However, if you choose not to submit a form, your child cannot be counted for funding under the program. **This form should be kept on file 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 _____
(As shown on school enrollment records)

Name of School _____

TRIBAL ENROLLMENT

Name of the individual with tribal enrollment: _____
(Individual named must be a descendent in the first or second generation)

The individual with tribal membership is the: Child Child's Parent Child's Grandparent

Name of tribe or band for which individual above claims membership: _____

The Tribe or Band is (select only one):

- Federally Recognized
- State Recognized
- Terminated Tribe (Documentation required. Must attach to form)
- 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. (Documentation required. Must attach to form)

Proof of enrollment in tribe or band listed above, as defined by tribe or band is:

A. Membership or enrollment number (if readily available) _____ OR

B. Other Evidence of Membership in the tribe listed above (describe and attach) _____

Name and address of tribe or band maintaining enrollment data for the individual listed above:

Name _____ Address _____
City _____ State _____ Zip Code _____

ATTESTATION STATEMENT

I verify that the information provided above is accurate.

Name Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Date _____

INSTRUCTIONS FOR THE ED 506 FORM

FOR APPLICANTS:

PURPOSE: To comply with the requirements in 20 USC 7427(a), which provides that: "The Secretary shall require that, as part of an application for a grant under this subpart, each applicant shall maintain a file, with respect to each Indian child for whom the local educational agency provides a free public education, that contains a form that sets forth information establishing the status of the child as an Indian child eligible for assistance under this subpart, and that otherwise meets the requirements of subsection (b)".

MAINTENANCE: A separate ED 506 form is required for each Indian child that was enrolled during the count period. A new ED 506 form does NOT have to be completed each year. All documentation must be maintained in a manner that allows the LEA to be able to discern, for any given year, which students were enrolled in the LEA's school(s) and counted during the count period indicated in the application.

FOR PARENTS/GUARDIANS:

DEFINITION: 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 and school name and grade level.

TRIBAL ENROLLMENT INFORMATION: Write the name of the individual with the tribal membership. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one name: either the child, child's parent or grandparent, for whom you can provide membership information.

Write the name of the tribe or band of Indians to which the child claims membership. 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. If Terminated Tribe or Organized Indian Group is elected, additional documentation is required and must be attached to this form.

- **Federally Recognized** - an American Indian or Alaska Native tribal entity limited to those indigenous to the U.S. The Department of Interior maintains a list of federally-recognized tribes, which OIE can provide you upon request.
- **State Recognized** - an American Indian or Alaska Native tribal entity that has recognized status by a State. The U.S. Department of Education does not maintain a master list. It is recommended that you use official state websites only.
- **Terminated Tribe** - a tribal entity that once had a federally recognized status from the United States Department of Interior and had that designation terminated.
- **Organized Indian Group** - 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.

Write the enrollment number establishing the membership of the child, if readily available, or other evidence of membership. If the child is not a member of the tribe and the child's eligibility is through a parent or grandparent, either write the enrollment number of the parent or grandparent, or provide other proof of membership. Some examples of other proof of membership may include: affidavit from tribe, CDIB card or birth certificate. Write the name and address of the organization that maintains updated and accurate membership data for such tribe or band of Indians.

ATTESTATION STATEMENT: Provide the name, address 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.

The Department of Education will safeguard personal privacy in its collection, maintenance, use and dissemination of information about individuals and make such information available to the individual in accordance with the requirements of the Privacy Act.

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, SW, LBJ/Room 3W203, Washington, D.C. 20202-6335. OMB Number: 1810-0021 Expiration Date: 02/29/2020.

HEALTH INFORMATION AND MEDICAL TREATMENT AUTHORIZATION 2022-2023

Student Name: _____ Grade: _____ D.O.B. _____

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____

HEALTH INFORMATION:

Are there any illnesses (diabetes, asthma, etc.) surgeries, injuries, or other limitations which might affect the student's ability to fully participate in any school activities? This information will be shared only with pertinent staff members:

Are there any allergies the student may have? (Food, Milk, Peanuts, Medications, Animals, Etc.):

MEDICAL TREATMENT AUTHORIZATION:

The following are medications which are stocked in the school nurses' office. Please cross off any that you do not want your child to be given:

- PAIN/FEVER: Tylenol, (regular or chewable), Ibuprofen, Midol
- STOMACH: Pepto Bismol (generic), Mylanta, Tums
- COLDS: Cough Drops, cough syrup, cough tablets
- ALLERGIES/RASH: Hydrocortisone Cream, Benadryl tablet, Calamine Lotion, Bee Sting Kits
- BURNS: Dermacaine Ointment, Aloe Vera Gel, Burn Cream
- CUTS: Triple Antibiotic Ointment, Betadine, Hydrogen Peroxide
- BRUISES/SPRAINS: Ice Pack, Warm Pack, Ace Wrap

THE SCHOOL WILL ONLY TRANSPORT STUDENTS IN THE EVENT OF AN EMERGENCY.

I hereby grant permission for the following:

_____ Administration of the above medication to the student.

_____ Transportation of the student to the IHS in case of emergency.

_____ Administration of first aid to the student.

Signature of Parent/Guardian: _____ Date: _____

Standing Rock Community Schools
Authorization for Medication Administration

Child: _____ Date of Birth: _____

Parent/Guardian _____

Home Phone: _____ Work: _____ Cell: _____

I request and authorize Standing Rock Community Schools' personnel to supervise the medication/treatment prescribed on this form to my child. I understand the medication must be provided in a bottle identifying the name and telephone number of pharmacy, the student's name, the physician's name and dosage prescribed. I understand that the school district and school personnel will not be held liable for any adverse effects of the medication. **MEDICATION FOR SCHOOL USE ONLY WILL NOT BE DISPENSED TO PARENTS.** If you want your child to have medication on the weekend, it is the parent's responsibility to get weekend medication from your child's physician. Students are subject to random drug screening if the school has concerns about the student taking their medication.

Parent/Guardian Signature: _____

Physician's Name: _____ Phone: _____

- Name of medication/treatment _____
- Total daily dosage _____
- Amount and times to be administered at school _____
- Method of administration _____
- Precautions and reactions to observe and report _____

Physician's Signature _____

Physician's signature, medication/treatment needs to be reviewed at the beginning of each year.

Physician may call changes to the school nurse with written confirmation within 24 hours. Faxes are acceptable.

Medication for school use only will be picked up by the school nurse or school personnel if it is being dispensed from HIS.

Medication brought to the school must be sent in its original pharmaceutical container with child's name and dosage.

NO MEDICATION WILL BE DISPENSED WITHOUT PRIOR WRITTEN PARENTAL CONSENT.

School Nurse Signature: _____ Date: _____

Standing Rock Community Grant School
AUTHORIZATION FOR ROUTINE MEDICAL, VISION, IMMUNIZATION MENTAL HEALTH CARE

I affirm that I am the Parent and/or Legal Guardian of the child listed below:

_____	_____
STUDENT	BIRTH DATE

If I am unable to accompany my child to their medical, vision, immunization, or mental health appointment to obtain routine care, I hereby **give consent** to the Standing Rock Community Grant School assigned personnel to transport and accompany my child listed above to appointments. Mental Health appointments will be transport only. Parent/Legal Guardian is required to accompany their child to their initial appointment.

I further understand that this consent **applies Only** to accompany child to medical, vision, and immunizations appointments, and **applies Only** for transportation in regards to mental health appointments.

I understand that in-case of an emergency, I or my listed emergency contact will be responsible in accompanying my student at the emergency room.

Signed by:

_____	_____
Parent/Legal Guardian	Date

<input type="checkbox"/> Decline consent (check)	
_____	_____
Parent/Legal Guardian	Date



Standing Rock
Community School

Health Information

Complete this form annually to inform us about your student's health condition that affects his or her school day

Section A: Demographics					
Student Name: Last		First		Middle	Date of Birth
School Year	School Name	Grade	Teacher	Gender:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent/Legal Guardian Name		Home Phone Number	Cell Phone Number	Work Phone Number	
Parent/Legal Guardian Name		Home Phone Number	Cell Phone Number	Work Phone Number	
Section B: Life Threatening Health Conditions					
Does your child have a potentially life-threatening health condition to include any of the following?					
<input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Seizure requiring rescue medication <input type="checkbox"/> Allergy requiring epinephrine <input type="checkbox"/> Severe Asthma					
Section C: Current Health Conditions					
Condition	Check if yes	Comment			
ADD/ADHD	<input type="checkbox"/>	Provider Diagnosed: <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergies		Regular Known Allergies: _____			
• Food	<input type="checkbox"/>	Foods: _____ Epinephrine <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date received _____			
• Food Intolerance	<input type="checkbox"/>	Foods: _____ Gastrointestinal/Digestive Distress <input type="checkbox"/> Yes <input type="checkbox"/> No Dietary Restriction/Preference <input type="checkbox"/> Yes <input type="checkbox"/> No			
• Bee Sting-symptoms other than local redness/swelling	<input type="checkbox"/>	Epinephrine: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date received _____			
• Latex	<input type="checkbox"/>				
Anxiety	<input type="checkbox"/>	Provider Diagnosed: <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Blood Disorder	<input type="checkbox"/>				
Cancer	<input type="checkbox"/>	Currently Immunocompromised: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dental/Oral Health Condition	<input type="checkbox"/>				
Depression	<input type="checkbox"/>	Provider Diagnosed: <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Diabetes	<input type="checkbox"/>	Method of Insulin Administration: <input type="checkbox"/> Syringe <input type="checkbox"/> Pen <input type="checkbox"/> Pump			
Eating Disorders	<input type="checkbox"/>	Provider Diagnosed: <input type="checkbox"/> Yes <input type="checkbox"/> No Under Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Heart	<input type="checkbox"/>				
Kidney/Urinary Tract Disorders	<input type="checkbox"/>				
Migraines	<input type="checkbox"/>				



Standing Rock
Community School

Health Information

Complete this form annually to inform us about your student's health condition that affects his or her school day

Last Name:		First Name:	Date of Birth
Section C: Current Health Conditions Continued			
Condition	Check if yes	Comment	
Muscle/Bone/Joint	<input type="checkbox"/>		
Respiratory	<input type="checkbox"/>	Triggers: <input type="checkbox"/> Exercise <input type="checkbox"/> Environmental <input type="checkbox"/> Other: _____	
• Asthma	<input type="checkbox"/>	Number of Emergency Room (ER) Visits in the last calendar year: _____	
		Inhaler <input type="checkbox"/> Yes <input type="checkbox"/> No Will it be provided to the school <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Cystic Fibrosis	<input type="checkbox"/>		
• Lung Disease (other than Asthma)	<input type="checkbox"/>	Type: _____	Date of last episode _____
Seizure/Neurological	<input type="checkbox"/>		
Skin Condition	<input type="checkbox"/>	<input type="checkbox"/> Eczema <input type="checkbox"/> Other: _____	
Stomach/Bowles (IBS, Crohn's, etc.)	<input type="checkbox"/>		
Other Health Concerns	<input type="checkbox"/>		
Vision Conditions	<input type="checkbox"/>	<input type="checkbox"/> Contacts/Glasses <input type="checkbox"/> Non-correctable <input type="checkbox"/> Other: _____	
Hearing Conditions	<input type="checkbox"/>	<input type="checkbox"/> Hearing Aid(s) <input type="checkbox"/> Other _____	
Section D: Health Procedures			
If your child has a health condition, does your child require any health procedures or need any special equipment during the school day?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If you answered Yes, please describe: _____			
Parent/Guardian is responsible for providing the school with any medication, special food, equipment that the student may require during the day.			
Parental Consent: I agree to allow my child's healthcare providers(s) to discuss information contained in the form with SRCS staff and IHS/Public Health Nurse <input type="checkbox"/> Yes <input type="checkbox"/> No			
Healthcare Provider Name _____		Healthcare Provider Phone _____	
Parent/Guardian Name (Print or Type) _____		Parent/Guardian Signature _____	Date _____
Public Health Nurse Use Only Below this Line			
<input type="checkbox"/> Reviewed <input type="checkbox"/> Immunizations UTD <input type="checkbox"/> Health Conditions List(Medical Flag) <input type="checkbox"/> Action Plan/Health Plan or Procedure			
Notes: 			
Public Health Nurse Name (Print or Type) _____		Public Health Nurse Signature _____	Date _____

MCKINNEY VENTO ELIGIBILITY QUESTIONNAIRE

Student Residency Verification Document

This document is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? *Check one box*

Section A	Section B
<input type="checkbox"/> in a shelter <input type="checkbox"/> with more than one family in a house or Apartment <input type="checkbox"/> in a motel, car or campsite <input type="checkbox"/> with friends or family members (other than parent/guardian) <p><u>CONTINUE:</u> if you checked a box in Section A, complete #2 and the remainder of this form</p>	<input type="checkbox"/> Choices in Section A do not apply <p><u>STOP:</u> If you checked this section, you do not need to complete the remainder of this form. Submit to school personnel</p>

2. The student lives with:
- | | |
|---|--|
| <input type="checkbox"/> 1 parent | <input type="checkbox"/> a relative, friend(s) or other adult(s) |
| <input type="checkbox"/> 2 parents | <input type="checkbox"/> alone with no adults |
| <input type="checkbox"/> 1 parent & another adult | <input type="checkbox"/> an adult that is not the parent or the legal guardian |

School: _____

Name of Student _____ Male Female

Birth Date ____/____/____ Age: _____ Social Security# (if appropriate): _____

Name of Parent(s)/Legal Guardian(s) _____

Address _____ Zip _____ Phone _____

Signature of Parent/Legal Guardian _____ Date _____

School Use Only – School Administrator’s determination of Section A circumstances:
--

If the parent has checked Section B above, completion of form is not required. For any choices in Section A, this form must be completed and provided to School Registrar immediately after completion. Form will be kept separately from the Student Permanent Record for audit purposes during the year.

Name and phone number of a School Contact Person who may know of the family’s situation:
 _____ Date faxed _____

**BIE Home Language Survey
2021-2022 School Year**

Standing Rock Community School

First Name:

Last Name:

Federal Code: 25: CFR 32.3

"It's the responsibility of the federal government to provide comprehensive education programs and services for Indians and Alaska Natives."

Federal requirements direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. BIE has contracted with WIDA (World Class Instructional Design and Assessment) to provide English Learner Assessments and Supports identified in this Home Language Survey.

BIE Mission Statement:

"Provide quality education opportunities from early childhood through life in accordance with the Tribes' needs for cultural and economic well-being..."

School Mission Statement:

Purpose: The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services. As parents or guardians, your cooperation is requested in complying with these requirements.

Please respond to each of the questions listed as accurately as possible.

For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

If you have any questions you have the right to share them before your student's English proficiency is assessed.

- 1. Which language did your child learn when they first began to talk?**

- 2. Which language does your child most frequently speak at home?**

- 3. Which language do you (the parents/guardians) use more often when speaking with your child?**

4. Which language is spoken more often by other adults in the home?

5. Do you believe your child might need additional support learning the academic language for math, science, reading, or writing?

Additional Information (Optional)

Please sign and date this form in the spaces provided below, then return this form to your child's school. Thank you for your cooperation.

Signature of Parent or Guardian _____

Date _____

School Official Verification _____

Criteria for Screening

If a language other than English is identified for any of the primary language questions above, your child will be recommended for screening.

***** Please Note: SOME items in this template can be modified to represent specific needs of LEAs in efforts to better gain knowledge of student EL status. Questions 1-3 are not negotiable and must remain as stated per federal requirements. Additionally, the Federal Code, BIE Mission Statement, and Purpose sections remain as stated. Thank you.**

Request for School Records
STANDING ROCK COMMUNITY SCHOOLS
Registrar 701-854-9009

Email records to: c.archambault@k12.nd.us
9189 Hwy 24 Fort Yates, ND 58538

To Whom It May Concern:

_____ has enrolled in grade _____
(Students Name)

At Standing Rock School.

School previously attended: _____

Address: _____ City: _____ State: _____

The following information is needed in order to establish proper placement for this student:

___ Official Transcript from previous school

___ Complete record of immunization

___ Certificate of Indian Blood (if applicable)

___ Birth Certificate

___ Special Services (IEP, LEP plan, Counseling services, Title I, Health Care plan,
504 plan, RTI plan, Etc.)

___ Assessment Data: (NWEA, State Testing, AIMSweb, DIBELS, etc.)

___ RTI Intervention

___ Dates of Enrollment

___ Attendance Reports

___ Behavior Reports

___ Other _____

I hereby request the information be sent to the address above or fax to the number listed. Thank you for your assistance.

Please Check: Elementary K-5 Middle School 6-8 High School 9-12

Parent Signature

Date

Parent Name (Please Print) _____

A school district in which a student enrolls may request records from a school the student last attended without a parental signature of approval. See "Privacy Act" / Section 438, Subsection (b) (1), Parts A & B, Page 97, as amended in 1976, 20 U.S.C. Sec. 1232g (b) (1) (a).