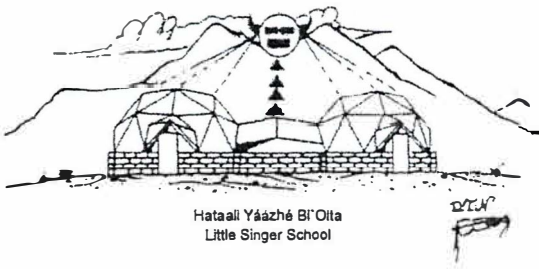


WELCOME TO:

LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * (928) 686-6108

Listed below is important information you must provide to enroll your child (ren):

1. *Kindergarten: a child is eligible for admission if he/she is five (5) years of age prior to September 30, and/or Kindergarten readiness of the current school year.*

2. *You **must have a current updated** documentary proof of the required immunization*

3. *Social Security Card*

4. *Census Number and/or Certificate of Indian Blood*

5. *Copy of Birth Certificate*

6. *Current transcript/report card from last previous school attended*

Please note:

- *All above documents must be on file before we can accept your child (ren) for enrollment.*

- *Absences: a student absent for ten consecutive days of unexcused absences will be withdrawn from enrollment.*

0MB Control No. 1076-0122 (Expires: 06/30/2024)

LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * (928) 686-6108

STUDENT ENROLLMENT APPLICATION

Type of School:	Funding:	School Year:
(X) Day	(X) Pub.Law 100-297	(☐ 21/22
( ) Boarding	( ) Pub. Law 93-638 Contract	(☐ 22/23
( ) Dormitory	( ) BIA Operated	(☐ 23/24

Student's Name: _____ Grade Applying for: Select
LAST FIRST MIDDLE

Date of Birth: _____ Gender: ☐ M ☐ F Place of Birth: _____

Census Number: _____ Tribal Affiliation: _____ Degree Indian: _____

Agency Name: _____ Home Phone Number: _____

Mother's Name: _____ Work Phone Number: _____

Email Address: _____ Cell Phone Number: _____

Census Number: _____ Tribe: _____ Agency: _____

Father's Name: _____ Work Phone Number: _____

Email Address: _____ Cell Phone Number: _____

Census Number: _____ Tribe: _____ Agency: _____

Guardian's Name: _____ Work Phone Number: _____

Email Address: _____ Cell Phone Number: _____

Mailing Address: _____

Physical Address: _____

Name/Phone Number of person to contact if parent cannot be reached: _____

Student Participated in Special Education: ☐ Yes ☐ No

Name of Previous School Attended: _____ Grade Completed: Select

Address: _____ Phone Number: _____

Reason for Leaving: _____

Dominant language spoken in the home: (1) _____ (2) _____

I AM LEGALLY RESPONSIBLE FOR MY CHILD AND HEREBY APPLY FOR HIS/HER ADMISSION TO THIS SCHOOL.
I UNDERSTAND THAT ADDITIONAL INFORMATION MAY BE REQUESTED BEFORE THE STUDENT IS ENROLLED.

Signature of Parent/Guardian: _____ **Date:** _____

* *

School Application: ☐ **Approved** ☐ **Not Approved** **Principal Signature:** _____

Signature of Agency Official: _____ **Date:** _____

LITTLE SINGER COMMUNITY SCHOOL

P O. Box AQ * Winslow, Arizona 86047 * (928) 686-6108

REQUEST FOR STUDENT RECORDS

STUDENT'S NAME_____**DOB**_____**GRADE** Select

Name of School Last Attended_____

Address_____City_____State_____Zip_____

Phone Number_____Fax Number_____

PLEASE SEND THE FOLLOWING INFORMATION:

- Transcript/Report Cards or Withdrawal grades
- AIMS/Achievement Test Scores
- Immunization/Health records
- Discipline & Attendance
- Birth Certificate
- Certificate Indian Blood
- **IF AVAILABLE** send Met or Psychological or Psychiatric Records, Special Ed, IEP records. Please forward to ATTN: SPED Teacher. **Please send as soon as possible. Thank you.**

While I understand that educational records may be sent without written consent, I also request that psychological, speech education and other pertinent information be sent. **Thank you in advance for your help and cooperation.**

_____ _____

Parent/Requester's Signature Date

1st Request:_____

2nd Request:_____

3rd Request:_____

BIE Home Language Survey
2022-2023 School Year

(Little Singer 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: "*Hooghan Haz'ą́qgi, K'é Binikááhgóne' Ólta' bee Hółdzil*"

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.**

Hataali Yáázhé Bi'Olta
Little Singer School

LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * (928) 686-6108

STUDENT'S TRAVEL AUTHORIZATION

I, (We) hereby grant permission for my, (Our) child:

_____ Select

Child's Name Grade

participates in field trips. I understand that my child will be properly chaperoned and all precautions will be taken to insure his/her safety. The purpose field trips may include the following: Recreational, School Clubs, Town Trips, On-Reservation, Off-Reservation, Overnight, Out-Of-State, Extracurricular and others.

Out-of-State Trips must have School Board approval with separate signed parental permission slip.

Instructional Goals: To develop a continual Bilingual and Bicultural program incorporating a curriculum with Navajo and English components for Navajo Students in grades Kindergarten through sixth inclusively.

PERMISSION IS GRANTED FOR MEDICAL ATTENTION, IF ANY ACCIDENT OCCURS AND SUCH MEDICAL HELP IS NEEDED, I ALSO RELIEVE THE SCHOOL FROM ANY LIABILITY FOR INJURY DURING THIS FIELD TRIP TO MY CHILD.

_____ _____

Date Parent/Guardian Signature

OMB Number 1810-0021

U.S. DEPARTMENT OF EDUCATION
OFFICE OF INDIAN EDUCATION
WASHINGTON, DC 20202

TITLE VII STUDENT ELIGIBILITY CERTIFICATION

Elementary and Secondary Education Act, Title VII, Part A, Subpart I

Parents: Please return this completed form to your child's school. In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program. **This form will become part of your child's school and will not need to be completed every year. This form will be maintained at the school** and information on the form will not be released without your written approval.

Definition: Indian means any individual who is (1) a member (as defined by the Indian tribe or band) of an Indian tribe or band, including those Indian tribe or bands terminated since 1940, and those recognized by the State in which the tribe or band reside; or (2) a descendent in the first or second degree (parent or grandparent) as described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an Eskimo or Aleut or other Alaska Native; or (5) a member of an organized group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

NAME OF CHILD _____ Date of Birth _____

School Name **LITTLE SINGER COMMUNITY SCHOOL** Grade Select

NAME OF TRIBE, BAND OR GROUP _____

Tribe, Band or Group is: (check one)

☐ Federally Recognized, Including Alaska Native ☐ State Recognized ☐ Terminated ☐ Organized Indian Group Meeting #5 of the Definition Above

Name of individual with tribal membership: _____

Individual named is (check one): ☐ Child Proof of ☐ Child's Parent ☐ Child's Grandparent

membership, as defined by tribe, band, or group is: A. _____

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

B. Other (explain) _____

Name and address of organization maintaining membership data for the tribe, band or group:

_____

I verify that the information provided above is accurate: _____

PARENT'S SIGNATURE _____ DATE _____

Mailing Address _____ Telephone _____

PAPERWORK BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collectoin 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 imporving 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, S.W., FOB-6/Room 3W111, Washington, D.C. 20202-6335.

LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * (928) 686-6108

SCHOOL PERMISSION CHECK-OUT FORM

Student's Name: _____ Grade: Select

Student's Name: _____ Grade: Select

Student's Name: _____ Grade: Select

Student's Name: _____ Grade: Select

My child(ren) listed above can be checked out only by the following person(s) listed below:

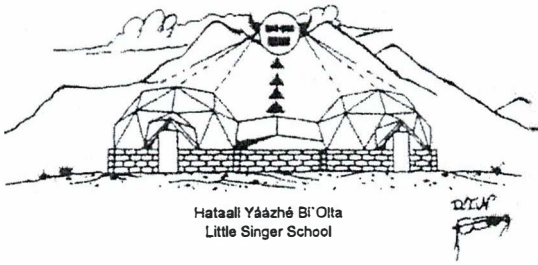
NAME OF PERSON (Must be 18 years old to check out the child)	RELATIONSHIP

The following people may **not** check out my child: (**must have legal court document on file**)

NAME OF PERSON	RELATIONSHIP	REASON FOR DENIAL

_____ _____

Parent/Guardian Signature Date



LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * (928) 686-6108

Photo/Videotape Release Form

Throughout the school year, there may be times when Little Singer Community School staff, the media, or other organizations, with the approval of the school principal, may take photographs of students, audiotape/videotape students, or interview students for school-related stories in a way that would individually identify a specific student. Those photographs and/or audio/videotaped images or interviews may appear in school publications; on the Web; in the news media; or in other nonprofit, education-related organizations' publications. Please complete this form, and return it to your child's school.

I hereby grant unto my child's school and to the Little Singer Community School permission to use my child's photograph and/or videotaped image for the purposes mentioned above. I understand and agree that Little Singer Community School may use these photos and/or videotaped images in subsequent school years unless I revoke this authorization by notifying the school principal in writing. I further grant unto Little Singer Community School permission to allow my child to be photographed, audio/videotaped, or interviewed by the news media or other organizations for school-related stories or articles.

☐ **Accept** ☐ **Decline**

Student's Name: _____

Parents/Guardian Signature:_____ Date:_____

WIHCC
Hózhóójí dóó k'é

WINSLOW INDIAN HEALTH CARE CENTER

Health History Form
Public Health Nursing

Student's Name _____ Date _____

Parents Names _____Date of Birth _____

Has the student been in the hospital this past year? _____

_____

_____

Is the student taking any medications? _____

If yes, what is the name of the medication?_____

What is the medication for?_____

Does the student have allergies to anything? _____What? _____

_____

_____

Which hospital/clinic does the student usually go to? _____

_____

In case of an emergency who do we need to contact? _____

_____

Who does the student live with? _____

What are the directions to the home where the child lives? _____

_____

Do you have any health concerns? _____

_____

_____

Did your child receive any immunizations over the summer? _____

If yes, please list the Date and where the immunization was given._____

_____

_____

Revised 06/2018

500 North Indiana Avenue • Winslow, AZ 86047 • (928) 289-6197 • FAX (928) 289-6126 •
www.wihcc.com

WIHCC

500 North Indiana Avenue
Winslow, Arizona 86047

PARENTAL/GUARDIAN CONSENT FOR SCHOOL HEALTH SERVICES

Full Name of Student_____ **DOB**_____

Name of School Little Singer Community School

I, _____**, authorize Winslow Indian Health Care Center (WIHCC) to arrange for/ or to provide the following health services for my child while he/she is attending school and/or the dormitory:**

1. **Emergency medical health care for accidents or illnesses (as defined by EMTALA); including medical exam, routine lab services, X-ray procedures, and other necessary tests.**
2. **Mental health services including evaluation consultation and treatment as necessary.**
3. **Transportation of the child to and/or from another health care facility for these services.**
4. **The school to work with WIHCC Public Health Nursing on immunization tracking and record updating based on verified sources like RPMS, immunization registries, or via health department records. Release of immunization information between WIHCC and the school.**

☐ **I hereby give consent for all of the above services .**

☐ **Exceptions or Special Instructions:** _____

I, as the parent/guardian, also agree to:

1. **Submit my child's immunization record to the school at admission to the school.**
2. **Submit a WIHCC Data Base Form if my child is a new student.**
3. **Take my child to a health care facility for an immunization update, in a timely manner, if any immunizations are deemed missing.**
4. **Take my child for medical follow-up, in a timely manner, to be evaluated for any failed screenings, such as hearing or vision screenings.**

Print Name _____ **Signature** _____

Relationship _____ **Address** _____

Phone Number_____ **School Year:** 2022/2023

PLEASE RETURN THIS FORM TO THE SCHOOL PRINCIPAL

(Revised 7/2018)

WIHCC
Hózhóóji dóó k'é

WINSLOW INDIAN HEALTH CARE CENTER

DATABASE

NAME (LAST, FIRST, MIDDLE) uuu	OTHER NAMES USED(MAIDEN NAME)	WIHCC NO.	SEX ☐M ☐F

BIRTH DATE	PLACE OF BIRTH (CITY, STATE)	SOCIAL-SECURITY NO.	MARITAL STATUS	INTERNET ☐Y ☐N Email Address:

CURRENT COMMUNITY	DATE MOVED	LOCATION OF HOME (DIRECTIONS TO YOUR HOME, ETC. PLEASE BE SPECIFIC.)

MAILING ADDRESS	CITY/STATE	ZIP CODE

HOME PHONE NUMBER	MESSAGE PHONE NUMBER	WORK PHONE NUMBER

INDIAN BLOOD QUANTUM	TRIBE	DEGREE	CENSUS NUMBER	CIB ☐Y ☐N
	OTHER TRIBE	DEGREE	RELIGION	

FATHER'S NAME	CITY OF BIRTH	STATE OF BIRTH
MOTHER'S MAIDEN NAME	CITY OF BIRTH	STATE OF BIRTH

EMPLOYER(IF APPLICABLE)	SPOUSE'S EMPLOYER(IF APPLICABLE)
EMPLOYER'S ADDRESS	SPOUSE'S EMPLOYER'S ADDRESS
EMPLOYER PHONE NUMBER	SPOUSE'S EMPLOYER PHONE NUMBER

IF YOU ARE UNEMPLOYED, PLEASE GIVE SOURCE OF INCOME

☐UNEMPLOYMENT ☐RETIREMENT ☐SSI ☐SSB ☐WELFARE ☐OTHER

NAME OF EMPLOYER (FATHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER
NAME OF EMPLOYER (MOTHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER

EMERGENCY CONTACT PERSON		NEXT OF KIN CONTACT PERSON	
RELATIONSHIP	PHONE NUMBER	RELATIONSHIP	PHONE NUMBER
ADDRESS		ADDRESS	

HEALTH INSURANCE INFORMATION

DO YOU HAVE MEDICARE COVERAGE?	YES ☐	NO ☐	DO YOU HAVE RAILROAD RETIREMENT COVERAGE?	YES ☐	NO ☐
DO YOU HAVE AHCCCS (MEDICAID)?	YES ☐	NO ☐	DO YOU HAVE PRIVATE INSURANCE COVERAGE?	YES ☐	NO ☐

MILITARY SERVICE?	YES ☐	NO ☐	BRANCH	CLAIM NUMBER	ENTRY DATE	SEPARATION DATE

VIETNAM VETERAN?	YES ☐	NO ☐	SERVICE CONNECTED?	YES ☐	NO ☐

HOUSEHOLD INFORMATION: How many family members in your household – including children?

PLEASE READ AND SIGN CAREFULLY

I authorize Winslow Indian Health Care Center to release any medical information or records necessary to process my Medicare, Medicaid or other insurance claims. I authorize my insurance company to pay medical benefits directly to Winslow Indian Health Care Center. If I am a non-beneficiary, I understand co-payments and deductibles will be requested at the time of service. I understand that I will be responsible for all costs if my account should be turned over to collections.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN	DATE

Patient Medical History- Mobile Dental Clinic

WIHCC | WINSLOW INDIAN HEALTH CARE CENTER

Name: (Last,First,Middle) Please Print*	Date of Birth:	School Name: Little Singer School

Have you been a patient in the hospital within the last two years? If YES, please write specifics of visit / admittance.

Please list any medications and/or substances / drugs that you are now taking, or have taken in the last year. Please be specific.

PLEASE ANSWER EACH QUESTION WITH SPECIFIC STATEMENT

☐	☐	Are you allergic to any medications? Please list items:	
☐	☐	Chest pain or heart attack	Date of Attack:
☐	☐	Heart Murmur	Date of Diagnosis:
☐	☐	Heart Valve Replacement Surgery or Heart Surgery	Date of Surgery:
☐	☐	Rheumatic Fever	
☐	☐	Pacemaker	
☐	☐	High Blood Pressure	Have you taken your medication(s) today?
☐	☐	Stroke	
☐	☐	Epilepsy or Seizures	
☐	☐	Do you, or a relative have Diabetes?	Have you taken your medication(s) today?
☐	☐	Arthritis or Rheumatism	
☐	☐	Artificial Joint / Dentures	Which joint / Denture?
☐	☐	Asthma	
☐	☐	Tuberculosis	
☐	☐	Sinus Trouble	
☐	☐	Ulcers	
☐	☐	Kidney Disease or Dialysis	
☐	☐	Cancer or Tumors	
☐	☐	Hepatitis or Liver Disease	
☐	☐	Blood Transfusions	
☐	☐	Sexually Transmitted Disease	
☐	☐	Have you ever had any severe or uncontrolled bleeding?	
☐	☐	Have you been exposed to the AIDS Virus?	
☐	☐	Are you HIV positive?	
☐	☐	Do you use Alcohol?	
☐	☐	Do you use tobacco?	
☐	☐	Do you have any concerns about receiving Dental treatment?	

FEMALES ONLY

☐ YES	☐ NO	Are you Pregnant?
☐ YES	☐ NO	Are you on Birth Control?
Date of last Menstrual Period:		
Comments:		

Please list any other medical conditions that you may have:

The Photo Release is for the use of Winslow Indian Health Care Center or for any other publication(s) or purposes uses by the WIHCC now or anytime in the future. WIHCC may also use and/or publish my name in conjunction with this/these photograph(s), or use my name in an accompanying article related to the photograph, or any article(s) for WIHCC publications.

I further attest I am the parent or legal guardian and give Permission. **Accept** ☐ **Decline** ☐

WIHCC DENTAL CONSENT FORM

Preventative Restoration is hard plastic coatings which protect the grooved surfaces of permanent teeth. They seal the deep pits and fissures and prevent decay. Minor risks include gagging, swallowing/aspiration of required dental materials, and small temporary change in bite.

Standard Restorations are amalgam or tooth colored fillings that are placed after all decay (caries) is removed.

Fluoride Varnish Program can help reduce cavities.

Periodontal Programs teach your child about gum disease and its prevention. Additionally, we may be able to provide a cleaning for certain grades as time and resources permit. Minor after effects may include bleeding or sore gums.

Emergency dental services are available as needed. If emergency treatment is necessary informal consent will also be obtained from the child's legal guardian (parent, school, representative, etc.)

Anesthetic Risks Include: discomfort, rapid pulse, swelling, bruising, infection, anxious feelings, allergic reactions, and lip chewing in children. Anesthetics occasionally are not effective in some patients.

We participate in School Externship/Residencies; Dental Students & Hygiene Students may see you.

The above answers are true to the best of my knowledge. I give my consent for myself or my child under the age of 18 to receive routine care such as examinations, x-rays, cleaning or fillings and for any other type of dental care as explained by the dentist.	
Signature or Thumbprint, Parent or Legal Guardian:	Date:
Signature of Dentist:	Date:

WIHCC
Winslow Indian Health
Care Center

500 North Indiana Avenue
Winslow, Arizona 86047

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Winslow Indian Health Care Center ***Notice of Privacy Practices*** pamphlet at: (check one)

☐ Winslow Indian Health Care Center; ☐ Leupp Health Clinic; ☐ Dilkon Health Clinic

Child's Name: _____

Grade: Select

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Date
(State relationship to Patient) or
Witness (if signature is by thumbprint or mark)

_____ _____
Signature and Title of WIHCC Date
Employee

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the WIHCC Notice of Privacy Practices because:

_____

_____

_____

_____ _____
Signature and Title of WIHCC Date
Employee