STANDING ROCK SCHOOL
ENROLLMENT INFORMATION
RETURNING STUDENTS ONLY

The following information **MUST** be provided to the school **BEFORE** students will be allowed to attend school.

Please fill out this enrollment packet completely. This information is very important for your student.

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.

*****You will need to contact the school if any information changes. This includes medical issues that may have changed and affects your student. Please contact the nurse for changes. Thank you**

RESTISTRATION FORM 2024-2025
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: ☐Yes ☐No	CIB: ☐Yes ☐No
Birth Certificate: ☐Yes ☐No	Entry Date:
State ID#:	Student ID: NASIS ID:
Teacher:	Sent for Records:
Received:	Transfer from:

STUDENT INFORMATION

Student Name: Last: First: MI:		Have you ever attended SRCS: ☐Yes ☐No If yes, what grade _____	
Preferred Name:	Date of Birth:	Age:	Gender: ○M ○F
Grade for the 2024-2025 schoolyear:	Primary Phone Number ( )		
Language Spoken at Home:	Has your child ever received EL services? ○Yes ○No Where:_____		

Student Lives With (Please Check Only One): ☐Both Parents ☐Parents Share Custody ☐Mother Only ☐Father Only
☐Mother & Stepfather ☐Father & Stepmother ☐Other Guardian/ CPS:_____

Student is Oldest in this School: ○Yes ○No	Student is Oldest in District: ○Yes ○No	Is this a Single Parent Household: ○Yes ○No

Child's Race: ☐African American ☐American Indian ☐Asian ☐Caucasian ☐Hispanic/Latino ☐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? ☐Yes ☐No If Yes Primary Disability:_____

Does this student have a 504 Accommodation Plan? ☐ Yes ☐ No	Is this student currently expelled or suspended? ☐ Yes ☐ No

PARENT/GUARDIAN INFORMATION

Father	Mother	Other Guardian
Relationship: ☐ Legal Parent ☐ Foster Parent ☐ Guardian ☐ Custodian ☐ Other:_____	Relationship: ☐ Legal Parent ☐ Foster Parent ☐ Guardian ☐ Custodian ☐ 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: ☐Home ☐Work ☐Cell ( )
Emergency Contact #2	Relationship to Student:	Daytime Phone Number: ☐Home ☐Work ☐Cell ( )
Emergency Contact #3	Relationship to Student:	Daytime Phone Number: ☐Home ☐Work ☐Cell ( )

Continued on Other Side

TRANSPORTATION INFORMATION

Transportation Needs:

- ☐ Both AM/PM
- ☐ AM Only — AM Pick Up Address: _____
- ☐ PM Only — PM Drop Off Address: _____
- ☐ No Busing Needed

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

MCKINNEY VENTO ELIGIBILTY QUESTIONAIRE

Where is your child/family currently living? The information below is confidential and assists the district in determining eligibility of services for students under the McKinney-Vento Act. Please check the appropriate box:

- ☐ Single family permanent residence (house, apt., trailer house, etc.)
- ☐ Doubled-Up (sharing housing with another family/individual due to economic hardship)
- ☐ Living in a temporary residence while building, purchasing a home, or waiting for housing
- ☐ Unsheltered (Car/Campsite)
- ☐ Motel/Hotel ☐ Foster Home
- ☐ In a shelter or transitional housing program
- ☐ Other : _____

Child(ren) ages birth to 21 living in home other than parent/guardian

Name	Date of Birth	Relationship to You	Name of School (if enrolled)

TO BE COMPLETED BY PARENT / GUARDIAN

Throughout the year, your child will have the opportunity to take a number of field trips with the class to various points of interest in the area. You will be notified of each trip a few days before the excursion. By signing below, I give Standing Rock Community School permission for my child

_____ to accompany his/her class on field trips sponsored by the school during the school year.

Parent/Guardian Signature _____

My relationship to the student is:

I hereby certify that all the information contained in this form is true and accurate to the best of my knowledge.

Printed Name: _____

Parent/Guardian Signature *Date*

Your child is being asked to take part in an evaluation of the STITPPI program. The purpose is to see how the Theíc'iȟila (Know Your Worth) program, which teaches the Get Real curriculum, is working. You give your consent by signing below.

☐ Yes ☐ No Parent/Guardian Signature _____ Date _____

Health Information

Standing Rock Community School

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:
				☐ Male ☐ 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?

☐ Diabetes Type 1 ☐ Seizure requiring rescue medication ☐ Allergy requiring epinephrine ☐ Severe Asthma

Section C: Current Health Conditions

Condition	Check if yes	Comment
ADD/ADHD	☐	Provider Diagnosed: ☐ Yes ☐ No Under Treatment: ☐ Yes ☐ No
Allergies • Food	☐	**Regular Known Allergies:** _____ Foods: _____ Epinephrine ☐ Yes ☐ No If Yes, Date received
• Food Intolerance •	☐	Foods: _____ Gastrointestinal/Digestive Distress ☐ Yes ☐ No Dietary Restriction/Preference ☐ Yes ☐ No
• Bee Sting- symptoms *other* than local redness/swelling	☐	Epinephrine: ☐ Yes ☐ No If Yes, Date received _____
• Latex	☐	
Anxiety	☐	Provider Diagnosed: ☐ Yes ☐ No Under Treatment: ☐ Yes ☐ No
Blood Disorder	☐	
Cancer	☐	Currently Immunocompromised: ☐ Yes ☐ No
Dental/Oral Health Condition	☐	
Depression	☐	Provider Diagnosed: ☐ Yes ☐ No Under Treatment: ☐ Yes ☐ No
Diabetes	☐	Method of Insulin Administration: ☐ Syringe ☐ Pen ☐ Pump
Eating Disorders	☐	Provider Diagnosed: ☐ Yes ☐ No Under Treatment: ☐ Yes ☐ No
Heart	☐	
Kidney/Urinary Tract Disorders	☐	
Migraines	☐	

Health Information

Standing Rock Community School

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	☐	
Respiratory • Asthma	☐	Triggers: ☐ Exercise ☐ Environmental ☐ Other: _____ Number of Emergency Room (ER) Visits in the last calendar year: _____ Inhaler ☐ Yes ☐ No Will it be provided to the school ☐ Yes ☐ No
• Cystic Fibrosis	☐	
• Lung Disease (other than Asthma)	☐	Type: Date of last episode
Seizure/Neurological	☐	
Skin Condition	☐	☐ Eczema ☐ Other:
Stomach/Bowles (IBS, Crohn's, etc.)	☐	
Other Health Concerns	☐	
Vision Conditions	☐	☐ Contacts/Glasses ☐ Non-correctable ☐ Other:
Hearing Conditions	☐	☐ Hearing Aid(s) ☐ 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?

☐ Yes ☐ 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 ☐ Yes ☐ 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

☐ Reviewed ☐ Immunizations UTD ☐ Health Conditions List(Medical Flag) ☐ Action Plan/Health Plan or Procedure

Notes:

_____ _____ _____

Public Health Nurse Name (Print or Type) Public Health Nurse Signature Date

U.S. Department of Health and Human Services
Indian Health Service
The Federal Health Program for American Indians and Alaska Natives

Public Health Service

In Reply Refer To:

PHS Indian Hospital
Box J
Fort Yates ND 58538

Dental Consent Form

Please checkmark ✓ the boxes below, marking each treatment you would like your child to receive. With your signature below. you authorize your consent for IHS dental to perform the marked treatments if able and warranted.

YES	NO	
☐	☐	**Screening: a visual assessment of the oral cavity. No x-rays are taken. This does not replace a dental exam done in clinic.**
☐	☐	**Cleaning: a toothbrush or rubber cup polish will be completed. Hand-scaling will be completed if needed.**
☐	☐	**Fluoride Varnish: a protective coating that releases fluoride which strengthens teeth and prevents tooth decay.**
☐	☐	**Sealants: a thin plastic coating painted and hardened onto the grooves of undecayed teeth. Screening required.**

Allergies: _____

Medical Conditions: _____

Medications: _____

_____

Child's name **DOB**

_____

Parent / Guardian Name **Signature** **Date**

_____

School / Head Start Center **Grade** **Teacher**

Rev. 5/23/23 KSE