

SHONTO PREPRATORY SCHOOL K-8



Please use Blue/Black Ink only.

STUDENT ENROLLMENT FORM

Student's Last Name	First Name	Middle Name	Suffix	Grade
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Household Contact Number <input type="checkbox"/> Home <input type="checkbox"/> Cell		
Mailing Address		City	State	Zip
Physical Address (Where student will reside during school year.)				

STUDENT'S TRIBAL AFFILIATION INFORMATION PER CERTIFICATE OF INDIAN BLOOD

Tribe/Agency	Enrollment Number	Degree
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Please check any Special Serviced Previously received:

☐ Special Education (IEP) ☐ 504 Accommodation ☐ Gifted/Talented ☐ English Language Learner (ELL)

Home Language Survey

- What is the language that the student first acquired? ☐ Navajo ☐ English Other:
- What is the language most often spoken by the student? ☐ Navajo ☐ English Other:
- What is the primary language used in the home regardless of the language spoken by the student? ☐ Navajo ☐ English Other:

RESPONSIBLE PAREN/GUARDIAN INFORMATION

*If other than birth parents, court orders, legal issues, guardianship and/or Power Of Attorney forms must be on file.

<input type="checkbox"/> Parent Mother/Father <input type="checkbox"/> *Guardian	Name & Address, if different from above.	*Contact Number	Email
		*Ok to send text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tribal Affiliation & Enrollment Number		Navajo Nation Chapter Affiliation	

<input type="checkbox"/> Parent Mother/Father <input type="checkbox"/> *Guardian	Name & Address, if different from above.	*Contact Number	Email
		*Ok to send text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tribal Affiliation & Enrollment Number		Navajo Nation Chapter Affiliation	

EMERGENCY CONTACT (Other than parent/guardian)

Name	Contact Number	Physical Address
1.		
2.		

THE FOLLOWING ADDITIONAL PEOPLE HAVE PERMISSION TO PICK UP MY CHILD FROM SCHOOL

Limit four (4). The person(s) on the list MUST BE OVER 21 YEARS OF AGE.

Name	Relationship	Name	Relationship
1.		3.	
2.		4.	

Name: _____

PREVIOUS SCHOOL ATTENDED

School Name	Address
Phone	Fax
Dates Attended	Grade Completed
Reason for transferring:	
1. Has your child been suspended/expelled from previous school? If yes, reason? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Retained? (Grade/Year) <input type="checkbox"/> Yes <input type="checkbox"/> No	

DISCLAIMER AND SIGNATURE *to be signed by Parent/Legal Guardian.*

I am legally responsible for this student and hereby apply for his/her admission to this school. Therefore I certify that the foregoing information is accurate and complete to the best of my knowledge. I also understand that additional information may be requested by the school from myself and other public agencies in accordance with the rules and regulations or the Family Privacy Act to complete the enrollment of my child.

Print Name

Signature

Date

OFFICIAL USE ONLY

THIS STUDENT PROVIDED ALL NECESSARY DOCUMENTS AND BACKGROUND CLEARANCE TO ATTEND SHONTO PREPARATORY K-8 SCHOOL.

- ☐ Degree of Indian Blood/CIB
- ☐ Birth Certificate
- ☐ Current Immunization

Approval of School Application:

- ☐ Approved
- ☐ Approved with Contract
- ☐ Denied Principal Initials: _____

Signature of Registrar

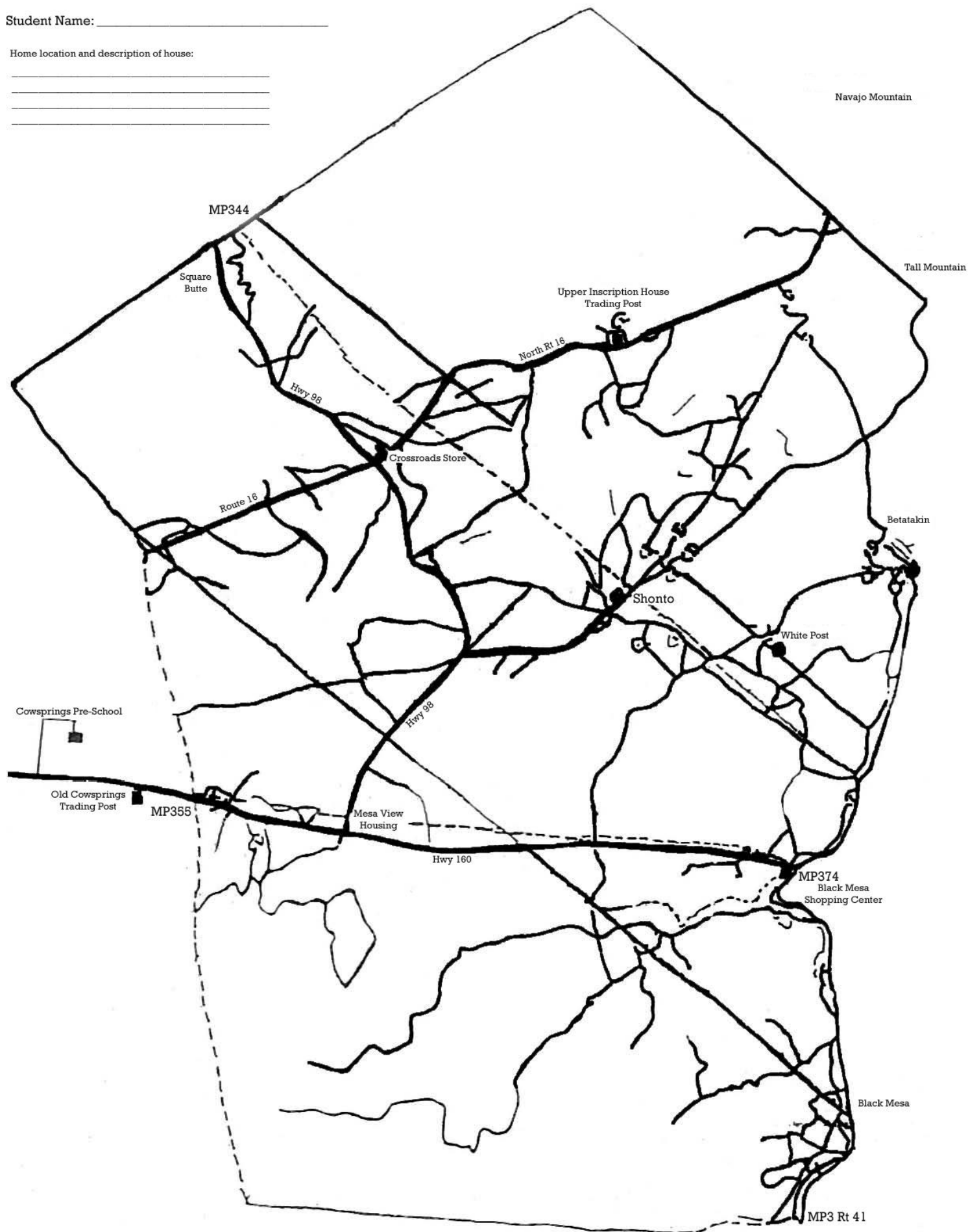
Date

Signature of Education Program Administrator

Date

Student Name: _____

Home location and description of house:



SHONTO PREPARATORY SCHOOL (SY 2022-2023)
HEALTH HISTORY QUESTIONNAIRE & CONSENT FORM

IMM. UTD: _____

GRADE: _____

Student Name: _____ DOB: _____ Gender: Male () or Female ()

Parent(s): _____ Home Location: _____

Cell phone: _____ Work phone: _____

EMERGENCY CONTACT NUMBER(S):

If the school cannot contact either parent/guardian, please list a "Next of Kin" or a relative who would have authority to advise us regarding your child and/or to locate you immediately.

Name: _____ Relation to Child: _____ Phone #: _____

HEALTH HISTORY QUESTIONNAIRE: Explain "YES" or "other" answers below.**Has your child had any of the following health conditions listed below? Circle YES or NO.**

ADD/ADHD	NO	YES	Heart Murmur/Disease	NO	YES	Allergic to food(s);	NO	YES
Anemia	NO	YES	Hepatitis	NO	YES			
Asthma (diagnosed)	NO	YES	High Blood Pressure	NO	YES	Allergic to Medicine(s);	NO	YES
Bleeding Disorder	NO	YES	Kidney Disease	NO	YES			
Bronchitis	NO	YES	Meningitis	NO	YES	Allergic to insect bites	NO	YES
Chicken Pox	NO	YES	Migraine Headache	NO	YES	Allergic to pet dander	NO	YES
Diabetes	NO	YES	Pneumonia	NO	YES	Thyroid problem	NO	YES
Dietary Restrictions	NO	YES	Rheumatoid Arthritis	NO	YES	Under Physician's Care	NO	YES
Epilepsy/Seizures	NO	YES	Scoliosis	NO	YES	History of COVID-19	NO	YES
Eyeglasses/Contacts	NO	YES	Vision/Hearing Problems	NO	YES	Other: _____	NO	YES

Explain "yes" or "other" questions: _____

NON-PRESCRIPTION MEDICATION CONSENT

I, _____, (Parent or Legal Guardian), authorize the following non-prescription medication to be administered as needed for my child by the School Nurse or designated SPS staff;

___ Children's Tylenol	___ Allergy Relief Eye Drop	___ Blistex	___ Children's Pepto Bismol Tablets
___ Tylenol (325 mg)	___ Eye Lubricant	___ Carmex	___ Hydrocortisone 1% Cream
___ Children's Ibuprofen	___ Cough Suppressant	___ Neosporin	___ Head Lice Shampoo
___ Ibuprofen (200 mg)	___ Throat Lozengers	___ Wart Band-Aid	___ Children's Benadryl
___ Orajel Toothache	___ Children's Sudafed	___ Mouth Sore Gel	(Benadryl is administered only as a temporary relief).

Special Instruction _____

"My child's prescription medication(s) will be provided in a labelled container with his/her name, the prescription name, specific instructions and expiration date. If at any time the information must be changed, I will notify the school nurse or administrator in writing. I agree to and do hereby hold SPS and its employees harmless from any and all claims, demands, causes of actions, liability or loss of any sort, because of or arising out of act or omissions with respect to this medication."

Parent Signature: _____ Print Name: _____ Date: _____

PUBLIC & INDIAN HEALTH SERVICE CONSENT FORM

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON WITH PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

I (We), _____, Parent(s) of _____
(Parent/Legal Guardian) (Student)

have read the Consent Form for the Public and Indian Health Service to arrange for or to provide the following health services for my child. (Please Check Mark ✓)

1. ____ Dental Care include dental examinations, preventive use of fluorides and necessary emergency dental care.
2. ____ Emergency health care for accident or illness.
3. ____ Health care include medical examinations, sport physicals, school health screenings, routine laboratory studies, x-ray procedure and routine immunizations.
4. ____ Mental health services include evaluation and treatment as necessary.
5. ____ Optometry care for eye examinations and eye glasses.
6. ____ Psychiatric services to include assessment, treatment, and medication as necessary.
7. ____ Transportation of child to and/or from a health facility for these services.

PLEASE CHECK THE APPROPRIATE BOX (ES):

- ☐ - I hereby give consent for all of the above services.
- ☐ - Exceptions or Special Instructions: _____
- ☐ - I hereby give consent for reasonable cause and essential need to assure the health and safety of my child to Shonto Preparatory School staff while my child is in attendance.

Parent/Guardian Signature: _____

Please Print Name: _____

Address: _____ City: _____ Zip: _____

Phone#: _____ Alternate Phone #: _____

Relationship: _____

Date: _____

***Valid Until: June 2023**

✓Check the one that applies: ____ Enrolled in AHCCCS, ____ No Health Insurance,
____ Other Health Insurance, # _____

Please be advised that Shonto Preparatory School staff will make every attempt to contact you before any of the above services are rendered. *This consent is only valid for one year from the date it was signed, a new one needs to be signed yearly.