Leupp Schools, Inc.
Academic Office
HC-61 Box D
Winslow, Arizona 86047
Phone: (928) 686-6211

**Welcome to L.S.I**

**First Day of School**

**August 4, 2025**

**School Year**

**2025-2026**

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**FOR LSI OFFICE USE ONLY** **HOME OF THE BRAVES**

STUDENT NAME _____ GRADE_____ (BUS) _____ (DORM)_____ (WALK-IN )_____

**REQUIRED DOCUMENTS FOR ENROLLMENT**

**Use this Check Off list as a guide to complete the documents. Use a Black Pen to fill-out the forms. Thank You.**

## Returning Student Enrollment Check List

| | |
|---|---|
| BIE Registration Form | |
| LSI Registration and Permission to Check out Form | |
| LSI Medical History | |
| **Current Immunization Records. PRINTED after July 1, 2025.**<br>*** NO ADMITTANCE without immunization records**<br>**(A.R.S. 15-81-874).** | |
| Legal or Temporary Guardianship Documents (If applicable). | |
| Annual Participation P.E. (If participating in Sports). | |
| | |
| WIHCC Data Base | |
| WIHCC Consent for School Health Services Form. | |
| | |

***Disclaimer: Completion of required documents does not guarantee enrollment: All required forms must be submitted before attending school. Return forms to Front Office. Thank You***

BIA Form.624
OMB No. 1076-012

Grade Level: _____
Residential: _____
Day-Bus: _____

# Leupp Schools, Inc.

## Student Enrollment Application

**Entry Date:** **Withdrawal Date:**

**Native American Student Information System (NASIS) ID NO.**

| *Student Name: LAST First Middle:* | *Gender: (Circle)* Female: Male: | *Date of Birth:* | *Enrollment Number:* | *Degree of Indian Blood:* |
|---|---|---|---|---|
| | | | | |

| *Student Address: City: State: Zip Code:* | *Birth Place:* | *Tribal Affiliation:* | *Chapter Affiliation:* |
|---|---|---|---|
| | | | |

| *Home Location:* | *Language most Spoken at Home:* | *Language most Spoken by Student:* |
|---|---|---|
| | Navajo: English: | Navajo: English: |

| *With whom does the student live?* | *Did student participate in ELL?* | *Did student participate in Special Education?* |
|---|---|---|
| **Both Parents Father Mother Grandparents Guardian Other** | | |

Guardianship or Custodial issues must include proper notarized/court documentation, unless we receive copies that assigns custody to one we must assume that, both parents can visit/parents can visit/pick up the student from school. Who has legal guardianship of the student?

| | |
|---|---|
| Father: Tribal Affiliation: | Mother: Tribal Affiliation: |
| Address (city,state,zip): | Address (city,state,zip): |
| Home Location: | Home Location: |
| Home Phone: Work Phone: | Home Phone: Work Phone: |
| Email: Cell/Pager: | Email: Cell/Pager: |
| Employer: Census No: | Employer: Census No: |
| Contact Allowed: Received student mailings? | Contact Allowed: Received student mailings? |
| Guardian Name: | Contact Allowed: Received student mailings? |
| Address (city,state,zip): | Home Location: |
| Home Phone: Work Phone: | Cell/Pager: Other: |
| Employer: | Email: |
| **Emergency Information: (other than parent/guardian):** | **Emergency Information: (other than parent/guardian):** |
| Relationship to Student: May Pick up Student? | Relationship to Student: May Pick up Student? |
| Home Phone: Work Phone: | Home Phone: Work Phone: |
| Cell/Pager: Other: | Cell/Pager: Other: |

## SCHOOL HISTORY:

*For students whose last academic year was 8th grade:*

Name of School: _____ Address: _____

Phone Number: _____ Grade Completed: _____ Dates Attended: _____

*List all schools you have attended:*

Previous School Attended: _____ Address _____ Phone No. _____

Reason for transferring: _____ Grade Completed: _____ Dates Attended: _____

Previous School Attended: _____ Address _____ Phone No. _____

Reason for transferring: _____ Grade Completed: _____ Dates Attended: _____

***Has the student ever been removed or is the student in the process of being removed from a previous school due to disciplinary action?*** _____ .

I am legally responsible for this student and hereby apply for his/her admission to Leupp Schools, Inc. I understand that additional may be required by the school before this student is officially enrolled.

I recognize that this is a public document and that falsification of information on this document may constitute violation of the criminal laws. I further hereby certify the inform contained herein is true and correct. I understand that any legal update of the information on this enrollment form is my responsibility.

_____ _____ _____

*Print name of Parent/Legal Guardian* *Signature of Parent/Legal Guardian* *Date*

*OFFICIAL USE ONLY* *Verified by:*

I certify that the above named student is enrolled member with the Navajo Tribal Indian Census as being of: _____

_____ Degree of Indian Blood. _____ Enrollment/Census Number. _____ Agency.

APPROVAL OF SCHOOL APPLICATION: _____ Approved _____ Not Approved

_____ _____ _____ _____

*Signature of Principal or Registrar* *Date* *Signature of Education Program Administrator* *Date*

**LEUPP SCHOOLS, INC.** **SCHOOL YEAR 2025-2026**

# PERMISSION TO CHECK OUT STUDENTS FROM L.S.I.

NAME: _____ GRADE: _____

PARENTS/GUARDIANS: _____ PHONE: _____

ALTERNATE #: _____

LOCATION OF RESIDENCE: _____ CLINIC MOST OFTEN USED: _____

RESIDENTIAL: _____ BUS: _____ WALK IN: _____

**(Required for all student of LSI regardless of age)**

**I give my permission for the following people to check out my child. I will notify the school prior to each checkout, by telephone or a written note.**

| **Name of person:** *Must be over the age of 18* | **Relationship:** | **Phone Number:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**The following people CANNOT check out my child:**

| **Name of person:** | **Relationship:** | **Reason for Denial:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

_____ _____

Signature of Parent/Guardian Date

**FOR OFFICE USE ONLY/NOTES**

LEUPP SCHOOLS
INCORPORATED
Building the Future, Keeping the Past

# Medical History Permission and Medical Consent Form

**Students Name:**_____ **Grade:**_____ **DOB:**_____

**Mailing Adress:**_____

**Community in Which Student Lives / From:**_____

**Emergency Contact:**_____ **Phone #:**_____

**Relationship to Student:**_____

**Medical Insurance:**_____ **Policy#:**_____

**Physician:**_____ **Phone#:**_____

**What Health Facility does the Student go to:**_____

**Medical Conditions: (Example: Asthma, Scoliosis, Eye Conditions, Diabetes, Eczema, Anxiety, etc.):**_____

_____

**Food Allergies:**_____

**Seasonal Allergies:**_____

**Allergic to Medications:**_____

**Previous Operations or Illnesses:**_____

**Medication Instructions: (If your child is taking prescribed Medication, please list below)**

| Medication | Dose | Start Date | End Date | Frequency Route |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I authorize the Leupp School's, Inc. Nursing Staff and Faculty Staff to give the medication(s) listed above to my child. Furthermore, I understand that if my child is to carry specific 'As Needed Medications, Leupp Schools, Inc. will not be held liable for any loose or damaged medication(s) or dispensing devices.

Parent / Guardian Signature Name (Print):_____

Parent / Guardian Signature:_____ Date:_____

**All prescribed Medications must be checked in with Leupp Schools, Inc. Nursing Staff must be checked in with Leupp Schools, Inc. Nursing Staff and must have a pharmacist's label with recommended dosage. Medication must be brought in to school in its original container labeled by a pharmacist. Students are not permitted to have prescription or over-the-counter medications in their possessions on campus, except those required to treat asthma. At the end of the school year the parent or guardian must retrieve remaining medications. Medications not claimed at the end of the school year will be discarded.**

WIHCC

WINSLOW INDIAN HEALTH CARE CENTER

# DATABASE

| NAME (LAST, FIRST, MIDDLE) | | 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 insuranc 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 c 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 t collections.

| SIGNATURE OF PATIENT, PARENT OR GUARDIAN | DATE |
|---|---|
| | |