



KIN DAH ŁICHÍ'Í ÓLTA'

HOME OF THE WOLVERINES

Child Name: _____

Grade: _____

CHECK LIST: Application Requirements

Need the following documents, before enrolling a **NEW STUDENT**:

- Enrollment Forms (All sections must be completed with signature)
- Withdrawal Slip (From Previous School)
- C.I.B (Certificate of Indian Blood)
- Birth Certificate
- Updated Immunization with current year **2024** (Computerized Copy Only)
- Update Guardianship Documents (if needed)
- Verification of Home location
- Title VI ED 506 Indian Student Eligibility Certification Form
- Health Forms - Emergency Health, Health History, The Smiles Movement, & Allergy Form Required (If your child has a food/medication allergy)
- BIE Home Language Survey Form (complete)
- McKinney Vento Questionnaire
- Student Handbook Policies & Procedures
- Appendix G, I, L, M, N, and Parent School Compact.
- Physical Examination Form (3rd-6th graders who will participate in sports)

P.O. Box #800 * Ganado, Arizona 86505 * PH: (928)755-3439/3430 FAX: (928)755-3448

Mission Statement

Kin Dah Lichi'i Olta' is committed to providing a safe and inclusive learning environment where every student can thrive academically, socially and culturally.

KIN DAH LICH'I OLTA'
APPLICATION FOR STUDENT ENROLLMENT IN BUREAU FUNDED DAY SCHOOL
UNITED STATES DEPARTMENT OF THE INTERIOR
SCHOOL YEAR: _____

STUDENTS INFORMATION:

GRADE APPLYING FOR: _____

1. NAME OF STUDENT: _____
Last Name First Name Middle Name

MAILING ADDRESS: _____
PHYSICAL ADDRESS: _____

DATE OF BIRTH: _____ F () M () PLACE OF BIRTH: _____

TRIBAL AFFILIATION: _____ AGENCY: _____

ENROLLMENT NUMBER: _____ DEGREE OF BLOOD: _____

CHAPTER AFFILIATION: _____

TELEPHONE: _____ MESSAGE NUMBER: _____

2. FAMILY AND BACKGROUND INFORMATION (PLEASE FILL OUT ALL INFORMATION):

PARENT OR LEGAL GUARDIAN (circle one)

FATHER NAME: _____	MOTHER NAME: _____
GUARDIAN'S NAME: _____	RELATIONSHIP: _____
ADDRESS: _____	ADDRESS: _____
_____	_____
TRIBAL AFFILIATION: _____	TRIBAL AFFILIATION: _____
HOME AGENCY: _____	HOME AGENCY: _____
LIVING () DECEASED ()	LIVING () DECEASED ()
EMPLOYER: _____	EMPLOYER: _____
OCCUPATION: _____	OCCUPATION: _____
CELL PHONE NUMBER: _____	CELL PHONE NUMBER: _____
WORK PHONE NUMBER: _____	WORK PHONE NUMBER: _____
CELL PHONE NUMBER: _____	CELL PHONE NUMBER: _____
EMERGENCY NUMBER: _____	EMERGENCY NUMBER: _____
EMAIL: _____	EMAIL: _____

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

PARENT/GUARDIAN SIGNATURE

DATE

REGISTRAR

DATE

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SY: _____
KIN DAH LICH'I OLTA'
AUTHORIZED STUDENT CHECK-OUT LIST

NAME OF STUDENT	GRADE
I/WE _____ PARENT/GUARDIAN NAME	RELATION TO STUDENT
PHONE NUMBER	OTHER CONTACT PHONE NUMBER

AUTHORIZED THE FOLLOWING PERSON(S) TO CHECK OUT MY CHILD IN CASE OF EMERGENCY, WHEN I AM NOT AVAILABLE OR CANNOT BE REACHED. IF I DON'T HAVE THEM ON THE LIST I WILL WRITE A NOTE.

NAME OF ADULT	RELATION TO CHILD	HOME LOCATION	PHONE NUMBER:

**** NOTE: AUTHORIZE PERSON MUST BE 18 YEARS OF AGE OR OLDER. AN I.D. WILL BE REQUIRED****

PARENT/GUARDIAN SIGNATURE	DATE
---------------------------	------

Mission Statement

SY: _____
KIN DAH LICH'I OLTA'
EMERGENCY CONTACT FORM/CONNECT 5:

NAME OF STUDENT _____

GRADE _____

PARENT(S)/GUARDIAN PRIMARY CELL NUMBER:

TEXT MESSAGING:

1. _____

YES

NO

2. _____

EMAIL: _____

NOTE: IF YOUR PRIMARY OR MOBILE NUMBER HAS CHANGED, PLEASE INFORM THE SCHOOL AS SOON AS POSSIBLE. THIS INFORMATION IS IMPORTANT FOR YOUR CHILD/CHILDREN'S SAFETY AND IN CASE OF EMERGENCY. THANK YOU.

3. DO CHILD HAVE OTHER SIBLINGS ATTENDING KDLO YES NO

IF YES, PLEASE LIST BELOW:

NAME OF STUDENT _____ GRADE _____

NAME OF STUDENT _____ GRADE _____

NAME OF STUDENT _____ GRADE _____

NAME OF STUDENT _____ GRADE _____

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HOME OF THE WOLVERINES

Dear Parents,

Keeping you informed is a top priority at Kin Dah Lichi'i Olta. That's why we have adopted the Connect 5 Notification Service which will allow us to send a telephone, text message or e-mail message to you providing important information about school events or emergencies. We anticipate using Connect 5 to notify you of school delays or cancellations due to inclement weather, as well as remind you about various events, including report card distribution, open house, field trips, and more. In the event of an emergency at school, you can have peace of mind knowing that you will be informed immediately by phone.

What you need to know about receiving calls sent through Connect 5

- Caller ID will display the school's main number when general announcement is delivered.
- Caller ID will display 411 if the message is a dire emergency.
- Connect 5 will leave a message on any answering machine or voicemail.
- If the Connect 5 message stops playing, press any key 1-9 and the message will replay from the beginning.

The successful delivery of information is dependent upon accurate contact information for each student, so please make certain that we have your most current phone numbers. If this information changes during the year, please let us know immediately.

Note that the primary phone number will be called for standard and emergency calls; the emergency numbers will only be used in an emergency, and all will be dialed simultaneously. Thank you for your cooperation and if you have any questions, please don't hesitate to contact us at (928)755-3439 or 3430.

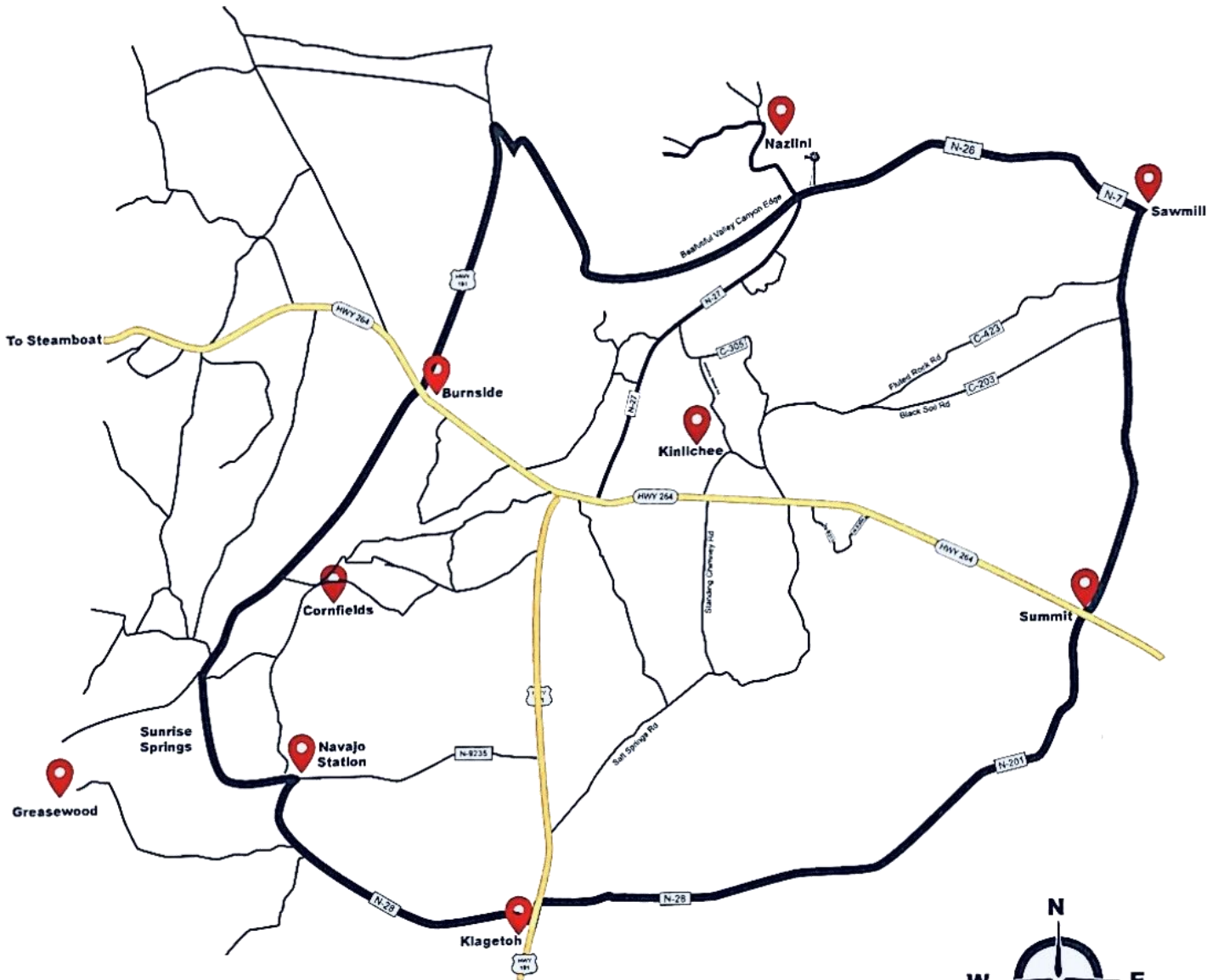
We are very excited to incorporate Connect 5 as a tool to improve parent communication and look forward to having the ability to deliver real time information to you and provide awareness of all the great events that take place within the school.

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Verification of Home Location SY _____



Student Name: _____ Grade _____

Location of Home: _____
(Please be Specific)

Parent/Guardian: _____

Phone Number: 1. _____ 2. _____

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KIN DAH ŁICHI'Í ÓLTA'

HOME OF THE WOLVERINES

The School's Health Office extends a warm welcome to all children and their parent(s) or guardian(s) to Kin Dah Lichi'i Olta for another exciting school year. Here are a few reminders from the School's Health Office when parent(s) or guardian(s) are concerned about their child(ren).

The following information is intended as a guide to help with their decision.

- ❖ If your child has vomited or had diarrhea within the pass 24 hours
- ❖ If your child has open sores or a rash of unknown origins
- ❖ If your child has head lice
- ❖ If your child has redness, irritated, or discharged from the eye(s)
- ❖ Persistent cough or persistent running nose
- ❖ After an illness and until your child has eaten a full mean and their temperature has been normal for at least 24 hours without medication
- ❖ If he/she has had a throat culture, wait until you have received the results and know that it is not strep throat.
- ❖ Until 24 hours after antibiotic treatment is started and your child has a normal temperature for 24 hours without fever reducing medication

If your child has been sick and missed two or more days, a doctor statement is required to excuse absences.

Immunization:

Arizona Revised Statues (ARS) 15-872 (B) states that "a pupil shall not be allowed to attend school without submitting documentary proof to the school administrator unless the pupil is exempted from immunization".

This means upon enrollment to KDLO you are required to submit a current up-to-date with current year immunization record for your child(ren) unless you have written documents for exemptions.

Kindergarten and 6th grader's immunizations are reported annually to the Arizona Department of Health Services on November 15 of every year. Please check with the school health office to see if your child has updated immunization on file. A 10 day grace period is given to ensure enough time to turn in your child immunization. If your child's immunization record is not updated, your child may not be allowed to attended school until their immunization record is updated with the school health office. **Student taken home due to inadequate immunization is NOT an EXCUSED ABSENT.**

Vision and Hearing Screening:

All vision and hearing screening are done at KDLO by the Health Assistant. Rescreening are required for students whom fail the first screening and will be determine by the Health Assistant.

BACK 

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Sport Physical Exam:

Before your child can participate in any sport at KDLO a Sport Physical Examination is required. Obtaining a Sport Physical is the responsibility of the parents for their child(ren) to participate in any sort of organized sport activities that requires a Sport Physical.

Prescription Medication(s):

Prescription medication(s) must be brought to the school by the parent or guardian. **NO MEDICATION IS TO BE TRANSPORTED BY STUDENT ON SCHOOL BUS.** All prescribed medication(s) must be in original pharmacy container with the student's name, name of medication(s), doctor's name and specific instruction for administration. A written doctor's statement is required for medication(s) to be administered at school and for your child(ren) record. Parent or guardian must sign a school consent form for the School Health Assistant to dispense or administer medication.

Head Lice:

The School Health Office recommends that each parent or guardian periodically screens their child(ren) hair for lice. Head lice is most common communicable childhood infestation and outbreaks among Preschool and elementary school-age children. Head lice can spread among children who engage in behaviors such as sharing combs, brushes, jackets and hats. Head Lice Treatment can be bought at any department store such as Wal Mart, Walgreens, Family Dollar and Safeway. You can come by the Health Office to get more information on head lice transmission, infestation, treatment and nit removal.

Chronic Head Lice incidents will be referred to the local CHR or Public Health Nurse.

Educating your child on head lice may prevent infestation among school children. Please work with school personnel to attain a louse-free, education-oriented environment. If you need additional information, please contact the school health office. **Your child can return to back to school as long as Head Lice is completely gone.**

The School Health Office is for Emergency and First Aid purpose. It is the responsibility of the parents or guardian to take their child(ren) to their routine medical or dental appointments including triage clinic. Accidents that happen at home should be treated and take care at home. All injury that occur on KDLO property will be handle as an Emergency bases and parent or guardian are require to comply with KDLO polices.

SY _____

KIN DAH LICH'I OLTA' EMERGENCY HEALTH FORM

Gender

MALE FEMALE

STUDENT: LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
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MOTHER/GUARDIAN NAME:	WORK NUMBER	CELL NUMBER	LOCATION OF HOME
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FATHER/GUARDIAN NAME:	WORK NUMBER	CELL NUMBER	LOCATION OF HOME
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ADDRESS	CITY	STATE	ZIP CODE
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EMERGENCY CONTACT (WHEN PARENT/GUARDIAN NOT AVAILABLE)

(1) CONTACT NAME: _____	(2) CONTACT NAME: _____
CONTACT NUMBER: _____	CONTACT NUMBER: _____
RELATION TO STUDENT: _____	RELATION TO STUDENT: _____
LOCATION OF HOME: _____	LOCATION OF HOME: _____
DOES THIS CONTACT HAVE PERMISSION TO PICK UP AND CARE FOR YOUR CHILD? ___ YES ___ NO	DOES THIS CONTACT HAVE PERMISSION TO PICK UP AND CARE FOR YOUR CHILD? ___ YES ___ NO

ALLERGIES/MEDICAL CONDITIONS TO BE AWARE OF:

___ ALLERGIES	___ EPILEPSY	___ DIABETES
___ SEASONAL	___ HEART PROBLEMS	___ NONE
___ FOOD: _____	___ RECURRING ILLNESS	
___ MEDICATION: _____	___ OTHER: _____	
___ OTHER (EXPLAIN): _____	COMMENT/SPECIAL INSTRUCTION: _____	
___ ASTHMA IS A PLAN OF ACTION NEEDED? ___ YES ___ NO		

A PHYSICIAN'S STATEMENT WILL BE REQUIRED FOR ALL FOOD ALLERGIES, MEDICAL CONDITONS, EPILEPSY MEDICATION, PRESCRIBED MEDICATION(S) OR EPI PEN. A MEDICATION CONSENT FOR WILL NEED TO BE COMPLETED AND SIGNED IF YOU CHILD SHOULD NEED HIS/HER MEDICATION ADMINISTERED DURING SCHOOL HOURS.

THE SCHOOL HEALTH OFFICE HAS LIMITS AS TO WHAT MEDICATIONS CAN BE ADMINISTERED TO STUDENTS. LISTED BELOW ARE WHAT IS AVAILABLE IN TREATING MINOR ILLESSES AND/OR INJURIES THAT MAY OCCUR DURING SCHOOL HOURS. WITH YOUR PERMISSION, AND AT THE DISCRETION OF THE SCHOOL HEALTH PROFESSIONAL, PLEASE INDICATE (WITH A CHECK) THE MEDICATIONS YOU GIVE CONSENT TO ADMINISTER.

___ YES ___ NO ACETAMINOPHEN (TYLENOL)	___ YES ___ NO ANTIBOTIC OINTMENT	___ YES ___ NO ANTIPRUITIC OINTMENT
___ YES ___ NO IBPROFEN	(FOR MONOR CUTS/SCRAPES)	(FOR ITCHING) * ANTI-ITCH CREAM
___ YES ___ NO ORGAL	___ YES ___ NO EYE DROPS	* HYDROCORTISONE CREAM
___ YES ___ NO COUGH DROPS		* CALADRYL LOTION

AS A PARENT OR LRGAL GUARDIAN OF THE ABOVE NAMED STUDENT, I ENTRUST KIN DAH LICH'I OLTA' HEALTH PERSONNAL TO CARE AND PROVIDE FOR MY CHILD'S HEALTH/MEDICAL CARE WHILE IN SCHOOL. IN THE EVENT OF AN EMERGENCY, I GIVE MY CONSENT FOR 911 TO BE NOTIFIED AND BE TRANSPORTED TO LOCAL HOSPITAL. THE SCHOOL HEALTH PERSONNEL HAS MY PERMISSION TO EXCUTE NECESSARY DECISIONS UNTIL MY ARRIVAL. I FURTHER UNDERSTAND THAT THE SCHOOL DOES NOT CARRY HEALTH INSURANCE FOR MY CHILD. FOR THAT REASON, I HAVE PROVIDED THE SCHOOL HEALTH OFFICE WITH THE REQUIRED INFORMATION.

SIGNATURE OF PARENT/LEGAL GUARDIAN

DATE

KIN DAH LICH'I OLTA'

SY: _____

HEALTH OFFICE

DEVELOPMENTAL HISTORY FORM

ALL INFORMATION IS KEPT CONFIDENTIAL. PLEASE FILL OUT THE FORM COMPLETELY.

NAME OF STUDENT: _____ DATE OF BIRTH: _____

A. FAMILY HISTORY

Who ALL lives in the home besides the student: _____

Are there any recent family problems? (Illness, accidents, separations, divorce, death): _____ NO _____ YES

Explain: _____

B. BIRTH/HEALTH HISTORY

Condition of infant at birth: _____ Any complications at birth? _____ NO _____ YES

Explain: _____

Does the student have problems with any of the following: (if yes, please explain)?

- Speech _____ Yes _____ No _____
- Heart _____ Yes _____ No _____
- Joint _____ Yes _____ No _____
- Extremities _____ Yes _____ No _____
- Abdomen _____ Yes _____ No _____
- Seizure _____ Yes _____ No _____
- Asthma _____ Yes _____ No _____
- Ears/Hearing _____ Yes _____ No _____
- Eyes/Vision _____ Yes _____ No _____
- Other _____ Yes _____ No _____

Has student ever been examined by an Eye Doctor? When? _____ Yes _____ No _____

Does he/she wear glasses? _____ Yes _____ No _____

Is Eye Prescription up-to-date? _____ Yes _____ No _____

Has student ever fainted or become unconscious? When? _____ Yes _____ No _____

Has student ever been hospitalized? Why/When? _____ Yes _____ No _____

Has student ever had any surgeries? Explain _____ Yes _____ No _____

Has student ever received Special Education Services? Grade/ School _____ Yes _____ No _____

Does student have a current IEP? _____ Yes _____ No _____

Has student had any of the following childhood diseases/illnesses: When?

- Chicken Pox _____ Yes _____ No _____
- Measles _____ Yes _____ No _____
- Mumps _____ Yes _____ No _____
- Hepatitis A or B _____ Yes _____ No _____
- Meningitis _____ Yes _____ No _____
- Pertussis (Whooping Cough) _____ Yes _____ No _____

Does student have problems with bedwetting or incontinence? How long? _____ Yes _____ No _____

Does student have any current behavioral problems? (Mental/Emotional) _____ Yes _____ No _____

Is student taking any prescribed medication? (Explain) _____ Yes _____ No _____

INITIALS OF PARENT/LEGAL GUARDIAN

DATE

SY _____

Medical Statement for Special Dietary Accommodations.

In order for your child to have their school meals modified or substituted please have a State Recognized Authority fill out this form in full.

OFFICE STAFF ONLY
Send to Nutritionist as soon as form is received.
Date Received: _____ Initials: _____
Complete: Incomplete:

Part I (To be completed by Parent/Guardian)

Name of Student (Last): _____ (First): _____ Date of Birth: ___/___/___

School Year: _____ Grade: _____ Student ID#: _____

Which Meals will the child eat at school? (please circle) Breakfast Lunch After School Snack

Parent/Guardian Name: _____ Phone Number: _____

I give Student Services/Child Nutrition Services permission to speak with the below named medical authority to discuss the dietary needs described below.

Parent/Guardian Signature _____ Date: _____

Part II (To be completed by a State Recognized Medical Authority only)

Medical Condition: _____

Does this medical condition restrict the student's diet? Yes No

If yes, please explain how the medical condition or disability restrict their diet:

Does the child have a food allergy? Yes No

If yes to any of the above questions, Part III must be completed and signed by a State Recognized Medical Authority. If no to both question accommodations are not required to be made through Child Nutrition Services.

Foods to be omitted due to food allergy or disability:

<input type="checkbox"/> Wheat	<input type="checkbox"/> Gluten	<input type="checkbox"/> Eggs	<input type="checkbox"/> All eggs protein (albumin, etc.)
<input type="checkbox"/> Soy Protein	<input type="checkbox"/> Milk	<input type="checkbox"/> All dairy products	<input type="checkbox"/> All milk protein (casein, whey, etc.)
<input type="checkbox"/> Seafood	<input type="checkbox"/> Peanuts	<input type="checkbox"/> All Nuts	<input type="checkbox"/> Tree Nuts

Other (please be specific): _____

Foods to be substituted: _____

Part III (to be completed and signed by a State Recognized Medical Authority)

This diet order is: ___ Permanent (this diet order will remain in effect during the time the student is enrolled at KDLO. A new diet order will be required to change any aspect of information provided in this diet order.)

This diet order is: ___ Temporary (this diet order is effective for the current school year. A new form will be required annually.)

Name of Medical Authority (please Print): _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Please read the backside

INSTRUCTIONS

Part I (to be filled out by parent or guardian):

Name of student: Enter the student's last name then first name in the appropriate fields.

Date of Birth: Enter the student's six-digit date of birth, e.g., May 12, 1988 = 05/12/88.

School Year: Enter the current school year that your child will be attending.

Circle which meals the child eats at school: You may circle multiple options. Please circle even if the child only eats the meals occasionally.

Parent/Guardian: Enter the full name of the student's parent(s) or legal guardian(s).

Phone number: Complete with the area code(s) and phone number, in case of emergency.

Signature of Parent/Guardian: Enter the signature of parent or legal guardian's name. Enter the date when the form was signed.

Part II (to be filled out by medical authority):

Medical Condition: Enter the patient's clinical diagnosis for the condition which requires dietary modification.

Circle Yes or No if the medical condition restricts the patient's diet.

Explain how the medical condition restricts their diet: This is description of the patient's conditions related to dietary modification. Indicate the necessary dietary modification and specify the changed to be made.

Check Yes or No if the child has food allergy.

Check all of foods that need to be omitted due to the food allergy, medical condition or disability. If the items are not listed, please fill in the additional foods items under "other".

Food to be substituted: State which food substitutions, if any, must be made related to the medical condition or food allergy.

Other dietary modification required: Provide an explanation of what must be done to accommodate the child if it is not listed above. For example, this could include caloric modification related to medical condition.

Check if the diet order is permanent or temporary. The diet order is permanent if the child will need to have dietary modifications for the rest of their life. The diet order is temporary if the diet modification is necessary for one year or less.

Name of Medical Authority: Print the name of the medical authority completing this form.

Medical Authority Signature: Enter the signature of the medical authority filing out the form and the dates signed. Enter phone and fax number.

Recognized Medical Authority: The seven medical professional listed below are permitted to complete and sign a medical statement for meal accommodations in the Child Nutrition Programs administered in Arizona.

- Physicians (A.R.S §§ 32-1454(N), 32-1491)
- Physician Assistants (A.R.S. §32-2532)
- Dentists (see A.R.S. §§ 32-1263.01€ , 32-1298)
- Nurse Practitioners (A.R.S. § 32-1663(G))
- Homeopathic Physicians (A.R.S. §§ 32-2934(O), 32-2951)
- Naturopathic Physicians (A.R.S. §§ 32-1501, 32-1551(I), 32-1581)
- Osteopathic Physicians (A.R.S. §§ 32-1855(J), 32-1871)

The Smiles Movement



PO Box 767
Camp Verde, AZ 86322

thesmilesmovement@gmail.com

Ph: 928-567-1832
Fax: 928-567-6500

Please return this form to the school!

DEAR CONCERNED PARENT:

Dental disease is the #1 reason children miss school. The Smiles Movement has been providing care for your children for over 30 years at no charge to you. You have a choice; you can choose to go through the process at IHS, or enjoy the convenience of having our experienced doctors care for your child at their school. We thank you for once again choosing our practice that over the years has served thousands of children. To participate, your child must be enrolled in an appropriate AHCCCS program which is easily done at most IHS facilities.

IF YOU CHOOSE TO HAVE YOUR CHILD CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name _____ Male _____ Female _____

Child's Social Security Number _____ Date of Birth ____/____/____

Emergency Contact _____ Phone # _____

School Name Kin Dah Lichii Olta Teacher's Name _____ Grade _____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Has your child had?	NO	YES		NO	YES
Allergy to medication	___	___	Heart Murmur	___	___
Rheumatic Fever	___	___	Bleeding Disorders	___	___
Psychiatric Treatment	___	___	High Blood Pressure	___	___
Seizure Disorder	___	___	Asthma	___	___
Diabetes	___	___	Hepatitis/Jaundice	___	___
AIDS/HIV Positive	___	___	Anemia	___	___
Hospitalizations	___	___	Latex Allergy	___	___
Vision or speech problems	___	___	Other Serious Illness	___	___
Could your child be pregnant?	___	___			

Is your child under a Physician's care? NO ___ YES ___

Is your child taking any medication? ___

Any problems with local anesthetic? ___

PLEASE EXPLAIN ANY "YES" ANSWERS: _____

What is your primary concern for your child's oral health? _____

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME
- WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME

CONSENT FOR TREATMENT
AND
ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1. YES. I give permission for my child to receive necessary treatment!
I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.
I consent to the sharing of this information with the IHS Dental program.

2. No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.

I understand that I may refuse to sign this Consent and Acknowledgement.

X _____ Date _____
Parent or Guardian

Please print your name _____

If you have any questions, please call our office at 928-567-1832



BIE Home Language Survey
School Year: _____
Kin Dah Lichi'i Olta'

First Name: _____ **Last Name:** _____

Federal Code: 25: CFR 32.3 & Revised CFR 30.109

"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:

"Provide a child centered learning environment that promotes student achievement embedded in cultural diversity toward meeting the demands of a global society."

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 that 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?**



BIE Home Language Survey
School Year: _____
Kin Dah Lichi'i Olta'

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 related to other languages within the home or school?

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.**



KIN DAH ŁICHÍ'Í ÓLTA'
HOME OF THE WOLVERINES



APPENDIX G
Kin Dah Lichi'i' Olta'
SY _____
Permission and Release to Publish
Student's First Name and/or Picture on the Media.

As the parent or guardian of _____, I understand the benefits
(Students Name)
and risks of publishing works on the Internet or other forms of publication. In consideration of the benefits of allowing my student to publish his/her work, first name and/or picture on the School's Web page or other forms of publication.

I hereby give permission for the student's

- a. First name and Last name ONLY to be published on the Web or other forms of publication.**

Name of student

Yes No Initials

OR

- b. First name and photograph with no identifying information to be published on the web or other forms of publication.**

Name of student

Yes No Initials

Further, I accept full responsibility for the publication of the student's name and/or picture as set forth in the publication attached hereto and agree to release and hold the School harmless from any and all damages or injury to me or to the student arising from said publication.

Parent or Guardian (printed)

Parent or Guardian (signature)

Date



KIN DAH ŁICHÍ'Í ÓLTA'

HOME OF THE WOLVERINES



APPENDIX I
Kin Dah Lichi'i' Olta'
SY _____
USER ACCEPTABLE USE AGREEMENT

Student User Name: _____ Grade: _____

I understand that my computer use is not private and that the School will monitor my activity on the computer system.

I have read the School's electronic communications system policy and administrative regulations and net etiquette guidelines and agree to abide by their provisions. I understand that violation of these provisions may result in suspension or revocation of system access and/or disciplinary action against me.

User's signature _____ Date: _____
(Student)

Parent Initial _____

Staff Signature/Title _____ Date: _____



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APPENDIX L
Kin Dah Lichi'i' Olta'
SY _____
PARENT/GUARDIAN ACCEPTABLE AGREEMENT, RELEASE AND WAIVER

Student Name: _____

Grade: _____

PARENT OR GUARDIAN

I do not give permission for my child to participate in the School's electronic communication system.

I have read the School's electronic communications system policy, administrative regulations and net etiquette information. In consideration for the privilege of my child using the School's electronic communications system and in consideration for my child having access to the public networks, I hereby release the School, its operators and any institutions with which they are affiliated from any and all claims and damages of any nature arising from my child's use of, or inability to use, the system including, without limitation, the types of damage identified in the School's policy and administrative regulations.

I give permission for my child to participate in the School's electronic communication system and certify that the information contained on this form is correct.

Signature of Parent or Guardian

Date

Phone Number



KIN DAH LICHÍ'Í ÓLTA'

HOME OF THE WOLVERINES



APPENDIX M
Kin Dah Lichi'i' Olta'
SY _____
Student Handbook-Parent Acknowledgement

I, _____, have read and discussed the Student Handbook with my child and I
(Parent/Guardians Name)
will support my child to abide by these rules and regulations.

Parent/Guardian Signature

Date:

Please return this form to your homeroom teacher within two weeks after enrollment or as established by the Principal

Kin Dah Lichi'i' Olta'
Student Handbook -Parent Acknowledgement

Check all that apply:

1. _____ I have read the KDLO Handbook
2. _____ My teacher has reviewed the Student Handbook with me.
3. _____ I understand and will abide by the rules and regulations.

Student Signature: _____

Date: _____

Teacher Signature: _____

Date: _____



KIN DAH ŁICHÍ'Í ÓLTA'

HOME OF THE WOLVERINES

APPENDIX N

Kin Dah Lichi'i' Olta'

SY _____

Notification and Acknowledgement of School Enrollment of
Truancy and Attendance Policies

Student: _____ Teacher: _____ Grade: _____

ARIZONA STATE TRUANCY LAW

A.R.S. §15-802 requires that a person having custody of a child between six (6) and sixteen (16) years of age must send the child to school full time when the school is in session, unless statutorily excused. Failure to ensure that a child attend school is a criminal offense and subjected to a fine of up to \$500 plus surcharges and a possible jail sentence of up to 30 days.

A.R.S §13-3613 and 13-3612 require parent(s) guardian(s) to not commit any act which causes, encourages or contributes to a child's dependency. A dependent child is one who, among other acts, refuses to attend school. Contributing to the Dependency of a Minor is a criminal offense, which carries a fine of up to \$2500 and a possible jail sentence of up to six (6) months in jail.

Pursuant to school policy, the school will notify the parent(s)/guardian(s) upon determining that the minor child is absent from school without permission. The parent(s)/guardian(s) must contact the school within twenty-four (24) hours of the notice regarding the unexcused absence and inform the appropriate school personnel the reason for the absence.

The school's attendance department must determine if the excuse is valid and acceptable. The attendance department may require further documentation to substantiate the reason for the absence. Students and parents must understand that school attendance is not a matter of choice, but a legal requirement.

NAVAJO NATION TRUANCY LAW

(Title 10 Subsection §502 Compulsory School Attendance-Generally §118) Education in Navajo schools shall be compulsory as to children between the ages of five (5) and eighteen (18) years as prescribed and defined in 10 NNC §118 of the Navajo Nation Education Code.

(Title 10 Subsection §503 Application of State Laws and Navajo Nation Laws §118) The Navajo Nation Council consents to the application of state compulsory school attendance laws to the Indian of the Navajo Nation and their enforcement on Indian lands of the Navajo Nation wherever an established public school district lies or extends within the Navajo Nation. In addition, 10 NNC §118 of the Navajo Education Policies regarding compulsory attendance shall apply to all Navajo minors between ages five (5) and eighteen (18) and to all persons having care and custody of such minors who are within the civil and criminal jurisdiction of the Navajo Nation.

I HAVE BEEN NOTIFIED OF THE ABOVE TRUANCY LAWS AND THE KDLO ATTENDANCE POLICIES AND ACKNOWLEDGE AND COMMIT TO COMPLIANCE WITH SAID POLICIES.

Parent/Guardian Name

Parent/Guardian Signature

Date



KIN DAH LICHÍ'Í ÓLTA'

HOME OF THE WOLVERINES



PARENT/SCHOOL COMPACT

TITLE 1

Kin Dah Lichi'i' Olta'

SY _____

Kin dah Lichi'i Olta' has been designed as a title school wide plan. All students in Kin dah Lichi'i Olta' are considered Title 1 students and are eligible for supplement education services.

At Kin Dah Lichi'i Olta' we feel that good communication between teachers and parents is essential to the education process. We send individual students' progress reports home to parents four times each year. We schedule a time for parents/teacher conferences three times each year for discussion about your child's teacher(s) at any time. You are encouraged to observe and participate in school and classroom activities throughout the school year. In addition to these activities, the following are the expectations of the school and from the parents to provide the best education for our students:

As a staff we will:

Give our best effort.

- Continuously expand your child's educational ability.
- Expect high quality performance.
- Expect social acceptable behavior.
- Discipline with dignity

As a parent I will:

- Contact the school with any concerns.
- Work with the school so my child can gain full potential from the education experience.
- Help teach responsible behavior to my child.
- See that my child attends school regularly.
- Encourage daily reading, interactive and limits television/video games.
- Stress the importance to my child to do their work.
- Set aside the time each day for homework.

As a student I will:

- Attend school regularly and be on time.
- Be prepared for class.
- Listen and participate in class.
- Respect and cooperate with teacher(s)/others.
- Follow all school rules.
- Complete and return all work/homework assignments.

I have read and agree to the above compact expectations. I will discuss them with my child.

Student's Signature

Parent/Guardian Signature

Date

Principal/RegistrarSignature

