Lukachukai Community Board of Education, Inc.
"Commitment to Children, Commitment to Progress"
7001 IR 12 P.O. Box 230
Lukachukai, Arizona 86507
Phone: (928) 291-0008 Fax: (928) 787-3191

STUDENT ENROLLMENT APPLICATION
School Year 2025-2026

Child Name: _____ **Grade:** _____

New Application Checklist

_____ Student Enrollment Application
_____ Withdrawal Slip from Previous School (If transferring from another school)
_____ Certificate of Indian Blood (CIB)
_____ Birth Certificate
_____ Updated Immunization with CURRENT YEAR (Computerized Copy Only)
_____ Updated Guardianship Documents (If necessary)
_____ Allergy form Required (If your child has a food/medication allergy)
_____ Physical Examination Form (5th -8th grade students who will participate in sports)
_____ Application for Free and Reduced-Price School Meals
_____ Health Packet
_____ IEP (If necessary)

Returning Student Application Checklist

_____ Student Enrollment Application
_____ Updated Immunization with CURRENT YEAR (Computerized Copy Only)
_____ Updated Guardianship Documents (If necessary)
_____ Allergy form Required (If your child has a food/medication allergy)
_____ Physical Examination Form (5th -8th grader who will participate in sports)
_____ Application for Free and Reduced-Price School Meals
_____ Health Packet
_____ IEP (If necessary)

Submit the application and required documents directly to Lukachukai Community School.
DO NOT SUBMIT TO AGENCY.

Approved by Principal: _____

Date: _____

STUDENT ENROLLMENT APPLICATION
UNITED STATES DEPARTMENT OF THE INTERIOR FOR STUDENTS ENROLLED IN THE BUREAU-FUNDED SCHOOL

1. STUDENT INFORMATION

Grade Applying For (Check One)	KG	1st	2nd	3rd	4th	5th	6th	7th	8th

Student Name	Last Name	First Name	Middle Name

Mailing Address	Address	City & State	Zip Code

Chapter Affiliation (Check One)	Lukachukai	Round Rock	Tsaile/Wheatfields	Other (What Chapter?)

Contact Information	Phone Number	Message Number	Email Address

Date of Birth & Gender	Month/Day/Year			Gender (Circle One)	
				Female	Male

Tribal Affiliation		Degree of Blood (Circle One)	¼	½	¾	Full	NA
Agency		Census Number					

2. FAMILY AND BACKGROUND INFORMATION (Please fill out all):

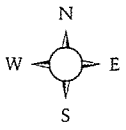
Mother / Legal Guardian (Circle One)		Father / Legal Guardian (Circle One)	
Name:		Name:	
Address:		Address:	
Home Phone #:		Home Phone #:	
Cell Phone #:		Cell Phone #:	
Emergency Ph #:		Emergency Ph #:	

3. OTHER SIBLINGS ATTENDING LUKACHUKAI COMMUNITY SCHOOL?

( ) **Yes** If yes, please list siblings below and circle grade. ( ) **No**

Name	Grade								
	KG	1st	2nd	3rd	4th	5th	6th	7th	8th
	KG	1st	2nd	3rd	4th	5th	6th	7th	8th
	KG	1st	2nd	3rd	4th	5th	6th	7th	8th
	KG	1st	2nd	3rd	4th	5th	6th	7th	8th

4. VERIFICATION OF HOME LOCATION: Physical Address



5. AUTHORIZATED STUDENT CHECK-OUT/EMERGENCY CONTACT LIST

I/WE AUTHORIZE THE FOLLOWING PERSON(S) TO CHECK OUT MY CHILD OR BE CONTACTED IN CASE OF EMERGENCY WHEN I AM NOT AVAILABLE OR CANNOT BE REACHED.

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

Name of Adult	Relationship to Child	Home Location	Phone Number

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

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Date

OMB Control No. 1810-0021 (Exp. 06/30/2026)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

Arizona Department of Education

Office of English Language Acquisition Services

Home Language Survey

The responses to this Home Language Survey (HLS) are used by the school to provide the most appropriate instructional programs and services for the student. **The answers below will determine if a student will take the Arizona English Language Learner Assessment (AZELLA).** Please respond to each of the three questions as accurately as possible. If you need to correct any of your responses, this must be done **before** the student takes the AZELLA Placement Test.

1. **What language do people speak in the home *most* of the time?**

   _____

2. **What language does the student speak *most* of the time?**

   _____

3. **What language did the student *first* speak or understand?**

   _____

Student Name_____ District Student ID_____

Date of Birth_____ SSID_____

Parent/Guardian Signature_____ Date_____

District or Charter_____

School_____

Please provide a copy of the Home Language Survey to the EL Coordinator/Main Contact on site.

In AzEDS, please enter all three HLS responses.

These HLS questions are in compliance with Arizona Administrative Code (R7-2-306(B)(1),(2)(a-c). (Revised 05-2023)

LUKACHUKAI COMMUNITY BOARD OF EDUCATION, INC.

'Commitment to Children, Commitment to Progress'

Phone #: (928) 291-0008 Fax #: (928) 787-3191

Home of the Eagles

Remind

Dear Parents/Guardians,

Keeping you informed is a priority at Lukachukai Community School. The Remind App is a notification service that allows our school to send text messages directly to your phone and provide important information re: school emergencies, delays, events and/or cancellations.

What you need to know about Remind App:

- ✓ Your contact information will be saved until you request to have it removed.
- ✓ Text message of general school announcement will be sent to your phone.
- ✓ You may respond with questions/answers.
- ✓ All conversations are saved.

The effective distribution of information depends on accurate contact information of each student. Therefore, please make certain that our school receives and files your most current phone numbers. If your phone number should change during the school year, please notify our school immediately.

We are excited to once again have Remind App as a communication system with our parents/guardians this school year.

If you have any questions re: our school's Remind App, please feel free to contact our school at (928) 291-0008.

( ) Include me in the school's Remind App messaging.

Phone #: (_____) _____ - _____

( ) Do not include me in the school's Remind App messaging.

Mission Statement

"LCBE, INC. provides a strong comprehensive curriculum that enhances and strengthens individuality and independence in our global societies."

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Technology Agreement and Release of Liability Form

Lukachukai Community School, Inc. (LCS, Inc.) authorizes students to use technology owned or otherwise provided by the school as necessary for instructional purposes. The use of technology is a privilege permitted at the school's discretion and is subject to the conditions and restrictions outlined in applicable policies, administrative regulations, and this Agreement. LCS reserves the right to suspend access at any time, without notice, for any reason. LCS expects all students to use technology responsibly to avoid potential problems and liability. LCS may restrict the sites, material, and/or information students can access through the system. Each student authorized to use school technology and his/her parent/guardian shall sign this Agreement to indicate that they have read and understand the agreement. LCS reserves the right to monitor and record all use of school technology, including, but not limited to, access to the Internet or social media, communications sent or received from school technology, or other uses. Monitoring/recording may occur at any time without prior notice for any legal purposes, including, but not limited to, record retention and distribution and/or investigation of improper, illegal, or prohibited activity and equipment provided by the school. All passwords created for or used on any school technology are the sole property of LCS. The creation or use of a password by a student on school technology does not create a reasonable expectation of privacy.

LCS technology includes, but is not limited to computers, the school's computer network including servers and wireless computer networking technology (Wi-Fi), the Internet, email, USB drives, wireless access points (routers), tablet computers, smartphones and smart devices, telephones, cellular telephones, personal digital assistants, pagers, wearable technology, any wireless communication device including emergency radios, and/or future technological innovations, whether accessed on or off site or through school-owned or personally owned equipment or devices.

Students/Parents are expected to use school technology safely, responsibly, and for educational purposes ONLY. Students shall not share their assigned online services account information, passwords, or other information used for identification and authorization purposes. They shall use the system only under the account to which they have been assigned. Since school technology is intended for educational purposes, students shall not have any expectation of privacy in any use of school technology. Students are prohibited from using school technology for improper purposes, including, but not limited to, use of school technology to:

1. Access, post, display, or otherwise use material that is discriminatory, libelous, defamatory, obscene, sexually explicit, or disruptive.

2. Bully, harass, intimidate, or threaten other students, staff, or other individuals ("cyberbullying").

3. Disclose, use, or disseminate personal identification information (such as name, address, telephone number, Social Security number, or other personal information) of another student, staff member, or other person, intending to threaten, intimidate, harass, or ridicule that person.

4. Infringe on copyright, license, trademark, patent, or other intellectual property rights.

5. Intentionally disrupt or harm school technology or other school operations (such as destroying school equipment, placing a virus on school computers, adding or removing a computer program without permission from the teacher or other school personnel, changing settings on shared computers).

6. Install unauthorized software.

7. "Hack" into the system to manipulate the school's or other users' data.

8. Engage in or promote any unethical practice that violates any law, policy, administrative regulation, or school practice.

9. Parents are responsible for the proper use of school-issued equipment. If damaged, parents must compensate the school for the replacement cost.

10. All equipment issued to your household must be returned immediately if your child(ren) is no longer enrolled with Lukachukai Community School. An appointment will be scheduled to retrieve the equipment

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If a student uses a personally owned device to access school technology, he/she shall abide by all applicable policies, administrative regulations, and this Agreement. Any such use of a personally owned device may subject the contents of the device and any communications sent or received on the device to disclosure according to a lawful subpoena or public records request. Suppose a student becomes aware of any security problem (such as any compromise of the confidentiality of any login or account information) or misuse of school technology. In that case, he/she shall immediately report such information to the teacher or other school personnel. Violations of the law, policy, or this agreement may result in revocation of a student's access to school technology and/or discipline, up to and including suspension or expulsion. In addition, violations of the law, policy, or this agreement may be reported to law enforcement agencies as appropriate.

The Children's Internet Protection Act (CIPA) was passed as mandated by the federal law enacted by Congress to address concerns about access to offensive content over the Internet on school and library computers. Our school and library comply with CIPA, providing technologies that go above and beyond content filtering to protect our children.

I am responsible for the security and care of the laptop. **Suppose items are stolen, lost, or damaged due to negligence or intentional misuse. In that case, the user will assume the financial responsibility for repair costs or the fair market value of the assessed equipment, determined by the LCS, Inc. IT department.** I understand that all laptop computers, equipment, and/or accessories that the cooperative has provided me are the property of Lukachukai Community School. I agree to the terms outlined. I am responsible for any damage, theft, or loss of the laptop computer and/or related equipment and accessories due to negligence. I understand that violating the terms and conditions set out will result in restriction and/or termination of my use of the laptop computers, equipment, and/or accessories, and may result in further disciplinary actions.

Student Name: _____ Grade: _____

Parent Name: _____ Parent Phone: _____

Chrome Book..... $400.00
Chrome Book Charger.....$20.00
HOTSPOT/WIFI
WI-FI Device..... $80.00
WI-FI Charger.....$10.00

All technology devices must be returned to LCS, Inc., before transcripts, withdrawal, and promotion certificates can be released.

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Name: _____

PHOTOGRAPH AND VIDEO RELEASE

Lukachukai Community School, Inc. (LCS, Inc) uses photographs and videos of our students in a variety of printed and online media, including, e-newsletters, the school's website, brochures, admissions materials, school sports activity, fundraising efforts, school activities in general the school's official social media outlets, and occasionally with local or national news media. We sometimes use students' names, images, and work samples to promote the school. These might include photographs, video/audio recordings, quotations, student writing, and artwork. In all digital communications, students are identified mainly by first name and the first initial of their last name (e.g., John D.). *Full names are never used in digital publications, but may be used in print publications when appropriate.*

Additionally, photographs, video, and/or audio tapes of student performances and student work samples intended for publication or display may be stored in the school archives and/or library for preservation.

This Media Release form requests your consent to use your student's name, image, words, and/or work in school publications and for the above archival purposes. Students whose families do not consent will be placed on a "Media Consent Denied" list.

This agreement covers only official LCS, Inc. publications intended for the general public. All students are presented with in-house publications such as classroom newsletters and online publications that are access-restricted and require passwords.

Please choose the option below, sign it, and return the form immediately.

MEDIA RELEASE FORM

Please check one of the options below, sign and date, and return to LCS, Inc.

I, being the parent or guardian of

_____A student

at LCS, Inc. hereby:

Consent:_____ Do NOT Consent: _____

...that video/audio recordings, photographs, electronic images, quotations, and sample work of or by my student may be used by LCS, Inc. for materials and publications, and may subsequently be digitally archived by LCS, Inc.

Failure to return this form will be regarded as "consent" by LCS, Inc.

Signature_____Date _____

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School Year 2025-2026 Application for Free and Reduced-Price School Meals

Complete one application per household. Please use a pen (not a pencil).

STEP 1 List ALL infants, children, and students up to and including grade 12 in your household (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member**: "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals.

Child's First Name	MI	Child's Last Name	School Name	Foster Child	Homeless, Migrant, Runaway
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR? Circle one: Yes / No

If you answered NO > Complete STEP 3. **If you answered YES** > Write a case number here then go to STEP 4 (Do not complete STEP 3) **Case Number:**

Write only one case number in this space.

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip to the back of this application and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income Section.

The "Sources of Income for Adults" chart will help you with the Adult Household Members Income Section.

A. Child Income

Sometimes children in the household earn income. Please include the TOTAL GROSS income earned by all Children Household Members listed in STEP 1 here.

Child GROSS income $ ____ How often? ☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly

B. All Adult Household Members (including yourself)

List only the Adult Household Members (including yourself) **even if they do not receive income**. For each Household Member listed, if they do receive income, report total GROSS income (amount before taxes and deductions) for each source in whole dollars only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	GROSS Earnings from Work	How often?	Public Assistance/ Child Support/Alimony	How often?	Pensions/Retirement/ All Other Income	How often?
	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly
	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly
	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$ Type text here	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly
	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly	$	☐ Weekly ☐ Bi-Weekly ☐ 2x Month ☐ Monthly

C. Total Household Members

(Children and Adults) ____

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X ____ **Check if no SSN** ☐

STEP 4 Contact information and adult signature

Mail Completed Form to: Lukachukai Community School 7001 IR P.O BOX230 Lukachukai AZ 86507

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Signature of adult completing the form ____ Today's date 7/1/25

Printed name of adult completing the form ____ Daytime Phone and Email (optional) ____

Street Address (if available) ____ Apt # ____ City ____ State ____ Zip ____

OFFICE USE ONLY

☐ Error Prone

Eligibility: Free___ Reduced___ Denied___

Determining Official's Signature: _____ **Date:** _____

☐ **Case # Application** ☐ **Foster Application** ☐ **Directly Certified: Date of Disregard:** _____

☐ **Income Application** ☐ **Homeless/Migrant/Runaway**

Household Size: _____

Total Income: _____ Per: ☐ Week ☐ Bi-Weekly (Every 2 Weeks) ☐ 2x Month ☐ Monthly ☐ Annual

☐ **Selected For Verification:** Confirming Official's Signature: _____ Date: _____

Follow-Up Official's Signature: _____ Date: _____

INSTRUCTIONS Sources of Income

Sources of Income for Children	
Type of Income	**Examples**
Earnings from work	A child has a job where they earn a salary or wages.
Social Security -Disability payments	A child is blind or disabled and receives Social Security benefits.
-Survivor Benefits	A parent is disabled, retired, or deceased and their child receives social security benefits.
Income from persons *outside* the household	A friend or extended family member *regularly* gives a child spending money.
Income from any other source	A child receives income from a private pension fund, annuity or trust.

Sources of Income for Adults		
Earnings from Work	**Public Assistance/ Alimony/Child Support**	**Pensions/Retirement/All Other Income**
- Salary, wages, cash bonuses - Net income from self-employment (farm or business) **If you are in the U.S. Military:** - Basic pay and cash bonuses *(do not include combat pay, FSSA, or privatized housing allowances)* -Allowances for off-base housing, food and clothing	- Unemployment benefits - Workers Compensation - Supplemental Security Income (SSI) - Cash Assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private Pensions or disability - Regular income from trusts or estates - Annuities - Investment Income - Earned Interest - Rental Income - Regular cash payments from outside household

OPTIONAL Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced-price meals.

Ethnicity (check one):

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more):

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.
To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:
mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; or
fax: (833) 256-1665 or (202) 690-7442;
or email:Program.Intake@usda.gov

This institution is an equal opportunity provider.

CLEAR BAG POLICY

For Students:

In an effort to improve the safety measures currently in place, LCBE, Inc. requires all KG-8th students to use clear backpacks. Students participating in an extracurricular activity are permitted to carry non-transparent bags to store items pertaining to their particular activity (i.e. athletics, overnight). Upon entry into the school, all extracurricular activity bags must be stored in lockers or designated areas. All bags are subject to search. Additionally, the maximum size for non-transparent bags that students in grades 6-8th are permitted to carry during the school day, such as pencil bags and purses, will be 6" x 9". Residential students are allowed to continue using their luggage items; all bags are subject to search.

For Visitors and Spectators:

The clear bag policy at LCBE, Inc. will help ensure the safety of our students, staff, and guests.

As one of our ongoing security measures to help ensure the safety of our students, staff, and guests; we have a clear bag policy in place at school related events:

- Athletic events
- Programs and ceremonies
- Parent Teacher Conferences
- All other school activities (i.e. meetings)

This policy will limit the size and type of bags allowed for visitors and spectators.

- Clear tote - plastic, vinyl or PVC bags that do not exceed 12" x 6" x 12"
- Plastic storage bag - Clear one (1) gallon, re-sealable
- Small clutch size - approximately the size of a hand with or without a handle or strap. No larger than 6.5" and 4.5" with or without a handle or strap
- An exception will be made for medically necessary items after proper inspection. Please limit the number of items you bring to the LCBE, Inc..

Prohibited Items

Prohibited items include, but are not limited to:

- NO outside food and drinks
- All purses, bags or containers larger than a small clutch
- Backpacks
- Briefcases
- Camera Bags
- Fanny Packs
- Computer Bags
- Coolers
- Luggage of any kind
- Diaper Bags
- Drawstring Bags

Lukachukai Community Board of Education, Inc.
"Commitment to Children, Commitment to Progress"
7001 IR 12 P. O. Box 230
Lukachukai, Arizona 86507
Phone: (928) 291-0008 Fax: (928) 787-3191

Dear Parent (s) / Guardian (s),

WELCOME to School Year 2025-2026.

You will find a list of things you will need to bring for your child to complete his/her health packet. These are required documents that need to be filed in his/her health record. **ALL** medical information will be kept **CONFIDENTIAL**.

Every year we require new forms to be filled out so we can ensure that we have up to date parent / guardian contact information, medication, health condition or any changes.

Epi-pens and Albuterol are **not** supplied by the school. We ask the parent to please bring prescription medications to the health office and fill out a medication administration form and/or action plans signed by a prescriber prior to administering prescription/Over the counter (OTC) medication.

The school's designated staff will administer limited Over the counter (OTC) medication such as; Children's Benadryl, Children's Tylenol and Children's Pepto-Bismol.

Update all information regarding any changes in addresses, mailing address, any form of phone contact, medical (Immunization or health condition) and household changes.

We are looking forward to a safe and healthy school year.

Please check off all documents

___ Health Authorization Form
___ Medication Administration Form **(for prescribed/OTC medication)**
___ Physical Exam Form (**NOT** AIA Forms)
___ Immunization Form **(updated)**
___ Dental Permission Form **(IHS)**
___ The Smiles Movement

Grade _____Home Room Teacher_____

HEALTH AUTHORIZATION FORM

School Year 2025-2026

PURPOSE: To enable parents/guardians to AUTHORIZE emergency treatment for a child who becomes ill or injured while under school authority, when parents cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/ guardian. **PLEASE COMPLETE ALL THREE SECTIONS!**

Last Name:	First Name:	M. I	Gender:	D.O.B:

SECTION ONE - STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school health Office will always attempt to reach the Parent/Guardian listed below **FIRST**. Secondary contacts will be called if the parent/guardian cannot be reached. **PLEASE KEEP THESE NUMBERS CURRENT!**

Mother/Guardian Name: □ Lives with □ Legal Guardian	Address:	Phone No. Phone No.
Father/Guardian Name: □ Lives with □ Legal Guardian	Address:	Phone No. Phone No.
Emergency Contact Listing:	**Relationship to Student:**	**Phone No.**
1.		
2.		

Other Siblings attending LCS

Name	Grade	Name	Grade
1.		3.	
2.		4.	

SECTION TWO – STUDENT HEALTH HISTORY – please check appropriate box

□ My child has no health conditions including those listed below:

Allergies: □ Seasonal	□ Food (List):	□ Other Allergy (List):	□ Has EpiPen Prescription
□ ADD/ADHD	□ Congenital/Genetic	□ Ear/Nose/Throat	□ Pulmonary (Other than Asthma)
□ Asthma Needs Inhaler at School: Y N	□ Eyes/Vision Wears Glasses/Contacts: Y N	Diabetes (circle one) Type 1 Type 2	□ Cardiovascular (list) _____ High Blood Pressure: Y N
□ Cancer	□ Dermatologic/Skin	□ Stomach/GI	□ Musculoskeletal
□ Long Term Medications (List):	□ Eating Disorder	□ Bladder/GU	□ Dental/Oral
	□ Endocrine other than Diabetes	□ Hematology/Bleeding Disorders	□ Psychiatric (List Meds):
□ Any other Health Conditions:		□ Migraines	

- My child may be given an antacid for upset stomach: □ Yes □ No
- My child may be given Tylenol for fever or discomfort: □ Yes □ No
- My child may be given Benadryl for allergies, runny nose, sneezing, watery eyes, and itchy nose or throat: □ Yes □ No

SECTION THREE – INSURANCE INFORMATION

Student's Name:	Subscriber's Name:	ID#:

TO GRANT CONSENT

In case of an emergency involving my child AND I CANNOT BE REACHED; I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's provider listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only.

- **I understand health screenings (including vision, hearing, height, weight, blood pressure) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings.**

Parent/Guardian Signature: _____Date:_____

BUREAU OF INDIAN EDUCATION
AUTHORIZATION TO ADMINISTER PRESCRIBED/OVER-THE-COUNTER MEDICATION

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize designated and properly instructed school personnel to administer prescribed medication as directed by the prescribing physician or other duly licensed provider (PART II below). I certify that I have legal authority to consent to the administration of prescribed medication following the provider's order. I understand additional prescriber/parent authorizations will be necessary for each medication to be administered, and if the dosage of the medication is changed. If necessary, I authorize the designated school health care official to communicate with the prescriber or the student's health care provider as allowed by HIPAA.

STUDENT INFORMATION

Student Name _____ **Date of Birth** _____ **Gender M** ____ **F** ____
Last First MI

School: LUKACHUKAI COMMUNITY SCHOOL **Grade**_____ **School Year**_____ **Height (inches)** _____ **Weight (lbs)**_____

List all medication(s) student is taking, including over-the-counter medication(s):

_____

_____

List any known drug allergies/reactions: _____

Parent/Guardian Signature _____ **Date** _____

Contact Number(s): _____ **(Day)** _____ **(Evening)**

PART II—TO BE COMPLETED BY THE PRESCRIBER

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ **Diagnosis:** _____
Dosage: _____ **Time(s)/Frequency to be given:** _____
Route of Administration: _____ **PRN (as needed) ___Yes ___No If PRN, (signs/symptoms):** _____
_____
Side Effects:_____
Begin Medication: _____ **Stop Medication:** _____
Date Date

Special Instructions:
Refrigeration required? ____Yes ___No
Is medicine a controlled substance? ____Yes ___No
Is this an emergency self carry/self administration medication? ___Yes ___No
Has student been instructed in the proper self administration of medicine? ___Yes ___No

Prescriber's authorization for self carry/self-administration of emergency medication: _____
Signature Date

Prescriber's Name/Title: _____ **Phone**_____
(Type or Print)

Address:_____ **Fax**_____
Prescriber's signature: _____ **Date**_____

PART III—TO BE COMPLETED BY School Nurse/Other Duly Licensed Health Care Provider

□ Parts I and II above are completed, including signatures.
□ Prescription medication is properly labeled by a pharmacist and within the expiration date.
□ Medication label and prescriber order are consistent.
□ Over-the-counter medication is in an original container with manufacturer's dosage label intact.

Principal/Authorized School Personnel Signature _____**Date**_____

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SPORTS PARTICIPATION PHYSICAL EXAM FORM

Name:	DOB:	Date of Visit:

Ht: _____ **Wt:** _____ **BMI:** _____ **HR:** _____ **BP:** _____

Vision: R: 20/_____ L: 20/_____ **Corrected:** Yes or No

Allergies: (Food and Medicine): **Medications:**

Significant Past Medical History:

History of Concussion: Yes or No **Family History of Sudden Death:** Yes or No

PHYSICAL EXAM	NORMAL	ABNORMAL
MEDICAL		
Appearance		
HEENT		
CV		
Lungs		
Abdomen		
Genitourinary		
Skin		
Musculoskeletal		
Neck		
Back		
Shoulder/Arm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Neuro		

Notes: _____
□ **Cleared Without Restrictions**
□ **Not Cleared for:** □ **All Sports** □ **Certain Sports** _____ □ **Reason:** _____
Recommendations: _____

Name of Provider (Print) _____ **Exam Date:** _____

Address: _____ **Phone:** _____

Signature of Provider: _____ **MD/DO/NP/PA-C**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Health Services Administration

Chinle Comprehensive Health Care Facility
Indian Health Service
P.O. Box PH
Chinle, Arizona 86503

April 30, 2025

Dear Parent or Guardian,

In partnership with your child's school, the Chinle Service Unit Dental Clinics of the Indian Health Service will be performing screenings, sealants, and fluoride treatments during the 2025 – 2026 school year. With your permission, your child can be transported with classmates from the school, be seen by a dentist, and transported back to the school.

Studies have shown that children with poor oral health do not perform as well in school. Oral pain in children has been associated with greater numbers of absences from school and lower Grade Point Averages. Giving permission for your child to have this screening will enable us to diagnose any oral health problems you may not be aware of. Application of Fluoride varnish helps increase the strength of tooth enamel making teeth less susceptible to tooth decay. Sealants are applied to grooves and pits of teeth to prevent bacteria from getting in the grooves and causing tooth decay. Sealants and fluoride treatment have both been found to significantly reduce the incidence of tooth decay.

The above procedures are useful and helpful in helping your child have an enjoyable time at school and to reach their learning potential, but most important is regular brushing and flossing of teeth with a fluoridated toothpaste and helping them to avoid drinking sugar containing or diet drinks and eating candy between meals.

After the screening, the school nurse will send a report of our findings to you and if sealants were needed and placed. We will also let you know on the report if further treatment is needed. If further treatment is needed please call one of our clinics below to schedule your child.

We are excited to offer this care in partnership with your child's school, and to be able to help your child have optimal oral health. For us to see your child during this event, please fill out the attached forms and return them to your child's teacher.

Respectfully,

Benjamin Glick DMD
Dental Program Director
U.S. Indian Health Service; Navajo Area; Chinle Service Unit

Chinle Dental Clinic
Chinle Hospital
928-674-7152 (Adults)
928-674-7154 (Under 13 Y.O.)

Pinon Dental Clinic
Pinon Health Center
928-725-9505

Tsaile Dental Clinic
Tsaile Health Center
928-724-3618

Chinle Comprehensive Health Care Facility
Indian Health Service
P.O. Box PH
Chinle, Arizona 86503

Student Information

Student Name: _____ Teacher: _____ School: _____

DOB: _____ Census#: _____ CHC#: _____ Grade: _____

FAMILY CONTACT INFORMATION:

Please check the check box to indicate primary contact:

☐ Mother / Legal Guardian Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

☐ Father / Legal Guardian Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Primary Mailing Address: _____

INSURANCE INFORMATION: The Chinle Dental Clinics are part of Indian Health Services. Therefore, they will bill insurance and AHCCCS accordance with Indian Health Service policies. You will not receive a bill or owe any money for this service.

Insurance Company Name: _____

Address: _____ Group Number: _____

Employer or Group Insured: _____

Medical History

Allergies: If yes, to what:	☐ Yes	☐ No	Excessive Bleeding:	☐ Yes	☐ No
Liver Disease / Hepatitis	☐ Yes	☐ No	Heart / Vascular Diseases:	☐ Yes	☐ No
Seizures:	☐ Yes	☐ No	Heart Murmur:	☐ Yes	☐ No
Asthma: Use inhaler? If so, what medicine:	☐ Yes	☐ No	Takes medication: If yes, what?	☐ Yes	☐ No

Other Chronic Illness, bad reactions to medicine and treatment: _____

_____

I have indicated above any chronic illnesses, allergies and any bad reactions to medicine my child has had in the past.

_____ _____

Parent / Guardian name and signature Date

CONSENT FORM

Student's Name: _____ DOB: _____

1. I want my child to be seen during this event and give permission to the following to be performed, **indicated by my initials** in the line in front of each paragraph:

_____ **Dental screening** performed by licensed I.H.S. Dentist or Dental Hygienist. We can't fix it, if we don't know what is broken. This screening will include looking closely at the teeth for caries, evaluating the health of the gums, include an oral cancer screening, evaluation and evaluation of the TMJ and orthodontic relationships. (Please initial your consent for the dentist to perform a dental exam).

_____ **Fluoride varnish** is effective in preventing and reversing the early signs of dental caries (tooth decay). Fluoride incorporates into the tooth structure making it stronger resulting in teeth that are more resistant to decay. Fluoride also acts to repair areas in which minor decay may have already begun. Fluoride treatments are most effective when applied after all the plaque and build up have been removed from teeth during a dental cleaning. With consent we will apply fluoride to your child's teeth after they are cleaned. (If you do not consent, we will perform the cleaning and not apply Fluoride varnish).

_____ **Dental sealants** are "plastic like" materials placed in the pits and fissures (grooves) of teeth to prevent bacteria from growing in the "crevices" and causing caries. Pits and fissures of teeth are often difficult areas to get clean, and often the bristles of the brush may not even be able to enter these pits and fissures to remove dental plaque. Dental sealant is used to fill in these "Crevices" to keep plaque out. Dental sealants have been shown to be safe and very effective at reducing decay rates. Regular checkups are important to ensure sealants are not broken which could lead to dental decay. The application of sealants is painless, but as with any dental procedure sometimes gagging or swallowing of dental materials (non-toxic) could occur. For a few days after sealant placement your child may notice minor changes to their bite, this will become less noticeable as the excess sealant material wears away over time. (If you would like us to place dental sealants, on any teeth that they are indicated for, please place your initials on the appropriate line).

_____ _____

Parent / Guardian Name and Signature Date

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_____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
Allergy to medication	___	___
Rheumatic Fever	___	___
Psychiatric Treatment	___	___
Seizure Disorder	___	___
Diabetes	___	___
AIDS/HIV Positive	___	___
Hospitalizations	___	___
Vision or speech problems	___	___
Could your child be pregnant?	___	___

	NO	YES
Heart Murmur	___	___
Bleeding Disorders	___	___
High Blood Pressure	___	___
Asthma	___	___
Hepatitis/Jaundice	___	___
Anemia	___	___
Latex Allergy	___	___
Other Serious Illness	___	___

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 AKNOWLEDGEMENT 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

PLEASE TURN OVER AND COMPLETE