2023-2024 STUDENT REGISTRATION FORM FOR PINE RIDGE SCHOOL/BUREAU FUNDED SCHOOL

STUDENT'S NAME: _____ GRADE: _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ GENDER: _____ PLACE OF BIRTH: _____

CELL PHONE: _____ EMAIL: _____

DISTRICT WHERE STUDENT IS ON CENSUS: _____ STUDENT ENROLLED IN A TRIBE: YES ☐ NO ☐

IF YES, NAME OF TRIBE: _____ ENROLLMENT #: _____

NAME OF HOME AGENCY: _____ BLOOD DEGREE: _____

FATHER'S NAME: _____
FIRST MIDDLE LAST

HOME PHONE: _____ CELL: _____ WORK: _____

MAILING ADDRESS: _____ PHYSICAL ADDRESS: _____

EMAIL: _____

TRIBE AFFILIATION: _____ ENROLLMENT #: _____

HOME AGENCY: _____ BLOOD DEGREE: _____

MOTHER'S NAME: _____
FIRST MIDDLE LAST

HOME PHONE: _____ CELL: _____ WORK: _____

MAILING ADDRESS: _____ PHYSICAL ADDRESS: _____

EMAIL: _____

TRIBE AFFILIATION: _____ ENROLLMENT #: _____

HOME AGENCY: _____ BLOOD DEGREE: _____

LEGAL GUARDIAN: _____ **OTHER (group home, etc.)**

HOME PHONE: _____ CELL: _____ WORK: _____

MAILING ADDRESS: _____ PHYSICAL ADDRESS: _____

EMAIL: _____

I am legally responsible for this student and hereby apply his/her admission to this school. I understand that additional information may be requested by the school before & after the student is enrolled.

Parent/Guardian Signature: _____ Date: _____

Approved ☐ Not Approved ☐ Registrar: _____ Date: _____

Bus:
Physical directions to your home and house #: _____
_____
_____

List 2 contact names and contact numbers for EMERGENCY & CHECK OUT:

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

(Please remember parents are allowed to check out their child unless there is a custody statement on file. Only other persons stated on the student check out list will be allowed to check out students)

List any Siblings registered here at Pine Ridge School:
Name: _____ Grade: ____ Name: _____ Grade: ____
Name: _____ Grade: ____ Name: _____ Grade: ____
Name: _____ Grade: ____ Name: _____ Grade: ____
Name: _____ Grade: ____ Name: _____ Grade: ____

SCHOOLS PREVIOUSLY ATTENDED: (PRS REGISTRAR FAX: 605-867-2386)

School Name: _____ Student on a Current IEP (SPED)? Y or N

Phone #: _____ Fax: _____

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

School Name: _____ Student on a Current IEP (SPED)? Y or N

Phone #: _____ Fax: _____

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

School Name: _____ Student on a Current IEP (SPED)? Y or N

Phone #: _____ Fax: _____

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

U.S. Department of Education Office of Indian Education Washington, DC 20202

TITLE VI ED 506 INDIAN STUDENT ELIGIBILITY CERTIFICATION FORM

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count. You are not required to complete or submit this form. However, if you choose not to submit a form, your child cannot be counted for funding under the program. This form should be kept on file 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 _____ (As shown on school enrollment records) Name of School

TRIBAL ENROLLMENT

Name of the individual with tribal enrollment: _____

(Individual named must be a descendent in the first or second generation)

The individual with tribal membership is the: _____ Child _____ Child's Parent _____ Child's Grandparent

Name of tribe or band for which individual above claims membership: _____

The Tribe or Band is (select only one): _____ Federally Recognized _____ State Recognized _____ Terminated Tribe (Documentation required. Must attach to form) _____ 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. (Documentation required. Must attach to form)

Proof of enrollment in tribe or band listed above, as defined by tribe or band is:

A. Membership or enrollment number (if readily available) _____ OR

B. Other Evidence of Membership in the tribe listed above (describe and attach)

_____

Name and address of tribe or band maintaining enrollment data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

ATTESTATION STATEMENT

I verify that the information provided above is accurate.

Name Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Date _____

Pine Ridge School

Bilingual

Certification

Program

Student Name: _____

Date of Birth: _____ **Grade:** _____

(print) Parent/Guardian: _____

My child's native language is _____. My child is knowledgeable of English and both are spoken in the home and at school.

I give permission for my child to participate in the Bilingual Program offered at the Pine Ridge School.

_____ ___/___/___

Signature of Parent/Guardian **Date**

PINE RIDGE SCHOOL

Parental Permission for School Health Program and Routine Medical Care by Indian Health Service

Child's Name: _____ **Grade:** _____

The following are routine health care services, provided in school facilities by school health personnel with secondary services provided by the Pine Ridge IHS Pediatrician or Physicians.

1. **Administer prescribed or over the counter medications**
2. **Apply bandages, dressing, or topical medications for the treatment of dry lips, lacerations, abrasions, impetigo, minor burns, scabies, ring worm and cold sores.**
3. **Apply elastic bandages to sprains.**
4. **Transport children and meet parent at I.H.S. or other medical facilities <u>for emergency treatment only.</u>**
5. **Provide physical assessment to check for signs or symptoms of illness.**
6. **Provide head checks to all students three times a school year. (See student handbook for detailed policy)**
7. **Any other treatment deemed necessary by the school nurse, for the safety and wellbeing of the student.**

List any medications child is taking: _____

List any medical problems/Drug Allergies/Food Allergies: _____

_____

(Drug Allergies/Food Allergies must be supported with a doctor's statement)

List any physical problems and/or limitations: _____

_____

List any diseases or ailments your child has had: _____

_____

I give permission & authorize Pine Ridge School staff to give my child the selected medicine:

☐ **Acetaminophen (non-aspirin)** ☐ **Antacid** ☐ **Cough Drops**
☐ **None of the above**

Parent Signature: _____

Persons to contact in case of an emergency:

Name: _____ **Relationship:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Name: _____ **Relationship:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUPLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

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

Student Name: _____

Date of Birth: _____ Grade: _____

Medicaid#: _____

I have read the consent form for the Indian Health Services to arrange for or to provide the following health services for my child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures and skin tests.
2. Dental care including dental examinations, preventive use of fluorides and necessary emergency dental procedures.
3. Mental health services including evaluations, referrals and treatment as necessary.
4. Transportation of the child to and/ or from another health facility for these services.

○ I hereby give consent for all of the above services.

○ Exceptions or special instructions: _____

_____

_____

Parent/Guardian Signature:

_____

Date: _____

Valid until: _____

PINE RIDGE SCHOOL

PARENTAL PERMISSION SLIP

Grade: _____

Student Name: _____

OFF CAMPUS ACTIVITIES:

My child has permission to attend and participate in off campus activities under the auspices of the Pine Ridge School. Activities may include, but are not limited to, academic, social, counseling, athletic and recreational (class field trips, end of the year trips, etc.). I understand the students will be properly chaperoned by the school personnel and all precautions will be taken to insure my child/children's safety. I understand that these trips may be overnight and may cross state lines. I agree that the reasonable cause and assurance for the health and safety of all students, Pine Ridge School Staff may act in loco parentis.

Parent/Guardian Signature:

_____

Date: _____

BIE McKinney-Vento Enrollment/Referral

The purpose of this form is to address the requirements of the McKinney-Vento Act, Title X, Part C of the No Child Left behind Act. This document wilt be used to share with school staff and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

1. Is your current address a temporary living arrangement? Yes___ No____

2. Is your temporary address due to loss of housing or economic hardship? Yes____ No____

If answer to both questions is, "YES", please continue, otherwise stop here. Thank you!

Student Information

Student Name(s) _____

Age(s) _____

Grade Level(s) _____

School Site(s) _____

Parent/Guardian Name(s): _____

Parent/Guardian/Youth phone number: _____

○ Cellular phone ○ Work Phone ○ Shelter Phone ○ Family/Friends Residence

Residency Information

Are you a high school student who is currently living on your own? Yes____No____

Where does the student stay at night?

☐ Shelter ☐ Temporary Housing ☐ 0ther: _____

Address/Directions: _____

_____

Shelter Contact Person: _____

The family/youth has been residing within the school district boundaries and intend to stay. (Please initial) _____

Does the student wish to continue at school of origin? Yes ___ No___

- Is school of origin a boarding school? Yes ___ No___
- If present school is a boarding school, will student be enrolled in residential dorm? Yes ___ No___

Agreed Upon Services

Educational Services Description: _____

_____

After-school Services Description: _____

_____

Transportation Services

Pick-up Location: _____

Drop-off Location (if different):_____

Health Services

Immunizations: _____

Dental: _____

Food/Clothing: _____

Free Lunch: _____

Counseling: _____

The parent/guardian/youth understand that the agreed upon services are supplemental to the regular instructional day and will be re-evaluated to determine which need to be continued. In the event that the family/youth residency changes, it is their responsibility to notify School Liaison/Designee immediately.

_____ _____

Parent/Guardian/Youth Date School Liaison/Designee Date

Pine Ridge School

Bus Route Form

Student Names & Grades:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

CHECK ONE:

- ☐ Martin, Allen, Batesland, Wakpamni, Wolf Creek
- ☐ Kyle, Sharps, Evergreen, Porcupine, Wounded Knee
- ☐ Rockyford, Manderson, Wounded Knee
- ☐ Oglala-High School
- ☐ Oglala, North Ridge, Trailer Courts-Elem & MS
- ☐ Pine Ridge-Elementary
- ☐ Pine Ridge-High School
- ☐ Red Shirt, White River, #6
- ☐ Slim Buttes, White Clay, Fraggle Rock, Cherry Hill
- ☐ #4 off road

Physical Directions to your Home:

_____

_____

_____

_____

Parent/Guardian Name & Phone Numbers:

_____

_____

Pine Ridge School

PHOTO/VIDEO RELEASE

Student's Name: _____ Grade: _____

Print Parent's/Guardian's Name: _____

Date: _____

Parent's/Guardian's Signature: _____

☐ I hereby grant unto my child's school permission to use my child's photograph and/or videotaped image for School Activities, Website & Newsletter Publication. I understand and agree that Pine Ridge School may use these photos and/or videotaped images unless I revoke this authorization by notifying the school Registrar in writing. I further grant unto Pine Ridge School permission to allow my child to be photographed, audio/ videotaped, or interviewed by the news media or other organizations for school related stories or articles.

☐ I do not grant unto Pine Ridge School permission to use my child's photograph and/or videotaped image for School Activities and newspaper publication.

Do you have internet access at home? YES ☐ NO ☐

Do you have a computer or tablet at home for your child to do homework? YES ☐ NO ☐

TRIO Educational Talent Search (TS)

The University Of South Dakota

Participant Application 2022

6-12th ONLY!

PLEASE FILL OUT COMPLETELY IN BLUE OR BLACK INK!

STUDENT INFORMATION ***needed for program requirements. All information will remain confidential***

Student Last Name: _____ First Name: _____ MI: ____

Age:_____ Birth Date: ____/____/_____ Gender: Female Male

Citizenship: US Citizen Perm Resident. # A_____ Other _____(attach verification)

Student email address: _____ Address if diff than parent(s): _____

Ethnicity: American Indian Asian Black Hispanic White Pacific Islander Two or more

Current Grade:_____ Student is in Upward Bound MSIP Gear Up Out of school adult

School attending: _____ Highest grade completed: _____

(Expected) **high school graduation** year: _____ or GED completion date (mm/yy):___/___

PARENT/ GUARDIAN INFORMATION**: Full Name(s):** _____

Address: _____ City/ State: _____, _____ Zip: _____

Phone: _____ or _____ Parent email: _____

1. Does either guardians in the home have a 4 year college (bachelor) degree? Yes No
2. Number of Household Members: _____
3. **Income**: I certify that my total household **taxable income** during the last calendar year was $_____.

Form 1040. Taxable income is on line 15 on the 2021 tax form. This is the income **AFTER all the deductions** have been taken out.
(You don't have to disclose your income if you receive any form of public assistance).

Family receives Public Assistance (ex: EBT, WIC, Medical Assistance, CHIP, TANF, General Assistance) Yes No

Student is ward of the court Yes No

Student resides in foster home Yes No

Current Plans:

4 yr College/ University 2 yr College 2 or 4 year Tribal College GED

Vo-Tech School Military Other: _____

Talent Search Services requested: Please check all that apply.

Tutoring	Acad. Counseling	Goals/ Decisions Making	Financial Aid/ FAFSA
Study Skills	Career Awareness	Cultural Awareness Activ.	Scholarship Search
Self Esteem	Computer Assistance	College Preparation	Summer Program
Campus Visits	Family Activities	Acquiring Adult Life Skills	GED Assistance
Other Field Trips	Problem Solving	ACT Preparation	Other: _____

I certify the above information is correct. I give permission to the TRIO Talent Search Program to provide services and to obtain information necessary to determine program eligibility and assistance needed, including transcripts, student email address(es), income verification, test scores and eventually college enrollment verification.

A dependent student under the age of 24 must obtain a parent signature. Contact your TS advisor for questions regarding dependency status. Unless you indicate otherwise, we may publish your picture on display boards or in TS newsletters, local newspapers, and brochures.

☐ I do not want my picture published.

_____ _____ _____ _____

Student Signature Date **Parent/ Guardian** Signature Date

OFFICE USE ONLY: TS Entry Date: ___/___/____ TS Staff: _____ LI FG LIFG Other

Director Signature: _____

DELTA DENTAL

Delta Dental Mobile Program
Patient Information Form

Please fill out this form completely. If you have questions, please ask a Delta Dental staff member. Thank You!

Patient's Legal Name _____ **Birth Date** (mm/dd/yyyy) _____

School Attending _____ **Grade** _____ **Age** _____ **Sex** (circle) M F

Ethnicity: (circle) *White* *Black or African American* *Asian* *American Indian* *Hispanic/Latino* *Other*

Home Address _____
Mailing Address City State Zip

Phone Numbers: Home (____) _____ Work (____) _____
Cell (____) _____

Parent/Guardian Name _____ Relation to patient _____

Emergency Contact: Person to contact in case of an emergency
Name _____ Relation to patient _____ Phone (____) _____

Income: Which of these best represents your annual household income? (circle one)
Less than $10,000 *$10,000-20,000* *$20,000-30,000* *More than $30,000*

Household Size: How many children age 21 or younger live in your household? _____

Dental History Note: Dental visits should start at first tooth.	Yes	No	
Is this the patient's first dental visit? Past or current dentist name_____			If no, how long has it been? (√) ___less than 2 years ___more than 2 years
Has the patient visited the ER/hospital for dental pain in the last year?			If "yes", how many times?
Has dental pain caused you or your child to miss school and/or work in the last year?			If "yes", circle – school work both How many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____ Date of last medical exam (mm/yy) _____			
Does the patient have a current medical condition?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism			
Is patient pregnant?			

Has the patient had a history of or had difficulty with the following? Check any that apply (√)

- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Birth defects
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Epilepsy/ seizures
- ☐ Excessive bleeding
- ☐ Other _____
- ☐ Fainting
- ☐ Heart problems
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mono
- ☐ Rheumatic fever
- ☐ Tuberculosis

Please explain your answers: _____

Reason for Visit: Check any that apply (√)

☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else

☐ Toothache/mouth pain/face swelling ☐ Other (specify)_____

Patient Behavior	Yes	No	
Does the patient brush daily?			
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			
Is the patient using tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			
Does anyone in the household use tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided.

MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.

Medicaid/ SCHIP **Private DENTAL Insurance** (please provide copy of card) **None**

Medicaid Number/ Policy Number _____

Dental Ins. Name: _____ policy #_____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

Treatment Consent and Agreement

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)

give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular dental exams by a dentist. Each item needs to be answered in order to receive dental care.

Yes	No	
		Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
		Dentist Exam (including dental x-rays)
		Restorative Services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.
		Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.
		The use of nitrous oxide (laughing gas) may be used as deemed necessary.
		I have been offered and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices.

Parent/Legal Guardian signature _____ Date _____

DELTA DENTAL

SILVER DIAMINE FLUORIDE INFORMED CONSENT

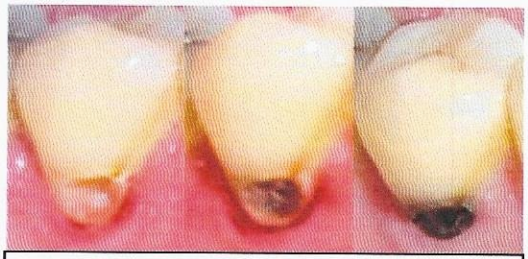
Silver Diamine Fluoride (SDF) is a liquid medication that is applied to active tooth decay to kill bacteria and stop the cavity from growing. We use SDF to prevent or stop tooth decay. We also use it to treat tooth sensitivity.

Benefits of receiving SDF:

- SDF can help stop tooth decay.
- SDF can postpone the need for traditional dental treatment (fillings, crowns, etc.) and delay/possibly eliminate the need for sedation/general anesthesia to complete dental treatment.

Risks related to SDF include, but are not limited to:

- Patients should not be treated with SDF if:
  - **He/she has an allergy to silver**.
  - There are painful sores or raw areas on the gums or anywhere in the mouth.
- **The decayed area of the tooth will be stained black permanently.** Healthy tooth structure will not stain.
- Tooth colored fillings and crowns may discolor if SDF is applied to them.
- If SDF contacts the gums or skin, a brown or white stain may appear. This color change is harmless, but cannot be washed off. The discoloration will go away in 1-3 weeks.



before, after 24 hours, and after 7 days of SDF treatment (UCSF Dental Center)

- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.

Alternatives to SDF include, but are not limited to:

- No treatment. No treatment will allow untreated decay to continue further damaging tooth structure, possibly leading to pain, infection, or tooth loss.
- Fillings, crowns, extractions or referral for advanced care which may include general anesthesia.

While SDF can stop tooth decay, it will not restore the tooth structure that has already been effected. You may still require restoration of the teeth (fillings, crowns, etc.).

I certify that I have read and fully understand this document. All of my questions have been answered.

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Name (Please Print): _____

Pine Ridge Dental Service Unit School Sealant Program Consent Form

Dear Families,
A free dental program will be in your child's school. Your child will receive preventative dental services that include a dental screening, tooth cleaning, sealants, fluoride varnish, silver diamine fluoride and tips on how to care for their teeth.

Name:_____ Date of Birth:_____Sex: M/F
School:_____ Grade:_____ Teacher: _____
Address: _____ City/State/Zip: _____
Parent/Guardian: _____ Cell Phone: _____
Email: _____ Home: _____Work: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Health History	**Yes**	**No**	
Allergies			**Reaction Type**
Medications			
Past Surgeries			
Pregnant			
Heart Conditions			

Condition	**Yes**	**No**	**Explanation**
Asthma			
HIV			
Hepatitis			Type:
Gastrointestinal			
Diabetes/Type			
Seizures			
Joint Replacement			
Hospitalizations			

CoVID 19 Screening	**Yes**	**No**
Tested positive for COVID 19		
Loss of taste or smell		
Cough		
Shortness of Breath		
Muscle Pain/Body Aches		
Nausea/Vomiting/Diarrhea		
Headache		
Fever/feverish		

	Yes	**No**
Are you experiencing any tooth pain?		
Is this your first dental visit?		
Does anyone smoke in the home?		
Do you brush your teeth daily?		

Dental Insurance	
Medicaid ID	
Private	
IHS	

Consent

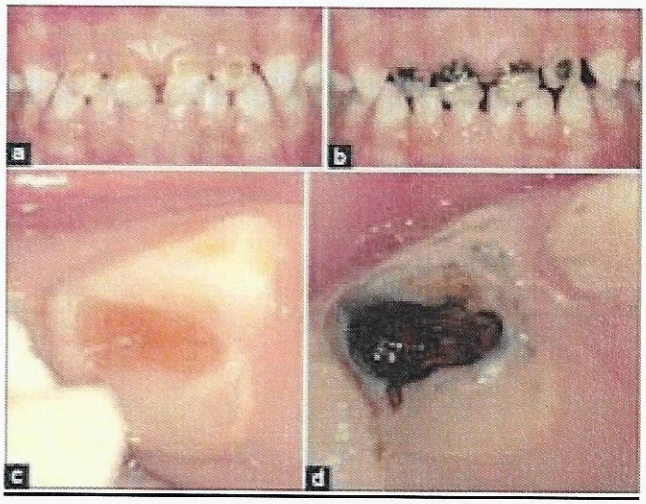
Yes	**No**	**Procedures**
		Dental screening, teeth cleaning, sealants, fluoride varnish
		Silver diamine fluoride (will turn area of tooth with cavity black, see attachment, baby teeth only)
		Dental exam, x-rays, nitrous oxide, fillings and extractions

Signature _____ **Date** _____
Provider _____ **Date** _____

Pine Ridge Dental Service Unit Silver Diamine Fluoride (SDF) Consent

Facts for consideration:

- Silver Diamine Fluoride (SDF) is an antibiotic liquid used on cavities to help stop the cavity process within the enamel (white part of tooth) and treat tooth sensitivity.
- Additional SDF application may be recommended.
- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.
- **The affected area will stain black permanently, this is an indication SDF is working.** Healthy tooth structure will not stain.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Color changes on the surface can normally be polished off. The edge between a tooth and filling may keep the color.
- If SDF gets on skin or gums, a harmless brown or white stain may appear and will disappear in 1-3 weeks.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied.
- **If allergic to SILVER SDF isn't a therapeutic option.**



PINE RIDGE VISION CENTER

Timothy L. Chancellor O.D. • Mark R. Winckler O.D. • Bradley C. Marcy O.D.

PERMISSION SLIP

DEAR PARENT OR GUARDIAN:

YOUR SCHOOL HAS CHOSEN TO TAKE PART IN A VISION SCREENING TO TAKE PLACE

Student's Name: _____ grade: ____

PLEASE SIGN AND RETURN THIS PERMISSION SLIP TO ALLOW YOUR CHILD'S VISION SCREENING.

Parent/Guardian Sign: _____

THOSE CHILDREN SCREENED WILL RECEIVE NOTICE IF THEY DID NOT PASS THE SCREENING AND YOU WILL BE URGED TO MAKE AN APPOINTMENT FOR A FULL VISION EXAM.

THANK YOU.

SINCERELY,

THE DOCTORS AT THE PINE RIDGE VISION CENTER

VISION SOURCE™

P.O. Box 399 • Pine Ridge, SD 57770 • (605) 867-2772 • Fax (605) 867-2320
www.visionsource-pineridge.com