BROCKTON SCHOOL DISTRICT #55

P.O. BOX 198
215 N. 5th STREET
BROCKTON, MONTANA 59213

(Revised 4/25/2024ac)

Date Received: _____/_____/_____

STUDENT ENROLLMENT APPLICATION

"Brockton Schools will ensure every student the opportunity to learn in a safe and culturally relevant environment with the expectation of high academic student achievement."

SUPERINTENDENT: Mr. Josh Patterson

PRINCIPAL: Mr. Evan Cummins

ASST. PRINCIPAL: Ms. RaeAnne Edmisten

DISTRICT CLERK: Mrs. Cheri Nygard

SCHOOL SECRETARY: Ms. Nicole Lone Bear

SCHOOL COUNSELOR: Mrs. Angela Cheek

District Building: 406.786.3195

District Building FAX: 406.786.3121

High School & Elementary: 406.786.3311

High School & Elem. FAX: 406.786.3377

Your child's application will not be considered complete without these forms:

REQUIRED FORMS	Attached	Missing
Birth Certificate		
Immunization Record		
If Applicable, Tribal Enrollment Verification		
If Applicable, Signed Parent & Student Out of District Contract		
If Applicable, a copy of Child Custody Forms		

BROCKTON SCHOOL DISTRICT #55

P.O. BOX 198
215 N. 5th STREET
BROCKTON, MONTANA 59213

STUDENT ENROLLMENT FORM

STUDENT INFORMATION

Student's Name: _____ **Birthdate:** _____/_____/_____
Last First Middle
Grade: _____ **Gender (Circle)**: Male Female **Social Security Number:** _____ - _____- _____
Ethnic Origin (Circle):
Asian, Hispanic or Latino, Black or African-American, White, Non-Hispanic, Native Hawaiian or Pacific Islander, American Indian OR Alaskan Tribal Affiliation: _____ **Tribal Enrollment #:** _____
Last School Attended: _____
Reason for leaving: _____

PARENT/GUARDIAN INFORMATION

Mother (Parent/Guardian): _____
Mailing Address (PO Box): _____ Physical Address: _____
Email Address: _____
Cell Phone: _____ Home/Message Phone: _____
Employer: _____ Work Phone: _____
Check below if applicable:
⬜Parent has Legal Custody ⬜Receive School Mailings ⬜Child Lives With ⬜Receive School Email/Message

Father (Parent/Guardian): _____
Mailing Address (PO Box): _____ Physical Address: _____
Email Address: _____
Cell Phone: _____ Home/Message Phone: _____
Employer: _____ Work Phone: _____
Check below if applicable:
⬜Parent has Legal Custody ⬜Receive School Mailings ⬜Child Lives With ⬜Receive School Email/Message

EMERGENCY CONTACT INFORMATION

In case of emergency, illness or accident, the school is authorized to contact
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

AUTHORIZED PERMISSION TO RELEASE

I, _____ give permission to have my child picked up at the Brockton School by the following people.
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Signature of Parent/Guardian: _____ Date: _____/_____/_____

AUTHORIZED SCHOOL COMMUNICATION

This form will provide Brockton Schools with information we need to ensure communication is correctly distributed to the proper person(s). It is intended to eliminate guesswork on "who to call" or "who makes decisions" and is meant only to improve school and home cooperation.
The school does not need copies of legal papers unless there is a conflict as to who may or may not have contact with the school in which case we will request the information. A copy of this form will be kept in the student's file.
Please provide the names and phone numbers of the adults (aunt, uncle, grandparent, family friend, step-parent, or relative) who will have dealings with the school.

Please check ✔ Below for Authorization

Name	Relationship	Phone	During Emergency child can be released	Attend Parent-Teacher Conference	Class Visits and/or field trip permission	Contact Regarding *Discipline**	Contact regarding *Education issues**

*(*Brockton School District will provide copies of Report Cards, Discipline Referrals and Progress Report if requested, but cannot prepare copies of ALL student work due to the high number of classroom staff time necessary to copy, package and post the material.)*

PARENT/GUARDIAN LEGAL STATUS

What is your own legal status or relationship to the child you are enrolling at Brockton School District?
Please ✔ check all that apply.

___ I am the Natural Parent
___ I have Sole Legal Custody
___ I have Joint Physical Custody
___ I have Joint Custody
___ I am a Step-Parent
___ I have educational rights specified in Divorce Agreement
___ I am a Court Appointed Legal Guardian (Social Service)

If any restraining orders are in effect please provide a copy. Also, if there are other considerations, particularly as they might relate to an individual who is not to have contact with your child, please describe them below.

_____
_____
_____

HOUSEHOLD INFORMATION

Please provide the name(s) of other children or relatives in the household and their relationship.

Name	Age	Relationship

Signature of Parent/Guardian: _____ Date: _____/_____/_____

BROCKTON SCHOOL DISTRICT
Parent Involvement Title I Compact

A Learning Partnership Between Home and School

PARENT/GUARDIAN COMMITMENT:

I want my child to reach his/her full academic potential, therefore I will commit to do all of the following:

- Ensure my child attends school each day.
- Send my child to school on time and ready to learn
- Review homework assignments and offer assistance when needed.
- Show an interest in my child's well-being by attending school functions, supporting school activities, and making every effort to attend parent-teacher conferences.
- Support learning by reading with my child nightly and allowing my child to see me read
- Other Concerns: _____
- **Parent/Guardian Signature of Agreement**: _____

CHILD COMMITMENT:

I want to reach my full academic potential, therefore I will commit to all of the following:

- Arrive at school and attend class on time each day.
- Show respect at all times to everyone who is part of the school by not acting hostile or creating fear for others.
- Obey all of the classroom and school rules and act accordingly.
- Pay attention in class and participate in classroom activities.
- Complete all classroom lessons and homework in a way that is accurate and neat.
- Other Concerns: _____
- **Student Signature of Agreement**: _____

SCHOOL ADMINISTRATION COMMITMENT:

We want all of our students to reach their full potential, therefore we commit to do all of the following:

- Frequently provide information to parents, staff and students pertaining to all areas of academics.
- Invite, encourage and reinforce parent involvement.
- Provide a positive, safe and caring school environment.
- Respond to students as individuals.
- **Administrative Signature of Agreement**: _____

THANK YOU.

BROCKTON SCHOOL DISTRICT
ACCEPTABLE USE POLICY

Terms and Conditions for Use of Electronic Media Including Internet

This is a legally binding document. Please read the following before signing this document. Electronic Media access includes computer networks, the Internet and email.

INTERNET-TERMS AND CONDITIONS

1. ACCEPTABLE USE - The use of electronic media (network and Internet) must be in support of the EDUCATIONAL goals of the school district. Transmission of any material in violation of any U.S. or state regulation is prohibited. This includes, but not limited to:
    - Copyrighted material
    - Threatening or obscene material
    - Material protected by trade secret
    - Material that users, parents or school personnel consider inappropriate or offensive.
2. PRIVILEGES - The use of the Internet is a privilege, not a right, and inappropriate use will result in cancellation of these privileges for the remainder of the school year for MAJOR OFFENSES and referral to the discipline process for MINOR OFFENSES.
3. NET ETIQUETTE - You are expected to abide by the generally accepted rules of network etiquette. These include (but are not limited to) the following:
   A.) Avoid offensive or inflammatory speech. Be courteous and polite.
   B.) Use appropriate language. Profanity or obscenity is not permitted at any time.
   C.) Do not reveal your personal address or phone numbers of students or colleagues. Be suspicious of messages asking for personal information or attempting to arrange meetings.
   D.) Electronic mail (e-mail) is not guaranteed to be private and is subject to review by network personnel. Messages relating to illegal activities may be reported to authorities.
   E.) Do not use the network in such a way that you would disrupt the work of others.
   F.) Do not quote or forward personal communication without the author's prior consent.

VANDALISM - Vandalism will result in cancellation of privileges. Vandalism is defined as any malicious attempt to harm or destroy hardware or data of another user, Internet or network. This includes, but is not limited to, the uploading or creation of computer viruses.

SECURITY - never share your password or account number with anyone. You may be held responsible for any policy violations that are traced to your account. Report any security problem on the Internet and do not demonstrate the problem with other users.

If a student is prohibited from computer use due to a violation of this policy, it is the sole discretion of a teacher as to whether their assignment may be altered or given an "0".

Terms and Conditions for Use of Electronic Media Including Internet

(Continued from previous page)

LIST OF MAJOR AND MINOR OFFENSES:

<table>
<tr><th><u>Minor Offenses</u></th><th><u>Major Offenses</u></th></tr>
<tr><td>1. Use of the network for any illegal purpose</td><td>1. Use of impolite, abusive, vulgar or offensive language.</td></tr>
<tr><td>2. Deliberately download or spread a computer virus.</td><td>2. Violate rules of net etiquette and common sense.</td></tr>
<tr><td>3. Vandalize computers, software, or network devices.</td><td>3. After computer files, desktops or other settings without permission.</td></tr>
<tr><td>4. Knowingly search for obscene, lewd or harmful information or that encourages illegal activity.</td><td>4. Use of copyrighted materials without permission of the legal matter.</td></tr>
<tr><td>5. Send messages that are racist, inflammatory activity.</td><td>5. Log on to another user’s account without permission.</td></tr>
<tr><td rowspan="14"><u>Consequences for Minor Offenses:</u>

<u>First Offense</u>: Privileges suspended for 3 days
● Discipline report filed with administration
● Parents Notified.

<u>Second Offense</u>: Privileges suspended for 2 weeks
● Discipline report filed with administration
● Parents called to the school for a meeting

<u>Third Offense</u>: Privileges suspended until the end of the school year.
● Discipline report filed with administration.</td><td>6. Download software, music or personal graphics without permission.</td></tr>
<tr><td>7. Participate in chat rooms on the Internet on school computers.</td></tr>
<tr><td>8. Use computers in the classrooms for purposes other than research.</td></tr>
<tr><td>9. Use computers for on-line shopping (students).</td></tr>
<tr><td>10. Use computers for downloading or playing games without permission.</td></tr>
<tr><td>11. Use Newsgroups or subscribe to List Serves (Students Only).</td></tr>
<tr><td>12. Load software from home without permission.</td></tr>
<tr><td>13. Download or install programs from the Internet without permission.</td></tr>
<tr><td>14. Use any web mail program other than school approved.</td></tr>
</table>

Brockton School District Acceptable Use Policy - Agreement to Terms
User Agreement

<u>TO BE SIGNED BY ALL USERS</u>

(Adults & Students within the Brockton School District)

USER NAME(Please Print): _____ Date: _____/_____/_____

USER SIGNATURE:: _____ Date: _____/_____/_____

P.L. 81-847

PARENT/PUPIL SURVEY

SURVEY DATE: _____/_____/_____

BROCKTON SCHOOL DISTRICT #55
ROOSEVELT COUNTRY

Name of Pupil(s)	Grade	Date of Birth	Address (where student is living)

1. If address is on Federal property, give name of property _____
2. Name of parent employed on Federal property with whom pupil(s) resides (Name as it appears on payroll) _____

Uniformed Services Only Complete #3. All others complete items 4 - 7

3. If a parent or guardian was a full time active duty member of the Air Force, Army, Navy, Marine Corps, Coast Guard, or was a Commissioned Officer of the Public Health Service or Environmental Science Administration on survey date complete the following:

A. Name _____ B. Rank _____
C. Serial Number _____ D. Branch of Service _____

4. Name & Address of Father and Mother's employer: _____
_____

5. Name & Address on property on which Father and Mother work: _____
_____

6. If a parent was a logger or rancher, did he/she spend more than 50% of the past calendar year ranching or logging Federal property? Yes _____ No _____

This survey must be signed and dated by the parent, guardian, or other legally appointed person in loco parentis.

Signature of Parent/Guardian: _____ Date: _____/_____/_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 08-31-2019
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

OMB Control No. 1810-0021 (Exp. 01/31/2024)

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): O child O child's parent O 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):

- O Federally Recognized Tribe
- O State Recognized Tribe
- O Terminated Tribe
- O Alaska Native
- O 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:

- O Membership or enrollment number establishing membership (if readily available) or
- O 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 _____

BROCKTON SCHOOL DISTRICT #55

P.O. BOX 198
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OUT OF SCHOOL DISTRICT CONTRACT

Any student who attends Brockton Schools, but does not live in the Brockton School District will be required to sign a behavioral contract. The contract has a duration of one calendar year from the time of enrollment or change of residence to outside the Brockton School District.
After one year if the student is still enrolled in the Brockton School District, the contract will be reviewed to see if it is in the best interest of the school district and the student to continue their association or to end it.
Even if the student is allowed to remain in the Brockton School District, a new contract with a one year duration will be signed to ensure against behavioral problems, poor attendance, or poor work habits in the classroom, if there were any violations during the duration of their contract.

PARENT/GUARDIAN & STUDENT CONTRACT

I (student), _____ agree to abide by the following rules of conduct in order that I might continue as a student in Brockton Public Schools:

1. I will attend school on a regular basis.
2. I will not be tardy to school or class.
3. I will refrain from creating disturbances in the classroom or on school grounds.
4. I will bring my books and other required materials to class.
5. I will follow directions from staff and administration and do my assigned work with a passing average that is acceptable to my teachers.
6. I will treat all school personnel and all teachers with respect.
7. I will not use or possess any alcoholic beverages, drugs including tobacco, on school grounds.

I understand that any failure on my part to live to the terms of this contract will result in losing my privilege of attending the Brockton Schools.

Student Signature: _____ Date: ____/____/____

Parent/Guardian Signature: _____ Date: ____/____/____

Prototype Household Application for Free and Reduced Price School Meals

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

APPLY ONLINE:
RETURN TO (School/District Name):
ADDRESS:

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

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

Check all that apply

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: SNAP, TANF, or FDPIR?

○ **NO** → Go to STEP 3.　　○ **YES** → Write case number here and proceed to STEP 4.

CASE NUMBER (NOT EBT NUMBER):

Write only one case number in this space.

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)
List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) 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)	Earnings from Work	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual	Public Assistance, Child Support, Alimony	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received? Weekly	Every 2 Weeks	2x Month	Monthly
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults) ☐

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (If Applicable)

Check if no Social Security Number ☐

Please see application's back for list of income sources.

B. Child Income
Sometimes children in the household earn or receive income.
Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual
$	○	○	○	○	○

STEP 4 Contact information and adult signature. <u>RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL:</u> Insert school address here

"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 (confirm) 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."

Print Name of Adult Signing the Form　　Signature of Adult　　Today's Date

Mailing Address (if available)　　City　　State　　Zip　　Phone (optional)　　Email (optional)

Return completed form to your child's school.

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**	
• Salary, wages, cash bonuses, tips, commissions • 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 • Veterans benefits • Strike benefits	• Social Security/Disability (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	• A child has a regular full or part-time job where they earn a salary or wages • A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits • A friend or extended family member regularly gives a child spending money • A child receives regular income from a private pension fund, annuity, or trust

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

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 (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.

DO NOT FILL OUT

For school use only.

Annual Income Conversion: Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income _____ How often? Weekly ○ | Every 2 Weeks ○ | 2x Month ○ | Monthly ○ | Annual ○

Household size _____ Categorical Eligibility ☐ Eligibility: Free ○ | Reduced ○ | Denied ○

Determining Official's Signature	Date	Confirming Official's Signature	Date	Verifying Official's Signature	Date

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number.' Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination

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

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Do not mail applications to this address, only complaints of discrimination.**

Return completed form to your child's school.

This institution is an equal opportunity provider.

HEALTH PROMOTION
DISEASE PREVENTION
FORT PECK TRIBES

HPDP Tribal Wellness Program School Based Health Clinics

Patient Health History Form

Student's Name _____ Today's Date _____
Student's Teacher _____ Grade _____

☐ **NO CHANGE IN INFORMATION**

Pregnancy & Birth History

While pregnant, did mother:
Have any complications?_____Yes No
Use alcohol, drugs or smoke?_____Yes No
Take any medications?_____Yes No
Length of pregnancy:_____Weeks
Type of delivery:_____
Birth weight:_____ lbs._____oz.
Newborn hearing screen passed?_____Yes No
Delivered at:_____
Name of Hospital

Child's Current Health

Is your child taking prescription or over the counter medications (i.e. vitamins)? _____Yes No
Name of medications:_____
_____
Any allergies to medications?_____Yes No
Please list:_____
_____
Any dental problems?_____Yes No
Any allergies to latex or anesthesia: Yes No

Family Health History

Parental Height: Mother:_____ Father:_____
Have and close family members **(parents, grandparents and siblings)** had any of the following **(State whom)**:

Hearing Problems:_____
Vision Problems:_____
Asthma:_____
Hay Fever or Allergies:_____
Heart Disease Prior to age 50:_____
High Blood Pressure:_____
Elevated Cholesterol:_____
Diabetes:_____
Thyroid Disease:_____
Kidney Disease:_____
Epilepsy (seizures):_____
Cancer (type):_____
Liver Disease:_____
Bleeding Disorder/Blood Clots:_____
Smokers:_____
Alcohol or Drug Abuse_____
Depression or Mental Illness:_____
ADHD:_____
Learning Disability:_____
Scoliosis:_____
Reactions to Anesthesia:_____
Other:_____

Child's Health History

Hospitalizations:_____Yes No
Illness:_____Date:_____
Surgeries:_____Yes No
Procedures:_____Date:_____
Injuries/Fractures:_____Yes No
Hearing Problems:_____Yes No
Vision Problems_____Yes No
Ear/Nose/Throat Problems_____Yes No
Asthma/Breathing Problems:_____Yes No
Hay Fever or Allergies:_____Yes No
Diabetes/Thyroid Problems:_____Yes No
Kidney Problems:_____Yes No
Heart Murmur/Conditions:_____Yes No
Stomach Problems:_____Yes No
Migraines or Headaches_____Yes No
Anemia/Low Iron:_____Yes No
Learning disability/ADHD:_____Yes No
Head Injury or Concussion:_____Yes No
History of High Fevers:_____Yes No

HEALTH PROMOTION
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CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT

MEDICAL/DENTAL/MENTAL HEALTH CONSENT: The HPDP School Based Health Centers (SBHC) must have a signed consent from a parent or legal guardian before providing services to youth, except where federal and/or state laws allow youth to access such treatment without parent/guardian consent.

I hereby request and authorize treatment for any and all health care services available from and deemed necessary by the providers and volunteers of the HPDP School Based Health Clinics. These services may include, but are not limited to, well-child care, evaluation, treatment of acute illness and injuries, immunizations, blood studies, dental screening and treatment (including varnish, sealants, cleanings), wellness counseling and mental health evaluations and counseling. Consent is also given for referral of care and, if needed, emergency transportation, to other physicians, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the SBHC staff. **Consent for service is authorized for any SBHC run by HPDP to provide services until your child reaches the age of 18 years old**. I may choose to limit or withdraw the consent for any or all services by notifying HPDP in writing.

I understand that I will be consulted and notified by phone or in person prior to any immunizations, laboratory /radiology tests or dispensation of medications, ***unless*** the condition is life threatening.

IMMUNIZATION REGISTRY: I authorize HPDP to enter my or my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to childcare facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

CONFIDENTIAL CARE: I am aware that the information about my child is confidential and will not be shared with others, including school personnel, except in the following circumstances: 1. Permission to share information is given by a signed release of information. 2. The student shows risk of suicidal behavior. 3. The student plans to do serious bodily harm to another person. 4. The student has a life-threatening problem and is under 18 years old. 5. There is a reason to suspect abuse or neglect. 6. Certain communicable diseases must be reported to the State Health Department. *A student's consent is legally required to release information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted disease, alcohol and drug use or mental health counseling. The SBHC encourages youth to involve parents/guardians in health care decisions whenever possible.*

ASSIGNMENT OF INSURANCE BENEFITS; I authorize HPDP to request on my behalf, and to collect directly, all public and private insurance coverage benefits (including Medicare, if applicable) due for products and services supplied by HPDP providers in the SBHC. In the event insurance benefits are paid directly to me, I will endorse to HPDP all checks for such payments.

MEDICARE CERTIFICATION (when applicable): I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct.

RELEASE OF HEALTH INFORMATION TO PAYERS: I authorize HPDP to disclose any health information to my insurers (including the Center for Medicare and Medicaid Services or its representatives, if applicable) necessary to facilitate the processing of claims or audit of payments relative to the services provided to me or my child by HPDP.

By signing below, I am acknowledging full understand of the above notice and hereby indemnify and hold harmless the providers, medical office and other persons who act in reliance upon this authorization.

Parent/Guardian Signature _____ Relationship _____ Date _____

HIPAA/NOTICE OF PRIVACY PRACTICES: We keep a record of the health care services we provide you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the HPDP Privacy Officer. The Fort Peck Tribes **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. The Fort Peck Tribes **Notice of Privacy Practices** is posted on our website at *http://www.fortpecktribes.org/hpdp/staff.html* and is posted in each SBHC.

By my signature below I also acknowledge I have been offered a copy of the Fort Peck Tribes **Notice of Privacy Practices.**

Parent/Guardian Signature _____ Date _____

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Fort Peck Tribes HPDP Wellness Program
Frazer School –Based Health Clinic (406) 695-2117
Wolf Point School-Based Health Clinic (406) 653-1653 or 653-1480
Poplar School – Based Health Clinic (406) 768 – 3384
Brockton School – Based Health Clinic (406) 786 – 3202

Authorization for the Administration of Over-The-Counter Medication by School Based Health Center Personnel

To help keep students in school, the HPDP school-based health centers stock a limited number of over the counter medications and medicated creams and ointments that may be administered to students enrolled in the program. Written consent must be provided from the parent/guardian, permitting HPDP personnel to administer medications to the student during the school year. Except in the event of an emergency, the student's parent or guardian will be called for verbal consent prior to the administration of any of these medications in order to avoid duplication of medication.

All medications will be routinely monitored for expiration dates and stored in the original bottle with unaltered label. Medications requiring refrigeration will be properly stored and transported. Medication will be administered in accordance with standing orders for the administration of these medications. Medications are administered by the HPDP Registered Nurses, Nurse Practitioners or Physicians trained in the methods of administration of medications.

Prescription medications require a separate authorization of medication form to be completed by a student's parent/guardian before these medications will be administered.

AUTHORIZATION BY PARENT/GUARDIAN

I hereby authorize the administration of the medications listed below by authorized HPDP personnel:

Can your child have the following medications in the School Based Health Clinic if necessary?

☐ Yes ☐ No	Acetaminophen (Tylenol) for pain or fever
☐ Yes ☐ No	Antibiotic ointment for abrasions, scratches, cuts, and burns
☐ Yes ☐ No	Benadryl for allergies or allergic reaction
☐ Yes ☐ No	Cetirizine (Zyrtec) for allergies
☐ Yes ☐ No	Cough drops for cough or sore throat
☐ Yes ☐ No	Cough medication (dextromethorphan) for cough
☐ Yes ☐ No	Honey for cough
☐ Yes ☐ No	Hydrocortisone cream or ointment for hives, insect bite, poison ivy or stings
☐ Yes ☐ No	Ibuprofen for mild headaches, joint or tooth pain, menstrual cramps
☐ Yes ☐ No	Lotion for dry skin
☐ Yes ☐ No	Lip balm for chapped lips
☐ Yes ☐ No	Tums for upset stomach or heart burn

Student Name _____ DOB _____

Printed Name _____ Relationship to student _____

Signature _____ Date _____

HEALTH PROMOTION
DISEASE PREVENTION
FORT PECK TRIBES

FORT PECK TRIBES HEALTH PROMOTION DISEASE PREVENTION PROGRAM

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Promotion Disease Prevention Program respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

How we may use and disclose your protected health information:

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories. Examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you. However, most uses or disclosures of any psychotherapy notes will require your authorization.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.
- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including: medical quality review by your health plan; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection and compliance programs
- We will not contact you to raise funds.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows:

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others:** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital
- **Public** health and safety purposes: As permitted or required by law, we may disclose protected health information: to prevent or reduce a serious, immediate threat to the health or safety of a person or the public; to public health or legal authorities; to protect public health and safety; to prevent and control disease, injury or disability; to report vital statistics such as births and deaths; and to report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA):** For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.

- **Workplace injury or illness:** State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions**: If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities**: We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

Your health information rights:
The health and billing records we create and store are the property of HP/DP. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about a service or treatment for which you paid directly.
    - Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
    - Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
    - Have us review a denial of access to your health information—except in certain circumstances.
    - Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
    - When you request, we will give you a list of **certain** disclosures of your health information. The list will not include disclosures **for treatment, payment, or health care operations.** You may receive this information without charge once every 12 months.
    - You have the right to restrict certain disclosures of PHI to a health plan when you (or any person other than the health plan) pays for treatment at issue out of pocket in full.
    - Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
    - Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.
- Notify you following any breach of the security of your protected health information.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting the HPDP office in Poplar to pick one up.

To ask for help or complain:
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:
The HPDP Privacy Officer
417 13th Avenue East
Poplar, Montana 59255
(406) 768-3383

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the HP/DP Privacy Officer at the above address You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR). We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

Web site: We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address:
http://www.fortpecktribes.org/hpdp/staff.html