The mandatory documents listed below must be included with the completed student enrollment application. The application process will be delayed if the student enrollment application is not complete.

____ Copy of Certification of Degree of Indian Blood

*Student applicant must be a member of, or is at least one-fourth degree Indian blood descendant of a member of, a tribe that is eligible for the special programs and services provided by the United States through the Bureau of Indian Affairs to Indians because of their status as Indians.*

____ Copy of social security card

____ Copy of birth certificate

____ Immunization record

____ Physical examination

____ Copy of medical assistance card or medical insurance card (both sides) or denial letter of medical assistance/coverage

____ Copy of most recent report card and school records as listed on page 5 of student enrollment application

____ Custody order, if applicable

____ Mental Health / counseling services information, if applicable

____ CD treatment information, if applicable

____ Juvenile court history, if applicable

____ 2019-2020 Application for Free and Reduced Price School Meals

Please complete all sections and answer all questions to the best of your knowledge. If a question doesn’t apply to your child, write “does not apply” or “N.A.”; if you don’t know, write “unknown” or “don’t know”. If you are having difficulty completing the application, contact your local BIA or Tribal education officials or social service officials for assistance or contact the Registrar at CNS.

Submitting a student enrollment application does not guarantee acceptance and/or enrollment of your child at CNS. An Admissions Committee will review the application and will determine if your child is approved for admission to CNS. A letter of acceptance or non-acceptance will be sent to the parent/legal guardian. Please notify CNS with any changes of address and/or telephone number(s).

**Do not withdraw your child from the school they are currently enrolled at until you receive confirmation that your child has been accepted at CNS.**

Please feel free to contact this office with any questions or concerns you may have. The mailing address, telephone number, and website for CNS are listed below:

Registrar / Admissions Committee  
Circle of Nations School  
832 8th Street North  
Wahpeton, ND  58075

1-701-672-7222  
1-701-642-1984 (fax number)  
www.circleofnations.org

**PLEASE SUBMIT COMPLETE APPLICATION BY AUGUST 1st.**
What grade is the student applying for?  (circle one)  4th Grade  5th Grade  6th Grade  7th Grade  8th Grade

Has the student previously attended CNS or previously applied to attend CNS?  (please circle)  Yes  No

If yes, when and what grade?  ________________________________________________________________

Name of Student:  ____________________________________________________________

Last  First  Middle

Other names used (include nicknames):  _______________________________________________________________

P.O. Box Address:  ____________________________  Street Address:  ______________________________________

City:  ____________________________  State:  ____________________________  Zip Code:  ____________________________

Gender:  (please circle)  Male  Female  Religious Affiliation (optional):  ____________________________

Date of birth:  ____________________________  Place of birth:  ____________________________

month/day/year  city/state

Tribal Membership:  ______________________________________________________________

Please attach a copy of student’s “Certification of Degree of Indian Blood” or supporting documentation proving at least one quarter (¼) degree Indian blood descendant.

Language(s) spoken by the student:  1)  ____________________________  2)  ____________________________

Language(s) spoken by others in the household:  1)  ____________________________  2)  ____________________________

Who does the student live with?  (circle one)  Both parents  Mother  Father  Grandparent(s)  Relative/Other:  ____________________________

Legal Guardian:  ______________________________________________________________

Relationship to student:  ____________________________

Address:  ______________________________________________________________

City, State, Zip Code:  ____________________________

Telephone numbers (please include area codes):

Home:  ______________________________________________________________

Cell:  ______________________________________________________________

E-mail address:  ______________________________________________________________

Emergency number:  ____________________________

Emergency contact:  ____________________________________________________________

Employee:  ______________________________________________________________
I am legally responsible for this student and hereby apply for his/her admission to the Circle of Nations School. I understand that CNS may request additional information before the student is accepted and/or enrolled. Further, I understand that failure to provide accurate information or falsifying or withholding information may result in the student’s non-acceptance to CNS or the immediate dismissal of the student from CNS. Please attach guardian documentation if applicable.
VERIFICATION OF CHILD CUSTODY

Name of Child: ______________________________________________________ Date of birth: ____________________

Name of Custodial Parent / Legal Guardian: _____________________________________________________________

Name of Non-Custodial Parent: _______________________________________________________________________

Custody set forth by (please circle): Birth  Divorce Decree  Court Order  Other: __________________________

Type of custody (please circle):  Sole custody  Joint custody  Other: ___________________________________

Please provide Circle of Nations School with a copy of the judgment issued regarding the custody of the above named child. In addition to providing the custody document, please answer the following questions:

- May the non-custodial parent have access to your child's school records (report card, progress report, class work, IEP, etc)?
  YES  NO

- May the non-custodial parent discuss your child’s progress with CNS staff members?
  YES  NO

- May the non-custodial parent visit your child at CNS?
  YES  NO

- May the non-custodial parent telephone your child at CNS?
  YES  NO

- May the non-custodial parent sign your child out from CNS?
  YES  NO

- Do you wish to be advised of any contact from the non-custodial parent?
  YES  NO

- Is there a restraining order in place?
  YES  NO
  If yes, please provide the name(s) of person(s) and a copy of the order:
  ______________________________________________________
  ______________________________________________________

Additional comments / restrictions regarding your child’s non-custodial parent that CNS should be aware of:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

___________________________________________________________  ________________
Signature of Legal Guardian                     Date
Name of Student: ________________________________________________________________

Student: In your own words, please write a short paragraph as to why you want to attend CNS: __________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Parent/guardian: Please state the reasons for applying to CNS: ____________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Student Travel

CNS provides transportation to CNS at the beginning of the school year, to home and return to CNS at the holiday break, and to home at the end of the year.

CNS does not provide transportation for family emergencies or medical appointments unless set up by the CNS School Nurse. The family is responsible for returning their student after home visits or check-outs.
RELEASE / TRANSFER OF SCHOOL RECORDS

Student’s Name: ___________________________ Date of birth: _______________ Grade: ____________

RELEASE TO: Registrar
Circle of Nations School
Telephone number: 701-672-7222
832 Eighth Street North
Fax number: 701-642-1984
Wahpeton, ND  58075

REQUESTED FROM: School Name: _______________________________________________________
School Address: _______________________________________________________________________
School Telephone Number: __________________________________________________________________
School Fax Number: _______________________________________________________________________

The following records are requested for enrollment purposes:

Educational records: Transcripts, grades, grade level, state standardized assessment results, NWEA assessment results, attendance, RTI services, Title I services, behavioral records

Special Education records: Interventions implemented, referral, assessment plan, meeting notices, written prior notices, initial consent for evaluation, psycho-educational reports, evaluation report, initial consent to place, IEP, progress reports

Health records: Immunization record
Other health related records: _________________________

Mental Health records: Mental health evaluation

Other: Certification of Degree of Indian Blood, birth certificate, other necessary documents: _______________________

I understand the above information is considered confidential and will be available for use by the Circle of Nations School staff and consultants only.

_________________________________________________________          _____________________
Signature of Legal Guardian or School Official        Date

The term, Educational Records, as used in this consent form is that defined by P.L. 93-380, Sec. 99.2, Definitions are: Those records which (1) are directly related to a student and (2) are maintained by an educational agency or institution or by a party acting for the agency or institution.
EDUCATIONAL INFORMATION

Student’s Full Name: ________________________________ Date of Birth: _____________________________

Grade: ____________________ Parent/Guardian Name: ____________________________________________

The academic progress of your child is very important to us. As your student begins their education endeavors at Circle of Nations School, it is important that they be placed in classes appropriate for their need. If you have information that would help in working with your child, please share the information with us by completing this questionnaire. The responses on this questionnaire will remain confidential and will be viewed only by the school Administrators, Counselors, your child’s teacher and Special Education personnel if necessary.

Has your student ever been in a:

- ☐ Yes ☐ No Gifted/Talented program? If yes, please list grade(s) _________________________________
- ☐ Yes ☐ No Special Education? If yes, please list grade(s) ______________________________________

If YES was checked, what is the child’s identified disability category?

<table>
<thead>
<tr>
<th>Emotionally Disturbed</th>
<th>Other Health Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Health Impairment-Minor</td>
<td>Visual Impairment</td>
</tr>
<tr>
<td>Autism</td>
<td>Developmental Delay</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td>Traumatic Brain Injury</td>
</tr>
<tr>
<td>Specific Learning Disability</td>
<td>Orthopedic Impairment</td>
</tr>
<tr>
<td>Cognitive Disability</td>
<td>Deaf-Blindness</td>
</tr>
<tr>
<td>Multi-handicapped</td>
<td>Speech Language Impairment</td>
</tr>
</tbody>
</table>

- ☐ Yes ☐ No 504 program? If yes, please indicate grade(s): ______________________________________
- ☐ Yes ☐ No Speech therapy program? If yes, please indicate grade(s): __________________________
- ☐ Yes ☐ No ESL program? If yes, please indicate grade(s): __________________________
- ☐ Yes ☐ No Has your student ever been retained/held back? If yes, please indicate grade(s): __________
- ☐ Yes ☐ No Has your student ever skipped a grade? If yes, please indicate grade(s): __________
- ☐ Yes ☐ No Has your student ever been identified as dyslexic? If yes, please indicate grade(s): __________
- ☐ Yes ☐ No Does the student have problems with schoolwork or homework? If yes, please explain: ________________

- ☐ Yes ☐ No Has the student ever been suspended or expelled from school? If yes, include school name, when, and why: __________________________________________

- ☐ Yes ☐ No Does the student have a history of truancy/not going to school? If yes, explain: ________________

- ☐ Yes ☐ No Did the student complete this past school year? If not, explain: ____________________________
EDUCATIONAL INFORMATION

Please list all the schools your child has previously attended below.

<table>
<thead>
<tr>
<th>Year</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>PK</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td></td>
</tr>
<tr>
<td>1st</td>
<td></td>
</tr>
<tr>
<td>2nd</td>
<td></td>
</tr>
<tr>
<td>3rd</td>
<td></td>
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<tr>
<td>4th</td>
<td></td>
</tr>
<tr>
<td>5th</td>
<td></td>
</tr>
<tr>
<td>6th</td>
<td></td>
</tr>
<tr>
<td>7th</td>
<td></td>
</tr>
</tbody>
</table>

Is there any other information which you feel might be useful toward assisting us in the proper placement of your child?

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

I, ____________________________________________, understand that, if I am unable to be contacted, and the school has reason to believe that my student may have a disability, the school will act “in loco parentis” (in the place of a parent) in order to meet the educational needs of my student. I may contact CNS’s special education department at any time during the special education assessment process to deny the school right to test my child for services.

___________________________________________________________
Signature of Legal Guardian

___________________________________________________________
Date
The CNS Gifted and Talented Program offers many opportunities in a variety of areas to the students of the school. In order for your child to participate, CNS and the Gifted and Talented Coordinator need your permission for your child to be evaluated to determine whether or not they are eligible for the special services provided by this program. We also need your permission to place your child in the program, if they qualify. The areas that the Gifted and Talented Program services are listed below. **Check any of the areas that you feel apply to your child and explain why in the spaces provided.**

- Intellectual Ability: _______________________________________________________________
- Creativity / Divergent Thinking: __________________________________________________
- Academic Aptitude / Achievement: ________________________________________________
- Leadership: ___________________________________________________________________
- Aptitude in Visual and Performing Arts: _____________________________________________

List something that the student is exceptionally good at doing or enjoys doing: __________________

_________________________________________________________________________________

Additional comments: __________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

I GIVE PERMISSION FOR MY CHILD, ________________________________________________,
TO BE EVALUATED AND PLACED IN THE GIFTED AND TALENTED PROGRAM AT THE CIRCLE OF NATIONS SCHOOL AND SAMPLES PLACED IN THE STUDENT’S FILE AS EVIDENCE OF THEIR ABILITIES.

_________________________________________________  ____________________________
Signature of Legal Guardian                              Date
STUDENT INFORMATION SUMMARY

Name of Student: ________________________________________________________________

What programs/activities has the student participated or is interested in? (circle all that apply)

<table>
<thead>
<tr>
<th>Special Education</th>
<th>Basketball</th>
<th>Volleyball</th>
<th>Cross Country</th>
<th>Football</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Government</td>
<td>Track &amp; Field</td>
<td>Tae Kwon Do</td>
<td>Music Lessons</td>
<td></td>
</tr>
<tr>
<td>College &amp; Career Classes</td>
<td>Cultural Activities: _________________</td>
<td>Other: _________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How does the student cope with problems? (Circle all that apply)

| Cry | Fight verbally | Fight physically | Ignore | Eat |
| Sleep | Use drugs | Use alcohol | Use inhalants | Pray |
| Other: ________________________________________________________ |

Describe any traumatic event the student has experienced (ex: death of close relative, abuse, divorce/separation of parents, etc.):

__________________________________________________________________________________________________

What is the most important information to know about the student?

__________________________________________________________________________________________________

Has the student ever been involved in gang activity?

Yes No

If yes, please explain: ________________________________________________________________

Has the student ever been arrested?

Yes No

If yes, give reason(s): ________________________________________________________________

How many times?

Has the student ever been in detention or jail?

Yes No

If yes, give reason(s): ________________________________________________________________

How many times?

Is the student currently on probation or ever been on probation?

Yes No

If yes, give reason(s): ________________________________________________________________

Duration of probation or sentence: ______________________________________________________

If applicable, please provide the name(s) and contact information of the judge, probation officer, D.O.C. Worker, or Court Services Worker that is currently working with the student and/or the family:

____________________________________________________________________________________

Name of service provider Telephone Number(s) / Contract Information

If applicable, please provide the name(s) and contact information of the social worker or caseworker or school counselor that has worked with the student and/or the family:

____________________________________________________________________________________

Name of social worker, caseworker, or school counselor Telephone Number(s) / Contact Information
STUDENT INFORMATION SUMMARY

Medical Assistance Number: ____________________________  Insurance Policy Number: ____________________________

Does the student have any medical problems or conditions?  Yes  No
If yes, please explain: ________________________________________________________________

Is the student currently receiving medical care from a physician?  Yes  No
If yes, please provide physician’s name and contact information: ____________________________

Has the student ever been on medication for mental health reasons?  Yes  No
If yes, please explain: ________________________________________________________________

Has the student ever been pregnant or have a child?  Yes  No
If yes, please explain: ________________________________________________________________

Has the student ever been hospitalized or treated for any of the following medical conditions?  (Circle all that apply)
Seizures / Convulsions  Headaches  Head injury  Epilepsy  Ulcers
Suicide attempt/ Overdose  Depression  Eating disorder  Allergies  Diabetes
Kidney problems  Serious accident  Surgery  Alcohol or drug issues
Other: _____________________________________________________________________________

Briefly describe any of the problems circled above: ________________________________________

_____________________________________________________________________________________

Does the student wear glasses or contacts or both?  Yes  No
If yes, please furnish provider’s name and contact information: ____________________________

Does the student have ear problems/infections, hearing problems, or wear a hearing aid?  Yes  No
If yes, please explain: __________________________________________________________________

Does the student have speech problems?  Yes  No
If yes, please explain: __________________________________________________________________

Has the student had any trouble associated with dental treatment?  Yes  No
If yes, please explain: __________________________________________________________________

Is the student currently receiving dental care or orthodontic care?  Yes  No
If yes, please furnish provider’s name and contact information: ____________________________

Does the student wet the bed?  Yes  No

Describe the student’s sleeping patterns: ________________________________________________

Is the student on a special diet?  Yes  No
If yes, please explain: __________________________________________________________________

_____________________________________________________________________________________

Signature of Legal Guardian ____________________________  Date ________________
FAMILY – SCHOOL COMPACT
CIRCLE OF NATIONS SCHOOL – WAHPETON, ND

We all agree that we want a positive, worthwhile living and learning experience for the students at Circle of Nations School. We agree to the following responsibilities:

<table>
<thead>
<tr>
<th>Academic</th>
<th>Student</th>
<th>Parent/Guardian</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will come to class on time prepared to learn and participate fully in class.</td>
<td>I will ensure my child stays in school and achieve to their potential.</td>
<td>We will provide a welcoming, safe, learning environment.</td>
<td></td>
</tr>
<tr>
<td>I will serve as a positive role model to my peers.</td>
<td>I will support high and realistic expectations for my child’s achievement and future education.</td>
<td>We will set high standards for student performance with respect to the individual learning styles.</td>
<td></td>
</tr>
<tr>
<td>I will seek assistance from my teachers.</td>
<td>I will communicate with the educational staff on my child’s achievement progress.</td>
<td>We will communicate with parent/guardian on the student’s accomplishments.</td>
<td></td>
</tr>
<tr>
<td>I will complete assignments accurately and on time.</td>
<td>I will support the school’s policy on homework.</td>
<td>We will provide appropriate instruction based on the school’s curriculum.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residential</th>
<th>Student</th>
<th>Parent/Guardian</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will use my free time wisely by reading for pleasure and joining cultural, recreational, and learning activities.</td>
<td>I will communicate with staff who are closely involved with my child.</td>
<td>We will provide a welcoming and safe home living environment.</td>
<td></td>
</tr>
<tr>
<td>I will seek assistance from the dorm staff or counselors when I have problems.</td>
<td>I will ensure my student’s health coverage is current through the school year.</td>
<td>We will contact parent/guardian with concerns about the student.</td>
<td></td>
</tr>
<tr>
<td>I will ask for help with homework.</td>
<td>I will support the residential program policies and guidelines.</td>
<td>We will provide an integrated home living environment that includes tutoring, cultural, wellness and prevention activities.</td>
<td></td>
</tr>
<tr>
<td>I will talk with my family about what I am learning, my interests, and my plans for the future.</td>
<td>I will use school information sources (newsletter, email, website) to keep with school issues and activities.</td>
<td>We will provide a regular schedule of after-school, evening, and weekend guidance activities.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Warrior Way – Be Respectful, Be Responsible, and Be Safe</th>
<th>Student</th>
<th>Parent/Guardian</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will respect the personal rights and property of myself and others.</td>
<td>I will talk with my child about respecting people and property.</td>
<td>We will treat students and parent/guardian with respect.</td>
<td></td>
</tr>
<tr>
<td>I will behave in a responsible manner.</td>
<td>I will set positive behavior expectations and reinforce school policies and procedures.</td>
<td>We will clearly articulate behavior expectations to students and parent/guardian.</td>
<td></td>
</tr>
<tr>
<td>I will inform an adult about bullying and harassment.</td>
<td>I will talk with my child about bullying, harassment, peer pressure, safety, and drug-free behavior.</td>
<td>We will take steps to prevent bullying and harassment.</td>
<td></td>
</tr>
<tr>
<td>I will keep myself safe and drug-free.</td>
<td>I will support the school’s discipline policy.</td>
<td>We will promote a safe and drug-free school.</td>
<td></td>
</tr>
</tbody>
</table>

Acceptance Signatures

___________________________    __________________________  
Student  Date  

____________________________  
Parent/Guardian  Date  

CEO  Date  

11
In the past, the Circle of Nations School has suggested that students not bring their cellphones and tablets to campus for fear of loss, damage, or theft. After much consideration, Administration has drafted the following pilot program policy regarding these items:

1. In an effort to improve communication between parents/families and students attending CNS, students will be permitted to bring cell phones with them to campus. Upon arrival at the dorms, students will be required to check their cell phones in, where the items will be kept secure in a locked room in each pod. Students will be permitted to “check out” their device at specific times during the evening to make phone calls and answer texts, etc. Cell phones may NOT be brought to school during the academic day. Phones must be clearly labeled with the child’s name.

2. Students will be permitted to bring their personal MP3 players/iPods/iPads to campus. These items will be to be labeled with the child’s name. Students may NOT bring these items to school during the academic day, and will only be permitted to use them during non-instructional time in the Residential Department.

3. Circle of Nations assumes NO LIABILITY for the theft, loss, or misuse of these items (e.g. a student allows another child to use his cell phone, using the student's prepaid minutes).

4. Circle of Nations will not replace any student cell phone or other device. It is the responsibility of the student to manage the devices properly according to the regulations established on each pod.

I acknowledge that I have read and agree to the Circle of Nations School cell phone and electronics policy. Should I choose to send electronic devices to the CNS campus with my child, I understand that CNS assumes no liability for these items. I also understand that should my child violate these policies he or she may lose electronic privileges temporarily or, in severe cases, the items may be sent home to the parent/guardian.

____________________________________  __________________________
Signature of Legal Guardian  Date
A Ropes and Challenge Course has been implemented to enhance our counseling programs. This course is designed to build trust, responsibility, and confidence within a highly structured group. The participants will increase their strengths physically, mentally, and emotionally through a series of activities which may include some climbing over 30-feet. The participants will be instructed in proper belay and spotting techniques and climbing strategies. Safety is the program’s first priority. Each activity will be closely supervised and all will be done in a manner referred to as “Challenge by Choice”. This will give the participant a chance to try an activity in a supportive atmosphere by his/her own choice.

Release executed on ____________________________, by ____________________________

Date PRINT: Parent/ Legal Guardian

of ___________________________________________________ (Mailing Address)

City / State / Zip

(Herein referred to as Releasor)

I contest that I am the legal guardian of (Student’s Name) ____________________________________________, and can legally enter into the following agreement:

In consideration of being permitted to participate in the Ropes and Challenge Course conducted by staff members in and around the property of the Circle of Nations School (hereafter referred to as Releasee), I, as Releasor, hereby release, waiver, and discharge the Circle of Nations School and its assignees from all liability for injury or damages which may be incurred as a result of participation in the Ropes and Challenge Course or any activities in connection with the Ropes and Challenge Course, whether by negligence or accident. The Releasor agrees to assume any and all risks involved in the student's participation in this activity.

If the Releasor brings an action and/or obtains a judgment against any third party for injuries or damages arising out of the above referenced activities, the Releasor will fully protect Releasee from any and all claims for contribution and/or indemnity.

Releasor states that he/she has carefully read the foregoing release and understands the contents thereof and signs this release as his/her own free act.

In witness thereof, Releasor has executed this release on the date shown.

__________________________________________

(Releasor – Parent/Legal Guardian) Date
PARENTAL CONSENT FORM

Student’s Name: ____________________________________________________________

Permission is granted for the above named student to participate in organized school related / sponsored activities and field trips as approved by CNS. It is understood that the student will be properly chaperoned by qualified school personnel and all precautions will be taken to insure his/her safety. Further, it is understood that these trips may be overnight and may cross state lines.

Yes  No

Exception(s):  ________________________________________________________________

Permission is granted for the above named student to participate in organized competitive sports approved by CNS. It is understood that a physical examination for the student is required before the student can fully participate in any competitive sports offered by CNS.

Yes  No

Students often request to have their hair cut, trimmed, colored, or highlighted (at their expense). Permission is granted for the above named student for the following choices (please circle):

- Haircuts  Yes  No
- Trims  Yes  No
- Coloring  Yes  No
- Highlighting  Yes  No

Additional comments / instructions: ________________________________________________

Students at CNS may have the opportunity to participate in sweat ceremonies for purposes of purification, prayer, personal spiritual guidance, and personal spiritual growth. Students may also have the opportunity to participate in church activities. Permission is granted for the above named student to participate in the following:

- Sweat ceremonies  Yes  No
- Church activities  Yes  No

Additional comments / instructions: ________________________________________________

_____________________________          _____________________
Signature of Legal Guardian                       Date
The purpose of this document is to address the requirements of the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. It will 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.

Person completing form: _____ Parent/Guardian _____ Other: (please specify) _________________________

1. Is the student’s current address a temporary living arrangement? Yes No
2. Is the student’s temporary address due to loss of housing OR economic hardship? Yes No

Student Information

Student Name: ___________________________________ Grade Level: ___________ Age: ___________
Parent/Guardian Name(s): ________________________________________________________________
Parent / Guardian / Youth phone number: ________________________________________________

☐ Cellular phone ☐ Work Phone ☐ Shelter Phone ☐ Family / Friend’s Residence

Residency Information

Where does the student stay at night?

☐ Doubled up (more than one family in a house, apartment, or mobile home)
☐ Hotels/ motels, temporary housing, campsite
☐ Shelter/transitional housing / awaiting foster care
☐ Unsheltered (cars, parks, etc.)

Address/Directions: ________________________________________________________________
Shelter Contact Person: _____________________________________________________________

☐ Choices listed above do not apply

What supplemental services would you like the student to receive?

Educational Services
Description: ______________________________________________________________________

After-school Services
Description: ______________________________________________________________________

Health Services
Immunizations ______________________________________________________________________
Dental ______________________________________________________________________________
Food/Clothing ______________________________________________________________________
Free Lunch __________________________________________________________________________
Counseling __________________________________________________________________________
Optometry __________________________________________________________________________

The parent/guardian understands the above 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 the Circle of Nations School Registrar/School Liaison immediately. If you have any questions, please call 701-672-7222, CNS Registrar. Fax number: 701-642-1984.

Signature of Parent/Guardian: ______________________________________________________________________ Date: ____________________
May 15, 2019

Dear Parent/Guardian,

The Family Educational Rights and Privacy Act (FERPA), a Federal law, requires the Circle of Nations School, with certain exceptions, to obtain your written consent prior to the disclosure of personally identifiable information from your child’s education records. However, Circle of Nations School may disclose appropriately designated “directory information” without written consent, unless you have advised the School to the contrary in accordance with School procedures. The primary purpose of directory information is to allow the Circle of Nations School to include this type of information from your child’s education records in certain school publications. Examples include:

- A playbill, showing your student’s role in a drama production
- The annual yearbook
- Honor roll or other recognition lists
- Graduation program
- Sports activity sheets, such as for wrestling, showing weight and height of team members

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent/guardian’s prior written consent. Outside organizations include, but are not limited to, companies that publish the yearbook, etc. In addition, two federal laws require local education agencies receiving assistance under the Elementary and Secondary Education Act of 1965 (ESEA) to provide military recruiters, upon request, with three directory information categories – names, addresses, and telephone listings – unless parent/guardians have advised the school that they do not want their student’s information disclosed without their prior written consent.

If you do not want Circle of Nations School to disclose directory information from your child’s education records without your prior written consent, you must notify the school in writing prior to enrollment date of your student. Circle of Nations School has designated the following information as directory information:

- Student’s name
- Participation in officially recognized activities and sports
- Address
- Telephone listing
- Weight and height of members of athletic teams
- Photograph
- Honors and awards received
- Date and place of birth
- Dates of attendance
- Grade level

If there are questions about your student’s rights under FERPA, please contact the School Principal, at 701-642-3796, ext. 231, or at Circle of Nations School, 832 8th Street North, Wahpeton, ND 58075.

If you do not wish directory information about your student to be disclosed, please inform CNS in writing and submit the letter to the school prior to the enrollment date of your student.

Sincerely,

Trevor Gourneau, Principal

(Keep this page for your information.)
Patient Registration / Update Indian Health Service

Patient’s Name: ___________________________ Maiden: _______________________

Other Names Used: ___________________________ Sex: M _____ / F _____

Chart Number: ___________________________ Date of Birth: ___________________________ Religion: ___________________________

Tribe of Enrollment: ___________________________ Enrollment Number: ___________________________

Indian Blood Quantum: 4/4 _____ 3/4 _____ 1/2 _____ 1/4 _____ 1/8 _____ Other: ___________________________

Present Community (where you live): ___________________________ Number of years: ___________________________

Social Security Number: ___________________________ Birthplace (Town/State): ___________________________

Home Phone: ___________________________ Work Phone: ___________________________ Cell Phone: ___________________________

Do you have any of the following insurances?

Medicare: Yes_____ No_____ If yes, give number: ___________________________ Eff. Date: ___________________________

Medicaid: Yes_____ No_____ If yes, give number: ___________________________ Eff. Date: ___________________________

Private Health Insurance: Yes_____ No_____ If yes, give number: ___________________________

Eff. Date of Insurance: ___________________________ Policy Holder & Name: ___________________________

Name & Address of Insurance Company: ___________________________

Place of Employment: ___________________________

Spouse’s Place of Employment: ___________________________

Are you a veteran: Yes_____ No_____ If yes, give branch: ___________________________

Father’s Name: ___________________________ Place of Birth: ___________________________

Mother’s Name (maiden): ___________________________ Place of Birth: ___________________________

Parents’ Place of Employment, if minor: Mother: ___________________________ Father: ___________________________

Emergency Contact: ___________________________ Relationship to You: ___________________________

Address: ___________________________ Town: ___________ State/zip: ___________ Telephone #: ___________________________

Next of Kin (If same as above, write SAME):

Name: ___________________________ Relationship to You: ___________________________

Address: ___________________________ Town: ___________ State/zip: ___________ Telephone #: ___________________________

Optional: Do you have internet access? No_____ Yes_____ If yes, where: ___________________________

**Please provide a copy of your SS#, enrollment papers, birth certificate, and any insurance you may have: Medicare, Medicaid, Private Health Insurance, for your records here that we can keep on file. This info is useful to reach you and your family for future appointments, Contract Health Care, and mostly for upkeep of your medical records.
1. Ethnicity: ________________________________
   Hispanic or Latino

2. Primary language: ________________________________

3. Other languages spoken: ________________________________

4. Preferred language: ________________________________

5. Are you a migrant worker? Yes or No
   Please pick one if yes:
   Migrant agricultural worker
   Seasonal agricultural worker

6. Are you homeless? Yes or No
   Please pick one if yes:
   Homeless shelter
   Transitional
   Doubling up
   Street
   Other
   Unknown

7. Advance directives? Yes or No
   Do you have a Power of Attorney or Living Will?

8. Internet access? Yes or No
   If yes, where: ________________________________

9. Email address: ________________________________

10. Generic Health Permission: Yes or No
    Do we have permission to send Generic Health Information to your email address?

11. Preferred method: ________________________________
    What is your preferred method to receive reminders?
    Phone
    Email
    Mail
NOTICE TO PATIENTS ON ELIGIBILITY & REFERRALS

It is the policy of Sisseton Indian Health Service to provide health care to people who are regarded within the scope of the Indian Health program as specified in the INDIAN HEALTH MANUAL, Part 2, Chapter 2 – Persons to whom services may be provided.

A person may be referred by a Physician of delegated personnel of the Indian Health Service: when the medical care required cannot be provided by the Indian Health facility. INDIAN HEALTH SERVICE WILL NOT AUTHORIZE PAYMENT for this care until the eligibility requirements are met:

1. You must be eligible for Direct Care: To be eligible for DIRECT CARE, you must be an Indian from a Federally Recognized Tribe of the United States and you may reside anywhere within the United States. You are allowed up to 30 days to show proof of being Indian from a Federally Recognized Tribe of the U.S. Proof shall be in the form of a letter or statement from his/her Tribe which contains their enrollment number and degree of Indian blood if not enrolled. It is the responsibility of the patient, parent, or guardian to obtain this proof. If proof is not shown within that frame of time, services will not be allowed at the Indian Health Service facility.

2. You must be eligible for Contract Health Care: This is care provided away from Indian Health Service facility. YOU MUST MEET THE DIRECT CARE REQUIREMENTS AND YOU MUST RESIDE WITHIN A DELIVERY AREA called the “On or Near Regulation,” “ON” refers to an Indian eligible for DIRECT CARE AND LIVES within the boundaries of the reservation where the Indian Health Service facility is located. The “NEAR” refers to the MEMBERS OF THE TRIBE who live ON or NEAR (the counties are defined in the Federal Regulations) the reservation where the Indian Health Service facility is located.

If a patient does not meet BOTH eligibility requirements for DIRECT CARE AND CONTRACT HEALTH CARE, Indian Health Service will not pay for care provided at a non-IHS (private sector) health care facility.

INDIAN OR CANADIAN OR MEXICAN ORIGIN
Any Indian or Canadian or Mexican origin is not eligible for care with IHS.

NON-INDIAN BENEFICIARIES
Any non-Indian woman pregnant with an eligible Indian’s child will be required to show proof that she is eligible for prenatal and postnatal services either through marriage to an eligible Indian male or by statement from the eligible Indian that she is carrying his child.

*Any questions concerning the above policy should be directed to the Service Unit Director.

I have read and received a copy of the above information, all my questions have been answered, and I understand the information.

Signature: ______________________________________ Date: ____________________
ADMISSION INFORMATION FOR EMERGENCY MEDICAL CARE

Please submit a copy of medical assistance card and/or any vision, dental, and health insurance card(s). In addition, please include signed, notarized parental consent for health services form and release of information forms.

1. Patient/Student Information

Full legal name: ____________________________________________________________

Current address: Circle of Nations School, 832 8th Street North, Wahpeton, ND 58075

Date of Birth: ___________________________ Gender: ______________________

Social Security Number: ___________________________ Medical facility: ________________

Primary Physician: ___________________________ Telephone number: ________________

2. Legal Guardian Information

Guardian’s Name: ___________________________________ SSN: __________________________

Guardian’s Address: ___________________________ DOB: __________________________

Telephone number(s): ___________________________________________________________________

Emergency contact (in addition to Legal Guardian): Circle of Nations School

Emergency contact telephone number: (701) 642-3796, ext. 256

MANDATORY - Please complete the sections below (all that apply):

3a. Medical Assistance State and Number: ___________________________________________

Billing Address: __________________________________________________________________

Telephone Number(s): ____________________________________________________________

3b. Insurance Company: __________________________________________________________

Telephone Number(s): ____________________________________________________________

Policy Number: ___________________________ Group Number: __________________________

3c. Indian Health Service Unit: _____________________________________________________

Address: ______________________________________________________________________

Telephone Number(s): ___________________________ Fax number: ______________________

4. Medical Information for Student

Food allergies: __________________________________________________________________

Medication allergies: __________________________________________________________________

Current medications / prescriptions: __________________________________________________________________

Medical conditions: __________________________________________________________________

Additional information: __________________________________________________________________

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

Name of Student: ___________________________________________ Birth date: _________________________

I (We) __________________________________________________ am (are) the parent(s) / legal guardian(s) of the above named student. I (We) have read and understand the consent and give the Circle of Nations School in Wahpeton, ND permission to arrange for and/or to provide the following health services for my (our) child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures, skin tests, immunizations - including flu vaccine and HPV, and administration of medication.
2. Routine dental care including dental examinations, preventative use of fluorides, and necessary emergency dental care.
3. Optometry care including optometry examinations.
4. Mental health services including evaluation, treatment, and medication, as necessary.
5. Emergency health care for accidents or illness.
6. Transportation of child to and/or from health facilities for these services.
7. Health education and instruction including, but not limited to, the following subjects: diabetes, nutrition, exercise, AIDS, STD’s, age and gender appropriate sex education, and routine health maintenance.

( ) I hereby give consent for all of the above services.
( ) Exceptions or special instructions: ____________________________________________________________

Signed: ________________________________________________ Date: _________________________

Relationship to student: ____________________________ Valid until: _________________________

TO BE COMPLETED BY NOTARY PUBLIC:

State of __________________________

County of _________________________

Signed before me on _________________ by __________________________

Date Name(s) of Individual(s)

__________________________________________
Signature of notarial officer

My commission expires: ____________________ Title of Office

* Person is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.
AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient/Student: __________________________________________ Date of birth: ________________

Disclosure of information from the above named patient/student record is hereby requested.

The information is to be released from:

- Name of facility: __________________________________________________________
- Address: __________________________________________________________________
- City/State/Zip Code: _______________________________________________________
- Telephone Number: ______________________________________________________

and is to be provided to:

School Clinic – Circle of Nations School
832 8th Street North
Wahpeton, ND  58075
701-642-3796, ext. 256

The purpose or need for this disclosure is for the student’s school medical file while enrolled and in attendance at the Circle of Nations School.

The information to be released is from my:

- Medical Record
- Dental Record
- Other (specify) __________________________________________________________________

and includes:

- Only information related to (specify): __________________________________________
- Only the period or events from: ________________________ to ________________________

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of signature.

________________________________________          ____________________
Signature of Patient/Student                          Date

________________________________________          ____________________
Signature of Legal Guardian or Authorized Representative (if necessary)  Date

This information is to be released for the purpose(s) 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 U.S.C. 552a(i)(3)). In the case of alcohol and drug patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31(d).
HIPAA Privacy Authorization Form

** Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

**1. Authorization**
I authorize ________________________________________ (healthcare provider) to use and disclose the protected health information regarding ________________________________________ (student) described below to __________________________ (individual seeking the information).

**2. Effective Period**
This authorization for release of information covers the period of healthcare from:

a. □ _______________ to _______________.

** OR **
b. □ all past, present, and future periods.

**3. Extent of Authorization**

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

** OR **

b. □ I authorize the release of my complete health record with the exception of the following information:
   □ Mental health records
   □ Communicable diseases (including HIV and AIDS)
   □ Alcohol / drug abuse treatment
   □ Other (please specify): ________________________________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.

5. This authorization shall be in force and effect until _______________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_________________________________________  __________________________________________
Signature of patient or personal representative  Date

_________________________________________
Printed name of patient or personal representative and his or her relationship to patient
PAPERWORK REDUCTION ACT STATEMENT: This information is collected to identify each student’s instructional and residential program classification. It will be used to allocate appropriated funds on a weighted student unit formula. The information is supplied by a respondent to obtain or retain a benefit, that is provide appropriate schooling and the needed funding. It is estimated that responding to the request will take an average of 15 minutes to complete. This includes the amount of time it takes to gather the information and fill out the form. If you wish to make comments on the form, please send them to the Information Collection Control Officer, Bureau of Indian Affairs, 1849 C Street NW, Mail Stop 4603 MIB, Washington, DC 20240. Note: Comments, names, and addresses of commenters are available for public review during regular business hours. If you wish us to withhold this information, you must state this prominently at the beginning of your comment. We will honor your request to the extent allowable by law. In compliance with the Paperwork Reduction Act of 1995, as amended, the collection has been reviewed by the Office of Management and Budget and assigned a number and expiration date. The number and expiration date are at the top right corner of the form. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless there is a valid OMB clearance number.

PRIVACY ACT STATEMENT: This information is collected as provided by 5 U.S.C. 552A. The Office of Indian Education Programs is authorized to collect this information in accordance with Public Laws 95-561, 98-511, 99-89, and 100-297. This information will be used to determine the level of funding to be distributed by formula to BIA funded elementary and secondary schools. Weighted student units, the value of basic and specialized instructional and residential programs, are used to calculate the distribution of funds. The information may be disclosed to appropriate Department of Interior and Congressional Offices for policy and budgetary purposes. Collection of each eligible student’s social security number is authorized by Executive Order 9397 to avoid duplicate counts and for tracking purposes.