# Circle of Nations
# 832 8th St N
# Wahpeton ND 58075

Registrar / Admissions Committee
701-672-7222 701-642-1984 (fax)
www.circleofnations.org

Student Name: ___________________________Will be attending CNS for School year 2020-21

Does your household have internet yes no

If no, do you have access to internet in your community yes no

**PARENTAL CONSENT: (please check all that apply)**

Permission to utilize the above named student's photographs, writings or illustrations for information/educational purposes
Yes No

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 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. A physical examination for the student is required before the student can fully participate in any competitive sports offered by CNS. Yes No

Permission is granted for the above named student for the following choices:
*Haircuts* Yes No *Coloring* Yes No *Highlighting* Yes No
Additional comments / instructions: ________________________________________________________________

________________________________________________________________________________

Permission to participate in Sweat Ceremonies and/or church activities.
Sweat ceremonies Yes No
Church activities Yes No

Additional comments / instructions: ________________________________________________________________

________________________________________________ ________________
**Signature of Legal Guardian** **Date**

**Student Name:** ______________________________

## FAMILY AND BACKGROUND INFORMATION

**Mother:** ______________________________
Address: ______________________________
______________________________
Tribal Affiliation: ______________________________
Telephone numbers:
Home: ______________________________
Cell: ______________________________
Other: ______________________________
Please circle: Living Deceased
Employer: ______________________________
Emergency contact: ______________________________
Emergency number: ______________________________
E-mail: ______________________________

**Father:** ______________________________
Address: ______________________________
______________________________
Tribal Affiliation: ______________________________
Telephone numbers:
Home: ______________________________
Cell: ______________________________
Other: ______________________________
Please circle: Living Deceased
Employer: ______________________________
Emergency contact: ______________________________
Emergency number: ______________________________
E-mail: ______________________________

**This section must be accompanied by a copy of the Custody Order if Legal Guardian is not a Parent**

**Legal Guardian -:** ______________________________
*(if not parent )*
Address: ______________________________
______________________________
Telephone numbers:
Home: ______________________________
Cell: ______________________________
Other: ______________________________
E-mail address: ______________________________

Relationship to student: ______________________________
Tribal Affiliation: ______________________________
Employer: ______________________________
Emergency contact: ______________________________
Emergency number: ______________________________

## 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.***
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**

**GIFTED AND TALENTED PROGRAM**
CIRCLE OF NATIONS-WAHPETON INDIAN SCHOOL

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: ______________________________________________

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

# CIRCLE OF NATIONS SCHOOL

## BIE McKinney-Vento Enrollment/Referral

This questionnaire is intended to address a child's eligibility for services provided and required by the McKinney-Vento Act of No Child Left Behind Act. Your answers will help the administration determine residency documents necessary for enrollment of the student. Please check any statement that applies to your child's residency. It will be school staff and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

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 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 your responsibility to notify the Circle of Nations School Registrar.*

Signature of Parent/Guardian: ________________________ Date: __________

# STUDENT HEALTH INFORMATION SUMMARY

Student Name: ________________________________

Medical Assistance Number: ________________________ Insurance Policy Number: ________________________

**Coronavirus**: Have you been exposed? Yes No Have you been tested ? Yes No Results: ___________

Has anyone in your household been infected Yes No If yes, did they recover? Yes No

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 | Surgery |
| Suicide attempt/ Overdose | Depression | Eating disorder | Allergies | Diabetes | Coronavirus |
| Serious accident | Kidney problems | 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

**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.

WOODROW WILSON KEEBLE MEMORIAL HEALTH CARE CENTER
PO BOX 189
100 LAKE TRAVERSE DRIVE
SISSETON, SD 57262

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

WOODROW WILSON KEEBLE MEMORIAL HEALTH CARE CENTER
PO BOX 189
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SISSETON, SD 57262

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 or 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: ______________

   Address: ______________________________

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.

( ) Exceptions or special instructions: ____________________________________________________________

Parent/Guardian Signature: ______________________________________________Date: _________________

## 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 purposed 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**