Application for Returning Student

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 2022-23

Grade: _____

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**

Coronavirus: For students 12 years and older – Has student received the Covid-19 vaccine? Yes No
If so, please provide date received: _____

Student Name: _____

FAMILY AND BACKGROUND INFORMATION

Mother: _____ **Father:** _____

Legal Guardian: ☐ Legal Guardian: ☐

Address: _____ Address: _____

_____ _____

Tribal Affiliation: _____ Tribal Affiliation: _____

Telephone numbers: Telephone numbers:

Home: _____ Home: _____

Cell: _____ Cell: _____

Other: _____ Other: _____

Please circle: Living Deceased Please circle: Living Deceased

Employer: _____ Employer: _____

Emergency contact: _____ Emergency contact: _____

Emergency number: _____ Emergency number: _____

E-mail: _____ E-mail: _____

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

Legal Guardian - _____ Relationship to student: _____

(if not parent) Tribal or County Program: _____

Address: _____ Tribal Affiliation: _____

_____ Employer: _____

Telephone numbers:

Home: _____

Cell: _____

Other: _____ Emergency contact: _____

E-mail address: _____ Emergency number: _____

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.

_____ _____

Signature of Legal Guardian Date

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: _____

Student & family language survey

What is the student's first language? _____ Is a language other than English used in the home? Y or N

If yes, what is the language? _____

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? _____ Have you been tested? _____ Results: _____

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/drug issues	Coronavirus	Other: _____	

Briefly describe any of the problems circled above: _____

Does the student wear eyeglasses / 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

**Please bring a copy of your SS Card, Enrollment papers, Birth Certificate, and any insurance you may have so we can keep it on file. This information is useful to reach you and your family for future appointments, Purchase referred Care and mostly up-keep of your Medical Records.

Patient's Name: _____ Maiden: _____

Other Names Used: _____ Sex: M F

Chart Number: _____ DOB: _____ 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): _____

Mailing Address: _____ Town/State : _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Do you have any of the following insurances?
Medicare Yes No If yes, list number: _____ Eff. Date: _____
Medicaid Yes No If yes, list number: _____ Eff. Date: _____
Private Insurance: Yes No
If yes, list number: _____ Eff. Date: _____
Policy Holder: _____

Place of Employment: _____ Spouse Place of Employment: _____
Are you a Veteran: Yes No If yes, what branch: _____

Father's Name: _____ Place of Birth: _____

Mother's Name: _____ Place of Birth: _____

Parents place of employment if minor: Mother: _____Father: _____

Emergency Contact: _____ Relationship to you: _____

Address: _____ Town/state: _____ Zip: _____ Phone: _____

Next of KIN: (If same as above, write SAME)
Name: _____ Relationship to you: _____

Address: _____ Town/state: _____ Zip: _____ Phone: _____

Updated 4/6/20

Patient Name: _____ Registration Intake Form #2

1. Ethnicity: (Select One) Hispanic or Latino Not Hispanic or Latino Unknown

2. Primary Language: _____

3. English Proficiency: (Select one) Very Well Well Not Well Not at all

4. Preferred Language: _____

5. Are you a migrant worker: Yes or No
   If yes, select one: Migrant Agricultural Worker Seasonal Agricultural Worker

6. Are you homeless: Yes or No

   If yes, select one:

Homeless Shelter	Street
Transitional	Other
Doubling Up	Unknown

7. Do you have Advance Directives? Yes or No
   If yes, select one: Power of Attorney Living Will

8. Internet Access: Yes or No Where: _____

9. Email Address: _____

10. DO we have permission to send Generic Health information to your email address? Yes or No

    If yes, what is your preferred methos to receive reminders?

    Please pick one:

    Email Letter Phone

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Woodrow Wilson Keeble Memorial Heath Care Center notice of Privacy Practices at:

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

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Date
(State relationship to Patient)
Witness (If signature is by thumb print or mark)

_____ _____
Signature and Title of I.H.S. Employee Date

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was able to acknowledge receipt of the Notice of Practices because:

_____

_____ _____
Signature of I.H.S. Employee Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service

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

(Before completing this form, please read information on reverse side or following page)

Name of Student _____ Date of Birth _____

I (We), _____
Have read the Consent Form for the Indian Health to arrange for or to provide the following health care services for this child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures, and skin tests.

2. Dental care including dental examinations, preventive use of fluorides and necessary emergency dental care.

3. Mental health services including evaluation and treatment as necessary.

4. Emergency health care for accidents illness.

5. Transportation of the child to and/or from another health facility for these services.
   - ☐ I hereby give consent for all of the above services.
   - ☐ Exceptions or Special Instructions:

     _____
     _____
     _____

Signed _____

Address _____

Relationship _____

Date_____ Valid Until _____

PLEASE RETURN THIS FORM TO THE SCHOOL

(The third page of this form is for you to keep)

_____
1 Person is defined as one who in the absence or the parent or legal guardian provides a home for the child such as next of kin.

IHS – 47
(10/88)

Copy 1 (IHS RECORD)

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: _____

Circle of Nations School
Release and Authorization for Dispensing Medication

To be completed by parent or guardian

I, _____

Give Circle of Nations school permission to administer the following medications on the Standing orders list (per package directions) to my child:

_____ _____

Student Name Date of Birth

Signature of Parent/Guardian: _____ Date:_____

Prescribed medications information: If your child takes scheduled medication, please complete the following:

Name of Medications:

_____

_____

Reason for taking medications:

_____

_____

Prescribed dose and route of medications:

_____

_____

Time of day the medication is to be taken:

_____

_____

How long will student be taking this medication:

_____

_____

Name of Doctor who prescribed the medication:

_____

_____

Name of Pharmacy, City, State of where medication was received from:

_____

_____

This form will allow us to give your child general over the counter medicines if needed

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