

Student Name: \_\_\_\_\_

BIA Form 6248  
OMB No. 1076-0122

United States Department of the Interior  
Bureau of Indian Affairs

SIHS/Rev – 04/2021

**School Year 2021-2022**

**Long Form**

**SHERMAN INDIAN HIGH SCHOOL  
RIVERSIDE, CALIFORNIA  
STUDENT ENROLLMENT APPLICATION**

**STUDENT IDENTIFICATION:**

**Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last

First

Middle

(Month/Day/Year)

Mailing: \_\_\_\_\_ Age: \_\_\_\_\_

Address

City

State

Zip

Residential: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Address

City

State

Zip

Student Email address \_\_\_\_\_ Student cell phone # \_\_\_\_\_

In which tribe is the student enrolled? \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION:**

A. \_\_\_\_\_ Father Mother Guardian Other

Parent/Guardian Name

Circle Relationship

Address

City

State

Zip

Tribal Affiliation

Email address: \_\_\_\_\_ Legal Guardian: ☐ No ☐ Yes Contact Allowed ☐ No ☐ Yes

Home Phone: ( ) \_\_\_\_\_ Lives with student: ☐ No ☐ Yes

Cell Phone: ( ) \_\_\_\_\_ Receive student mailings: ☐ No ☐ Yes

Work Phone: ( ) \_\_\_\_\_

B. \_\_\_\_\_ Father Mother Guardian Other

Parent/Guardian Name

Circle Relationship

Address

City

State

Zip

Tribal Affiliation

Email address: \_\_\_\_\_ Legal Guardian: ☐ No ☐ Yes Contact Allowed ☐ No ☐ Yes

Home Phone: ( ) \_\_\_\_\_ Lives with student: ☐ No ☐ Yes

Cell Phone: ( ) \_\_\_\_\_ Receive student mailings: ☐ No ☐ Yes

Work Phone: ( ) \_\_\_\_\_

**ANY GUARDIANSHIP OR CUSTODIAL ARRANGEMENTS MUST  
INCLUDE PROPER NOTARIZED/COURT DOCUMENTATION**

Student Name: \_\_\_\_\_

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## SECONDARY CONTACT INFORMATION

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### CHILD PROTECTION SERVICE/ CASE WORKER INFORMATION: (IF APPLICABLE)

Name		Agency		
Address	City	State	Zip	
Office Phone: (    ) _____		Email Address: _____		

### EMERGENCY CONTACTS (OTHER THAN PARENTS/GUARDIANS):

A. \_\_\_\_\_

Emergency Contact Name	Relationship to student	City	State	Zip
Home Phone: (    ) _____		Cell Phone: (    ) _____		

B. \_\_\_\_\_

Emergency Contact Name	Relationship to student	City	State	Zip
Home Phone: (    ) _____		Cell Phone: (    ) _____		

### TRIBAL EDUCATION OFFICE (LIST THE NAME OF THE TRIBE): \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Address: \_\_\_\_\_ FAX: (    ) \_\_\_\_\_

City, State, and Zip: \_\_\_\_\_

***IF SHERMAN CANNOT CONTACT A PARENT, GUARDIAN OR EMERGENCY CONTACT,  
SHERMAN WILL CONTACT SOCIAL SERVICES AND/OR LAW ENFORCEMENT.***

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### LOCO PARENTIS PERMISSION

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I agree, for reasonable cause and assurance for the health and safety of all students, Sherman Indian High School staff may act in *loco parentis*. They may, at their discretion, exercise search, seizure and drug testing while my student is in attendance at Sherman Indian High School. Such activities shall be in compliance with 25 CFR-Part 42.3, (b), "Rights of the Individual Student," and 34 CFR-Part 86.200, (b-e), "Drug Free Schools and Campuses."

\_\_\_\_\_  
(Parent/Legal Guardian Signature)

\_\_\_\_\_  
(Date)

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**PROHIBITING ALCOHOL / ILLEGAL SUBSTANCES AND GANG ACTIVITY**


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**PROHIBITING ALCOHOL / ILLEGAL SUBSTANCES**

Sherman Indian High School prohibits the use and possession of alcohol or illegal substances. Students under the influence of alcohol or illegal substances may, at administrative discretion, remain on-campus *if* both the student and parent agree that the student will comply with a rigorous intervention contract. Again, this will be an administrative option. Students who exhibit other negative behaviors will be sent home on Administrative Leave pending a hearing or in cases of a second offense within the academic year or the previous semester. Students under the influence or having drug paraphernalia are subject to drug testing. Refusal to test is considered a *positive test* in the state of California (students who refuse to be tested or searched will be sent home pending an Administrative Hearing). Possession of a controlled substance on school property in the state of California is a felony and subject to intervention by local law enforcement.

_____ <b>Parent/Guardian Signature</b>	_____ <b>Date</b>	_____ <b>Student Signature</b>	_____ <b>Date</b>
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**PROHIBITING GANGS AND GANG ACTIVITY**

The visibility of gang and gang-related activities at Sherman Indian High School causes a substantial disruption of and/or material interference with school and school activities. Gangs and gang-related activities are prohibited on SIHS school property or at SIHS school affiliated activities. Signing the following contract is a condition of enrollment at SIHS.

I hereby agree that I will not engage in the following activity or behavior  
while a student at Sherman Indian High School;

1. I will not wear, possess, use, distribute, display or sell any clothing (i.e. red, blue, towels, etc.) jewelry, emblem, badge, symbol, sign or any item deemed by administration which is evidence of membership or affiliation in any gang;
2. I will not communicate, either verbally or non-verbally, any gesture, handshake, slogan, or drawing to show membership or affiliation in a gang;
3. I will not commit any act which furthers gang activity including, but not limited to:
  - a. Soliciting others for membership in any gang;
  - b. Requesting any person to pay protection or otherwise intimidating or threatening any person;
  - c. Committing any illegal act or violation of SIHS policies;
  - d. Inciting other students to act with violence upon any other person.

I understand and agree to the provisions of this contract.

_____ <b>Parent/Guardian Signature</b>	_____ <b>Date</b>	_____ <b>Student Signature</b>	_____ <b>Date</b>
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## CRITERIA FOR BOARDING OR OUT-OF-BOUNDARY ENROLLMENT

Favorable action is recommended upon this application because this case conforms to the following criteria for boarding school or out-of-boundary enrollment. **Must check (✓) at least one factor in either column.**

### EDUCATIONAL FACTORS

Name of Federal/Public/Local school(s) that the student would attend: \_\_\_\_\_

- ☐ Grade level not offered.
- ☐ Are severely overcrowded.
- ☐ Do not offer student's grade level.
- ☐ Exceeds 1 1/2 miles walking distance to school or bus route.
- ☐ Do not offer special vocational/preparatory training necessary for gainful employment.
- ☐ Do not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences.
- ☐ Receiving school offers special academic program needed by student.

### SOCIAL FACTORS

In his/her environment, the student:

- ☐ Was rejected or neglected.
- ☐ Does not receive adequate parental supervision.
- ☐ Well-being was imperiled due to family behavioral problems.
- ☐ Has behavioral problems too difficult for solutions by family or local resources.
- ☐ Has siblings or other close relative(s) enrolled who would be adversely affected by separation.

Other Factors: ☐ Parent Choice ☐ Homeless ☐ Student ☐ Other \_\_\_\_\_

### ALUMNI INFORMATION:

Have any family members attended Sherman Indian High School? Please circle all that apply.

Grandmother   Grandfather   Mother   Father   Brother   Sister   Aunt   Uncle   Cousin

### TRIBAL ENROLLMENT OFFICE:

Contact Name

City

State

Phone Number

#### To be completed by Sherman Indian High School

Out-of-Boundary

\* Receiving Education Line Officer

\* To be signed ONLY by Sacramento Area Office

Sacramento Officer will sign during campus visitation

Sacramento Area Officer: \_\_\_\_\_ Date Approved: \_\_\_\_\_

Student Name: \_\_\_\_\_

## PERMISSION TO OBTAIN/RELEASE RECORDS

I do hereby give my permission for Sherman Indian High School, Riverside, California, a BIE school, to obtain and/or release a copy of my child's grades, transcripts, social/legal records, Title I, Special Education, 504 Plan and Special Academic Program records.

Student Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

## SCHOOL HISTORY

### FOR STUDENTS WHOSE LAST ACADEMIC YEAR WAS 8<sup>TH</sup> GRADE

Name of Middle School: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Year you were promoted: \_\_\_\_\_

**You MUST send your 8<sup>th</sup> grade promotion certificate/diploma, standardized test scores and your 7<sup>th</sup> & 8<sup>th</sup> Grade report cards.**

Please explain any D's and F's that are on your transcripts: \_\_\_\_\_

### FOR STUDENTS WHO HAVE PREVIOUSLY ATTENDED HIGH SCHOOL

Have you previously attended Sherman Indian High School? (circle) YES NO

If "yes" write years attended \_\_\_\_\_

Reason for leaving \_\_\_\_\_

Number of high schools you have attended? (circle)

1      2      3      4      4+

List all high schools you have attended (use back if necessary):

PLEASE ATTACH TRANSCRIPTS

Name of High School: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Dates you attended: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

FAX Number: \_\_\_\_\_ Age Entered : \_\_\_\_\_

Name of High School: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Dates you attended: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

FAX Number: \_\_\_\_\_ Age Entered : \_\_\_\_\_

Name of High School: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Dates you attended: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

FAX Number: \_\_\_\_\_ Age Entered : \_\_\_\_\_

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**EDUCATIONAL INFORMATION**


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My child has received the following services in school:

- ☐ GATE (Gifted & Talented Education)
- ☐ Bilingual Education
- ☐ AVID
- ☐ Student Study Team
- ☐ Section 504 Plan

**Special Education:**

- ☐ I have an IEP (Individual Education Plan).
- ☐ Special Education/Resource Room

**Date of current IEP:** \_\_\_\_\_**Date of current Psych Eval:** \_\_\_\_\_**Please submit with application.**

What is the first language you learned? \_\_\_\_\_

List any other languages spoken in your home: \_\_\_\_\_

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**TRAVEL INFORMATION**


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- ❖ **REAL ID for airline:** This federally mandated identification is needed for all passengers to board an aircraft. The deadline has been extended to October 1, 2021. In preparation of your students travel needs please keep this in mind. More information will be forth coming.

Please note:

- **ALL** public transportation travelers, under the age of 15 years, are required to travel with a companion over the age of 15 years. If needed, Sherman will provide the escort for official travel days **ONLY**. Sherman will not provide pick up or drop off at Los Angeles International Airport (LAX). Please use Ontario Airport (ONT) for airline travel.
- Students will incur luggage cost for airlines and are limited to 2 (two) large suitcases for buses or SUV pickups.

If the student misses any travel arrangements, it is the student, parent/guardian's responsibility to pay any and all additional fees. All other travel is at the expense of the student's family.

1. Will you be under the age of 15 as of August 1 of this year? ☐ Yes ☐ No
2. Which airport is closest to your residence (city, state)? \_\_\_\_\_
3. Which bus station is closest to your residence (city, state)? \_\_\_\_\_

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**ACKNOWLEDGEMENT OF OFFICIAL TRAVEL**


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I (Parent/Guardian) understand that Sherman will only pay four times of official travel:

*\*the beginning of the year    \*round trip at Christmas    \*and return home at the end of the year*

All other travel is the responsibility of the parent/guardian of the child. Students who are parentally withdrawn are responsible for return travel expenses.

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**Parent/Guardian Signature**


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**Date**

## SOCIAL INFORMATION

**If yes is checked, all lines must be completed. Please Note: A "yes" response to any question does not necessarily mean you will not be granted admission. A "yes" response will allow our staff to offer proactive assistance to help you succeed.**

1. **Has applicant missed 15 or more days of school in the last school year?** ☐ Yes ☐ No  
 School: \_\_\_\_\_ School: \_\_\_\_\_  
 Enrollment dates at school: \_\_\_\_\_ Enrollment dates at school: \_\_\_\_\_  
 Reason for absences: \_\_\_\_\_ Reason for absences: \_\_\_\_\_

2. **Has applicant ever been suspended?** ☐ Yes ☐ No **Expelled?** ☐ Yes ☐ No  
 School: \_\_\_\_\_ School: \_\_\_\_\_  
 Enrollment dates at school: \_\_\_\_\_ Enrollment dates at school: \_\_\_\_\_  
 Reason for suspension: \_\_\_\_\_ Reason for expulsion: \_\_\_\_\_  
**\*Attach Discipline Report(s)** **\*Attach Discipline Report(s)**

3. **Is applicant a ward of the court?** ☐ Yes ☐ No  
 If yes, a copy of the court order must be submitted.

4. **Has applicant ever been cited?** ☐ Yes ☐ No  
 Date: \_\_\_\_\_ Date: \_\_\_\_\_  
 Reason: \_\_\_\_\_ Reason: \_\_\_\_\_

5. **Has applicant ever been arrested/detained?** ☐ Yes ☐ No  
 Date: \_\_\_\_\_ Date: \_\_\_\_\_  
 Reason: \_\_\_\_\_ Reason: \_\_\_\_\_

6. **Does the applicant currently have a probation officer?** ☐ Yes ☐ No  
**If yes, an outline of your terms of probation must be attached to be considered for enrollment.**  
 Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
**When does your probation expire?** \_\_\_\_\_  
**Do you have pending court dates this academic year?** ☐ Yes ☐ No **When?** \_\_\_\_\_  
**Do you have the courts/PO permission to leave your legal jurisdiction to attend Sherman?** ☐ Yes ☐ No

I am legally responsible for this student and request consideration for his/her admission to Sherman Indian High School. I understand that the school may request additional information, including but not limited to; counseling, mental health, psychiatric care, child welfare, and probation before the student is enrolled. I also hereby certify that the information provided is true and accurate to the best of my knowledge and I understand that Sherman may verify all information. **Falsification or omission of any information is cause for immediate denial or release.** Student signature is also required if the student is 18 years of age or older or if the student is an emancipated minor (**documentation must be attached**).

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of student (if student is 18 years or older)**

\_\_\_\_\_  
**Date**

Student Name: \_\_\_\_\_

## PERMISSION FOR STUDENT CHECK OUT

Bureau of Indian Education (BIE), policy prohibits students from leaving campus with anyone other than the parent/guardian unless written consent is on file, and only under the following conditions:

- A student may be released to immediate\* family only who are 25 years or older with written parental/guardian permission and administrative approval.
- Students will not be released to anyone under the influence of drugs or alcohol.
- Residential staff and management may also choose not to release students when other conditions warrant.
- Staff will not be allowed to check out students unless they are in the immediate family.

**\* Immediate family is defined as mother, father, legal guardian, sister, brother, grandparent, aunt or uncle.**

Individuals wishing to check out a student must appear on the school campus and follow the school's checkout procedures. They may be asked to present a valid driver's license for identification purposes. If checkout occurs during instructional time, it may be considered an unexcused absence, which might affect the grade/performance of the student. Individuals checking out students over the weekend must return students to the dorm by 10:00 pm on the evening before school resumes.

The school will not be held responsible for:

- Any legal problems/expenses incurred by the student when checked out.
- Health care expenses incurred while the student is checked out.
- Any CHS (contract health service) expenses that accumulate as a result of an injury occurring while the student is checked out will be the responsibility of the parent/guardian.

By signing this document, the parent/guardian indicates understanding and approval of the above and authorizes permission for checkout.

Student Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

What Type of Checkout is granted ( ✓ )

- ☐ Off campus Checkout
- ☐ Overnight Checkout
- ☐ Weekend Checkout

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

What Type of Checkout is granted ( ✓ )

- ☐ Off campus Checkout
- ☐ Overnight Checkout
- ☐ Weekend Checkout

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

What Type of Checkout is granted ( ✓ )

- ☐ Off campus Checkout
- ☐ Overnight Checkout
- ☐ Weekend Checkout

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

What Type of Checkout is granted ( ✓ )

- ☐ Off campus Checkout
- ☐ Overnight Checkout
- ☐ Weekend Checkout

☐ Nobody has permission to check out my student at the present time.

**This permission will remain in effect until cancelled by the undersigned parent/guardian in writing.**

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)



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**MEDICAL INSURANCE INFORMATION**


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Please supply the following additional information:

1) \_\_\_\_\_  
(Print name of student)

2) \_\_\_\_\_  
(Social Security Number) (date of birth)

3) Is your child covered under any medical or dental insurance program? ☐ Yes ☐ No

a) If YES, what type of insurance (check one): ☐ Private Insurance ☐ Medicaid Insurance

i) For Private Insurance Holders: Please state the name of the insurance company, effective date, policy number, and group number in the spaces below: *Please enclose a copy of current insurance card (front and back).*

_____	_____
(Name of insurance company)	(Policy Number)
_____	_____
(Effective Date)	(Group Number)

ii) For Medicare Holders: Claim Number: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

I hereby assign to the IHS insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to my child by IHS. I authorize payment of such benefits directly to IHS. I understand that if any payments go directly to me that I must turn them into the Parker Indian Health Center Business Office or other designated IHS business office.

I have been given a copy of the Indian Health Service Notice of Privacy Practices (HIPAA).

I certify that the information given is true and accurate,

_____	_____
(Print name of parent or guardian)	(Signature of parent or guardian)

_____	_____
Address	City, State, Zip

(\_\_\_\_\_) \_\_\_\_\_  
(Number of parent / guardian who can be reached during the day)

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## CONSENT OF MEDICAL RELEASE

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Indian Health Service can arrange for and/or provide the following health services for my child:

**\*\*\*Note that according to California law, “effective January 1, 2016, parents or guardians of children in any school or child care facility, whether public or private, will no longer be allowed to submit a personal beliefs exemption to currently-required specified immunization requirements. SB 277 retains the medical exemption provided by a licensed physician.” \*\*\***

1. Health care including medical examinations, treatment, routine laboratory studies, x-ray procedures, skin tests, immunizations and all medications.
2. Medications administered by school dormitory personnel prescribed by Indian Health Service provider.
3. Emergency health care for accidents or illnesses.
4. Emergency dental care.
5. Surgical Procedures.
6. Mental health services including evaluation and treatment as necessary.
7. Psychiatric services to include assessment, treatment, and medication as necessary.
8. Transportation of child to and/or from another health facility for these services.

- I hereby give consent for all of the services listed above.
- Exceptions or Special Instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- I agree, for reasonable cause and assurance for the health and safety of all students, Sherman Indian High School staff may act in loco parentis.

Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_ Valid for: Two years from date signed

**Indian Health Service**  
**Phoenix Service Unit**  
**Sherman Indian High School Clinic**  
**Behavioral Health Consent for Treatment**

I have been informed of the following:

**Treatment Policy:** The Behavioral Health Department provides individual, couples, and group counseling on a voluntary basis. I may request counseling services or I might be referred by medical staff, dorm staff, academic staff and/or my parent/guardian. Under some circumstances, services may be provided via electronic media, in which case, I will be verbally informed of the associated limitations and risks. A provider will meet with me to complete a detailed personal history and will work with me to determine an effective treatment plan which may include the use of therapy, community resources, traditional healing, and the use of medications. I understand that I cannot be forced to participate in parts of the treatment plan that I do not think will be helpful or forced to take medications if I do not want to. The provider will verbally review with me the possible risks, benefits and limitations of any course of treatment presented to me and the risks of refusing treatment.

Court ordered treatment or evaluations are not provided.

**Rights and Responsibilities:** I have been informed of my Patient's Rights and Responsibilities and Privacy Practices at the I.H.S. Clinic at Sherman Indian High School. I understand if I have any concerns or complaints about my treatment, I may contact the supervisor, the Patient Advocate or Department Chief at Phoenix Indian Medical Center at any time

Phone Number (if applicable): \_\_\_\_\_ (602) 263-1518

For training and supervision purposes, my treatment may be audio or video taped and shown to other treatment team members. I have the right to refuse such taping before it occurs. All tapes are subject to the limits of confidentiality and privacy practices.

**Limits of Confidentiality:** I understand I have a right to privacy and limited confidentiality regarding my treatment in the Behavioral Health Department. No information about myself will be released without my signed consent for such release, within the limits allowed by applicable federal and state law. I understand confidentiality cannot be provided if I am feeling suicidal (want to hurt/kill myself), homicidal (thought or desire to hurt or kill others), or if there is a suspicion of child, elder, or disabled adult abuse. I understand that patient and treatment information may be shared and discussed with other health providers to optimize my mental health care. My Behavioral Health documentation will be documented in the E.H.R. (Electronic Health Record) and can only be viewed by authorized providers within the clinic or Phoenix Indian Medical Center.

**Patient Responsibilities:** I understand that it will be my responsibility to keep my appointments and actively participate in my treatment plan. Should I fail to show for 2 consecutive appointments without canceling, my active Behavioral Health chart will be closed, which means I will need to begin another initial treatment process. *For any patient presenting for treatment (child or adult who has a legal guardian), I will need to have written verification of my guardianship status in order to begin treatment.*  
*I agree to all of the above treatment consents and understand their meanings.*

Name of Student (please print): \_\_\_\_\_

Student's Signature: : \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PARENT/GUARDIAN QUESTIONNAIRE FOR ADOLESCENT PREVENTIVE SERVICES

**\*\*\*PLEASE BRING PAGES 12-15 to your Adolescent's Provider for Review during their Physical\*\*\***

***Please Note: A "yes" response to any question does not necessarily mean you will not be granted admission. A "yes" response will allow our staff to offer proactive assistance to help you succeed.***

### Adolescent Health History

1. Student's Primary Care Provider (PCP):

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

Permission given to send SIHS clinic records to PCP: \_\_\_\_\_ Yes \_\_\_\_\_ No

2. Do you have allergies to medicines, pollens, foods, or stinging insects? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes please provide the following: **(Please send filled prescription with student and also send refills)**

Name of allergen	Reaction (hives, breathing)	Epinephrine pen Required
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_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Please provide the following information about any medicines your adolescent is taking:

Name of Medicine	Dose	Frequency	Reason Taking/Diagnosis
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Has your adolescent had any in patient or outpatient treatment for mental health concerns, alcohol or drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide the following:

Age	Name of Treatment Facility/Therapist	How Long	Phone Number	Reason
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Have there been any changes in your adolescent's health during the past 12 months? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

6. Has your adolescent ever been hospitalized overnight for any reason? \_\_\_\_\_ Yes \_\_\_\_\_ No

7. Has your adolescent ever had any of the following health problems? If yes, at what age?

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	_____	_____	_____	Hepatitis (liver disease)	_____	_____	_____
Alcohol/drug use	_____	_____	_____	Low iron (anemia)	_____	_____	_____
Allergies/hay fever	_____	_____	_____	Pneumonia	_____	_____	_____
Asthma	_____	_____	_____	Heart Disease	_____	_____	_____
Bladder/kidney infections	_____	_____	_____	Scoliosis (curved spine)	_____	_____	_____
Blood disorders	_____	_____	_____	Seizures/epilepsy	_____	_____	_____
Cancer	_____	_____	_____	Severe acne	_____	_____	_____
Chicken Pox	_____	_____	_____	Stomach problems	_____	_____	_____
Cutting/self injury	_____	_____	_____	Suicide attempts	_____	_____	_____
Depression	_____	_____	_____	Surgery	_____	_____	_____
Diabetes	_____	_____	_____	Tuberculosis	_____	_____	_____
Eating Disorder	_____	_____	_____	Herpes Skin Infection	_____	_____	_____

If yes to any of the above please explain: \_\_\_\_\_

8. Has a doctor ever denied or restricted your participation in sports for any reason? \_\_\_\_\_ Yes \_\_\_\_\_ No

9. Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc) that caused you to miss a practice or game?  
If yes please explain injury and which extremity was affected: \_\_\_\_\_
10. Have you had any broken/fracture bones or dislocated joints that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? \_\_\_\_\_Yes \_\_\_\_\_No  
If yes please explain injury and which extremity was affected: \_\_\_\_\_
11. Have you ever had a stress fracture? \_\_\_\_\_Yes \_\_\_\_\_No
12. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? \_\_\_\_\_Yes \_\_\_\_\_No
13. Do you regularly use a brace or assistive device? \_\_\_\_\_Yes \_\_\_\_\_No
14. Do you cough, wheeze, or have difficulty breathing during or after exercise? \_\_\_\_\_Yes \_\_\_\_\_No
15. Does your heart race or skip beats during exercise? \_\_\_\_\_Yes \_\_\_\_\_No
16. Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ? \_\_\_\_\_Yes \_\_\_\_\_No
17. Do you have any rashes, pressure sores, or other skin problems? \_\_\_\_\_Yes \_\_\_\_\_No
18. Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to you head, having your "bell rung" or getting "dinged")? \_\_\_\_\_Yes \_\_\_\_\_No
19. Do you have headaches from exercise? \_\_\_\_\_Yes \_\_\_\_\_No
20. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers, or burners? \_\_\_\_\_Yes \_\_\_\_\_No
21. When exercising in the heat, do you have severe muscle cramps or become ill? \_\_\_\_\_Yes \_\_\_\_\_No
22. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? \_\_\_\_\_Yes \_\_\_\_\_No
23. Are you happy with your weight? \_\_\_\_\_Yes \_\_\_\_\_No
24. Are you trying to gain or lose weight? \_\_\_\_\_Yes \_\_\_\_\_No
25. Has anyone recommended you change your weight or eating habits? \_\_\_\_\_Yes \_\_\_\_\_No
26. Do you limit or carefully control what you eat? \_\_\_\_\_Yes \_\_\_\_\_No
27. Has your adolescent fainted or passed out DURING or AFTER exercise, emotion or startle? \_\_\_\_\_Yes \_\_\_\_\_No
28. Has your adolescent ever had extreme shortness of breath during exercise? \_\_\_\_\_Yes \_\_\_\_\_No
29. Has your adolescent had extreme fatigue associated with exercise (different from other kids)? \_\_\_\_\_Yes \_\_\_\_\_No
30. Has your adolescent ever had discomfort, pain or pressure in his/her chest during exercise? \_\_\_\_\_Yes \_\_\_\_\_No
31. How old were you when you had your first menstrual period? \_\_\_\_\_
32. How many periods have you had in the last year? \_\_\_\_\_
33. Does the applicant have medical problems that interfere with school attendance and/or need medical care while at Sherman Indian High School? \_\_\_\_\_Yes \_\_\_\_\_No  
If yes, please explain: \_\_\_\_\_  
Please include name, address, and phone, of the clinic or doctor normally seen by the student:  
Doctor/Clinic: \_\_\_\_\_ Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_
34. Does the applicant (male or female) have children? \_\_\_\_\_Yes \_\_\_\_\_No  
If yes, please list below
- | Name of child | Age   | Child cared by | Relationship to child |
|---------------|-------|----------------|-----------------------|
| _____         | _____ | _____          | _____                 |
35. Do you wear glasses or contact lenses? \_\_\_\_\_Yes \_\_\_\_\_No
36. Is either of the parents of the applicant incarcerated? \_\_\_\_\_Yes \_\_\_\_\_No  
Specify: \_\_\_\_\_
37. Does the applicant need a special diet? \_\_\_\_\_Yes \_\_\_\_\_No  
Specify: \_\_\_\_\_

**Family History**

1. Some health problems are passed from one generation to the next. Have you or any of your adolescent's blood relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "yes", please state the age of the person when the problem occurred and his/her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Birth Defects	_____	_____	_____	_____	_____
Blood disorders	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
(type _____)	_____	_____	_____	_____	_____
Deaf at birth (congenital deafness)	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
(Type I or Type II)	_____	_____	_____	_____	_____
Drinking problem	_____	_____	_____	_____	_____
Or alcoholism	_____	_____	_____	_____	_____
Drug addiction	_____	_____	_____	_____	_____
Endocrine/	_____	_____	_____	_____	_____
gland disease	_____	_____	_____	_____	_____
Enlarged Heart	_____	_____	_____	_____	_____
(Cardiomyopathy)	_____	_____	_____	_____	_____
Heart attack/stroke	_____	_____	_____	_____	_____
(before age 55)	_____	_____	_____	_____	_____
Heart attack/stroke	_____	_____	_____	_____	_____
(after age 55)	_____	_____	_____	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Heart Rhythm Problems (Arrhythmias)	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____
High cholesterol	_____	_____	_____	_____	_____
Incarceration	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____
Learning disability	_____	_____	_____	_____	_____
Liver disease	_____	_____	_____	_____	_____
Marfan Syndrome	_____	_____	_____	_____	_____
Mental health	_____	_____	_____	_____	_____
Mental retardation	_____	_____	_____	_____	_____
Migraine headaches	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____
Pace Maker or Implanted Defibrillator	_____	_____	_____	_____	_____
Seizures/epilepsy	_____	_____	_____	_____	_____
Smoking	_____	_____	_____	_____	_____
Sudden Death of Unknown Cause	_____	_____	_____	_____	_____
Suicide	_____	_____	_____	_____	_____
Tuberculosis/lung Disease	_____	_____	_____	_____	_____

2. With whom does the adolescent live most of the time? (Check all that apply)
- |  |                             |                            |
|--|-----------------------------|----------------------------|
| _____ Both parents (in same household) | _____ Stepmother            | _____ Sister(s)/ages _____ |
| _____ Mother                           | _____ Stepfather            | _____ Other _____          |
| _____ Father                           | _____ Guardian              | _____ Alone                |
| _____ Other adult relative             | _____ Brother(s)/ages _____ |                            |

3. In the past year, have there been any of the following changes in the adolescent's family? (check all that apply)
- |                  |                    |                       |                     |
|------------------|--------------------|-----------------------|---------------------|
| _____ Marriage   | _____ Loss of job  | _____ Births          | _____ Incarceration |
| _____ Separation | _____ Move         | _____ Serious Illness | _____ Other: _____  |
| _____ Divorce    | _____ A new school | _____ Deaths          |                     |

**Parent/Guardian Concerns**

1. Please review the topics listed below. Check if you have a concern about your adolescent
- |                                     |                       |   |
|-------------------------------------|-----------------------|---|
| _____ Physical problems             | _____ Drug use        | _____ School grades/absences/dropout        |
| _____ Physical development          | _____ Weight          | _____ Smoking cigarettes/chewing tobacco    |
| _____ Change of appetite            | _____ Depression      | _____ Amount of physical activity           |
| _____ Sleep patterns                | _____ HIV/AIDS        | _____ Relationships with parents and family |
| _____ Diet/nutrition                | _____ Pregnancy       | _____ Sexually transmitted diseases (STD's) |
| _____ Guns/weapons                  | _____ Dating/parties  | _____ Self-image or self-worth              |
| _____ Emotional development         | _____ Alcohol use     | _____ Unprotected sex                       |
| _____ Lying, stealing, or vandalism | _____ Sexual behavior | _____ Excessive moodiness or rebellion      |
| _____ Choice of friends             | _____ Work/job        | _____ Sexual identity (homosexual/bisexual) |
| _____ Violence/gangs                | _____ Other _____     |   |
2. What seems to be the greatest challenge for your teen? \_\_\_\_\_
3. What is it about your teen that makes you proud of him or her? \_\_\_\_\_

Student Name: \_\_\_\_\_

Sherman Indian High School Clinic  
Adolescent Physical Exam

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

**CURRENT IMMUNIZATION RECORD AND FOLLOWING IMMUNIZATIONS  
ARE REQUIRED**

Rotavirus 3    Hepatitis B 3    Tdap 1    MMR 2    PCV(pneumococcal) 4  
Varicella 2    Hepatitis A 2    DTaP 5    Polio (IPV) 4    Men B (meningococcal B) 1-2  
PPD/Quant Gold – Annual    Hib (Haemophilus influenza type B) 3    MCV4 (Meningococcal ACWY) 2  
**Highly recommended: HPV: 3 doses**

**VISION (Corrected/Uncorrected)** OD \_\_\_\_\_ OS \_\_\_\_\_ **HEARING:** AD: Passed/Failed AS: Passed/Failed

HT \_\_\_\_\_ WT \_\_\_\_\_ BMI \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ T \_\_\_\_\_ O2 \_\_\_\_\_

	Initials	Normal	Abnormal Findings		Initials	Normal	Abnormal Findings
<b>Medical</b>				<b>Musculoskeletal</b>			
Appearance	_____	_____	_____	Neck	_____	_____	_____
Eyes/Ears/Throat/Nose	_____	_____	_____	Back	_____	_____	_____
Lymph Nodes	_____	_____	_____	Shoulder/Arms	_____	_____	_____
Heart	_____	_____	_____	Elbow/Forearm	_____	_____	_____
Murmurs	_____	_____	_____	Wrist/Hand/Fingers	_____	_____	_____
Pulses	_____	_____	_____	Hip/Thigh	_____	_____	_____
Lungs	_____	_____	_____	Knee	_____	_____	_____
Abdomen	_____	_____	_____	Leg/Ankle	_____	_____	_____
Genitourinary	_____	_____	_____	Foot/Toes	_____	_____	_____
Skin	_____	_____	_____				

Female LMP \_\_\_\_\_ HCG \_\_\_\_\_

**ALLERGIES:**

Name of allergen	Reaction (hives, breathing)	Epinephrine pen Required
_____	_____	_____
_____	_____	_____

**MEDICATIONS (Please send filled prescription with student and also send refills)**

Name of Medicine	Dose	Frequency	Reason Taking/Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____

**ASSESSMENT & PLANS:** \_\_\_\_\_

**CLEARANCE**

- ☐ I have reviewed "Parent/Guardian Questionnaire"
- ☐ Adolescent is cleared for Boarding School Attendance
- ☐ Adolescent is cleared for sports participation
- ☐ Cleared after completing evaluation / rehabilitation for \_\_\_\_\_
- ☐ Not cleared for \_\_\_\_\_ Reason \_\_\_\_\_

Provider Signature & Stamp: \_\_\_\_\_ MD, DO, NP, PA    Date: \_\_\_\_\_

Clinic Name & Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**SCHOOL REFERENCE FORM****MUST BE COMPLETED BY A TEACHER, COUNSELOR, OR PRINCIPAL**

The above student has applied for admission to Sherman Indian High School. Please fill out the following and return it **directly to the school**. Reference forms returned by the student will not be accepted.

1. How long have you known the student? \_\_\_\_\_ Current Grade Level \_\_\_\_\_
2. What discipline and attendance problems, if any, have you encountered with the student?  
\_\_\_\_\_
3. Has student ever been suspended?      Yes      No
4. If yes, for what, be specific: \_\_\_\_\_
5. Has student ever been expelled?      Yes      No
6. If yes, for what, be specific: \_\_\_\_\_
7. What is the student's Cumulative Grade Point Average? \_\_\_\_\_
8. How is the student's classroom behavior? (Be specific) \_\_\_\_\_  
\_\_\_\_\_
9. Is the student in the Special Education Program?      Yes      No
10. Is the student in the Gifted & Talented Program (GATE)?      Yes      No
11. Rate the student in terms of the following:

	Poor	Average	Good	Superior	Unknown
Integrity/Honesty					
Responsibility					
Consideration/concern for others					
Overall ability					
Motivation					
Maturity					
Attentiveness/Listening					
Ability to reason					
Desire to learn					

Name (Please Print): \_\_\_\_\_

School: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature &amp; Title: \_\_\_\_\_ Date: \_\_\_\_\_

If you should have any questions, please contact the Registrar at 951-276-6326, Extension 382.

Thank you for taking the time to complete this form.

Please send or fax completed reference forms to:

Sherman Indian High School

Attention: Registrar

9010 Magnolia Avenue

Riverside, California 92503

Fax to: 951-276-6055

To send by email, please call 951-276-6326, Extension 200



Student Name: \_\_\_\_\_

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**SCHOOL RECORDS RELEASE**

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***Please remove this form***  
***and send to the last school attended***

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am requesting educational records from: **(last school of attendance)**

Name of School: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Progress Records: Include transcript of grades, test results related to achievement and measurement, records of attendance (including NWEA/MAP testing and state assessments).

Special Education Records: To include speech and language evaluations, educational assessment, Student Study Team reports, most recent IEP, Signed psychological reports, other eligibility data/determinations and behavior intervention plans.

504 Plans all 504 Plans

To be sent to **Sherman Indian High School**  
**Attn: Registrar**  
**9010 Magnolia Ave**  
**Riverside, CA 92503**  
**Telephone: 951-276-6326, Extension 382**  
**Fax: 951-276-6055**

I hereby authorize the release of all records for the above named student.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Student signature is requested if 18 years or older.

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

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**THIS IS THE FINAL PAGE**

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**HAVE YOU COMPLETED IMPORTANT SIGNATURES AND DOCUMENTS?**

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1) Is the student's social security number correct (page 1)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) Has the Parent/Guardian signed the <u>Loco Parentis Permission</u> sheet, (page 2)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) Has the Parent/Guardian and student signed the <u>Prohibiting Alcohol/ Illegal Substances &amp; Gang Activity</u> (page 3)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4) Has the Parent/Guardian signed the <u>Permission to Obtain/Release School Records</u> , (page 5)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5) Is the acknowledgement of <u>Times of Official Travel</u> signed by parent/guardian (page 6)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6) Has the <u>Parent/Guardian signed</u> the bottom of page 7?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7) Has the Parent/Guardian signed the <u>Student Check Out Sheet</u> (page 8)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8) Has the Parent/Guardian signed the <u>Medical Insurance Information</u> , (page 9)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9) Has the Parent/Guardian signed the <u>Consent of Medical Release</u> , (page 10)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10) Has the Parent/Guardian signed the <u>Behavioral Health Consent</u> , (page 11)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11) <u>Physical Evaluation</u> – Date of physical must be within the last 6 months   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did you take pages 12, 13, 14, 15 to your physical appointment?  |                              |                             |
| 12) Did you request for a Teacher, Principal, or Counselor to complete the <u>School Reference Form</u> ?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13) Did the <u>School Records Request</u> get sent to the last School attended? (page 16)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14) Have you included the following documents?   |                              |                             |
| a) <u>Copy of Certificate of Indian Blood (CIB)</u>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) <u>Copy of Birth Certificate</u>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) <u>List of Immunizations-</u> Dated after January 01, 2021  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) <u>Copy of Official/Unofficial High School Transcripts</u><br>(8 <sup>th</sup> Graders: send copy of diploma, Standardized test scores and 7 <sup>th</sup> & 8 <sup>th</sup> Grade Reports) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) <u>Copy of Health Insurance Card (both sides)</u>   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) Attach copy of <u>custody/legal documents</u> and provide information on the person(s) who is responsible for the applicant.  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**If you have answered "NO" to any of the above questions,  
your acceptance will be delayed. Please review this page carefully.**

Mail, fax, or email application to:  
 Sherman Indian High School  
 Attn: Applications  
 9010 Magnolia Avenue  
 Riverside, CA 92503  
 951-276-6325 x 382    Fax: 951-276-6055  
 To send by email, please call 951-276-6326, Extension 200