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

_____ Copy of Certification of Degree of Indian Blood - *Student applicant must be a member of a Federally recognized tribe or is at least one-fourth degree Indian blood descendant (attach documentation)*

_____ Copy of social security card

_____ Copy of birth certificate

_____ Immunization record

_____ Physical examination

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

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

_____ Custody order, if applicable

_____ Mental Health / counseling services information, if applicable

_____ CD treatment information, if applicable

_____ Juvenile court history, if applicable

_____ Application for Free and Reduced Price School Meals

_____ Copy of most recent IEP (Individualized Education Plan), if applicable

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

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

Please feel free to contact this office with any questions or concerns you may have.

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

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

U.S. DEPARTMENT OF THE INTERIOR – BUREAU OF INDIAN EDUCATION
STUDENT ENROLLMENT APPLICATION

CIRCLE OF NATIONS – WAHPETON INDIAN BOARDING SCHOOL
832 Eighth Street North – Wahpeton, ND 58075

What grade is the student applying for? (circle one) **4th Grade** **5th Grade** **6th Grade** **7th Grade** **8th Grade**

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

If yes, when and what grade? _____

Name of Student: _____
Last First Middle

Other names used (include nicknames): _____

P.O. Box Address: _____ Street Address: _____
(physical location is required)

City: _____ State: _____ Zip Code: _____

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

Date of birth: _____ Place of birth: _____
month/day/year city/state

Tribal Membership: _____ Enrollment Number: _____
Please attach a copy of student's "Certification of Degree of Indian Blood" or supporting documentation proving at least one quarter (¼) degree Indian blood descendant.

Does your household have Internet services? Yes No

If no, do you have access to internet services in your community? Yes No

Student Name: _____

FAMILY AND BACKGROUND INFORMATION

Mother: _____

Legal Guardian : ☐

Address: _____

_____

Tribal Affiliation: _____

Telephone numbers:

Home: _____

Cell: _____

Other: _____

Please circle: Living Deceased

Employer: _____

Emergency contact: _____

Emergency number: _____

E-mail: _____

Father: _____

Legal Guardian: ☐

Address: _____

_____

Tribal Affiliation: _____

Telephone numbers:

Home: _____

Cell: _____

Other: _____

Please circle: Living Deceased

Employer: _____

Emergency contact: _____

Emergency number: _____

E-mail: _____

Legal Guardian -: _____ Relationship to student: _____

(if not parent)

Address: _____ Case Worker if applicable_____

_____ Employer: _____

Telephone numbers:

Home: _____

Cell: _____

Other: _____ Emergency contact: _____

E-mail address: _____ Emergency number: _____

Please list all household members (include ages and relationship to student): _____

_____

_____

Have any other family members attended Circle of Nations-Wahpeton Indian School? Yes No

If yes, please list names and relationship to student: _____

_____

_____

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)? 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**

RELEASE / TRANSFER OF SCHOOL RECORDS

Student's Name: _____ Date of birth: _____ Grade: _____

RELEASE TO: Registrar
Circle of Nations School
832 Eighth Street North
Wahpeton, ND 58075

Telephone number: 701-672-7222
Fax number: 701-642-1984

REQUESTED FROM: School Name: _____

School Address: _____

_____

School Telephone Number: _____

School Fax Number: _____

The following records are requested for enrollment purposes:

Educational records:	Transcripts, grades, grade level, state standardized assessment results, NWEA assessment results, attendance, RTI services, Title I services, behavioral records
Special Education records:	Interventions implemented, referral, assessment plan, meeting notices, written prior notices, initial consent for evaluation, psycho-educational reports, evaluation report, initial consent to place, IEP, progress reports
Health records:	Immunization record Other health related records: _____
Mental Health records:	Mental health evaluation
Other:	Certification of Degree of Indian Blood, birth certificate, other necessary documents: _____

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

_____ _____

Signature of Legal Guardian or School Official **Date**

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

EDUCATIONAL INFORMATION

Student's Name: _____Grade: _____Date of Birth: _____

Parent/Guardian Name: _____

The academic progress of your child is very important to us. It is important that they be placed in classes to meet their needs. The responses on this questionnaire will remain confidential and will be viewed only by the school Administrators, Counselors, your child's teacher and Special Education personnel if necessary.

Has your student ever been in any of the following programs: If yes, please check categories that apply

	Emotionally Disturbed		Other Heath Impairment
	Other Health Impairment-Minor		Visual Impairment
	Autism		Developmental Delay
	Hearing Impairment		Traumatic Brain Injury
	Specific Learning Disability		Orthopedic Impairment
	Cognitive Disability		Deaf-Blindness
	Multi-handicapped		Speech Language Impairment

□Yes □ No Gifted and Talented Program. If yes, please indicate grade(s): _____

□Yes □ No 504 program. If yes, please indicate grade(s): _____

□ Yes □ No Speech therapy program. If yes, please indicate grade(s): _____

□ Yes □ No ESL program. If yes, please indicate grade(s): _____

□ Yes □ No Has your student ever been retained/held back. If yes, please indicate grade(s): _____

□ Yes □ No Has your student ever skipped a grade. If yes, please indicate grade(s): _____

□ Yes □ No Has your student ever been identified as dyslexic. If yes, please indicate grade(s): _____

□Yes □ No Does the student have problems with schoolwork or homework. If yes, please explain: _____

_____

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

_____

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

_____

□Yes □ No Did the student complete this past school year? If not, explain: _____

_____

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

_____ _____

Signature of Legal Guardian Date

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

Updated May 2020

STUDENT INFORMATION SUMMARY

Name of Student: _____

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

Special Education	Basketball	Volleyball	Cross Country	Football
Student Government	Track & Field	Tae Kwon Do	Music Lessons	
College & Career Classes	Cultural Activities	Art	Other: _____	

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

Cry	Fight verbally	Fight physically	Ignore	Eat
Sleep	Use drugs	Use alcohol	Use inhalants	Pray

Other: _____

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

_____

_____

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

_____

Has the student ever been involved in gang activity? Yes No

If yes, please explain: _____

Has the student ever been arrested? Yes No

If yes, give reason(s): _____

How many times? _____

Has the student ever been in detention or jail? Yes No

If yes, give reason(s): _____

How many times? _____

Is the student currently on probation or ever been on probation? Yes No

If yes, give reason(s): _____

Duration of probation or sentence: _____

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

_____ _____

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

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

_____ _____

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

FAMILY – SCHOOL COMPACT - CIRCLE OF NATIONS SCHOOL – WAHPETON, ND

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

Academic

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

Residential

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

Warrior Way – Be Respectful, Be Responsible, and Be Safe

Student	Parent/Guardian	Staff
I will respect the personal rights and property of myself and others.	I will talk with my child about respecting people and property.	We will treat students and parent/guardian with respect.
I will behave in a responsible manner.	I will set positive behavior expectations and reinforce school policies and procedures.	We will clearly articulate behavior expectations to students and parent/guardian.
I will inform an adult about bullying and harassment.	I will talk with my child about bullying, harassment, peer pressure, safety, and drug-free behavior.	We will take steps to prevent bullying and harassment.
I will keep myself safe and drug-free.	I will support the school's discipline policy.	We will promote a safe and drug-free school.

Acceptance Signatures

_____ _____

Student Date Parent/Guardian Date

CIRCLE OF NATIONS SCHOOL
Cell Phone and Electronics Pilot Program

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

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

2. Students will be permitted to bring their personal MP3 players/iPods/iPads to campus. These items will be to be labeled with the child's name. Students may use these items during non-instructional time.

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

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

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

_____ _____

Signature of Legal Guardian Date

PARENTAL CONSENT FORM

Student's Name: _____

Permission to utilize the above named student's photographs, writings, or illustrations for information/education purposes
Yes No
Additional comments/ instructions: _____

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 approved by CNS. It is understood that a physical examination for the student is required before the student can fully participate in any competitive sports offered by CNS. Yes No

Permission is granted for the above named student for the following:

Haircuts Yes No Coloring Yes No Highlighting Yes No

Additional comments / instructions: _____
_____

Permission to participate in sweat ceremonies and/or Church activities for purposes of purification, prayer, personal spiritual guidance, and personal spiritual growth.

Sweat ceremonies Yes No Church activities Yes No

Additional comments / instructions: _____
_____

_____ _____
Signature of Legal Guardian **Date**

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: _____

May 15, 2020

Dear Parent/Guardian,

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

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

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

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

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

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

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

Trevor Gourneau, Principal

(Keep this page for your information.)

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

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 _____ Phone # _____

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

Name: _____ Relationship to You: _____

Address: _____ Town_____ State/zip _____Phone #: _____

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
100 LAKE TRAVERSE DRIVE
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