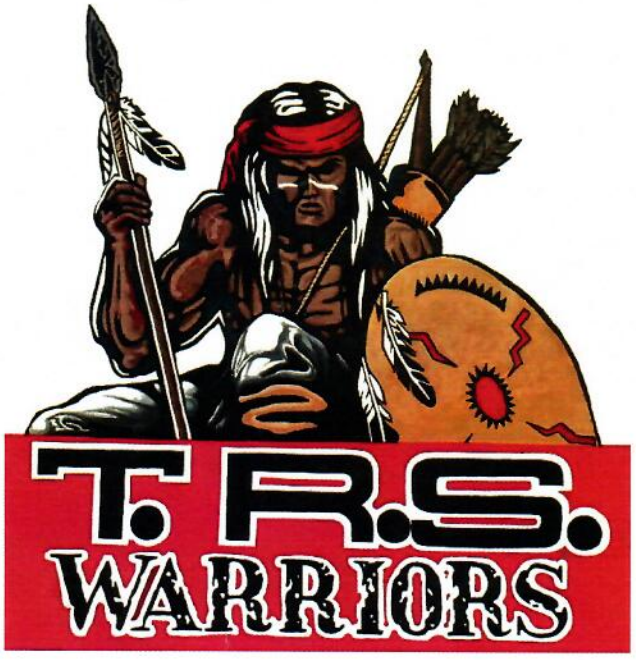
Theodore Roosevelt School
P.O. Box 567
Fort Apache, AZ 85926
Phone (928) 338-4464 Fax (928) 338-1009

New Student Enrollment Forms

School Year 2021-2022

"Intelligence plus Character is the good of Education"



Marla Wilkerson Principal/ CSA

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Please remember***, before*** accepting a student to attend Theodore Roosevelt School the following documents ***must*** accompany the enrollment packet and proper procedures must be followed.

_____ Birth Certificate or Baptismal Document (***No child*** will be **accepted *without*** a copy on file, funding issues arise when a copy is not on file).

_____ Certificate of Indian Blood (***No child*** will be **accepted *without*** a copy on file, funding issues arise when a copy is not on file).

_____ Updated Immunization record (According to the Arizona Revised Statute S15-871-874; and Arizona Administrative Code R-9-6-701-708; students must have proof of all required immunizations, or a valid exemption form, in order to attend school.

_____ Legal Documentation. If you are not the legal guardian or custodial parent of the student, we ***require*** one of the following documents for enrollment:

- Court sanctioned custody documents
- Social Services placement letter
- Power of Attorney form signed and notarized

_____ On-Site COVID-19 Testing Consent Form ***must*** be signed.

_____ Completed Enrollment Packet. ***If you are not the custodial parent, do not sign***. Legal or temporary guardianship documents must be attached before signature is valid.

_____ Student Interview (If student had behavior issues at previous school)

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A Bureau Funded Day/Boarding School

Please submit the application to Theodore Roosevelt School for review and approval. The school will review the application and render a decision.

STUDENT INFORMATION

Grade applying for _____ Check One: Dorm Student ____ Day Student ____

Name _____
First Middle Last

Physical Address _____

Mailing Address _____

Date of Birth _____ Gender ____ Male ____ Female

Tribal Affiliation _____

Social Security Number _____-_____-_____

Child lives with ____ Both parents ____ Mother ____ Father ____ Other _____

PREVIOUS SCHOOL ATTENDED

School Name _____ Grade completed _____

Address _____ City _____ State ____ Zip _____

Dates Attended _____ Reason for leaving _____

- Student participated in the Special Education Program ❒ Yes ❒ No
- Student participated in the Gifted and Talented Program ❒ Yes ❒ No
- Did the student miss more than 15 days in the last year? ❒ Yes ❒ No
- Student was suspended? ❒ Yes ❒ No
- Student was expelled? ❒ Yes ❒ No

If you responded "Yes" to any of the above, please explain _____

_____

_____

_____

_____

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GUARDIANS MUST SUBMIT LEGAL CUSTODY DOCUMENTS

Parent/Guardian's Name (1) _____
(First) (Last)

Home Address _____

Phone (Home) _____ (Work) _____

Parent/Guardian's Name (2) _____
(First) (Last)

Home Address _____

Phone (Home) _____ (Work) _____

EMERGENCY CONTACT IF UNABLE TO REACH PARENT(S)/GUARDIAN(S)

Name _____
(First) (Last)

Relationship to Student _____

Phone (Home) _____ Phone (Cell) _____

School Check-out List

ONLY the following individuals have my permission to check my/our child out of school:
Note: The persons listed below **must** be at **least** 18 *years old*. (All names must be printed)

1. _____ Relationship _____ Phone _____
2. _____ Relationship _____ Phone _____
3. _____ Relationship _____ Phone _____
4. _____ Relationship _____ Phone _____

Signature of Parent/Guardian _____ Date _____

Theodore Roosevelt School

OVER THE COUNTER MEDICATION CONSENT FORM

Student Name_____ Grade_____

Over the counter (OTC) medications are drugs that do not require a prescription and are purchased "over the counter". OTC medications may at times need to be administered. This form is ***required before*** OTC medications can be administered at school.

PLEASE CHECK OFF EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

__Antibiotic cream (i.e. Bacitracin Cream, Antiseptic)
__Hydrocortisone cream
__Calamine lotion
__Medicated lip ointment
__Eye drops for dryness
__Cough drops/throat lozenges
__Cough Medicine
__Pepto Bismol
__Antacid (i.e. Mylanta)
__Antihistamine (i.e. Benadryl, Diphen)
__Ibuprofen
__Acetaminophen (Tylenol)

The medications indicated above may be administered to my student. I understand that such administration will **not** be done under the supervision of medical personnel. I also agree that any first aid treatment may be given as needed.

Does your student have any known allergies? ___No ___Yes

If yes, ***complete* Allergy Action Plan & Medication Consent Form (If needed) **

Does your student take any prescription medication on a regular basis? __No __Yes
If yes, ***complete* Medication Consent form**

Does your student have asthma? __No __Yes
If yes, ***complete* Medication Consent form**

Does your student have any current health conditions? __No __Yes
If yes, please list: _____

_____

_____ _____
(Parent/Guardian Print Name) (Parent/Guardian Signature)

_____ _____
(Parent/Guardian Phone Number) DATE

Theodore Roosevelt School

ALLERGY ACTION PLAN

Student Name_____ D.O.B._____ Grade_____

Emergency Contact Name_____ Phone Number_____

History of Asthma? __No __Yes (Higher risk of severe reaction)

Student Photo

ALLERGY: (check appropriate)

- ☐ Foods (list):_____
- ☐ Medications (list):_____
- ☐ Latex: Circle: Type I (anaphylaxis) Type IV
- ☐ Stinging Insects (list):_____
- ☐ Other:_____

RECOGNITION AND TREATMENT

If food ingested or contact w/ allergen occur: Give CHECKED Medication		EpiPen	Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth		
Skin	Hives, itchy rash, swelling of the face or extremities		
Gut	Nausea, abdominal cramps, vomiting, diarrhea		
Throat	Tightening of throat, harseness, hacking cough		
Lung	Shortness of breath, repetitive coughing, wheezing		
Heart	Thready pulse, low BP, fainting, pale, blueness		
Neuro	Disorientation, dizziness, loss of conscience		
If reaction is progressing (several of the above areas affected), GIVE:			

DOSAGE:

Epinephrine: Inject into outer thigh ☐ EpiPen 0.3 mg OR ☐ EpiPen Jr. 0.15 mg

Antihistamine: Benadryl_____mg To be given *only if able to swallow*.

Other:_____

****EpiPen must be provided by the parent/guardian and will be locked in the office.****

_____ My child has received instruction in the proper use of the EpiPen and/or when to request
(Parent Initials) antihistamine (Benadryl).

If the severity of symptoms changes, potentially life-threatening local Emergency Medical Services will be contacted prior to notifying parent/guardian.

_____ _____

(Parent/Guardian Print Name) (Parent/Guardian Signature)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

Consent of Parent/Legal Guardian or other person who has primary responsibility for the care of the child.

Name of Student _____ SSN# _____

Birthdate _____ Tribe _____

I (we) have read the consent form from Indian Health to arrange for, or to provide the following health services for this child:

1. Healthcare including medical examinations, routine laboratory studies, x-ray procedures, and skin tests.
2. Dentalcare including dental examinations, preventive use of fluoride, and any necessary emergency dental care.
3. Mental Health services including treatment when necessary.
4. Emergency Healthcare for accidents and illnesses.
5. Transportation of the child to and from another health facility for these services:

❒ I hereby give consent for all services.

❒ Exceptions or special instructions: _____

_____

❒ I hereby give consent for reasonable cause and essential need to assure the health and safety of my child to Theodore Roosevelt School staff while my child is in attendance.

Parent/Guardian signature _____

Printed Name _____

Address _____

City/State/Zip Code _____

Relationship _____

Phone# _____ Alternate# _____

Date _____ Valid until _____

OMB Control No. 1810-0021 (Exp. 01/31/2024)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

Theodore Roosevelt School

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Parental Permission Form

Authorization for Release of Student Records

Date of Request _____

Student Name _____

He/she was a student at your school during the _____ school year.

I hereby authorize (previous school)

_____

_____

_____

Fax # _____

Phone # _____

Release information to (current school):

Theodore Roosevelt School **Fax (928) 338-1009**
P.O. Box 567 **Phone# (928) 338-4464**
Fort Apache, AZ 85926

Please release the following records:

- ❒ Transcripts of grades (most recent)
- ❒ Achievement test records
- ❒ SPED (ESS) records
- ❒ Attendance records
- ❒ Behavioral/Discipline records
- ❒ AZELLA/WICA results
- ❒ Other _____

Behavior problems _____

_____

It is understood that the confidential nature of these records will be maintained. Only authorized personnel will have access to this information.

_____ _____
Parent/Guardian Signature Relationship to child

_____ _____
Mailing Address Date

_____
City, State, Zip Code

_____ _____
Authorized School Official's Signature Date

Theodore Roosevelt School
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OFFICE OF INDIAN EDUCATION PROGRAMS

Exceptional Education

Release/Transfer Records Form

Student:	Date of Birth
Parent/Guardian:	Address (Street or P.O. Box, State and Zip Code

Records Requested by:

Name: Theodore Roosevelt School
Address: P.O. Box 567, Fort Apache, AZ 85926
Phone: (928) 338-4464 Fax: (928) 338-1009

Records Requested from:

Name: _____

Address: _____
Address (Street or P.O. Box, State and Zip Code)

Request for Records

- ❒ Consent of Evaluation
- ❒ Medical Health History
- ❒ Case History
- ❒ Classroom Observations
- ❒ Discipline Records
- ❒ Evaluation Team Summary Report
- ❒ IEP
- ❒ Initial Consent for Placement
- ❒ Evaluation Report(s)
- ❒ Other _____

Purpose of Request

- ❒ Routine Transfer
- ❒ Evaluation
- ❒ Due Process
- ❒ Other _____

This is to certify that I agree to the release of records checked above with the understanding that they will be released only for the purpose stated above and only to the person/institution stated above. I also understand that the school will either destroy or return to me; the parent/guardian, any records received that are not required for the purpose checked above.

_____ _____
Parent/Guardian Signature of eligible student Date

The undersigned releases these records with the understanding that they are being released only for the purpose(s) above and only to the person/institution stated above.

_____ _____
Authorized School Official Date

Theodore Roosevelt School
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Field Trip Permission

I, _____, parent/guardian of _____
Name of Parent/Guardian Student's name
hereby grant permission for the 2021-2022 school year to Theodore Roosevelt School to allow my child to participate in any school-sponsored field trips, under the supervision of the school personnel with the following conditions:

_____ permission is granted, if school vehicles are used for transportation.

_____ permission is granted when the student walks from school to the site of the field trip.

Signature of Parent/Guardian _____ Date _____

Daily Transportation

I, _____, parent/guardian of _____
Name of Parent/Guardian Student's name
give permission for the 2021-2022 school year for my child to:

_____ always ride the bus/school vehicle, unless checked-out at the front office.

_____ walk home, *but* **must** ride the bus on severe weather days

Signature of Parent/Guardian _____ Date _____

Parent Waiver

I hereby release Theodore Roosevelt School of all liability if my child refuses to board the designated school bus or vehicle for transportation home or to a scheduled event as part of a trip.

I understand it is not the responsibility of the TRS Staff but the decision of my child to board and ride any of the school vehicles when told to do so. Furthermore, it is the sole decision of my child to refuse to board or ride in any school vehicle when told to do so. If my child refuses to board the bus or vehicle it is my responsibility to transport my child.

Signature of Parent/Guardian _____ Date _____

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Parental Consent for Counseling

Name of Student _____ DOB _____
I give permission for my child to receive any counseling with the ABHS Staff for the 2021-2022 school year.

Signature of Parent/Guardian _____ Date _____

Media Release Form

Theodore Roosevelt School believes in recognizing student accomplishments by sharing them with the community which will include:

- Releasing student names and/or photographs to local media
- Posting on our school website
- Displaying student names and/or photographs on the school bulletin boards

If you agree to allow TRS to publish, post, distribute and/or display your child's name and/or photograph or other information related to his/her achievements for the 2021-2022 school year, please sign below.

I/we agree to grant permission for my child's name and/or photograph to be published, posted, distributed, and/or displayed in any local media source and/or on the school's internet website for publicity and/or recognition purposes.

Signature of Parent/Guardian _____ Date _____

Certification

I certify, under perjury of the law, that the information provided anywhere in this enrollment form is true, correct, and complete, to the best of my knowledge and belief. I am responsible for the student named below, and hereby apply for his/her admission to Theodore Roosevelt School. I understand that, if the school requires additional information, I will provide the information requested.

Signature of Parent/Guardian _____ Date _____

Theodore Roosevelt School
P.O. Box 567
Fort Apache, AZ 85926
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Dear Parent(s)/Guardian(s):

Please be reminded that electronic devices such as: cell phones, iPods, tablets, etc. are not allowed at school. If students bring such devices, then the school staff is authorized to take them and deliver them to the front office where they will be locked up. The device(s) will ***not*** be returned until the *end of each semester*. Students are allowed to use the school phones in every classroom and the office with permission. A parent/guardian will need to come to the school and sign out the device(s) at the end of the semester.

Sincerely,

Marla Wilkerson, Principal

By signing, you are aware and agree to the terms stated above.

_____ _____

Parent/Guardian's Signature Date

Theodore Roosevelt School
P.O. Box 567
Fort Apache, AZ 85926
Phone (928) 338-4464 Fax (928) 338-1009

Parent/Student Responsibilities

I support and encourage my child's education. In order to be successful at Theodore Roosevelt School, I agree that my child has the following responsibilities:

1. Attending all classes regularly except when ill or properly excused. Meet all class requirements and school obligations.
2. Following school rules and policies that govern daily school attendance, behavior, discipline, academic requirements, including possession, use, and distribution of illegal substances, drug paraphernalia and weapons.
3. The responsibility to respect the privacy and space of others.
4. The responsibility to live in peace and harmony with fellow students and school employees, respecting the privacy and space of others.
5. The responsibility to make decisions that will not infringe on the rights, health, and safety of others or be disruptive to the educational process.
6. Respect the rights of others to express their freedom of religion and culture.
7. Expressing opinions and ideas respectfully so as not to slander, defame, or use abusive language against others. Express one's self in such a way as not to be disruptive or use abusive language to others or be disruptive to the educational process or classroom procedures.
8. May write my opinions and ideas but may not write them if they are not true, or if they hurt another person or group.
9. Respect the rights of the other students and person in regard to the rights of the person included in this code or as guaranteed by law.
10. Schedule a meeting so as not to disrupt the educational process nor interfere with approved school activities.

In addition, I understand that if my inappropriate behaviors should result in any damage or vandalism of school and other people's property that I am subjecting myself to consequences that may require monetary payment(s) by me and/or my parents.

I understand that I am here to learn and to develop positive self-worth and should I choose to defy the rules and authority, my consequences are at the discretion of the disciplinary team or administration which may include: dismissal, suspension, or expulsion from the school.

_____ _____

Student's Signature Date

As a parent, I will encourage my child to attend school daily and to follow the school rules and policies.

_____ _____

Parent/Guardian Signature Date

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Student Residency Verification Document

This document is intended to address the McKinney-Vento Act. Your answers will help the administrator determine the residency documents necessary for the enrollment of this student.

1. Presently, where is the student living? *Check one box*.

Section A	**Section B**
❒ in a shelter ❒ with more than one family in a house or apartment ❒ in a motel, car, or campsite ❒ with friends or family members (other than a parent/guardian) **Continue:** *If you checked a box in **Section A**, complete #2 and the remainder of this form.*	❒ Choices in Section A do not apply **STOP:** *If you checked this section, you do **NOT** need to complete the remainder of this form. Submit to school personnel.*

2. The student lives with:

❒ 1 parent
❒ 2 parent's
❒ 1 parent and another adult
❒ a relative, friend(s), or other adult(s)
❒ alone with no adults
❒ an adult that is not the parent or guardian

School: Theodore Roosevelt School

Name of Student _____ ❒ Male ❒ Female

Birthdate _____ Age _____ Social Security # _____

Name of Parent(s)/Guardian(s) _____

Address _____ State _____ Zip _____

Phone# _____

Signature of Parent/Guardian _____ Date _____

For School Use Only – School Administrator's Determination of Section A Circumstances:

If the parent checked Section B above, completion of this form is not required. For any choices in Section A, this form must be completed and provided to school Registrar immediately after completion. This form will be kept separately from the students' permanent record for audit purposes during the year.

Name and phone number of a school contact person who may know of the family's situation:

_____ Date faxed _____

Home Language Survey

2021-2022 Academic Year

Bureau of Indian Education

Student's Name: _____

Instructions

This survey is to be completed by the parent or legal guardian of the student enrolling in **Theodore Roosevelt School**. Completion of this survey is optional, although it may lead to additional resources or supports being provided to assist in your child's education. Please circle or write the answer requested.

Student Languages

1. What was the first language your child learned?

   English Another Language (list) _____

2. What language is the one that is primarily spoken by your child in the home?

   English Another Language (list) _____

3. Do you believe your child might need additional help with English to learn other academic areas such as math, science, social studies, reading, or writing? Yes No

Adult Languages

4. How many adults live in your home? _____
5. How many of these adults primarily speak a language, other than English, in the home? _____
6. What languages, other than English, are spoken in the home?

   _____ _____

7. Do you or the other adults in your home need translated documents for the school to provide information to you concerning your student? Yes No
8. Do you or the other adults in your home require a translator to discuss your student's academic progress with educators at the school? Yes No

On-Site COVID-19 Testing Consent Form – Parent/Guardian

Theodore Roosevelt School wants students and staff to safely return to in-person learning. As such, we will be implementing a COVID-19 testing program that is convenient, non-invasive, safe, and free of charge.

Each parent or legal guardian must read and sign this form for their minor child to participate in school-based COVID-19 testing.

By signing this Consent Form, I give my consent for my child to participate in the COVID-19 testing program, and I authorize the collection of my child's nasal swab or saliva sample for the public health purposes of the program. I understand that:

- ***Theodore Roosevelt School, in partnership with the Johns Hopkins University Center for American Indian Health (JHCAIH) Project SafeSchools,*** will provide COVID-19 testing using a lower nasal swab or saliva technique.
- The testing program will regularly occur during the school day when parents are not present.
- There are two types of tests my child may receive while at school: Pooled tests and/or individual screening tests.
  - Pooled tests do NOT provide individual results to a person. However, if a positive result is produced from a pooled test, all persons in that pool/group will be notified.
  - Individual screening tests do provide individual results. Each parent/guardian will be notified if your child's test is positive.
  - Regardless of whether my child participates in pooled tests or individual screening tests, a follow-up diagnostic test may be necessary. The local public health authority, Indian Health Service, will provide guidance in this case.
  - As with any COVID-19 test, there is the potential for incorrect (false positive or false negative) results.
- I give my permission for the test results to be shared with JHCAIH, Indian Health Service, and Theodore Roosevelt School.
  - I understand that my child's test results will be provided to ***these organizations*** to allow for appropriate public health response and reporting, included as required by law to local and state public health authorities.
  - I acknowledge that JHCAIH would also like to analyze the data on testing as part of a research project to improve understanding of the benefits and challenges of COVID-19 testing in schools.
  - I understand that while JHCAIH, the testing provider and the laboratory may have access to personal information I provide for testing, my child's identity will not be shared for research purposes.
- I understand that JHCAIH and Theodore Roosevelt School are not acting as my child's medical provider. This testing does not replace treatment by a medical provider. I assume responsibility to take appropriate action with regards to my child's test results.
- I agree that I will seek medical advice, care, and treatment from my child's medical provider as needed, and especially if my child's condition worsens.
- I understand that I can change my mind and cancel my permission for testing at any time, but such cancellation will not affect information already reported. To cancel permission for COVID-19 testing, contact Theodore Roosevelt School.

- I understand that I can revoke permission to share data for research purposes but can still get testing for my child at school without consenting to share data for research purposes. To cancel permission to share data for research purposes but keep permission to participate in school-based COVID-19 testing, contact Theodore Roosevelt School.
- I understand that JHCAIH, in collaboration with the testing provider (Ginkgo Bioworks, Inc. d/b/a Concentric by Ginkgo) and laboratory (Translational Genomics Research Institute (TGen)) is researching and tracking variants to COVID-19 for epidemiological and public health purposes.

Name of Child

Date of Birth

Parent/Guardian Name *(please print clearly)*

Parent/Guardian Signature

Date

Return this Consent Form in one of three ways:

1. Email: brockwell@trswarriors.com
2. Drop it off at Theodore Roosevelt School
3. Mail to School (address below)

Theodore Roosevelt School
PO Box 567
Fort Apache, AZ 85926

CONSENT FORM FOR HEALTHCARE SERVICES

Your child may be eligible for healthcare services at a free school-based health clinic (Healthcare Clinic) offered by Indian Health Services. The Healthcare Clinic may provide some or all of the following services:

1. Preventive healthcare screenings
2. Physical examinations for school and sports participation
3. Immunizations
4. Diagnosis and treatment of health problems
5. Counseling for health maintenance and health risk behaviors
6. Assessment for mental health referrals
7. Dental services

If you would like your child to receive healthcare services, please complete, sign and return this Consent Form for Healthcare Services. If you have questions about the services available or treatment that is being provided to your child, please contact the Healthcare Clinic personnel directly at 928 338 4911 x3633. Please note that the Healthcare Clinic is operated entirely by Indian Health Services and not by the Whiteriver Unified School District.

_____ _____

Name of Child Name of Parent/Guardian

_____

Name of School

CONSENT:

I hereby give permission for my child to receive healthcare services at the Healthcare Clinic that is located at my child's school. I understand that the Healthcare Clinic is operated by Indian Health Services and is not operated by the Whiteriver Unified School District. I understand I have the right to revoke this consent at any time by giving written notice of such revocation to Healthcare Clinic personnel.

_____ _____

Parent or Guardian Signature Date

[A separate consent form must be completed for each child.]

Whiteriver Service Unit
Consent Form Children Vaccinations
(<18 years of age)

Dear Parents/Guardians:

The Whiteriver IHS Hospital is working with **Theodore Roosevelt School** to update your child's vaccines (shots) during the **2021-2022 school year.** We will hold vaccination clinics during the year, and your child's school will let you know the specific dates. There will be no cost to you for this vaccine, whether or not your child is Native American.

The vaccine consent form includes the option to accept vaccination for your child by signing the consent form. If you do not wish for your child to be vaccinated, do not sign the form and vaccinations will not be given to your child during the clinic.

To give consent for your child to receive vaccines while at school:

- Sign and date the consent form to accept vaccination for your child.
- Return the consent form to the school.
- If you accept vaccination, the vaccine will be given to your child during the vaccination clinic.
- If, at any time, you change your mind about having your child vaccinated, you can contact the Whiteriver IHS Immunization Outreach team at 928-594-5228 or email megan.dill@ihs.gov.

Please visit the CDC's vaccination web site at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html and also https://www.cdc.gov/vaccines/parents/index.html for more information. If you do not have internet access and would like more information or a printed copy of the Vaccine Information Sheet, please contact us. Your child's health care provider can also answer your questions about any shots your child is due for and give the shots as well.

The Arizona State vaccine record (ASIIS) as well as your child's chart at the hospital will be used to screen for vaccines that are due. We will screen for any vaccines given at other locations (within Arizona) as well as any medical conditions/medications that may affect if your child is eligible for certain vaccines.

Sincerely,

Whiteriver IHS Hospital Immunization Outreach Team
LCDR Megan Dill, Hospital Immunization Clinical Coordinator (acting)
LCDR Anna Kit, LT Kristen Parker, Clinical Staff Pharmacists

Please answer all of the following questions. The answers are important to us, so we can be sure to give the right vaccines. By signing this form, you are giving consent for Whiteriver Service Unit to administer all recommended immunizations by the Advisory Committee on Immunization Practices (ACIP) during the **2021-2022 school year** at **Theodore Roosevelt School** and acknowledging receipt of the Vaccine Information Statements (VIS) which can be found at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.

CONSENT FOR CHILD'S VACCINATION:

By signing below, I give consent to the WHITERIVER INDIAN HEALTH SERVICE HOSPITAL and its staff for my child named on this form to be vaccinated during the vaccination clinic. (If this consent form is not signed, then your child will not be vaccinated).

Parent/ Legal Guardian Name: _____ **Date:**_____

Signature of Parent/Legal Guardian: _____

Child's Name: _____ **Chart # or Birthday:** _____ **Age:**_____

	YES	NO
1. Is your child Native American/ Alaska Native?	☐	☐
2. Does your child have any serious allergies? If so, what?_____	☐	☐
3. Has your child ever had a serious reaction to a vaccine? If so, what?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
5. Does your child have any of the following: asthma, cancer, diabetes (or other type of metabolic disease), or disease of the immune system, lungs, heart, kidneys, liver, nerves, or blood? If so, what?:	☐	☐
6. Has your child taken cortisone, prednisone, any other steroid, anticancer drug, antiviral drug or had radiation treatment in the past 3 months? If so, explain:- _____	☐	☐
7. Has your child received a transfusion of blood or a blood product, or been given immune (gamma) globulin in the past year? If so, explain: _____	☐	☐
8. If the child is a baby, have you ever been told that he/she had Intussusception (the telescoping of one portion of the intestine into another)?	☐	☐
9. Is your child pregnant?	☐	☐
10. Has your child received vaccines anywhere else OTHER THAN Whiteriver Hospital? If so, **where**?	☐	☐

To make sure that we have all information needed to vaccinate your child, please completely fill out the information in the boxes. This includes your name and signature, child's name and birthday/ chart number, and answers to all questions.

Public Health Service, PO BOX 860
Whiteriver Service, Unit, I.H.S. 928 338 3615

DEPARTMENT OF HEALTH & HUMAN SERVICES

School Dental Services Consent Form
For Whiteriver Dental Clinic

Dental sealants are one of the best ways to prevent tooth decay. Cavities can cause a child pain to chewing and can affect their studying and sleep. Fortunately, we can try to prevent cavities by sealants. Sealant is a hard plastic coating, which protects the grooved surface of teeth. Sealants seal the deep pits and fissures, keeping bacteria out and preventing decay.

The application is painless and does not require numbing or drilling the teeth. The process uses only the cleaner to shampoo the tooth, cotton to keep the tooth dry, sealant (which is painted on the tooth with a brush), air, water and the sealant light. Minor risks might include gagging, swallowing/aspirating of required dental materials and small changes in bite.

As a service to our patients, dental staff members travel to the schools to place sealants. Children can receive a dental screening, sealants and fluoride varnish application.

_____YES, I consent for my child to receive 3 services: a dental screening, sealants and fluoride. Rest assured we will not be doing any fillings or extractions, nor giving your child any shots.

_____NO, I do not want my child to receive the above three services.

If yes, please provide us with the following information:

Students Name:_____ School: _____ Grade: _____
Teacher: _____ Birthdate: _____
Whiteriver I.H.S. chart # if you know it: _____

Please list any allergies your child may have: _____
Please list any medications your child is on: _____
Please list any health conditions your child may have (for example, seizures, asthma, heart murmurs, etc):
_____

Signature of Parent or Guardian: _____ Date: _____

_____
(for dental staff use only)

Patient received fluoride on date: _____
Sealants placed on teeth: _____

The Smiles Movement

PO Box 767
Camp Verde, AZ 86322

thesmilesmovement@gmail.com

Ph: 928-567-1832
Fax: 928-567-6500

Please return this form to the school!

DEAR CONCERNED PARENT:

The Smiles Movement has been providing excellent dental care in our fully functional mobile dental units at your children's schools for over 20 years. Your child may be eligible to receive routine dental care at no charge to you. We require background checks for all of our personnel and all of our doctors have experience in pediatric dentistry.

To participate in this valuable service, your child must be enrolled in an appropriate Arizona AHCCCS program. Enrollment is available at most IHS facilities.

IN ORDER TO BE CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name_____Male_____Female_____

Child's Social Security Number_____Date of Birth____/____/____

Emergency Contact_____Phone #_____

School Name_____Teacher's Name_____Grade____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOUR CHILD:

Has your child had?	NO	YES		NO	YES
Allergy to medication	___	___	Heart Murmur	___	___
Rheumatic Fever	___	___	Bleeding Disorders	___	___
Psychiatric Treatment	___	___	High Blood Pressure	___	___
Seizure Disorder	___	___	Asthma	___	___
Diabetes	___	___	Hepatitis/Jaundice	___	___
AIDS/HIV Positive	___	___	Anemia	___	___
Hospitalizations	___	___	Latex Allergy	___	___
Vision or speech problems	___	___	Other Serious Illness	___	___

Is your child under a Physician's care? NO___YES___
Is your child taking any medication? ___ ___
Any problems with local anesthetic? ___ ___

PLEASE EXPLAIN ANY "YES" ANSWERS:_____

What is your primary concern for your child's oral health?_____

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- **HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME**
- **WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME**

CONSENT FOR TREATMENT AND AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1. _____ **YES. I give permission for my child to receive necessary treatment!**

2. _____ **No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.**

3. **I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.**

I understand that I may refuse to sign this Consent and Acknowledgement.

X_____ **Date**_____

Parent or Guardian

Please print your name_____

If you have any questions, please call our office at 928-567-1832

PLEASE TURN OVER AND COMPLETE