



WIDE RUINS COMMUNITY SCHOOL



P.O. Box 309 Chambers, Arizona 86502

Phone (928)652-3251

-

Fax (928)652-3286

Student Enrollment Application SY 2021-2022

~Education is the ray of light that will lighten up our students at Wide Ruins Community School~

The following information is needed for each student at the time of enrollment. Students will not be permitted to start school until all the required documents are received and completed

1. COMPLETED ENROLLMENT PACKET
(MUST BE SIGNED BY THE PRINCIPAL AND CUSTODIAL PARENT/LEGAL GUARDIAN)
2. MAP (LOCATION OF HOME) DRAW EXACT LOCATION OF HOME INCLUDE RURAL HOUSE NUMBER
3. CHECK OUT FORM
4. MEDIA PARENT CONSENT FORM
5. STUDENT HEALTH HISTORY QUESTIONNAIRE AND CONSENT FORM
6. MEDICAL TREATMENT AUTHORIZATION FORM
7. WIDE RUINS COMMUNITY SCHOOL RESIDENCY VERIFICATION DOCUMENT (MCKINNEY-VENTO)
8. PRIMARY HOME LANGUAGE OTHER THEN ENGLISH (PHLOTE) FORM
9. TITLE VII STUDENT ELIGIBILITY CERTIFICATION FORM
10. PHYSICAL EXAM FORMS ARE AVAILABLE AT THE FRONT OFFICE (SPORTS)
11. ****UPDATED IMMUNIZATION RECORD FOR NEW AND RETURNING STUDENTS****
12. 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 CUSTODY DOCUMENTS
 - *SOCIAL SERVICE PLACEMENT LETTER
 - *TEMPORARY (ACADEMIC YEAR) GUARDIANSHIP SIGNED AND NOTARIZED
 - *OTHER COPIES OF LEGAL DOCUMENTS, I.E., RESTRAINING ORDERS
13. **NEW STUDENTS, PLEASE BRING THE FOLLOWING DOCUMENTS:**
 - **CERTIFICATE OF INDIAN BLOOD**
 - **BIRTH CERTIFICATE**
 - **WITHDRAWAL/RELEASE FROM PREVIOUS SCHOOL**

Vision: We will learn in harmony today and throughout the future at Wide Ruins Community School
Mission: Wide Ruins Community School will provide academic excellence and cultural awareness for our children.

Bureau of Indian Education
Wide Ruins Community School
 Student Enrollment Application

Grade Level: _____

Dorm: _____

Day-Bus: _____

Entry Date: _____

Withdrawal Date: _____

Native American Student Information System (NASIS) ID NO.													
Student Name: LAST			FIRST		Middle		Gender: Female Male		Date of Birth:	Census Number:	Degree of Indian Blood:		
Student Address:							Birth Place:		Tribal Affiliation:	Chapter Affiliation:			
Home Location:					Language Most Spoken at Home:			Language Most Spoken by Student:					
					NAVAJO ENGLISH			NAVAJO ENGLISH					
With whom does the student live?					Did student participate in English Language Learn ELL?			Did student participate in Special Education?					
Both Parents		Father	Mother	Grandparents		Guardian		Other		YES	NO	YES	NO
Guardianship or Custodial issues must include proper notarized/court documentation, unless we receive copies that assigns custody to one parent, we must assume that both parents can visit/pick up the student from school. Who has legal guardianship of the student?													
Father:			Tribal Affiliation:				Mother:			Tribal Affiliation:			
Address (city,state,zip):						Address (city,state,zip):							
Home Location:						Home Location:							
Home Phone:						Home Phone:							
Email:			Work Phone:			Email:			Work Phone:				
Employer:			Cell/Pager:			Employer:			Cell/Pager:				
Contact Allowed:			Receive student mailings?			Contact Allowed:			Receive student mailings?				
Guardian Name:						Contact Allowed:			Receive student mailings?				
Address (city,state,zip):						Home location:							
Home Phone:			Work Phone:			Cell/Pager:			Other:				
Employer:						Email:							
Emergency Contact: (non-parent/guardian):						Emergency Contact: (non-parent/guardian):							
Relationship to Student:			May pick up Student?			Relationship to Student:			May pick up Student?				
Home Phone:			Work Phone:			Home Phone:			Work Phone:				
Cell/Pager:			Other:			Cell/Pager:			Other:				
SCHOOL HISTORY													
List all Schools you have attended:													
Previous School Attended:				Address:				Phone Number:					
Reason for transferring:				Grade Completed:				Dates Attended:					
Previous School Attended:				Address:				Phone Number:					
Reason for transferring:				Grade Completed:				Dates Attended:					

Has the student ever been removed or is the student in the process of being removed from a previous school due to disciplinary action? _____.

- I am legally responsible for this student and hereby apply for his/her admission to Wide Ruins Community School. I understand that additional information may be required by the school before this student is officially enrolled.
- I recognize that this is a public document that falsification or information on this document may constitute violation of the criminal laws. I further hereby certify the information contained herein is true and correct. I understand that any legal update of the information on this enrollment form is my responsibility.

 Print name of Parent/Legal Guardian

 Signature if Parent/Legal Guardian

 Date

OFFICIAL USE ONLY	Verified by:
-------------------	--------------

I certify that the above named student is enrolled member with the Navajo Tribal Indian Census as being of:

_____ Degree of Indian Blood _____ Enrollment/Census Number _____ Agency

APPROVAL OF SCHOOL APPLICATION: _____ Approved _____ Not Approved _____ Hold

 Signature of Principal or Registrar

 Date

 Signature of Education Program Administrator

 Date



WIDE RUINS COMMUNITY SCHOOL



P.O. Box 309 Chambers, Arizona 86502

Phone (928)652-3251

-

Fax (928)652-3286

CHECK OUT FORM

Student Name (PRINT)

Parent/Guardian's Name (Print)

Parent/Guardian Email Address

Parent/Guardian Phone Number

Who is authorized to check your child out of school?
Your child will **ONLY** be released to you or those listed below:
ALL PERSONS CHECKING OUT STUDENTS MUST BE 18 YEARS OR OLDER
A picture I.D. may be required.

Name of Person (s)

Phone Number

Relationship to child

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILD SECURITY:

The following person (s) is/are NOT permitted to check out this student.
(Please check box(es)).

- Temporary Order of Protection (Copy needed for student's file)
- Legal Guardianship Order
- Permanent Protection Order (Copy needed for student's file)
- Social Services Order
- Other: _____

Name of Person (s)

Relationship to Child

_____	_____
_____	_____
_____	_____

Please notify the school IMMEDIATELY of any changes in the above information.

Parent/Guardian's Signature

Date



WIDE RUINS COMMUNITY SCHOOL



P.O. Box 309 Chambers, Arizona 86502

Phone (928)652-3251

-

Fax (928)652-3286



Student Name:	Grade:	Phone Number:
Location of Home:	IN/OUT of Boundary (<i>office Use</i>)	
Parent/Guardian Signature:		
<i>If you live out of boundaries, a signed Boundary Waiver must be attached before enrollment approval</i>		
I Certify that my Residence is where the (X) is on the map above		



WIDE RUINS COMMUNITY SCHOOL



P.O. Box 309 Chambers, Arizona 86502

Phone (928)652-3251

-

Fax (928)652-3286

MEDIA PARENT CONSENT FORM

School Year: _____

Student Name:

Date of Birth:

MEDIA

As part of Wide Ruins Community School promotion of school activities or recognition of students achievements. Wide Ruins Community School staff members or the news media may photograph or video individual students or groups of students, while they are engaged in school activities not normally open to the public.

Please mark your preference in the following applicable statement:

1, My Child's image (photograph or video) may be reproduced on any publications, newspaper, or newscast
YES () NO ()

2, My Child's first and last name may be used to identify his/her photography.
YES () NO ()

3, My Child's class (teacher/grade/school) may be used to identify his/her photography.
YES () NO ()

This is in compliance with the "Family Education Rights and Privacy Act of 1974"

Please list any other restrictions you wish to place in the identification of your child's photographs

Parent/Guardian Name (print):

Parent/Guardian Signature:

Date:



WIDE RUINS COMMUNITY SCHOOL



P.O. Box 309 Chambers, Arizona 86502

Phone (928)652-3251

Fax (928)652-3286

STUDENT HEALTH HISTORY FORM

FOR OFFICE USE ONLY	
TEACHER _____	GRADE _____

STUDENT INFORMATION			
Legal Last Name	Legal First Name	Legal Middle Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender <input type="radio"/> F <input type="radio"/> M	Birthdate <input type="text"/>	Grade <input type="text"/>	Phone <input type="text"/>

STUDENT HEALTH HISTORY					
Please indicate below if your child has ever had any of the following. If yes, please indicate the child's age at the time					
<input type="checkbox"/> Arthritis	Age	<input type="checkbox"/> Diabetes	Age	<input type="checkbox"/> High Blood Pressure	Age
<input type="checkbox"/> Allergies (<i>note type below</i>)		<input type="checkbox"/> Ear Infection		<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Skin Rashes
<input type="checkbox"/> Asthma		<input type="checkbox"/> Eczema		<input type="checkbox"/> Osgood Schlatter's	<input type="checkbox"/> Sore Throat (frequent)
<input type="checkbox"/> Bronchitis/Pneumonia		<input type="checkbox"/> Epilepsy/Seizures		<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Strep/Tonsillitis
<input type="checkbox"/> Chicken Pox/Varicella		<input type="checkbox"/> Hear Concerns		<input type="checkbox"/> Scoliosis/Curvature of the spine	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cystic Fibrosis		<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Urinary Tract Infections

Allergy Type (*food, medication, bee sting, etc.*)

Please respond "Yes" or "No" to the following questions:

<input type="checkbox"/> Y <input type="checkbox"/> N	Is the student receiving treatment for any physical problems?	<input type="checkbox"/> Y <input type="checkbox"/> N	Has the child ever had a psychological examination?
<input type="checkbox"/> Y <input type="checkbox"/> N	Is the child restricted from physical education (<i>P.E.</i>)?	<input type="checkbox"/> Y <input type="checkbox"/> N	Has the child ever had a serious accident or injury?
<input type="checkbox"/> Y <input type="checkbox"/> N	Has the child ever had an accident or injury requiring hospitalization or surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N	Has the child ever been placed in special classes? (<i>LD, speech, reading, hearing/visual impaired, emotional or physical handicap</i>)?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does the child wear glasses?	<input type="checkbox"/> Y <input type="checkbox"/> N	Does the child have any other vision difficulties?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does the child have any speech difficulties?	<input type="checkbox"/> Y <input type="checkbox"/> N	Does the child have any hearing loss?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does the child wear a hearing aid?	<input type="checkbox"/> Y <input type="checkbox"/> N	Has the child had tubes put into his/her ears?
<input type="checkbox"/> Y <input type="checkbox"/> N	Are there any significant behaviors that may affect this child's performance in school or that may be of concern?	<input type="checkbox"/> Y <input type="checkbox"/> N	Is the student currently prescribed or taking any medication

Medications my child is currently prescribed or taking

Please explain any "Yes" answers

OVER THE COUNTER MEDICATIONS				
By checking the item(s) below, you grant the district/school permission to administer the recommended dosage:				
<input type="checkbox"/> Non Aspirin/Acetaminophen	<input type="checkbox"/> Anbesol (<i>tooth pain</i>)	<input type="checkbox"/> Antacid	<input type="checkbox"/> Antibiotic Ointment (<i>cuts/abrasions</i>)	<input type="checkbox"/> Antiseptic Wash
<input type="checkbox"/> Antiseptic Wash	<input type="checkbox"/> Caladryl (<i>insect bites or itching</i>)	<input type="checkbox"/> Cough Drops	<input type="checkbox"/> Lip Balm/Vaseline	<input type="checkbox"/> Motrin/Ibuprofen
		<input type="checkbox"/> Saline (<i>Eye Drops</i>)		

OTHER INFORMATION	
Hearing and vision screenings will be administered as required by state guidelines.	
PLEASE NOTE: In the event of serious illness or injury, your child will be taken to the hospital by ambulance if necessary. Emergency treatment will be provided until parent and/or legal guardian can be contacted. Expenses for emergency transportation and/or treatment is the responsibility of the parent and/or legal guardian.	
Please Print Parent/Guardian Legal Name _____	
Parent/Guardian Signature _____	Date _____



WIDE RUINS COMMUNITY SCHOOL



P.O. Box 309 Chambers, Arizona 86502

Phone (928)652-3251

Fax (928)652-3286

EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM

School Year: _____

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practice to contact them. This form should accompany the child in the event of off-site trips or emergency relocation of the program.

Minor's Full Legal Name:
Home Address:
Date of Birth: _____ Gender: FEMALE___ MALE___
Physician's Name and Location of Practice:
Physician's Phone # (if known): ()
Medical Insurer/Health Plan:
Allergies to Medications:
Allergies (other):
Please note all conditions for which the child is currently receiving treatment: _____ _____
Note any other significant medical information: _____ _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant authorization and consent for **WIDE RUINS COMMUNITY SCHOOL STAFF/NURSE/RESIDENTIAL** (Hereafter "Designated Adult") to administer general first aid treatment for any minor/major injuries or acute illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I do authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

Signed this _____ day of _____, 20____
This authorization of effective through:
Parent/Legal Guardian Signature:
Printed Name:
Witness Signature:
Printed Name:



WIDE RUINS COMMUNITY SCHOOL



P.O. Box 309 Chambers, Arizona 86502

Phone (928)652-3251

Fax (928)652-3286

Student Residency Verification Document

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

1. Presently, where is the student living? Complete only one section – A or B.

Section A	Section B
<input type="checkbox"/> in a shelter <input type="checkbox"/> with more than one family in a house or apartment <input type="checkbox"/> in a motel, car, or campsite <input type="checkbox"/> with friends or family members (other than parent/guardian) Please complete #2 and #3 below:	<input type="checkbox"/> Choices in Section A do not apply (both parents are in the household and child lives with both parents in the same home). Skip #2 and complete #3 below:

2. The student lives with:

- One parent
- A relative, friend(s) or other adults(s)
- Two parents
- Alone with no adults
- One parent & another adult
- An adult that is not the parent or the legal guardian

3.

School _____

Name of Student _____

Male Female

Birth Date ____/____/____ Age: _____

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

Address _____ Zip _____ Phone _____

Signature of Parent/Legal Guardian _____ Date _____

School Use Only – School Administrator's determination of Section A circumstances

If the parent has checked Section B above, completion of form is not required. For any choices in Section A, this form must be completed and provided to School Registrar immediately after completion. Form will be kept separately from the Student Permanent Record for audit purposes during the year.

Name and phone number of a School Contract Person who may know of the family's situation:

Date Faxed: _____



WIDE RUINS COMMUNITY SCHOOL

P.O. Box 309
Chambers, Arizona 86502

Phone: (928) 652-3251
Fax: (928) 652-3286

GOVERNING BOARD

PresidentGlenna Thompson
Vice-President.....Kathleen Lee
Secretary.....Louise Nelson
Member.....Ella Shirley
Principal..... Jeannie M. Lewis

RECORD/TRANSCRIPT REQUEST FORM

STUDENT NAME		DATE OF BIRTH	GRADE
FORMER SCHOOL INFORMATION			
SCHOOL			
MAILING ADDRESS			
CITY		STATE	ZIP
PHONE		FAX	

PARENT AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize, by my signature below, for my child's SCHOOL RECORDS, including all GRADES, TEST SCORES, IEP's, and any other information pertinent to his/her transcript to be sent to the WRCS school requesting them.

PRINT PARENT/LEGAL GUARDIAN NAME	PARENT/LEGAL GUARDIAN SIGNATURE	DATE

Official Use Only

REQUEST	DATE	PRINT NAME/TITLE	SIGNATURE
1 ST			
2 ND			
3 RD			

I hereby and herein request for the following Transfer Documents

- | | | |
|---|--|--|
| <input type="checkbox"/> School Test Scores | <input type="checkbox"/> School Report Cards | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Remedial Reading | <input type="checkbox"/> Gifted/Talented | <input type="checkbox"/> Special Education Classes |
| <input type="checkbox"/> Promotion Certificates | <input type="checkbox"/> Individual Counseling | <input type="checkbox"/> Behavioral/Disciplinary Records |
| <input type="checkbox"/> Other _____ | | |

SCHOOL MAKING THE TRANSCRIPT REQUEST

Wide Ruins Community School
Attn: Fanassa Ashley, Receptionist/Registrar
Email: f.ashley@kinteelolta.org