**WIDE RUINS**

COMMUNITY SCHOOL

P.O. Box 309 Chambers, Arizona 86502 Phone (928)652-3251 - Fax (928)652-3286

**SY 2024-2025 Enrollment Application**

|  |
| --- |
| The following information and documents are needed for each student at the time of enrollment. Students will not be permitted to start school until all the required documents have been received and completed.You will be notified by Registrar upon approval. |
| ENROLLMENT FORMS: |
| * Completed Enrollment Application *(Signed by Principal and Parent / Legal Guardian)*
 |
| * Special Education Form
 |
| * Location of Home *(Draw Exact Location of home include Rural house number)*
 |
| * Check Out
 |
| * Media Consent
 |
| * Student Residency Verification
 |
| * Home Language Survey
 |
| * Title VII Student Eligibility Certification
 |
| * Student health History / Medical Treatment Authorization
 |
| * Student Consent Form
 |
| * Tsehootsooi Medical Consent Forms
 |
| * Student, Parent/Family, and School Title I – Compact
 |
| REQUIRED VITAL DOCUMENTS TO BE TURNED IN FOR ENROLLMENT: |
| * Birth Certificate
 |
| * Certificate of Indian Blood (CIB)
 |
| * Withdrawal/Release or final Report Card from previous school *(NEW STUDENTS)*
 |
| * *\*\*UPDATED IMMUNIZATION RECORD FOR NEW AND RETURNING STUDENTS\*\**
 |
| * If you are Legal Guardian or Custodial Parent, we require one of the following documents for enrollment:
* Legal Court Documents - Custody Documents, Restraining Orders, etc.
* Social Service Placement Letter
* Temporary (Academic Year) Guardianship signed and Notarized
* Other copies of Legal Documents, I.E.
 |

***“Education is the ray of light that will lighten up our students at Wide Ruins Community 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.

OFFICE STAFF ONLY

* Grade Level \_\_\_\_\_\_\_
* New \_\_\_\_\_­­ Returning \_­­\_\_\_
* Dorm \_\_\_\_\_ Day-Bus \_­­\_\_\_\_
* **NASIS ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Bureau of Indian Education

 **Wide Ruins Community School**

Student Enrollment Application

**SY 24/25**

**Entry Date:** **Withdrawal Date:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Student Name: LAST FIRST M.I. SUFFIX* | *Grade:* | *Gender:* | *Date of Birth:* | *Census Number:* | *Degree of Indian Blood:* |
|  |  | Female Male |  |  |  |
| *Mailing Address:* | ***Birth Place:*** | ***Tribal Affiliation:*** | ***Chapter Affiliation:*** |
|  |  |  |  |
| *Physical Address:* | ***With whom does the student live? (Circle all that apply)*** |
|  | Both Parents Father Mother Grandparents Guardian Other |
| 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: |
| Mailing Address: | Mailing Address: |
| Home Location: | Home Location: |
| Home Phone: Work Phone: | Home Phone: Work Phone: |
| Email:  | Email:  |
| Employer:  | Employer:  |
| Guardian Name: | Home Phone: |
| Mailing Address: | Email: |
| Home Location:  | Employer:  |
| Emergency Contact |
| Name: Relationship:  | Name: Relationship:  |
| Home Phone: Work Phone: | Home Phone: Work Phone: |
| 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? YES \_\_\_\_\_ NO\_\_\_\_\_** *\*See attached WRCS Policy Article IX Section 9.02 Enrollment Policy\**

* 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 |

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 Date* |

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**SPECIAL EDUCATION FORM**

**My Child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| has / has not | ever received Special Education services in the past |
| *(circle one)* |  |
|  |  |
| has / has not | receiving Special Education services now. |
| *(circle one)* |  |

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Gifted & Talented Education Program Information**

|  |  |
| --- | --- |
| has / has not | ever received Gifted & Talented services in the past and |
| *(circle one)* |  |
|  |  |
| has / has not | receiving Gifted & Talented services now. |
| *(circle one)* |  |

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

The last school my child attended was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Located at (city) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information helps the Wide Ruins Community School ensure that your child receives the best possible education and help he / she may need to be successful. Thank You.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| ***Parent / Guardian Signature*** |  | ***Date*** |

**WIDE RUINS**

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**LOCATION OF HOME**

|  |
| --- |
| Basic Compass Rose | Custom-Designed Graphic Objects ~ Creative Market |

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

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**CHECK OUT FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Student Name |  | Parent/Guardian’s Name  |  | Parent/Guardian Phone Number |

|  |
| --- |
| **WRCS Policy Article IX Section 9.31 Check-Out Procedures:** Parents or legal guardians of students must designate those persons who are authorized to check out their children on the student check out forms. *No phone calls or notes will be accepted for check out authorization*.***Person checking out a student should be prepared to show proper identification.*** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Person (s)** |  | **Phone Number** |  | **Relationship to child** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **The following person(s) is/are NOT permitted to check out this student. *Please check box(es)******\*\*copy of Official Court documents needed for student file\*\***** 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**

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|  |
| --- |
| MEDIA CONSENT FORM*School Year: 24 / 25* |
| Student Name: Date of Birth: |
|  |
| As part of Wide Ruins Community School promotion of school activities or recognition of student’s 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:* My Child’s name and image (photograph/video) may be reproduced on any publications, newspaper, newscast, school website and/or social media. YES ( ) NO ( )*\*This is in compliance with the “Family Education Rights and Privacy Act of 1974”\** |
| Parent/Guardian Name (print): |
| Parent/Guardian Signature: Date: |

**WIDE RUINS**

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**Student Residency Verification**

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** |
| * 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 parent/guardian)

***Please complete #2 and #3 below:*** | * 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:*** |

1. 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
1. School *Wide Ruins Community 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.

\_\_\_\_\_\_\_\_\_\_ Does Qualify under McKinney-Vento Act \_\_\_\_\_\_\_\_\_\_ Does NOT Qualify

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

McKinney-Vento Liaison/Appointee Signature Date



**Arizona Department of Education**

Office of English Language Acquisition Services

**Home Language Survey**

The responses to this Home Language Survey (HLS) are used by the school to provide the most appropriate instructional programs and services for the student. **The answers below will determine if a student will take the Arizona English Language Learner Assessment (AZELLA).** Please respond to each of the three questions as accurately as possible. If you need to correct any of your responses, this must be done **before** the student takes the AZELLA Placement Test.

1. **What language do people speak in the home *most* of the time?**
2. **What language does the student speak *most* of the time?**
3. **What language did the student first speak or understand?**

Student Name District Student ID\_ Date of Birth SSID Parent/Guardian Signature Date School Wide Ruins Community School

Please provide a copy of the Home Language Survey to the EL Coordinator/Main Contact on site. In AzEDS, please enter all three HLS responses.

These HLS questions are in compliance with Arizona Administrative Code (R7-2-306(B)(1),(2)(a-c). (Revised 01-2020)

Office of English Language Acquisition Services

1535 West Jefferson Street • Phoenix, Arizona 85007 • (602) 542-0753 • [www.azed.gov/oelas](http://www.azed.gov/oelas)

OMB Number: 1810-0021

U.S. DEPARTMENT OF EDUCATION

OFFICE OF INDIAN EDUCATION

WASHINGTON, DC 20202

**TITLE VII STUDENT ELIGIBILITY CERTIFICATION**

Elementary and Secondary Education Act, Title VII, Part A, Subpart 1

|  |
| --- |
| **Parents: Please return this completed form to your child's school.** In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program**. This form will become part of your child's school record and will not need to be completed every year.** This form will be maintained at the school and information on the form will not be released without your written approval.***Definition: Indian means any individual who is (1) a member (as defined by the Indian tribe or band) of an Indian tribe or band, including those Indian tribe or bands terminated since 1940, and those recognized by the State in which the tribe or band reside; or (2) a descendent in the first or second degree (parent or grandparent) as******described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an******Eskimo or 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 October 19, 1994.*** |
| NAME OF CHILD**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth **\_\_\_\_\_\_\_\_\_\_**(As shown on school enrollment records)School Name Grade NAME OF TRIBE, BAND OR GROUP **Tribe, Band or Group is: (check one)****Organized Indian Group****Federally Recognized, State Meeting #5 of the** **Including Alaska Native Recognized Terminated Definition Above Name of individual with tribal membership: \_\_\_\_\_\_\_****Individual named is (check one): Child Child's Parent Child's****Grandparent****Proof of membership, as defined by tribe, band, or group is:**1. **Membership or enrollment number (if readily available) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR**

**Other (explain)** **Name and address of organization maintaining membership data for the tribe, band or group:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_**I verify that the information provided above is accurate:**PARENT'S SIGNATURE DATE**  **Mailing Address** Telephone  |

**STUDENT HEALTH HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| *Student Name: LAST FIRST Middle Suffix* | *Date of Birth:* | *Grade:* | *Gender:* |
|  |  |  | *Female Male* |
| *EMERGENCY CONTACT 1* | ***EMERGENCY CONTACT 2*** |
| Name: Relationship: | Name: Relationship: |
| Home Phone: Work Phone: | Home Phone: Work Phone: |

 Details / Year Details / Year Details / Year

Asthma YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eczema YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizures YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chickenpox YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Abdomen YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies *(seasonal, food, medication)\*\** YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*A PHYSICIAN’S STATEMENT WILL BE REQUIRED FOR ALL ALLERGIES (FOOD/SEASONAL/MEDICATION), DIETARY RESTRICTIONS, MEDICAL CONDITIONS, AND PRESCRIBED MEDICATION(S). AN AUTHORIZATION TO ADMINISTER PRESCRIBED/OVER THE COUNTER MEDICATION AND/OR DIETARY ACCOMODATION WILL NEED TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND MEDICAL PRESCRIBER IF YOUR CHILD SHOULD NEED DURING SCHOOL HOURS\*\***

1. Does he/she wear glasses? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Is student restricted from physical activities? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Has student ever had any surgeries? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Does student have any current behavioral problems (Mental/Emotional)? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Is student currently receiving any medical treatment? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Is student taking any medication regularly? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL TREATMENT AUTHORIZATION**

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.

|  |
| --- |
| Physician’s Name and Location: |
| Physician’s Phone # (if known): ( ) |
| Medical Insurer/Health Plan: |

**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 for: SY­­ 24/25  |
| Parent/Legal Guardian Signature: |
| Printed Name: |

**STUDENT CONSENT FORM**

**OVER-THE-COUNTER MEDICATION:**

The School Health office has limits as to what medications can be administered to students. With your permission, and at the discretion of the School Health Professional, please indicate (with a check) the medications you give consent to administer.

* **Fever over 100 degrees, headache, pain, muscle ache, menstrual cramps**

May give *Acetaminophen (Tylenol)* every 4 hours as needed. Children’s dosage is based on weight.

May give *Ibuprofen (Advil, Motrin)* every 4 hours as needed according to label directions.

* **Sore throat or cough**

May give *Cough Drops* or *Throat Lozenges* according to label directions.

* **Toothache/tooth pain**

May apply *Anbesol (Orajel)*

* **Mild itching due to rash or insect bites**

May apply *Anti-itch Cream*, *Calamine Lotion*, or *Hydrocortisone Cream* according to label directions.

* **Cold Sore**

May apply *Blistex Ointment* according to label directions.

* **Eye irritations, burning, itching, allergies, and discomfort**

May use *Eye Wash* to flush the affected eye or *Eye Drops* as needed according to label directions.

***If your child is vomiting, has a high temperature of 100 degrees or more, is coughing or is generally not well, please keep your child at home and notify WRCS immediately. See doctor or contact a hospital of your choice for further medical evaluation on your child’s condition. A doctor’s note is required for absences to be excused.***

I authorize my child to participate in the following activities as well if needed:

1. Help clean my child’s outer ear with Q-tip YES / NO
2. Trim my Child’s fingernails/toenails YES / NO
3. Treatment for Head Lice\* YES / NO

*(Hair and Body checks if suspected of head lice and/or bed bugs)*

1. Administer Prescribed Medication by a Licensed Physician YES / NO

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

***Parent/Guardian Signature Date***



PO Box 649 Fort Defiance, AZ 86504 Phone: 928.729.8010 Fax: 928.729.8019 Website: WWW.fdihb.org

a facility of fort defiance Indian hospital board, Inc.

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Parent/Guardian,

Your state recommends certain health screenings, by grade, which may include vision, hearing, height/weight, and blood pressure. The Public Health Nursing staff of Fort Defiance Indian Hospital, Inc. coordinates these screenings each fall. The health information collected during this screening will be recorded in your child’s Fort Defiance Indian Hospital record and your child’s school health record. You will be notified of any unusual findings. Your student’s information will only be shared in the event that he/she is referred for further evaluation.

Additionally, Public Health Nursing will conduct an immunization record review to ensure that your student is adequately protected from preventable illnesses. You will be notified if your child is due for any vaccines.

Enclosed, you will also find a health history update. Please complete this form. It will be placed in your child’s school health record.

As the parent or legal guardian of the student named above, I hereby consent to have Fort Defiance Indian Hospital, Inc. staff provide the state recommended health screenings for my child: **\_\_\_Yes \_\_\_No**

Does your child have a chart with FDIH? **\_\_\_Yes \_\_\_No**

For the purpose of recording your child’s information, please provide the number: \_\_\_\_\_\_\_\_\_\_\_\_

I understand that these health care services are non-invasive and are only screenings. The FDIHB Public Health Nurses will make recommendations if needed, for follow-up with a Medical Provider.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent or legal guardian Valid for 1 year

**---PLEASE RETURN THIS FORM TO THE SCHOOL--**

**STUDENT HEALTH HISTORY**

 **FORT DEFIANCE SERVICE UNIT**

**TO BE FILLED OUT AND SIGNED BY PARENTS**

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Family Physician/Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Family Dentist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

**Has your child ever had or now have?**

Details Year Details Year

Allergy Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anemia Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Joint Pain Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Arthritis Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Trouble Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menstrual Cramps Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Back Pain Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Migraine Headaches Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Concussion Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Knocked Out Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Loss of Consciousness Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Knee Injury Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rheumatic Fever Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eczema (skin rash) Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Scoliosis Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emotional Problems Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spine Injury Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Epilepsy (seizures) Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sinus Trouble Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fainting Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sore Throats (chronic) Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing Trouble Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Murmur Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neck Injury Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wrist Injury Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hernia (rupture) Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Elbow Injury Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ankle Injury Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical procedure (Operation) Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Elbow Injury Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During the past 12 months was your child hospitalized? Yes ( ) No ( )

2. During the past 12 months did your child have any injuries requiring medical Yes ( ) No ( )

 attention or is he/she now under a physician care?

3. During the past 12 months did your child have any illness lasting more than one week? Yes ( ) No ( )

4. Does your child take any medication regularly? Yes ( ) No ( )

5. Do you feel that there should be limits on your child’s participation in activities because Yes ( ) No ( )

 of symptoms of illness, injury, or abnormalities of family history known to you or your

 Physician?

6. During the past 12 months has your child had any fractures, sprains/dislocations? Yes ( ) No ( )

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Does your child have any allergies to medications, plants, foods, etc.? Please list. Yes ( ) No ( )

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

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

8. Medications Now Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Does your child wear prescription glasses? Yes ( ) No ( )

10. Does your child have a diagnosed hearing condition? Yes ( ) No ( )

 Has she/he been followed by an audiologist? Yes ( ) No ( )

11. Please explain any “yes” answers

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

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

We the undersigned, have answered the above questions to the best of our ability. The information given is true. We understand that school personnel will rely on the information provided.

If emergency service involving medical action or treatment is required and neither the parents nor guardians can be contacted, I hereby consent for the student named above to be given medical care at the facility selected by the school.

Signature of parent or guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (permission valid for 365 days unless rescinded)

Revised 8/30/04

**Wide Ruins Community School, Inc.**

**School Year 2024-2025**

**Student, Parent/Family, and School Title I – Compact**

We, the Wide Ruins Community School, establish this compact to foster the success of our students. We believe this is accomplished through the planned partnership parents, families, students, teachers, and administrators. Goals that ensure academic achievement of the state standards; help every student develop a sense of responsibility and respect of self and others; and, provide guidelines for meaningful two-way communication between home and school are guaranteed through the following responsibilities in this agreement.

|  |
| --- |
| **As a Student……..** |
| **Students** benefit when adults in their school community are bonded by strong relationships. They recognize that they, too, are partners with their parents and teachers in their success. I will:***Reading/Literacy**** Read regularly for pleasure as well as to learn.
* Ask my family to read with me or read to me 15 minutes each day 5 days a week.

***Study habits/Self-directed learning**** Listen to my family, teachers, and others who help me learn, and ask questions when I need help.
* Complete my homework on time and in a thorough and legible way.

***Respect/Responsibility**** Come to school on time, and ready to learn.
* Always try my best.
* Respect myself and the rights of others.

***Community**** Deliver messages from school to home and home to school to help inform my parents and teachers of events and activities that help support my learning experience.
* Encourage my family to participate in events and programs sponsored by my school community (e.g., Open House, Family Nights, Parent-Teacher-Student Conferences.)
 |
| **Student Signature:** | **Date:** |
| **As Parent/Guardian/Family…..** |
| **Parents/Families** understand that involvement in their child’s education is the number one determining factor in a child’s academic success. To make education a top priority in our home, I will:***Reading/Literacy**** Read to or with our child 15 minutes per day 5 days a week.
* Help to reinforce our child’s reading and math skills with direction of the teacher.
* Know our child’s interests and encourage reading for pleasure.
* Discuss our child’s progress in reading and math in ways that show our high expectations.

***Study habits/Self-directed learning**** Make sure our child has a routine for homework that works for our family and follows our school’s homework guidelines. If our child doesn’t have homework on any given day, we will encourage independent reading time, (or read together if in K or 1st grade), review reading or math skills, or prepare for projects, quizzes or tests.
* Review our child’s homework and sign student planner each night.
* Discuss our child’s effort and potential in ways that show high expectations.

***Respect/Responsibility**** Make sure our child attends school regularly, is on time, and is prepared to learn.
* Stress the importance of school and classroom behavior expectations in family conversations.
* Encourage my child to demonstrate respect for school personnel, classmates, and school property.

***Community**** Communicate promptly with my child’s teacher whenever a concern or question arises.
* Respond promptly to my child’s teacher or the school regarding requests or information.
* Attend/participate in open house, parent/teacher conferences, Family Nights or other school events.
 |
| **Parent/Guardian Signature:** | **Date:** |
| **As a Teacher….** |
| **Teachers** will provide high-quality curriculum and instruction in a supportive and effective learning environment that enables our students to meet (state’s name) academic standards. (See key Academic goals for this school year in Plan4Learning portal). In addition, I will:***Reading/Literacy**** Keep parents informed of the reading and math skills their children are learning, and how they can reinforce these skills at home.
* Guide students in selecting reading materials that match their interests and independent reading levels.

***Study habits/Self-directed learning**** Teach students how to study and encourage active listening skills.
* Provide homework assignments relevant to daily instruction in accordance with the school homework guidelines.

***Respect/Responsibility**** Model and display responsible decision making and citizenship in all aspects of daily life.
* Maintain appropriate student behavior in the classroom so that all students can learn and be safe.

***Community**** Communicate frequently with parents about their children’s progress through quarterly report cards, and by notes, phone calls, and e-mails.
* Respond promptly to families’ concerns, messages and requests for information.
* Hold parent-teacher conferences, bi-annually, during which this compact will be discussed as it relates to the individual child’s achievement.
* Encourage families to participate in school community programs and events.
 |
| **Teacher Signature** | **Date:** |
| **As Principal…..** |
| Our school helps to strengthen the family-school partnership to enhance student learning through our School Community Council, Parent Teacher Organization, Family Nights, parent workshops, classroom visits by parents, and communication about students’ progress toward learning standards and state assessments. Family activities are posted on the school’s website, the parent bulletin board in the foyer, and distributed through student delivery. If you are interested in volunteering for our school, please complete the survey available at Open House or on the website at: www. **https://kinteelolta.org/.** There will be orientation and training for all interested family and community members. Please read and sign this Compact, then return it to your child’s teacher. Please post your copy in a place that can serve as a reminder of each school community member’s responsibilities toward the success of each and every child in our school community. We will refer to this compact at parent-teacher conferences and meetings that confirm our family-school partnership to enhance our students’ learning. **Principal**supports and encourages the efforts of all family-school partnerships in this school community. |
| **Principal Signature** | **Date:** |



**Request for Release of Student Records**

***\*for NEW Enrollment\****

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Student Name: |  |  | Date of Birth: |  |  | Current Grade: |  |

|  |  |
| --- | --- |
| Previous School Name: |  |
| Previous School Address: |  |
|  | City |  | Zip |  | State |  |
| Phone Number:Fax Number: |  |
|  |

You are hereby authorized to release from your records the following data regarding the above name student:

|  |  |
| --- | --- |
|  | Withdrawal & Transcripts (Grades, Assessment Scores, etc.) |
|  | Behavior Reports *if any* |
|  | Personal File (Birth Certificate, Certificate of Indian Blood, Guardianship papers) |
|  | Health Record (Most current Immunization Record, Physical Examination) |
|  | Special Education file (Current IEP, Psychological Evaluation, Speech, Counseling, etc.) |
|  | Gifted & Talented |

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

Parent / Guardian Signature Date

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
|  | DATE |  | SIGNATURE |
| 1st Request: |  |  |  |
| 2nd Request: |  |  |  |
| 3rd Request: |  |  |  |

Attn: Fanassa Ashley, Receptionist/Registrar

Email: f.ashley@kinteelolta.org