



Gila River Tribal Education Department Off Reservation Boarding School Checklist



- 1 Application
- 2 Birth Certificate
- 3 SS Card
- 4 Health Insurance/ AHCCCS ID
- 5 CDIB
- 6 Transcript
 - a 8th Grade Diploma ****If applying for 9th grade****
 - b Current Report Card
 - c Updated IEP (If applicable)
- 7 Current Immunization Record
- 8 Current Physical
- 9 Proof of Guardianship (non parent)
- 10 Social Summary (if student is receiving services)
 - a Probation
 - b Tribal Social Services
 - c Behavioral Health

ORBS Required Documents

- 11 ORBS Transcript Request Form
- 12 ORBS Disclosure of Confidential Information Consent Form
- 13 Parent and Student ORBS Handbook Agreement

Gila River Indian Community

Off-Reservation Boarding Schools

Post Office Box 97 Sacaton, AZ 85147

Office: (520) 562-3662 ext. 3621

Cell: (520) 610- 8577

Fax: (520) 562- 3348



Transcript Request Form

Date: / /

Student: _____

Date of Birth: / /

School : _____

Years attended: _____

Graduated: Yes No Year Graduated: /

Unofficial Transcript Official Transcript

Fax Unofficial to: (951) 276-6336

Mail Official To: Sherman Indian High School

9010 Magnolia Avenue

Riverside, CA 92503

Attn: Registrar

Comments: _____

Signature: _____

Date: _____

Gila River Indian Community Off-Reservation Boarding Schools



Office: (520) 562-3662

Cell: (520) 610- 8577

Fax: (520) 562- 2924

Email: Danielle.Allen@gric.nsn.us



DISCLOSURE OF CONFIDENTIAL INFORMATION CONSENT FORM 2017-2018

I _____ Parent/Guardian of _____

AUTHORIZE _____

NAME OF BOARDING SCHOOL

TO DISCLOSE TO THE OFF-RESERVATION BOARDING SCHOOLS OFFICE
FOR STUDENT'S FILES AND PARENT INFORMATION ONLY

ACADEMIC RECORDS

HOMELIVING REPORTS

MEDICAL STATUS

COUNSELING/REFERRALS

RELEASE TO THE GILA RIVER INDIAN COMMUNITY & OFF-RESERVATION
BOARDING SCHOOLS OFFICE FOR STUDENT RECOGNITION IN NEWSPAPER
ARTICLES AND PUBLIC RELATIONS

STUDENT RECOGNITIONS

**CLASS/GROUP/INDIVIDUAL
PHOTOS**

SIGNATURE OF PARENT/GUARDIAN

DATE

INFORMATION MAYBE DISCLOSED TO THE GILA RIVER INDIAN EDUCATION STANDING COMMITTEE



Gila River Indian Community

Off-Reservation Boarding Schools

Office: (520) 562-3662

Cell: (520) 610- 8577

Fax: (520) 562- 2924

Email: Danielle.Allen@gric.nsn.us



Application deadline to **ALL** boarding schools is **July 14, 2017**. Please turn in your application(s) along with **ALL REQUIRED DOCUMENTATION** to the Off-Reservation Boarding Schools office no later than **5:00 PM** on the deadline date.

Parent and Student ORBS Handbook:

The Purpose and Goal of the Off Reservation Boarding School Program (ORBS):

1. The ORBS Program is to provide assistance in completing school applications, and being a support system to the student and their families.
2. The purpose of the ORBS Advisor is to assist students in successfully completing applications, achieving academic success, and graduating from their school by providing as a liaison with the Gila River Indian Community that can support the students and their families.

Intake/Applications:

1. Interested parties are able to come to the Tribal Education Department (TED) Office to pick up an application for the boarding school they are interested in. Applications are also available online.
2. **ORBS Program does not accept, deny, or place students on a waiting list. We serve as a liaison to help complete and submit applications.**
3. A checklist of required documents will be provided to the family along with ORBS required documents and the application.
4. The required documents are mandated by the boarding schools. Our office advises students and families to submit a complete application with all required documents. **If an incomplete application is submitted the boarding school registrar will contact the family directly not the ORBS Advisor.**
5. Submission of an application **DOES NOT** automatically enroll the student into the school of choice. Each school has an Admissions Committee who reviews all applications. The decision is at the discretion of the committee and will be based on the merit of the application.
6. **ALL** sections of the application must be thoroughly completed. Campus admission committees **WILL NOT** review incomplete applications.
7. **ALL** medical and/or physical conditions must be disclosed in the application.

Appointments:

1. All new/Potential students are encouraged to meet with the ORBS Advisor.

2. Appointments are encouraged by Advisor to meet with student(s) and parents/guardians.
3. Walk-ins will be seen at Advisors availability.

Transportation:

1. Transportation to airport maybe available on a case by case basis. The transportation request must be approved by the TED Director/Assistant Director. Requests are to be submitted two weeks prior to date of departure. Transportation Requests are available at the TED office.
2. In the event of a death, **Parent(s)/Guardian(s) are responsible** for round trip transportation for student to attend all funeral services.

School Travel Information:

- Your School of choice will provide transportation for the students **4 Times** per school year:
 1. Beginning of the school year
 2. Winter Break
 3. Return from Winter Break
 4. End of the school year
- Campus travel agents will be in contact with you once the travel arrangements have been complete. Parents/Guardians are responsible to ensure a safe and timely departure.
- Students **Must** travel on the arranged dates and times. If for any reason a student cannot meet their designated travel itinerary, it is the **responsibility for the parent/guardian** to notify the proper officials **Before** departure. If proper notification is not given the parent may be held accountable for any charges or fees incurred.

Room and Board:

4. Your school of choice provides room and board as well as most educational supplies. Students are expected to provide themselves with personal items such as shampoo, toothpaste, clothing, shoes, etc. and one may prefer to acquire their own bedding. Please note that all personal items will be taken **AT YOUR OWN RISK**.

Parent/Guardian Responsibility:

6. Should the parent/guardian decide to **WITHDRAW** their student, it is the **RESPONSIBILITY OF THE PARENT** to make travel arrangements and cover all costs involved.
7. Parents **MUST UPDATE** the ORBS office on any information changes such as home locations, addresses, contact numbers, Withdraws, and Transfers.
8. Parents and students are encouraged to familiarize themselves with their school's policies and procedures, student rights and responsibilities, or student handbooks of their prospective schools.

9. Should violations of the law occur off campus, the student is subject to the **LOCAL LAW ENFORCEMENT**. Parents are responsible for all legal matters and fines incurred. If parents are required to be present for legal matters they are financially responsible for any travel accommodations.
10. Parent(s)/Guardian(s) should develop a working relationship with staff and administration at school of choice. Student grade reports are mailed directly to the parents/guardians. If you are not receiving the academic progress reports please contact the school, or the ORBS office.
11. Should you have any questions or concerns the ORBS office will assist you in contacting the academic, residential, or behavioral counselors at the schools. Teleconferences may be arranged through the ORBS Advisor and the office will assist you in faxing documents to the school.

I have read and discussed the above with the Off-Reservation Boarding School Advisor. I fully understand the contents of this document pertaining to the ORBS application process and the legal issues contained.

Parent(s)/Guardian(s)	Date
Student	Date
ORBS Advisor	Date



**Gila River
HEALTH CARE**

P. O. Box 38 – Sacaton, Arizona 85247

Contract Health Services for Medical Care

Boarding School/College Student Policy Statement

Date: _____

(Part I) STUDENT INFORMATION

Registered Student's Name: _____ DOB: _____

SSN#: _____ Tribal ID# _____ Home Phone: _____

Address Prior to Attending School: _____

Name and Address

Name & Address of Legal Parent (s) or Guardian (if under 18 years of age):

Father: _____ Phone: _____

Mother: _____ Phone: _____

Guardian: _____ Phone: _____

(Part II) FULL-TIME COLLEGE/VOCATIONAL/TECHNICAL STUDENT

"I certify that I am a registered student at _____ and lived on the _____ Reservation prior to my school attendance. I am registered Beginning _____ for the school year _____ as a full time Student. I am aware that it is my responsibility to renew this Student Application for each year _____ as a full-time student. I am aware that it is my responsibility to renew this Student Application for each year I am in full-time attendance at my College, Vocational, Technical, or academic program.

Student signature: _____ Date: _____

(Part III) SCHOOL INFORMATION

Official Name of School: _____

School Address: _____

School Registrar Phone #: _____ School Fax #: _____

(Part IV) SCHOOL REGISTRAR

I certify that _____ is registered full-time for the school year _____ Beginning _____ that Health Services required are not part of the school's health program or covered by insurance.

Signature and Title of School Official
6/30/2009

Date

(Part V) STUDENT INSURANCE INFORMATION

A. Medicaid (AHCCCS) Coverage:

Medicaid Name: _____ ID #: _____ Effective: _____
Call Arizona (AHCCCS for PRIOR AUTHORIZATION at 1-800-433-0425 Fax: 1-602-417-4687

B. Insurance: _____ Phone #: _____
Policyholder Name: _____ Policy #: _____

(Part VI) CHS NOTIFICATION

In accordance with the Regulations as published in the Federal register, dated August 4, 1978, 42 CFR, Part 36.23, 2-3E, Persons to whom CHS will be provided, federally recognized Indian students are affected as follows:

- A. Non-Emergency Services: Must have prior approval from Hu Hu Kam Memorial Hospital before services are rendered.
- B. Emergency Services: Notification must be received within 72 hours from initiation of services. Notification from any individual, parent, guardian, Boarding school staff, relative or provider of services is acceptable.

Phone: 1-888-HUHUKAM or (520) 562-3321 ext. 1052 or Fax to : 1-602-528-1324. After hours, please leave a voice message with the Managed Care Dept.

(Part VII) CERTIFICATION BY PATIENT REGISTRATION STAFF
(For Contract Health Service Eligibility Only)

I certify that _____ is a member/descendant of the _____ Indian Tribe. I acknowledge that _____ lived in his/her Contract Health Service Delivery Area (CHSDA) prior to the beginning of the school year in accordance with 42 CFR, Part 36, Contract Health Services.

Signature Patient Registration: _____ Date: _____

After PARTS I, II, III, IV, are completed, please return the student application to a Managed Care Staff member at Hu Hu Kam Memorial Hospital to complete the CHS eligibility section.

Hu Hu Kam Memorial Hospital Patient Registration Office Use Only:

Patient Registration updated on: _____
Entered on Page 8 in Patient Registration System on: _____
Application forwarded to Managed Care on: _____
Patient Registration Staff Completing form: _____

Student Name: _____

BIA Form 6248
OMB No. 1076-0122
SIHS/Rev - 10/2015
Long Form

United States Department of the Interior
Bureau of Indian Affairs

School Year 2017-2018

SHERMAN INDIAN HIGH SCHOOL RIVERSIDE, CALIFORNIA STUDENT ENROLLMENT APPLICATION

STUDENT IDENTIFICATION:

Social Security Number _____ - _____ - _____

Name: _____ Date of Birth: _____

Last First Middle (Month/Day/Year)

Mailing: _____ Age: _____

Address City State Zip

Residential: _____ Gender: Male Female

Address City State Zip

Student Email address _____ Student cell phone # _____

In which tribe is the student enrolled? _____

PARENT / GUARDIAN INFORMATION:

A. _____ Father Mother Guardian Other

Parent/Guardian Name Circle Relationship

Address City State Zip Tribal Affiliation

Email address: _____ Legal Guardian: No Yes Contact Allowed No Yes

Home Phone: () _____ Lives with student: No Yes

Cell Phone: () _____ Receive student mailings: No Yes

Work Phone: () _____ Military Veteran: No Yes Branch: _____

B. _____ Father Mother Guardian Other

Parent/Guardian Name Circle Relationship

Address City State Zip Tribal Affiliation

Email address: _____ Legal Guardian: No Yes Contact Allowed No Yes

Home Phone: () _____ Lives with student: No Yes

Cell Phone: () _____ Receive student mailings: No Yes

Work Phone: () _____ Military Veteran: No Yes Branch: _____

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

Student Name: _____

SECONDARY CONTACT INFORMATION

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

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

EMERGENCY CONTACTS (OTHER THAN PARENTS/GUARDIANS):

A.

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

B.

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

TRIBAL EDUCATION OFFICE (LIST THE NAME OF THE TRIBE): Aila River

Contact Person: Danielle Allen Phone: (520) 542-3662

Address: PO BOX 97 FAX: (520) 542-2924

City, State, and Zip: Sacaton, AZ 85147

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

LOCO PARENTIS PERMISSION

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

(Parent/Legal Guardian Signature)

(Date)

PROHIBITING ALCOHOL / ILLEGAL SUBSTANCES AND GANG ACTIVITY

PROHIBITING ALCOHOL / ILLEGAL SUBSTANCES

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

Parent/Guardian Signature	Date	Student Signature	Date
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PROHIBITING GANGS AND GANG ACTIVITY

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

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

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

I understand and agree to the provisions of this contract.

Parent/Guardian Signature	Date	Student Signature	Date
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CRITERIA FOR BOARDING OR OUT-OF-BOUNDARY ENROLLMENT

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

<u>EDUCATIONAL FACTORS</u>	<u>SOCIAL FACTORS</u>
<p>Name of Federal/Public/Local school(s) that the student would attend: _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> Grade level not offered. <input type="checkbox"/> Are severely overcrowded. <input type="checkbox"/> Do not offer student's grade level. <input type="checkbox"/> Exceeds 1 1/2 miles walking distance to school or bus route. <input type="checkbox"/> Do not offer special vocational/preparatory training necessary for gainful employment. <input type="checkbox"/> Do not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences. <input type="checkbox"/> Receiving school offers special academic program needed by student. 	<p>In his/her environment, the student:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Was rejected or neglected. <input type="checkbox"/> Does not receive adequate parental supervision. <input type="checkbox"/> Well-being was imperiled due to family behavioral problems. <input type="checkbox"/> Has behavioral problems too difficult for solutions by family or local resources. <input type="checkbox"/> Has siblings or other close relative(s) enrolled who would be adversely affected by separation.
<p>Other Factors: <input type="checkbox"/> Parent Choice <input type="checkbox"/> Homeless <input type="checkbox"/> Student <input type="checkbox"/> Other _____</p>	

ALUMNI INFORMATION:

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

Grandmother Grandfather Mother Father Brother Sister Aunt Uncle Cousin

TRIBAL ENROLLMENT OFFICE:

Contact Name	City	State	Phone Number
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To be completed by Sherman Indian High School	
Out-of-Boundary * Receiving Education Line Officer	* To be signed ONLY by Sacramento Area Office Sacramento Officer will sign during campus visitation
Sacramento Area Officer: _____	Date Approved: _____

Student Name: _____

PERMISSION TO OBTAIN/RELEASE RECORDS

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

Student Name: _____ Parent Signature: _____

Date of Birth: _____ Date: _____

SCHOOL HISTORY

FOR STUDENTS WHOSE LAST ACADEMIC YEAR WAS 8TH GRADE

Name of Middle School: _____ Phone: () _____

City, State, Zip _____ Year you were promoted: _____

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

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

FOR STUDENTS WHO HAVE PREVIOUSLY ATTENDED HIGH SCHOOL

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

If "yes" write years attended _____ Reason for leaving _____

Number of high schools you have attended? (circle) 1 2 3 4 4+

List **all** high schools you have attended (use back if necessary): PLEASE ATTACH TRANSCRIPTS

Name of High School: _____ Phone: () _____

City, State, Zip: _____ Dates you attended: _____

Reason for leaving: _____ FAX Number: _____ Age Entered: _____

Name of High School: _____ Phone: () _____

City, State, Zip: _____ Dates you attended: _____

Reason for leaving: _____ FAX Number: _____ Age Entered: _____

Name of High School: _____ Phone: () _____

City, State, Zip: _____ Dates you attended: _____

Reason for leaving: _____ FAX Number: _____ Age Entered: _____

Student Name: _____

EDUCATIONAL INFORMATION

My child has received the following services in school:

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

Special Education:

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

Date of current IEP: _____

Date of current Psych Eval: _____

Please submit with application.

What is the first language you learned? _____

List any other languages spoken in your home: _____

TRAVEL INFORMATION

Sherman will only pay for travel on official travel days.

- Beginning of the year
- Round-trip at Christmas
- End of the academic year

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

Please note: ALL public transportation travelers, under the age of 15 years, are required to travel with a companion over the age of 15 years. If needed, Sherman will provide the escort for official travel days **ONLY**.

*******STUDENTS MUST HAVE A PICTURE ID*******

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

ACKNOWLEDGEMENT OF OFFICIAL TRAVEL

I (Parent/Guardian) understand that Sherman will only pay four times of official travel (the beginning of the year, round trip at Christmas, and return home at the end of the year). All other travel is the responsibility of the parent/guardian of the child. Students who are parentally withdrawn are responsible for return travel expenses.

Parent/Guardian Signature

Date

SOCIAL INFORMATION

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

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

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

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

4. Has applicant ever been cited? Yes No
 Date: _____ Date: _____
 Reason: _____ Reason: _____

5. Has applicant ever been arrested/detained? Yes No
 Date: _____ Date: _____
 Reason: _____ Reason: _____

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

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

Signature of Parent/Legal Guardian

Date

Signature of student (if student is 18 years or older)

Date

PERSONAL INFORMATION FORM

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

1. Does the applicant have medical problems that interfere with school attendance and/or need medical care while at Sherman Indian High School? Yes No

If yes, please explain: _____

Please include name, address, and phone, of the clinic or doctor normally seen by the student:

Doctor/Clinic: _____ Address: _____

City/State/Zip: _____ Phone: (_____) _____

2. Does the applicant have any medication(s) he/she should be taking? Yes No

If yes, please list: _____

Please send a filled prescription with student upon arrival at Sherman. Remember also to send refills.

3. Does the applicant (male or female) have children? Yes No

If yes, please list names, ages, with whom the child will live, and their relation while applicant is at Sherman:

4. Has applicant received counseling or therapy at any time? Yes No

Name & title of counselor or therapist: _____

Address: _____

City/State/Zip: _____ Phone number: (_____) _____

Date: _____ Reason: _____

5. Is either of the parents of the applicant incarcerated? Yes No

Specify: _____

6. Does the applicant have allergies? Yes No

Specify: _____

7. Does the applicant need a special diet? Yes No

Student Name: _____

PERMISSION FOR STUDENT CHECK OUT

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

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

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

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

The school will not be held responsible for:

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

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

Student Name: _____

Name: _____
 Address: _____
 Phone: _____
 Relationship to student: _____

Name: _____
 Address: _____
 Phone: _____
 Relationship to student: _____

What Type of Checkout is granted (√)
 Off campus Checkout
 Overnight Checkout
 Weekend Checkout

What Type of Checkout is granted (√)
 Off campus Checkout
 Overnight Checkout
 Weekend Checkout

Name: _____
 Address: _____
 Phone: _____
 Relationship to student: _____

Name: _____
 Address: _____
 Phone: _____
 Relationship to student: _____

What Type of Checkout is granted (√)
 Off campus Checkout
 Overnight Checkout
 Weekend Checkout

What Type of Checkout is granted (√)
 Off campus Checkout
 Overnight Checkout
 Weekend Checkout

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

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

(Signature of Parent/Guardian)

(Date)

MEDICAL INSURANCE INFORMATION

Please supply the following additional information:

1) _____
(Print name of student)

2) _____
(Social Security Number) (date of birth)

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

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

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

(Name of insurance company) (Policy Number)

(Effective Date) (Group Number)

ii) For Medicare Holders: Claim Number: _____
Effective Date: _____

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

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

I certify that the information given is true and accurate,

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

Address City, State, Zip

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

CONSENT OF MEDICAL RELEASE

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

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

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

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

Signed: _____
Address: _____
Relationship: _____
Date: _____ Valid for: Two years from date signed

Student Name: _____

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

I have been informed of the following:

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

Court ordered treatment or evaluations are not provided.

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

Phone Number (if applicable): _____ (602) 263-1518 _____

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

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

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

Name of Student (please print): _____

Student's Signature: ; _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PARENT/GUARDIAN QUESTIONNAIRE FOR ADOLESCENT PREVENTIVE SERVICES

Adolescent Health History

1. Is your adolescent allergic to any medicines? Yes No
 If yes, what medicines: _____

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

Name of medicine	Reason Taken	How long taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your adolescent ever been hospitalized overnight for any reason? Yes No
 If yes, give the age at time of hospitalization and describe the problem

Age	Problem
_____	_____
_____	_____

4. Has your adolescent had any in patient or out patient treatment for alcohol or drugs? Yes No
 If yes, give the age, name of treatment facility, and how long

Age	Name of Treatment Facility	How Long
_____	_____	_____
_____	_____	_____

5. Has your adolescent ever had any serious injuries? Yes No
 If yes, please explain: _____

6. Have there been any changes in your adolescent's health during the past 12 months? Yes No
 If yes, please explain: _____

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

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

Family History

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

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____

	Yes	No	Unsure	Age at Onset	Relationship
Birth Defects	___	___	___	___	_____
Blood disorders	___	___	___	___	_____
Cancer (type _____)	___	___	___	___	_____
Depression	___	___	___	___	_____
Diabetes	___	___	___	___	_____
Drinking problem/alcoholism	___	___	___	___	_____
Drug addiction	___	___	___	___	_____
Endocrine/gland disease	___	___	___	___	_____
Heart attack/stroke (before age 55)	___	___	___	___	_____
Heart attack/stroke (after age 55)	___	___	___	___	_____
High blood pressure	___	___	___	___	_____
High cholesterol	___	___	___	___	_____
Incarceration	___	___	___	___	_____
Kidney disease	___	___	___	___	_____
Learning disability	___	___	___	___	_____
Liver disease	___	___	___	___	_____
Mental health	___	___	___	___	_____
Mental retardation	___	___	___	___	_____
Migraine headaches	___	___	___	___	_____
Obesity	___	___	___	___	_____
Seizures/epilepsy	___	___	___	___	_____
Smoking	___	___	___	___	_____
Suicide	___	___	___	___	_____
Tuberculosis/lung disease	___	___	___	___	_____

9. With whom does the adolescent live most of the time? (Check all that apply)

___ Both parents in the same household	___ Stepmother	___ Sister(s)/ages _____
___ Mother	___ Stepfather	___ Other _____
___ Father	___ Guardian	___ Alone
___ Other adult relative	___ Brother(s)/ages _____	

10. In the past year, have there been any of the following changes in the adolescent's family? (check all that apply)

___ Marriage	___ Loss of job	___ Births	___ Incarceration
___ Separation	___ Move	___ Serious Illness	___ Other: _____
___ Divorce	___ A new school	___ Deaths	

Parent/Guardian Concerns

11. Please review the topics listed below. Check if you have a concern about your adolescent

___ Physical problems	___ Drug use	___ School grades/absences/dropout
___ Physical development	___ Weight	___ Smoking cigarettes/chewing tobacco
___ Change of appetite	___ Depression	___ Amount of physical activity
___ Sleep patterns	___ HIV/AIDS	___ Relationships with parents and family
___ Diet/nutrition	___ Pregnancy	___ Sexually transmitted diseases (STD's)
___ Guns/weapons	___ Dating/parties	___ Self image or self worth
___ Emotional development	___ Alcohol use	___ Unprotected sex
___ Lying, stealing, or vandalism	___ Sexual behavior	___ Excessive moodiness or rebellion
___ Choice of friends	___ Work/job	___ Sexual identity (homosexual/bisexual)
___ Violence/gangs	___ Other _____	

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

Student Name: _____

Sherman Indian High School Clinic
Adolescent Physical Exam

Name _____ Birth Date _____ Age _____

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

Varicella: 2 doses; MMR: 2 doses; Hepatitis B: 3 doses; Tdap: 1 dose; MCV4: 2 doses
Highly recommended: HPV: 3 doses

HEARING (R) _____ (L) _____

VISION OD _____ OS _____

HT _____ WT _____ BMI _____ BP _____ P _____ R _____ T _____

✓ = Normal Blank = Not examined X = See Notes

__General	__Ears	__Nodes	__Lungs	__Elbow/Wrist	__Feet
__Skin	__Nose	__Thyroid	__Breasts	__Hands	__Hips
__Head	__Throat	__Heart	__Abdomen	__Knees	__Shoulder
__Neck	__Eyes	__Mouth	__Teeth	__Extremities	__Ankles
__Pulse	__Fundi	__Neuro	__Back		

UA _____ Blood Glucose _____ Female LMP _____ HCG _____

ALLERGIES _____

MEDICATIONS _____

ASSESSMENT _____

CLEARANCE

- Cleared for (a) boarding school attendance, (b) sports participation
- Cleared after completing evaluation / rehabilitation for _____
- Not cleared for _____ Reason _____

Provider Signature _____ MD, DO, NP, PA Date _____

Clinic Name & Address _____

Phone Number _____

Student Name: _____

SCHOOL REFERENCE FORM

MUST BE COMPLETED BY A TEACHER, COUNSELOR, OR PRINCIPAL

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

1. How long have you known the student? _____ Current Grade Level _____

2. What discipline and attendance problems, if any, have you encountered with the student?

3. Has student ever been suspended? Yes No

4. If yes, for what, be specific: _____

5. Has student ever been expelled? Yes No

6. If yes, for what, be specific: _____

7. What is the student's Cumulative Grade Point Average? _____

8. How is the student's classroom behavior? (Be specific) _____

9. Is the student in the Special Education Program? Yes No

Comments: _____

Name (Please Print): _____

School: _____ Phone: _____ Fax: _____

Signature & Title: _____ Date: _____

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

Thank you for taking the time to complete this form.

Please send or fax completed reference forms to:

Sherman Indian High School
Attention: Registrar
9010 Magnolia Avenue
Riverside, California 92503
Fax to: 951-276-6055

Student Name: _____

SCHOOL RECORDS RELEASE

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

Student Name: _____ Date of Birth: _____

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

Name of School: _____ Phone Number: _____

City: _____ State: _____ Fax Number: _____

Progress Records: Include transcript of grades, test results related to achievement and measurement, records of attendance.

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

504 Plans all 504 Plans

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

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

Parent Signature: _____ Date: _____

*Student signature is requested if 18 years or older.

Student Signature _____ Date: _____

THIS IS THE FINAL PAGE

HAVE YOU COMPLETED IMPORTANT SIGNATURES AND DOCUMENTS?

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- | | | |
|--|------------------------------|-----------------------------|
| 1) Is the student's social security number correct (page 1)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) Has the Parent/Guardian signed the <u>Loco Parentis Permission</u> sheet, (page 2)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) Has the Parent/Guardian and student signed the <u>Prohibiting Alcohol/ Illegal Substances & Gang Activity</u> (page 3)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4) Has the Parent/Guardian signed the <u>Permission to Obtain/Release School Records</u> , (page 5)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5) Is the acknowledgement of <u>Times of Official Travel</u> signed by parent/guardian (page 6)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6) Has the <u>Parent/Guardian signed</u> the bottom of page 7? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7) Has the Parent/Guardian signed the <u>Student Check Out Sheet</u> (page 9)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8) Has the Parent/Guardian signed the <u>Medical Insurance Information</u> , (page 10)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9) Has the Parent/Guardian signed the <u>Consent of Medical Release</u> , (page 11)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10) Has the Parent/Guardian signed the <u>Behavioral Health Consent</u> , (page 12)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11) <u>Physical Evaluation</u> – Date of physical must be within the last 6 months -- mail original copy (page 13, 14, 15) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12) Did you request for a Teacher, Principal, or Counselor to complete the <u>School Reference Form</u> ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13) Did the <u>School Records Request</u> get sent to the last School attended? (page 17)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14) Have you included the following documents?: | | |
| a) <u>Certificate of Indian Blood (CIB)</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) <u>Birth Certificate</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) <u>List of Immunizations- Dated after January 01, 2017</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) <u>Copy of Official/Unofficial High School Transcripts</u>
(8 th Graders: send copy of diploma, Standardized test scores and 7 th & 8 th Grade Reports) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) <u>Copy of Social Security Card</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) <u>Copy of Health Insurance Card (both sides)</u> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g) Attach <u>custody/legal documents</u> and provide information on the person(s) who is responsible for the applicant. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

Mail or fax application to:
 Sherman Indian High School
 Attn: Applications
 9010 Magnolia Avenue
 Riverside, CA 92503
 951-276-6325 x 382 Fax: 951-276-6055