

**NORTHERN CHEYENNE TRIBAL SCHOOLS
RETURNING STUDENT APPLICATION**

Name of Student _____

Last

First

Middle

Will this student be returning to N.C.T.S.? Yes _____ No _____ **Current Grade Level** _____

Parent Information Updates:

Mother _____ Home/Cell # _____ Work# _____

Father _____ Home/Cell # _____ Work # _____

Guardian _____ Home/Cell # _____ Work# _____

Emergency Contact _____ Home/Cell # _____ Work# _____

Do you have an email address? Yes _____ No _____ **If yes, address:** _____

Has your mailing address changed? Yes _____ No _____

If yes: Street/P.O. Box _____ City _____ State _____ Zip Code _____

Current Bus Route _____

Physical Address with directions: _____

Students will only be allowed to ride a different bus if we have permission from the parent/guardian and if they have a bus pass signed by a school official.

PARENTAL PERMISSION SLIP: As the parent/guardian of _____

- () NCTS has my permission to transport my child to and from school and/or from all school functions.
- () I allow my child to participate in all extra-curricular activities on or off the school grounds including, but not limited to, athletic events or school functions.
- () I approve the use of photographs, digital images or video of my child for, among other things, public Relations, school activities, advertisements, web site and fundraising.

Parent/Guardian Signature _____ **Date** _____

Please return application **along with updated immunization record and sealant program form** to:

Northern Cheyenne Tribal School, P.O. Box 150, Busby, Mt. 59016

*Applications will not be accepted if the requested documents are not attached.

*If your student will be joining fall sports, they will also need a current sports physical. If you have health insurance, please provide a copy of your insurance card.

Superintendent: 406-592-3646 ext. 132 * Principal (K-12) 406-592-3646 ext. 100

Student Name: _____ Grade: _____

NORTHERN CHEYENNE TRIBAL SCHOOL HEALTH HISTORY FORM AND PARENTAL CONSENT

HEALTH HISTORY

Please place an "X" on the appropriate line if your child has, or has had, any of the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Bee or Insect Sting Allergy | <input type="checkbox"/> Other Allergy: (list) _____ |
| Mild <input type="checkbox"/> Severe <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Menstrual Problems (females) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stomach/Bowel Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> TB (tuberculosis) | <input type="checkbox"/> Bleeding problem that required treatment |
| <input type="checkbox"/> Blood Transfusion(s) | <input type="checkbox"/> Migraine or severe headache |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent colds/sore throats |
| <input type="checkbox"/> Gallbladder Disease/Surgery | <input type="checkbox"/> Bronchitis/Lung Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hearing Problems/Earaches |
| <input type="checkbox"/> Vision problems/Wears Glasses/Contacts | <input type="checkbox"/> Mental Health/Behavioral Issues |
| <input type="checkbox"/> Drug or Alcohol Problems | <input type="checkbox"/> Skin Condition: _____ |

Please describe any other health conditions, surgeries, etc., not listed above:

Please list all medications and supplements your child currently takes on a regular basis, including over-the-counter medications and supplements and emergency medication such as an inhaler, epi-pen, or migraine/headache medication:

Parent or Guardian Signature

Date

(2 pages-complete back side)»

Consent of Parental/Legal Guardian

I/we hereby give informed consent for _____ to:
STUDENT

1. Receive first aid and/or medical/dental services in the event of an emergency, illness or injury.
2. Be transported to a clinic or hospital in the event of an emergency.
3. Take prescription medication properly ordered by a physician and labeled by a pharmacist while at school. (A note from a parent/guardian must also be signed and sent with all prescriptions).
4. Receive mental/emotional health services including evaluation and recommended treatment as necessary.
5. Be transported home or to another residence or place previously listed by parent/guardian in case of an illness for above listed services.

My signature below indicates that I have read and I understand the consent is being given by me. I have crossed out all items listed for which I do not give consent.

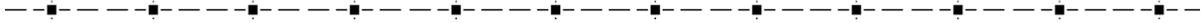
Signature of Parent or Guardian

Date

Information on Minimum Requirements for School Immunization

Vaccine	Total Number	Additional Dose Requirements
Polio	3 doses and	at least one dose after the fourth birthday
DTP/DT/DTaP/Td (<i>tetanus/diphtheria/ Pertussis</i>)	4 doses and	one dose must be given after the fourth birthday
Td Booster (<i>tetanus/diphtheria</i>)	1 dose	Prior to entering the 7 th grade a pupil must receive a dose of Td. This schedule applies To pupils who have completed the prior 4 Doses listed above.
MMR (<i>measles, mumps Rubella</i>)	Dose 1 on or after 1 st birthday	Dose 2 prior to kindergarten entry. <i>A pupil entering any grade from 7-12 who has not already received the 2nd dose at kindergarten age must receive the 2nd dose.</i>

Northern Cheyenne Services Unit
Lame Deer Dental Clinic



Dear Parent / Guardian:

The Northern Cheyenne Service Unit is offering a School Sealant Program to Native American students to prevent tooth decay. Participants will have sealants, preventive fluoride treatment(s) and interim restorative care if needed. These services will be provided at the school by an Indian Health Service dentist or dental hygienist. When your child is seen the school will send you a report on the status of your child's oral health.

This project is very important to the oral health of your child. Participation is entirely voluntary and without cost to you. We encourage you to allow your child / children to participate in this valuable health project. This preventive program, however, should not take place of proper home care and visits to your dental professional. If you have any questions regarding this project please contact Marti Caywood at 477-4464.

Please complete and **return this form to the school ASAP** to ensure your child is seen.

I **want** my child to participate in the school sealant program.

I **don't** want my child to participate in the school sealant program.

Name of child: _____ Date of birth: _____

Age: _____ Gender: _____ Grade: _____ Teacher: _____

Signature (Parent / Guardian): _____ Date: _____