The documents listed below must be included with the completed student enrollment application. The application process will be delayed if the student enrollment application is not complete.

_____ Copy of Certification of Degree of Indian Blood
Student applicant must be a member of, or is at least one-fourth degree Indian blood descendant of a member of, a tribe that is eligible for the special programs and services provided by the United States through the Bureau of Indian Affairs to Indians because of their status as Indians.
_____ Copy of social security card
_____ Copy of birth certificate
_____ Immunization record
_____ Physical examination
_____ Copy of medical assistance card or medical insurance card (both sides) or denial letter of medical assistance/coverage
_____ Copy of most recent report card and school records as listed on page 4 of student enrollment application
_____ Custody order, if applicable
_____ Mental Health / counseling services information, if applicable
_____ CD treatment information, if applicable
_____ Juvenile court history, if applicable

Please complete all sections and answer all questions to the best of your knowledge. If a question doesn't apply to your child, write "does not apply" or "N.A."; if you don't know, write "unknown" or "don't know". If you are having difficulty completing the application, contact your local BIA or Tribal education officials or social service officials for assistance or contact the Registrar at CNS.

Submitting a student enrollment application does not guarantee acceptance and/or enrollment of your child at CNS. An Admissions Committee will review the application and will determine if your child is approved for admission to CNS. A letter of acceptance or non-acceptance will be sent to the parent/legal guardian. Please notify CNS with any changes of address and/or telephone number(s).

Do not withdraw your child from the school they are currently enrolled at until you receive confirmation that your child has been accepted at CNS.

Please feel free to contact this office with any questions or concerns you may have. The mailing address, telephone number, and website for CNS are listed below:

Registrar / Admissions Committee
Circle of Nations School
832 8th Street North
Wahpeton, ND 58075

1-701-672-7222
1-701-642-1984 (fax number)
www.circleofnations.org

PLEASE SUBMIT COMPLETE APPLICATION BY AUGUST 1ST.

OMB Control Number: 1076-0122

U.S. DEPARTMENT OF THE INTERIOR – BUREAU OF INDIAN AFFAIRS
STUDENT ENROLLMENT APPLICATION
FOR BUREAU FUNDED SCHOOLS
AND FEDERAL BOARDING SCHOOLS

CIRCLE OF NATIONS – WAHPETON INDIAN BOARDING SCHOOL
832 Eighth Street North – Wahpeton, ND 58075
1-701-672-7222

What grade is the student applying for? (circle one) **4th Grade** **5th Grade** **6th Grade** **7th Grade** **8th Grade**

Has the student previously attended CNS or previously applied to attend CNS? (please circle) Yes No

If yes, when and what grade? ______________________________

1. IDENTIFICATION

Name of Student: ______________________________
Last First Middle

Other names used (include nicknames): ______________________________

P.O. Box Address: ______________ Street Address: ______________________________

City: ______________________ State: ____________ Zip Code: ______________

Gender: (please circle) Male Female Religious Affiliation (optional): ______________________

Date of birth: ______________ Place of birth: ______________________________
month/day/year city/state

Medical Assistance Number: ______________ Insurance Policy Number: ______________

Tribal Affiliation: ______________________ Home BIA Agency: ______________

Language(s) spoken by the student: 1) ______________ 2) ______________

Language(s) spoken by others in the household: 1) ______________ 2) ______________

Reason(s) for applying to CNS: ______________________________

____

____

____

2. FAMILY AND BACKGROUND INFORMATION

Name of student: ____________________

Who does the student live with? (circle one) Both parents Mother Father Legal Guardian Other ____________

Mother: ____________________ Please circle: Living Deceased

Address: ____________________ Tribal Affiliation: ____________________

City, State, Zip Code: ____________________ Employer: ____________________

Telephone numbers (please include area codes): Work: ____________________

Home: ____________________ Other: ____________________

Cell: ____________________ Emergency contact: ____________________

E-mail address: ____________________ Emergency number: ____________________

****

Father: ____________________ Please circle: Living Deceased

Address: ____________________ Tribal Affiliation: ____________________

City, State, Zip Code: ____________________ Employer: ____________________

Telephone numbers (please include area codes): Work: ____________________

Home: ____________________ Other: ____________________

Cell: ____________________ Emergency contact: ____________________

E-mail address: ____________________ Emergency number: ____________________

****

Legal Guardian: ____________________ Relationship to student: ____________________

Address: ____________________ Tribal Affiliation: ____________________

City, State, Zip Code: ____________________ Employer: ____________________

Telephone numbers (please include area codes): Work: ____________________

Home: ____________________ Other: ____________________

Cell: ____________________ Emergency contact: ____________________

E-mail address: ____________________ Emergency number: ____________________

****

Please list all household members (include ages and relationship to student):

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Have other family members attended Circle of Nations-Wahpeton Indian School? Yes No

If yes, please list names and relationship to student: ____________________

____

3. SCHOOL(S) PREVIOUSLY ATTENDED

Name of student: ______________________

School name: ______________________

Type of school: (circle one) BIA Tribal Public Alternative Private Other: ______________

Address: ______________ City, State, Zip Code: ______________

Telephone number (please include area code): ______________

Dates attended: ______________ Grade(s) completed: ______________

Reason for leaving: ______________________

School name: ______________________

Type of school: (circle one) BIA Tribal Public Alternative Private Other: ______________

Address: ______________ City, State, Zip Code: ______________

Telephone number (please include area code): ______________

Dates attended: ______________ Grade(s) completed: ______________

Reason for leaving: ______________________

If necessary, use an additional sheet of paper to list other schools attended and attach sheet to the student enrollment application.

What programs/activities is the student interested in? (circle all that apply)

Student Government	Basketball	Volleyball	Football
Cross Country	Track & Field	Tae Kwon Do	Music Lessons
College & Career Classes	Cultural Activities: ______________		

Other: ______________________

I am legally responsible for this student and hereby apply for his/her admission to the Circle of Nations School. I understand that CNS may request additional information before the student is accepted and/or enrolled. Further, I understand that failure to provide accurate information or falsifying or withholding information may result in the student's non-acceptance to CNS or the immediate dismissal of the student from CNS. Please attach guardian documentation if applicable.

______________________ ______________

Signature of Legal Guardian **Date**

RELEASE / TRANSFER OF SCHOOL RECORDS

Student's Name: ______________________ Date of birth: ____________ Grade: __________

RELEASE TO:	Registrar Circle of Nations School 832 Eighth Street North Wahpeton, ND 58075	Telephone number: Fax number:	701-672-7222 701-642-1984

REQUESTED FROM: School Name: ______________________________

School Address: ______________________________

____

School Telephone Number: ______________________________

School Fax Number: ______________________________

The following records are requested for enrollment purposes:

Educational records:	Transcripts, grades, grade level, state standardized assessment results, NWEA assessment results, attendance, RTI services, Title I services, behavioral records
Special Education records:	Interventions implemented, referral, assessment plan, meeting notices, written prior notices, initial consent for evaluation, psycho-educational reports, evaluation report, initial consent to place, IEP, progress reports
Health records:	Immunization record Other health related records: ______________
Mental Health records:	Mental health evaluation
Other:	Certification of Degree of Indian Blood, birth certificate, other necessary documents: ______________

I understand the above information is considered confidential and will be available for use by the Circle of Nations School staff and consultants only.

______________________________ ______________

Signature of Legal Guardian or School Official **Date**

The term, Educational Records, as used in this consent form is that defined by P.L. 93-380, Sec. 99.2, Definitions are: Those records which (1) are directly related to a student and (2) are maintained by an educational agency or institution or by a party acting for the agency or institution.

VERIFICATION OF CHILD CUSTODY

Name of Child: ______________________________ Date of birth: ______________

Name of Custodial Parent / Legal Guardian: ______________________________

Name of Non-Custodial Parent: ______________________________

Custody set forth by (please circle): Birth Divorce Decree Court Order Other: ______________

Type of custody (please circle): Sole custody Joint custody Other: ______________

Please provide Circle of Nations School with a copy of the judgment issued regarding the custody of the above named child. In addition to providing the custody document, please answer the following questions:

- May the non-custodial parent have access to your child's school records (report card, progress report, class work, IEP, etc)? YES NO
- May the non-custodial parent discuss your child's progress with CNS staff members? YES NO
- May the non-custodial parent visit your child at CNS? YES NO
- May the non-custodial parent telephone your child at CNS? YES NO
- May the non-custodial parent sign your child out from CNS? YES NO
- Do you wish to be advised of any contact from the non-custodial parent? YES NO
- Is there a restraining order in place? YES NO
  If yes, please provide the name(s) of person(s) and a copy of the order:

  ____

  ____

Additional comments / restrictions regarding your child's non-custodial parent that CNS should be aware of:

____

____

____

____

______________________________ ______________

Signature of Legal Guardian **Date**

CONFIDENTIAL STUDENT INFORMATION SUMMARY

Name of Student: ____

EDUCATIONAL INFORMATION:

Does the student have problems with schoolwork or homework? Yes No

If yes, please explain: ____

____

Has the student ever been retained/held back a grade? Yes No

If yes, include what school, what grade(s), and why: ______________________

____

Has the student ever been suspended or expelled from school? Yes No

If yes, include school name, when, and why: ______________________

____

Does the student have a history of truancy/not going to school? Yes No

If yes, explain: ____

____

Did the student complete this past school year? Yes No

If not, explain: ____

____

If you have specific educational concerns for your child that you would like addressed, please write a brief description of those concerns: ____

____

***If applicable*, please provide the name(s) and telephone number(s) of the social worker or caseworker or school counselor that have worked with the student and/or the family:**

______________________________	______________________
Name of social worker, caseworker, school counselor	Telephone Number(s)

SOCIAL INFORMATION:

How does the student cope with problems? (Circle all that apply)

Cry	Fight verbally	Fight physically	Ignore	Eat
Sleep	Use drugs	Use alcohol	Use inhalants	Pray

Other: ____

____

Describe any traumatic event the student has experienced (ex: death of close relative, abuse, divorce/separation of parents, etc.):

____

____

What is the most important information to know about the student? ______________________

____

____

Has the student ever been involved in gang activity? Yes No

If yes, please explain: ______________________________

____

Has the student ever been arrested? Yes No

If yes, give reason(s): ______________________________

____

How many times? ______________________________

Has the student ever been in detention or jail? Yes No

If yes, give reason(s): ______________________________

____

How many times? ______________________________

Duration of sentence: ______________________________

Is the student currently on probation or ever been on probation? Yes No

If yes, give reason(s): ______________________________

____

Duration of probation or sentence: ______________________________

***If applicable*, please provide the name(s) and telephone number(s) of the judge, probation officer, D.O.C. Worker, or Court Services Worker that is working with the student and/or the family:**

______________________________ ______________________________

Name of service provider Telephone Number(s)

MEDICAL / MENTAL HEALTH / VISION / DENTAL INFORMATION:

Does the student have any medical problems or conditions? Yes No

If yes, please explain: ______________________________

Is the student currently receiving medical care from a physician? Yes No

If yes, please provide physician's name and contact information: ______________________________

Has the student ever been on medication for mental health reasons? Yes No

If yes, please explain: ______________________________

Has the student ever been pregnant or have a child? Yes No

If yes, please explain: ______________________________

Has the student ever been hospitalized or treated for any of the following medical conditions? (Circle all that appl

Seizures / Convulsions	Headaches	Head injury	Epilepsy	Ulcers
Suicide attempt/ Overdose	Depression	Eating disorder	Allergies	Diabetes
Kidney problems	Serious accident	Surgery	Alcohol or drug issued	

Other: ______________________________

Briefly describe any of the problems circled above: ______________________________

____

Does the student wear glasses or contacts or both? Yes No

If yes, please furnish provider's name and contact information: ______________________________

Does the student have ear problems/infections, hearing problems, or wear a hearing aid? Yes No

If yes, please explain: ______________________________

Does the student have speech problems? Yes No

If yes, please explain: ______________________________

Has the student had any trouble associated with dental treatment? Yes No

If yes, please explain: ______________________________

Is the student currently receiving dental care or orthodontic care? Yes No

If yes, please furnish provider's name and contact information: ______________________________

Does the student wet the bed? Yes No

Describe the student's sleeping patterns: ______________________________

Is the student on a special diet? Yes No

If yes, please explain: ______________________________

______________________________ ______________________________

Signature of Legal Guardian Date

ADMISSION INFORMATION FOR EMERGENCY MEDICAL CARE

Please submit a copy of medical assistance card and/or any vision, dental, and health insurance card(s). In addition, **please include signed, notarized parental consent for health services form and release of information forms.**

1. **Patient/Student Information**

   Full legal name: ______________________________

   Current address: *Circle of Nations School, 832 8th Street North, Wahpeton, ND 58075*

   Date of Birth: ____________________ Gender: ____________

   Social Security Number: ____________________ Medical facility: ____________

   Primary Physician: ____________________ Telephone number: ____________

   Address: ______________________________

2. **Legal Guardian Information**

   Guardian's Name: ____________________ SSN: ____________

   Guardian's Address: ____________________ DOB: ____________

   Telephone number(s): ______________________________

   Emergency contact (in addition to Legal Guardian): *Circle of Nations School*

   Emergency contact telephone number: *(701) 642-3796, ext. 256 or ext. 257 after hours*

MANDATORY - Please complete the sections below (all that apply):

3a. Medical Assistance State and Number: ______________________________

   Billing Address: ______________________________

   Telephone Number(s): ______________________________

3b. Insurance Company: ______________________________

   Telephone Number(s): ______________________________

   Policy Number: ____________________ Group Number: ____________

3c. Indian Health Service Unit: ______________________________

   Address: ______________________________

   Telephone Number(s): ____________________ Fax number: ____________

4. **Medical Information for Student**

   Food allergies: ______________________________

   Medication allergies: ______________________________

   Current medications / prescriptions: ______________________________

   Medical conditions: ______________________________

   Additional information: ______________________________

   ____

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON *
WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

Name of Student: ______________________________ Birth date: ______________

I (We) ____

am (are) the parent(s) / legal guardian(s) of the above named student. I (We) have read and understand the consent and give the Circle of Nations School in Wahpeton, ND permission to arrange for and/or to provide the following health services for my (our) child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures, skin tests, immunizations - including flu vaccine and HPV, and administration of medication.
2. Routine dental care including dental examinations, preventative use of fluorides, and necessary emergency dental care.
3. Optometry care including optometry examinations.
4. Mental health services including evaluation, treatment, and medication, as necessary.
5. Emergency health care for accidents or illness.
6. Transportation of child to and/or from health facilities for these services.
7. Health education and instruction including, but not limited to, the following subjects: diabetes, nutrition, exercise, AIDS, STD's, age and gender appropriate sex education, and routine health maintenance.

( ) I hereby give consent for all of the above services.
( ) Exceptions or special instructions: ______________________________

Signed: ______________________________ Date: ______________

Relationship to student: ______________________ Valid until: ______________

TO BE COMPLETED BY NOTARY PUBLIC:

State of ______________________

County of ____________________

Signed before me on ________________ **by** ______________________________
Date **Name(s) of Individual(s)**

______________________________ Stamp
Signature of notarial officer

My commission expires: ________________ **Title of Office**

* Person is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient/Student: ______________________________ Date of birth: ____________

Disclosure of information from the above named patient/student record is hereby requested.

The information is to be released from:

Name of facility: ______________________________

Address: ______________________________

City/State/Zip Code: ______________________________

Telephone Number: ______________________________

and is to be provided to:

School Clinic – Circle of Nations School
832 8th Street North
Wahpeton, ND 58075
701-642-3796, ext. 256

The purpose or need for this disclosure is for the student's school medical file while enrolled and in attendance at the Circle of Nations School.

The information to be released is from my:

_____ Medical Record

_____ Dental Record

_____ Other (specify) ______________________________

and includes:

_____ Only information related to (specify): ______________________________

____

_____ Only the period or events from: ____________ to ____________

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of signature.

______________________________ ____________
Signature of Patient/Student Date

______________________________ ____________
Signature of Legal Guardian or Authorized Representative (if necessary) Date

This information is to be released for the purpose(s) stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 U.S.C. 552a(i)(3)). In the case of alcohol and drug patient records, a falsified authorization of disclosure is also prohibited under 42 CFR 2.31(d).

HIPAA Privacy Authorization Form

** Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize ____ (healthcare provider) to use and disclose the protected health information described below to ______________________________________ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. □ ____________ to ____________.
** OR **
b. □ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
** OR **
b. □ I authorize the release of my complete health record with the exception of the following information:
   - □ Mental health records
   - □ Communicable diseases (including HIV and AIDS)
   - □ Alcohol / drug abuse treatment
   - □ Other (please specify): ____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposed I may direct.

5. This authorization shall be in force and effect until ____________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ________________

Signature of patient or personal representative **Date**

____

Printed name of patient or personal representative and his or her relationship to patient

GIFTED AND TALENTED PROGRAM
CIRCLE OF NATIONS-WAHPETON INDIAN SCHOOL

The CNS Gifted and Talented Program offers many opportunities in a variety of areas to the students of the school. In order for your child to participate, CNS and the Gifted and Talented Coordinator need your permission for your child to be evaluated to determine whether or not they are eligible for the special services provided by this program. We also need your permission to place your child in the program, if they qualify. The areas that the Gifted and Talented Program services are listed below. **Check any of the areas that you feel apply to your child and explain why in the spaces provided.**

_____ Intellectual Ability: ____

_____ Creativity / Divergent Thinking: ____________________________________

_____ Academic Aptitude / Achievement: ___________________________________

_____ Leadership: ____

_____ Aptitude in Visual and Performing Arts: _____________________________

List something that the student is exceptionally good at doing or enjoys doing: ________________

____

Additional comments: ____

____

____

****

I GIVE PERMISSION FOR MY CHILD, _____________________________________,

TO BE EVALUATED AND PLACED IN THE GIFTED AND TALENTED PROGRAM AT THE CIRCLE OF NATIONS SCHOOL AND SAMPLES PLACED IN THE STUDENT'S FILE AS EVIDENCE OF THEIR ABILITIES.

______________________________________ ______________

Signature of Legal Guardian Date

Circle of Nations School
Acceptable Use Policy for Technology

The use of Circle of Nations technology and Internet access is a privilege, not a right. Students and staff are responsible for appropriate behavior while using school technology.

It is the Philosophy of Circle of Nations School that access to the Internet is necessary to provide electronic research skills that now are important to prepare citizens and future employees in today's Information Age. Access to the Internet will allow students and staff to research valuable information and allow them to communicate electronically.

The Internet also contains information that is inappropriate for student and staff use. The Circle of Nations School has taken precautions to restrict access to inappropriate material using an Internet content filtering system. Although staff will supervise the use of the Internet, we cannot guarantee that your child will not gain access to inappropriate material.

Access to school technology will be provided to users who agree to act in a responsible manner. Network storage areas shall be subject to the same scrutiny as other school property and facilities. Technology Managers may view files and communications to maintain the integrity of the system and ensure the appropriate and responsible use of school technology. Users of school technology agree that violations of the acceptable use policy will be subject to disciplinary consequences.

______________________________	______________________________
Charles Morin, Superintendent Circle of Nations School	Cassie South, Network Specialist Circle of Nations School

The following actions and/or activities are not permitted and will be subject to disciplinary action:

- Violating copyright laws
- Accessing and/or creating files or sites containing pornography, gang related material, and/or other inappropriate material
- Harassing, insulting or attacking others
- Physically or electronically damaging any school technology such as computer systems, other hardware and software.
- Using obscene language such as vulgar, obscene and/or sexually explicit.
- Participating or using unauthorized chat lines
- Bypassing CNS security and/or filtering systems
- Employing of school technology for commercial purposes or personal gain
- Using another person's user name or password
- Trespassing into another's folder, data, work, or files
- The inappropriate broadcasting of messages to mailing lists or individuals including "chain letters".
- Revealing a personal address or telephone number of anyone (including one's self) without permission of a teacher or administrator.
- Other activities or actions deemed inappropriate and not in the best interest of the Circle of Nations School and its students.

Violation of these policies will result in the following discipline consequences:

First Offense (Level I):	• Loss of Internet privileges for one week.
Second Offense (Level II):	• Loss of Internet privileges for two weeks.
Third Offense (Level III):	• Loss of all Internet privileges for four weeks. • Parents/guardians and all CNS staff contacted.
Fourth Offense (Level IV):	• Loss of all Internet privileges for the remainder of the school year. • Parents/guardians and all CNS staff contacted. • A note for future years may be placed into student's permanent file.

A student may be subject to a level two, a level three, or a level four disciplinary action on his/her first offense if the school administration finds the offense needs further consequences.

By signing this waiver, the student and his/her guardian understand that Circle of Nations makes no guarantees of any kind, whether expressed or implied, for the network services it is providing. The Circle of Nations School will not be responsible for any damages a user may suffer.

We acknowledge that we have read the Acceptable Use Policy for Technology and will comply with its requirements. This consent will continue in effect as long as the student is in school at Circle of Nations.

____
Legal Guardian Name (please print)

______________________________ ________________
Signature of Legal Guardian Date

____
Student / User Name (please print)

______________________________ ________________
Signature of Student / User Date

June 21, 2013

Dear Parent/Guardian,

The Family Educational Rights and Privacy Act (FERPA), a Federal law, requires the Circle of Nations School, with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, Circle of Nations School may disclose appropriately designated "directory information" without written consent, unless you have advised the School to the contrary in accordance with School procedures. The primary purpose of directory information is to allow the Circle of Nations School to include this type of information from your child's education records in certain school publications. Examples include:

- A playbill, showing your student's role in a drama production
- The annual yearbook
- Honor roll or other recognition lists
- Graduation program
- Sports activity sheets, such as for wrestling, showing weight and height of team members

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent/guardian's prior written consent. Outside organizations include, but are not limited to, companies that publish the yearbook, etc. In addition, two federal laws require local education agencies receiving assistance under the Elementary and Secondary Education Act of 1965 (ESEA) to provide military recruiters, upon request, with three directory information categories – names, addresses, and telephone listings – unless parent/guardians have advised the school that they do not want their student's information disclosed without their prior written consent.

If you do not want Circle of Nations School to disclose directory information from your child's education records without your prior written consent, you must notify the school in writing prior to enrollment date of your student. Circle of Nations School has designated the following information as directory information:

- Student's name
- Participation in officially recognized activities and sports
- Address
- Telephone listing
- Weight and height of members of athletic teams
- Photograph
- Honors and awards received
- Date and place of birth
- Dates of attendance
- Grade level

If there are questions about your student's rights under FERPA, please contact the School Principal, at 701-642-3796, ext. 231, or at Circle of Nations School, 832 8th Street North, Wahpeton, ND 58075.

If you do not wish directory information about your student to be disclosed, please indicate on the attached form and return that form to the school prior to the enrollment date of your student.

Sincerely,

Charles Morin, Superintendent

(Keep this page for your information.)

CIRCLE OF NATIONS SCHOOL – Wahpeton, ND
Family Educational Rights and Privacy Act (FERPA)

I have received information about my rights under FERPA and understand my right to request that any of the items listed below not be disclosed as Directory Information to any outside group, other than those having a legal right to the information, without my written permission. Those having a legal right might include federal auditors, those having oversight responsibilities, circumstances regarding health and safety, emergencies or other similar entities.

SELECT ONLY ONE BOX BELOW.

☐ **No restrictions.**
(CNS photographs, videotapes, and/or records students and their activities for publication in the CNS yearbook, CNS newsletters, Circle of Voices, local and tribal newspapers, other media groups, and brochures for promotional purposes in the local and home communities of CNS students. Permission is given to the Circle of Nations School, and/or persons acting for or through CNS, the right to use, reproduce, assign, and/or distribute photographs, films, video tapes, and sound recordings of the above named student, for use in materials CNS may create.)

OR

☐ I do not want any Directory Information regarding my child, ______________________________, disclosed.

(Nothing will be disclosed without written permission.)

OR

☐ I do not want the following Directory Information regarding my child, ______________________________, disclosed without written permission.

Check all that apply:

1. [ ] Student's name
2. [ ] Participation in officially recognized activities and sports
3. [ ] Address
4. [ ] Telephone listing
5. [ ] Weight and height of members of athletic teams
6. [ ] Photographs
7. [ ] Honors and awards received
8. [ ] Date and place of birth
9. [ ] Dates of attendance
10. [ ] Grade level

I am the legal guardian of ____.
(Student Name)

____ ____________________
Signature of Legal Guardian Date

Please return this page along with the completed student enrollment application for your child to the Admissions Office, Circle of Nations School, 832 Eighth Street North, Wahpeton, ND 58075.

FAMILY – SCHOOL COMPACT
CIRCLE OF NATIONS SCHOOL – WAHPETON, ND

We all agree that we want a positive, worthwhile living and learning experience for the students at Circle of Nations School. We agree to the following responsibilities:

ACADEMIC

Student	Parent/Guardian	Staff
I will come to class on time prepared to learn and participate fully in class.	I will ensure my child stays in school and achieve to their potential.	We will provide a welcoming, safe learning environment.
I will serve as a positive role model to my peers.	I will support high and realistic expectations for my child's achievement and future education.	We will set high standards for student performance with respect to the individual learning styles.
I will seek assistance from my teachers.	I will communicate with the educational staff on my child's achievement progress.	We will communicate with parent/guardian on the student's accomplishments.
I will complete assignments accurately and on time.	I will support the school's policy on homework.	We will provide appropriate instruction based on the school's curriculum.

RESIDENTIAL

Student	Parent/Guardian	Staff
I will use my free time wisely by reading for pleasure and joining cultural, recreational, and learning activities.	I will communicate with staff who are closely involved with my child.	We will provide a welcoming and safe home living environment.
I will seek assistance from the dorm staff or counselors when I have problems.	I will ensure my student's health coverage is current through the school year.	We will contact parent/guardian with concerns about the student.
I will ask for help with homework.	I will support the residential program policies and guidelines.	We will provide an integrated home living environment that includes tutoring, cultural, wellness and prevention activities.
I will talk with my family about what I am learning, my interests, and my plans for the future.	I will use school information sources (newsletter, email, website) to keep with school issues and activities.	We will provide a regular schedule of after-school, evening, and weekend guidance activities.

SAFE AND DRUG-FREE SCHOOL

Student	Parent/Guardian	Staff
I will respect the personal rights and property of myself and others.	I will talk with my child about respecting people and property.	We will treat students and parent/guardian with respect.
I will behave in a responsible manner.	I will set positive behavior expectations and reinforce school policies and procedures.	We will clearly articulate behavior expectations to students and parent/guardian.
I will inform an adult about bullying and harassment.	I will talk with my child about bullying, harassment, peer pressure, safety, and drug-free behavior.	We will take steps to prevent bullying and harassment.
I will keep myself safe and drug-free.	I will support the school's discipline policy.	We will promote a safe and drug-free school.

Acceptance Signatures

Student ____ Date ____ Parent/Guardian ____ Date ____ Superintendent ____ Date ____

PARENTAL CONSENT FORM

Student's Name: ____

Permission is granted for the above named student to participate in organized school related / sponsored activities and field trips as approved by CNS. It is understood that the student will be properly chaperoned by qualified school personnel and all precautions will be taken to insure his/her safety. Further, it is understood that these trips may be overnight and may cross state lines. Yes No

Exception(s): ____

____

****

Permission is granted for the above named student to participate in organized competitive sports approved by CNS. It is understood that a physical examination for the student is required before the student can fully participate in any competitive sports offered by CNS. Yes No

****

Students often request to have their hair cut, trimmed, colored, or highlighted (at their expense). Permission is granted for the above named student for the following choices (please circle):

Haircuts	Yes	No
Trims	Yes	No
Coloring	Yes	No
Highlighting	Yes	No

Additional comments / instructions: ____

____

****

Students at CNS may have the opportunity to participate in sweat ceremonies For purposes of purification, prayer, personal spiritual guidance, and personal spiritual growth. Permission is granted for the above named student to participate in the following:

Sweat ceremonies Yes No

Additional comments / instructions: ____

____

____ ____________________

Signature of Legal Guardian **Date**

CIRCLE OF NATIONS SCHOOL
BIE McKinney-Vento Enrollment/Referral
April 2012

The purpose of this document is to address the requirements of the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. It will be used to share with school staff and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

Person completing form: _____ Parent/Guardian _____ Other: (please specify) ____________________

1. Is the student's current address a temporary living arrangement? Yes No
2. Is the student's temporary address due to loss of housing OR economic hardship? Yes No

Student Information

Student Name: ______________________ Grade Level: __________ Age: __________

Parent/Guardian Name(s): ______________________

Parent / Guardian / Youth phone number: ______________________

☐ Cellular phone ☐ Work Phone ☐ Shelter Phone ☐ Family / Friend's Residence

Residency Information

Where does the student stay at night?

☐ Doubled up(more than one family in a house, apartment, or mobile home)
☐ Hotels/ motels, temporary housing, campsite
☐ Shelter/transitional housing / awaiting foster care
☐ Unsheltered (cars, parks, etc.)
Address/Directions: ______________________
Shelter Contact Person: ______________________
☐ Choices listed above do not apply

What supplemental services would you like the student to receive?

Educational Services
Description: ______________________
After-school Services
Description: ______________________
Health Services
Immunizations ______________________
Dental ______________________
Food/Clothing ______________________
Free Lunch ______________________
Counseling ______________________
Optometry ______________________

The parent/guardian understands the above services are supplemental to the regular instructional day and will be re-evaluated to determine which need to be continued. In the event that the family/youth residency changes, it is their responsibility to notify the Circle of Nations School Registrar/School Liaison immediately. If you have any questions, please call 701-672-7222, CNS Registrar – Shavonne Wilkie. Fax number: 701-642-1984.

______________________ Signature of Parent/Guardian ______________ Date

PAPERWORK REDUCTION ACT STATEMENT: This information is collected to identify each student's instructional and residential program classification. It will be used to allocate appropriated funds on a weighted student unit formula. The information is supplied by a respondent to obtain or retain a benefit, that is provide appropriate schooling and the needed funding. It is estimated that responding to the request will take an average of 15 minutes to complete. This includes the amount of time it takes to gather the information and fill out the form. If you wish to make comments on the form, please send them to the Information Collection Control Officer, Bureau of Indian Affairs, 1849 C Street NW, Mail Stop 4603 MIB, Washington, DC 20240. Note: Comments, names, and addresses of commenters are available for public review during regular business hours. If you wish us to withhold this information, you must state this prominently at the beginning of your comment. We will honor your request to the extent allowable by law. In compliance with the Paperwork Reduction Act of 1995, as amended, the collection has been reviewed by the Office of Management and Budget and assigned a number and expiration date. The number and expiration date are at the top right corner of the form. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless there is a valid OMB clearance number.

PRIVACY ACT STATEMENT: This information is collected as provided by 5 U.S.C. 552A. The Office of Indian Education Programs is authorized to collect this information in accordance with Public Laws 95-561, 98-511, 99-89, and 100-297. This information will be used to determine the level of funding to be distributed by formula to BIA funded elementary and secondary schools. Weighted student units, the value of basic and specialized instructional and residential programs, are used to calculate the distribution of funds. The information may be disclosed to appropriate Department of Interior and Congressional Offices for policy and budgetary purposes. Collection of each eligible student's social security number is authorized by Executive Order 9397 to avoid duplicate counts and for tracking purposes.

CERTIFICATE OF IMMUNIZATION

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 16038 (Revised 05-2012)

Division of Disease Control
2635 East Main Ave. PO Box 5520
Bismarck, ND 58506-5520
800.472.2180 or 701.328.3386

North Dakota law requires this form be completed* and provided to the childcare facility or school.

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Check type below€	Enter Month/Day/Year for Each Immunization Given				
Hepatitis B	Hepatitis B	☐					
Rotavirus	Rotavirus	☐					
Hib	*Haemophilus influenzae* type B	☐					
PCV	Pneumococcal conjugate	☐					
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis	☐					
OPV/IPV	Polio	☐					
MMR	Measles-Mumps-Rubella	☐					
Varicella	Chickenpox	☐			**History of Disease Date:**		
Hepatitis A	Hepatitis A	☐					
Td/Tdap	Tetanus-Diphtheria (and Pertussis)	☐					
MCV4	Meningococcal	☐					
HPV	Human Papillomavirus	☐					
Other		☐					

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician, Nurse, Local/State Health	Title	Date

If additional doses are added after initial signature, please initial dose and sign below.

Update signature #1:		
Physician, Nurse, Local/State Health:	Title:	Date:
Update signature #2:		
Physician, Nurse, Local/State Health:	Title:	Date:

My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) that my child's immunizations are incomplete and to submit a signed Certificate of Immunization.

Parent/Guardian Signature: Date:

Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

Medical Exemption: **The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.**

Physician Signature: Date:

€***Exemption:*** *(Indicate vaccine above)*

(Please check one) ☐ Religious ☐ Philosophical ☐ Moral ☐ History of Disease

Parent/Guardian Signature Date

NORTH DAKOTA
DEPARTMENT *of* HEALTH

2017 – 2018 School Immunization Requirements

	Number of Required Doses	
Vaccine Type	**Kindergarten-6th grade**	**Grades 7-12**
DTaP/DTP/DT/Tdap/Td*	5	5
Hepatitis B	3	3
IPV/OPV†	4	4
MMR	2	2
Varicella (Chickenpox)	2	2§#
Meningococcal¶	0	1
Tdap ϴ	0	1

* One dose of DTaP (pediatric diphtheria, tetanus, and acellular pertussis) vaccine must have been given on or after the fourth birthday. Only four doses are necessary if the fourth dose was administered on or after the fourth birthday. Three doses of Tdap (adolescent/adult tetanus, diphtheria, and acellular pertussis)/Td are required for children ages seven or older who were not previously vaccinated. Tdap should be used as the first dose followed by two doses of Td for children age seven or older not previously vaccinated.

† For polio vaccination, in all-IPV or all-OPV schedule: one dose must have been given on or after the fourth birthday. The final dose in the series should be administered on or after the fourth birthday and at least six months after the previous dose. If four doses are administered prior to age four, a fifth dose should be administered on or after age four. Only three doses of IPV are required if the third dose is given on or after the fourth birthday. Children born before August 2005 only need four doses separated by at least four weeks. These children do not need a dose after the age of four.

§ For the 2017-18 school year, two doses of varicella vaccine are required for kindergarten through ninth grade. If a child has a reliable history of chickenpox disease, the child is exempt from the vaccine requirement.

For the 2017-18 school year, one dose of varicella vaccine is required of children attending tenth through twelfth grade. If a child has a reliable history of chickenpox disease, the child is exempt from the vaccine requirement.

¶ One dose of meningococcal conjugate vaccine (MCV4) is required for entrance into the seventh grade. One dose of MCV4 must have been given on or after the tenth birthday.

ϴ One dose of Tdap vaccine is required for entrance into the seventh grade. One dose of Tdap must have been given on or after the seventh birthday.

Exemptions

Students may be exempt from immunization requirements for the following reasons:

- **Medical Exemption:** Requires a certificate signed by a licensed physician stating that the physical condition of the child is such that immunization would endanger the life or health of the child.
- **Philosophical, Moral or Religious Belief Exemption:** Requires a certificate signed by the parent or guardian whose sincerely held philosophical, moral or religious belief is opposed to such immunization.
- **History of Disease Exemption:** Requires a certificate signed by the parent or guardian or physician stating that the child has a reliable history of chickenpox disease.

NDHSAA Preparticipation Physical Evaluation Form

Starting with the 2010-11 school year, student athletes participating in NDHSAA sanctioned sports programs will be required to file a pre-participation health history screening and physical examination clearance form (page 4) with their school office prior to their participation on a yearly basis. As per NDHSAA Constitution and By-Laws, physical evaluations may be done by the following medical professionals: Medical Doctor, Doctor of Osteopathy, Physicians Assistant, Nurse Practitioner (MD, DO, PA, NP); the Athletic Pre-Participation Health History Screening and Physical Examination is valid for one school year; a physical examination must be completed on or after * **April 15** to be valid for participation the following school year.

*** Date amended by membership - October 2010**

The NDHSAA approved form explanations appear below:

History Form .... Page 1
To be filled out by Parent/Athlete prior to physical evaluation
The medical facility should keep this form.

Special Needs Supplemental History Form .... Page 2
Filled out ONLY if athlete is special needs.
The medical facility should keep this form.

Physical Examination Form .... Page 3
Completed by medical personnel and retained in medical facility file
The medical facility should keep this form.

Clearance Form .... Page 4
This is the ONLY form that should be returned to the school office.

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM - Parent/Athlete fill out prior to physical evaluation

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ______ Age ______ Grade ______ School ______________ Sport(s) ______________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ______		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ______________ Signature of parent/guardian ______________ Date ______

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NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

Revised: June 2010
Page 2

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM - Complete ONLY IF special needs athlete.

The medical facility should keep this form.

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ______ Grade ______ School ____________________ Sport(s) ____________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ______

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NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM - The medical facility should keep this form.

Name ______________________ Date of birth ______________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________

____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________

Reason ______________________

Recommendations ______________________

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of MD, DO, PA, NP (print/type) ______________________ Date ______________

Address ______________________ Phone ______________

Signature of MD, DO, PA, NP ______________________, MD or DO

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NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM - Return this page ONLY to school office

Name ______________________ Sex ☐ M ☐ F Age ________ Date of Birth ___________ Grade _______

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________

  Reason ______________________

Recommendations ______________________

____

____

____

____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of MD, DO, PA, NP (print/type) ______________________ Date ______________

Address ______________________ Phone ______________

Signature of MD, DO, PA, NP ______________________, MD or DO

EMERGENCY INFORMATION

Allergies ______________________

____

____

Other Information ______________________

____

____

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost for any medical attention may not be covered or paid by any high school or the North Dakota High School Activities Association. I hereby approve participation in athletic activities.

Grade of Athlete ____ School ________________ Sport(s) ______________________

Parent/Guardian Signature ______________________ Date ______________

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2017-2018 Application for Free and Reduced Price School Meals — Circle of Nations School

Complete one application per household. Please use a pen (not a pencil).

832 8th Street North, Wahpeton, ND 58075

STEP 1 — List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper)

Definition of Household Member: "Anyone who is living with you and shares income and expenses, even if not related."

Children in Foster care and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Read **How to Apply for Free and Reduced Price School Meals** for more information.

Child's First Name	Child's Last Name	School	Grade	Foster Child	Homeless, Migrant, Runaway
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Check all that apply

STEP 2 — Do any Household Members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF, or FDPIR?

If NO > Go to STEP 3.   **If YES >** Write a case number here then go to STEP 4 (Do not complete STEP 3)   **Case Number:**

STEP 3 — Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child income $ ______ How often? ○ Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly / Bi-Weekly / 2x Month / Monthly	Public Assistance/ Child Support/Alimony	How often? Weekly / Bi-Weekly / 2x Month / Monthly	Pensions/Retirement/ All Other Income	How often? Weekly / Bi-Weekly / 2x Month / Monthly
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○
	$	○ ○ ○ ○	$	○ ○ ○ ○	$	○ ○ ○ ○

Total Household Members (Children and Adults) ______

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X ______   Check if no SSN ☐

STEP 4 — Contact information and adult signature. Mail Completed Form To: Circle of Nations School, 832 8th Street North, Wahpeton, ND 58075

False information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) ______ Apt # ______ City ______ State ______ Zip ______ Daytime Phone and Email (optional) ______

Printed name of adult signing the form ______ Signature of adult ______ Today's date ______

INSTRUCTIONS — Sources of Income

Sources of Income for Children

Sources of Child Income	Example(s)
- Earnings from work	- A child has a regular full or part-time job where they earn a salary or wages
- Social Security - Disability Payments - Survivor's Benefits	- A child is blind or disabled and receives Social Security benefits - A Parent is disabled, retired, or deceased, and their child receives Social Security benefits
-Income from person outside the household	- A friend or extended family member regularly gives a child spending money
-Income from any other source	- A child receives regular income from a private pension fund, annuity, or trust

Sources of Income for Adults

Earnings from Work	Public Assistance / Alimony / Child Support	Pensions / Retirement / All Other Income
- Salary, wages, cash bonuses - Net income from self-employment (farm or business use the sum of tax lines 12, 13, 14, 17 and 18) If you are in the U.S. Military: - Basic pay and cash bonuses (do NOT include combat pay, FSSA or privatized housing allowances) - Allowances for off-base housing, food and clothing	- Unemployment benefits - Worker's compensation - Supplemental Security Income (SSI) - Cash assistance from State or local government - Alimony payments - Child support payments - Veteran's benefits - Strike benefits	- Social Security (including railroad retirement and black lung benefits) - Private pensions or disability benefits - Regular income from trusts or estates - Annuities - Investment income - Earned interest - Rental income - Regular cash payments from outside household

OPTIONAL — Children's Racial and Ethnic Identities

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

fax: (202) 690-7442; or

email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Do not fill out — For School Use Only

Annual Income Conversion: Weekly x 52; Every 2 Weeks x 26; Twice a Month x 24; Monthly x 12

Total Income ______ How often? ○ Weekly ○ Bi-Weekly ○ 2x Month ○ Monthly

Household Size ______

Categorical Eligibility ☐

Eligibility: ○ Free ○ Reduced ○ Denied

Determining Official's Signature ______ **Date** ______

Confirming Official's Signature ______ **Date** ______

Verifying Official's Signature ______ **Date** ______

HOW TO APPLY FOR FREE AND REDUCED PRICE SCHOOL MEALS

Please use these instructions to help you fill out the application for free or reduced price school meals. You only need to submit **one** application per household, even if your children attend more than one school in [School District]. The application must be filled out completely to certify your children for free or reduced price school meals.

Please follow these instructions in order! Each step of the instructions is the same as the steps on your application. If at any time you are not sure what to do next, please contact **[School/school district contact here---phone & email preferred]**.

PLEASE USE A PEN (NOT A PENCIL) WHEN FILLING OUT THE APPLICATION AND DO YOUR BEST TO PRINT CLEARLY.

STEP 1: LIST ALL HOUSEHOLD MEMBERS WHO ARE INFANTS, CHILDREN, AND STUDENTS UP TO AND INCLUDING GRADE 12

Tell us how many infants, children, and school students live in your household. They do NOT have to be related to you to be a part of your household.

Who should I list here?

When filling out this section, please include **all** members in your household who are:

- Children age 18 or under **and** are supported with the household's income;
- In your care under a foster arrangement, or qualify as homeless, migrant, or runaway youth;
- Students attending **[school/school system here]**, *regardless of age.*

A) ***List each child's name.*** For each child, print their first name, middle initial and last name. Use one line of the application for each child. When printing names, write one letter in each box. Stop if you run out of space. If there are more children present than lines on the application, attach a second piece of paper with all required information for the additional children.

B) ***Is the child a student at [name of school/school system here]?*** Mark 'Yes' or 'No' under the column titled "Student" to tell us which children attend **[name of school/school district here]**.

C) ***Do you have any foster children?*** If any children listed are foster children, mark the "Foster Child" box next to the child's name. **Foster children who live with you may count as members of your household and should be listed on your application.** If you are *only* applying for foster children, after completing STEP 1, skip to STEP 4 of the application and these instructions.

D) ***Are any children homeless, migrant, or runaway?*** If you believe any child listed in this section may meet this description, please mark the "Homeless, Migrant, Runaway" box next to the child's name and **complete all steps of the application.**

STEP 2: DO ANY HOUSEHOLD MEMBERS (INCLUDING YOU) CURRENTLY PARTICIPATE IN ONE OR MORE OF THE FOLLOWING ASSISTANCE PROGRAMS: SNAP, TANF, OR FDPIR?

If anyone in your household participates in the assistance programs listed below, your children are eligible for free school meals:

- The Supplemental Nutrition Assistance Program (SNAP) or **[insert State SNAP here]**
- Temporary Assistance for Needy Families (TANF) or **[insert State TANF here]**
- The Food Distribution Program on Indian Reservations (FDPIR)

A) IF *NO ONE* IN YOUR HOUSEHOLD PARTICIPATES IN ANY OF THE ABOVE LISTED PROGRAMS:

- ***Circle 'NO' and skip to STEP 3 on these instructions and STEP 3 on your application.***
- ***Leave STEP 2 blank.***

B) IF *ANYONE* IN YOUR HOUSEHOLD PARTICIPATES IN ANY OF THE ABOVE LISTED PROGRAMS:

- ***Circle 'YES' and provide a case number for SNAP, TANF, or FDPIR.*** You only need to write **one** case number. If you participate in one of these programs and do not know your case number, contact: **[State/local agency contacts here]. You must provide a case number on your application if you circled "YES".**
- ***Skip to STEP 4.***

STEP 3: REPORT INCOME FOR ALL HOUSEHOLD MEMBERS

A) Report all income earned by children. Refer to the chart titled "Sources of Income for Children" in these instructions and report the combined gross income for **ALL** children listed in Step 1 in your household in the box marked "Total Child Income." Only count foster children's income if you are applying for them together with the rest of your household. It is optional for the household to list foster children living with them as part of the household.

What is Child Income?

Child income is money received from outside your household that is paid **directly** to your children. Many households do not have any child income. Use the chart below to determine if your household has child income to report.

Sources of Income for Children

Sources of Child Income	Example(s)
• Earnings from work	• A child has a job where they earn a salary or wages.
• Social Security o Disability Payments o Survivor's Benefits	• A child is blind or disabled and receives Social Security benefits. • A parent is disabled, retired, or deceased, and their child receives social security benefits.
• Income from persons *outside* the household	• A friend or extended family member *regularly* gives a child spending money.
• Income from any other source	• A child receives income from a private pension fund, annuity, or trust.

FOR EACH ADULT HOUSEHOLD MEMBER:

Who should I list here?

When filling out this section, please include **all** members in your household who are:

- Living with you and share income and expenses, *even if not related and even if they do not receive income of their own.*

Do **not** include people who:

- Live with you but are not supported by your household's income **and** do not contribute income to your household.
- Children and students already listed in Step 1

How do I fill in the income amount and source?

FOR EACH TYPE OF INCOME:

- Use the charts in this section to determine if your household has income to report.
- Report all amounts in **gross income** ONLY. Report all income in whole dollars. Do not include cents.
    - Gross income is the total income received before taxes or deductions.
    - Many people think of income as the amount they "take home" and not the total, "gross" amount. Make sure that the income you report on this application has NOT been reduced to pay for taxes, insurance premiums, or any other amounts taken from your pay.
- Write a "0" in any fields where there is no income to report. Any income fields left empty or blank will be counted as zeroes. If you write '0' or leave any fields blank, you are certifying (promising) that there is no income to report. If local officials have known or available information that your household income was reported incorrectly, your application will be verified for cause.
- Mark how often each type of income is received using the check boxes to the right of each field.

B) ***List Adult Household member's name.*** Print the name of each household member in the boxes marked "Names of Adult Household Members (First and Last)." **Do not list any household members you listed in STEP 1.** If a child listed in STEP 1 has income, follow the instructions in STEP 3, part A.

C) ***Report earnings from work.*** Refer to the chart titled "Sources of Income for Adults" in these instructions and report all income from work in the "Earnings from Work" field on the application. This is usually the money received from working at jobs. If you are a self-employed business or farm owner, you will report your net income.

What if I am self-employed?

If you are self-employed, report income from that work as a **net** amount. This is calculated by subtracting the total operating expenses of your business from its gross receipts or revenue.

D) ***Report income from Public Assistance/Child Support/Alimony.*** Refer to the chart titled "Sources of Income for Adults" in these instructions and report all income that applies in the "Public Assistance/Child Support/Alimony" field on the application. Do not report the value of any cash value public assistance benefits NOT listed on the chart. If income is received from child support or alimony, only **court-ordered** payments should be reported here. Informal but regular payments should be reported as "other" income in the next part.

E) *Report income from Pensions/Retirement/All other income.* Refer to the chart titled "Sources of Income for Adults" in these instructions and report all income that applies in the "Pensions/Retirement/All Other Income" field on the application.

F) *Report total household size.* Enter the total number of household members in the field "Total Household Members (Children and Adults)." This number **MUST** be equal to the number of household members listed in STEP 1 and STEP 3. If there are any members of your household that you have not listed on the application, go back and add them. It is very important to list all household members, as the size of your household determines your income cutoff for free and reduced price meals.

G) *Provide the last four digits of your Social Security Number.* The household's primary wage earner or another adult household member must enter the last four digits of their Social Security Number in the space provided. **You are eligible to apply for benefits even if you do not have a Social Security Number.** If no adult household members have a Social Security Number, leave this space blank and mark the box to the right labeled "Check if no SS#."

Sources of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/All Other Income**
• Salary, wages, cash bonuses • **Net** income from self-employment (farm or business) • Strike benefits **If you are in the U.S. Military:** • Basic pay and cash bonuses (*do NOT include combat pay, FSSA or privatized housing allowances*) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Worker's compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veteran's benefits	• Social Security (including railroad retirement and black lung benefits) • Private Pensions or disability • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • *Regular* cash payments from outside household

STEP 4: CONTACT INFORMATION AND ADULT SIGNATURE

All applications must be signed by an adult member of the household. By signing the application, that household member is promising that all information has been truthfully and completely reported. **Before completing this section, please also make sure you have read the privacy and civil rights statements on the back of the application.**

A) *Provide your contact information.* Write your current address in the fields provided if this information is available. **If you have no permanent address, this does not make your children ineligible for free or reduced price school meals.** Sharing a phone number, email address, or both is optional, but helps us reach you quickly if we need to contact you.

B) *Sign and print your name.* Print your name in the box "Printed name of adult completing the form." And sign your name in the box "Signature of adult completing the form."

C) *Write Today's Date.* In the space provided, write today's date in the box.

D) *Share children's Racial and Ethnic Identities (optional).* On the back of the application, we ask you to share information about your children's race and ethnicity. **This field is optional and does not affect your children's eligibility for free or reduced price school meals.**