2017-2018
SCHOOL YEAR

Crazy Horse School

Tasunke Witko Owayawa

ENROLLMENT PACKET

STUDENT INFORMATION:

Student Last Name:_____ First:_____ Middle Initial:_____

Grade :_____ Birthdate:_____ Birth Place:_____

Enrollment #_____ Tribe Enrolled With:_____

Male____ Female _____ Social Security Number:_____-_____-_____

PARENT INFORMATION: *(List who is Responsible for your child/who do we send Report Cards to)*

Parent/Guardian Name:_____P.O.Box#_____

City:_____ Zip Code:_____

Home Phone:_____Work:_____Cell:_____

The following information will help us in planning. In no way does it enhance or limit enrollment status.

Has your child ever participated in either of these programs:

Special Education___ 504 Plan___ Gifted & Talented___

Is your child currently receiving Special Education Services? YES____ NO____

Does your child have a current Individual Education Plan (I.E.P)? YES____ NO____

Does your child have a current 504 Plan? YES_____ NO_____

HAS YOUR CHILD BEEN EXPELLED FROM PREVIOUS OR ANY SCHOOL YES____ NO_____

BUS ROUTE:/DIRECTIONS TO YOUR HOME:_____

*HOUSE #*_____

EMERGENCY CONTACT/CHECK OUT AUTHORIZATION FORM

1. *Name of Contact:*_____*Phone Number(s):*_____

2. *Name of Contact:*_____*Phone Number(s):*_____

3. *Name of Contact:*_____*Phone Number(s):*_____

Parent/Guardian Signature:_____ Date:_____

(IF NEW STUDENT) PLEASE PROVIDE COPIES OF: Birth Certificate, Tribal Enrollment, Medicaid Card, Immunizations, Social Security Card & Guardianship documentation (If child has been adopted, temporary placement etc.....)

CRAZY HORSE SCHOOL MEDICAL CONSENT FORM

The Pine Ridge Indian Health Service may render emergency medical care and health screening physicals including; Vision, hearing, dental exams and other screening clinics through a Signed Consent Form. It is against Federal Law for a Health Care Institution to provide routine medical care or dispense medications to a minor without a parental or guardian present. (Exceptions to a School Nurse)

Student Name:_____ Grade:_____ Date of Birth:_____

Emergency Contact:_____phone#:_____

Address:_____

Medical History:_____

Allergies:_____

Current Medications:_____

*I,_____ have read this Consent Form for **Julie Chipps, School E.M.T** & Indian Health Service to arrange for, or to provide the following health services for this child;*

1.___Emergency medical care for accidents or life threatening illnesses which occur at the school and will transport student and parent to the clinic/hospital if the ambulance is not available! ***Give throat Medications (Halls etc..) or Tylenol for fever or female Cramps.***

2.___Dental Care including dental examinations, preventative use of fluorides and necessary emergency dental care.

3.___Periodic screening and athletic physicals.

4.___Vision and Hearing screenings.

5.___Mental Health services including evaluation and treatment as necessary.

6.___Immunizations.

7.___Administer medications as ordered by physicians.

8.___I hereby give consent for all of the above services.

IS STUDENT ELIGIBLE FOR MEDICAID? YES / NO

If yes, what is the Medicaid#_____

PLEASE PROVIDE A COPY OF THE CARD WHICH WILL BE ATTACHED WITH THIS FORM.

_____ _____

Signature of Parent/Guardian Date

CRAZY HORSE SCHOOL
BUS CONTRACT 2017-2018 SY
"A SAFE TRIP FOR ALL STUDENTS IS A MUST"

ALL STUDENTS MUST FOLLOW THESE BUS RULES!!

Student:_____ Bus Route:_____

Direction to residence:_____

1. OBEY AND COOPERATE WITH ALL THE DIRECTIONS OF THE BUS DRIVER.
2. THE BUS DRIVER IS AUTHORIZED TO ASSIGN SEATS.
3. ALWAYS STAY IN YOUR SEAT UNLESS TOLD OTHERWISE BY BUS DRIVER.
4. ABSOLUTELY NO FIGHTING, PUSHING OR SHOVING ON THE BUS.
5. ABSOLUTELY NO TAMPERING WITH ANY BUS EQUIPMENT.
6. ABSOLUTELY NO DAMAGING BUS OR EQUIPMENT.
7. ALWAYS KEEP HEAD, HANDS AND FEET INSIDE OF THE BUS AT ALL TIMES.
8. ABSOLUTELY NO EATING (Sun Flower Seeds etc..) OR DRINKING ON THE BUS, UNLESS APPORVAL FROM BUS DRIVER.
9. ABSOLUTELY NO PETS OR ANY OTHER ANIMALS ON THE BUS.
10. ALWAYS HELP TO KEEP THE BUS CLEAN.
11. NO PROFANE (CUSSING) ON THE BUS.
12. IF BEHAVIOR ON BUS ENDANGERS THE OCCUPANTS, BUS DRIVER WILL STOP THE BUS AND CALL THE LAW ENFORCMENT TO REMOVE STUDENT(S) CAUSING THE DISRUPTION.

****

Violation of the above bus rules could result in your student losing their bus riding privileges. Should your child break the bus rules, you may be asked to transport your child to and from school or you may be asked to ride the bus with your child. REMINDER THE BUSSES ARE EQUIPED WITH CAMERAS.

Your signature below states that you have received a copy of this form and understand the rules.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date

CRAZY HORSE SCHOOL

INTENSIVE BILINGUAL PROGRAM
CERTIFICATION FORM
2017-2018 SY

Student Name:_____ Grade:_____

Parent/Guardian:_____ Address:_____

I,_____hereby state that my child's Native Language is LAKOTA. The language most spoken in the home is Lakota. If a Language other than Lakota is spoken, please state Here:_____.

Please check below for permission or not to give permission for your child to attend Bilingual classes at Crazy Horse School during the School Year 2011-2012.

_____ *I **do give permission** for my child to participate in the ISEP Intensive Bilingual Program.*

_____ *I **do not** want my child to participate in the ISEP Intensive Bilingual Program.*

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal's Signature Date

PROGRAM ELIGIBILITY REQUIREMENTS:

Students are eligible in the Intensive Bilingual Education Program if he/she meets one of the following criteria;

A.___ Comes from a home in which a language other than English is most relied upon to communicate; or

B.___ Comes from an environment in which a language other than English has had a significant impact on his or her level of English Proficiency; or

C.___ has sufficient difficulty understanding, speaking, reading or writing the English language to deny him or her opportunity to learn successfully in an all English Curriculum.

CRAZY HORSE SCHOOL

2017-2018 SY

VIDEO/PICTURE CONSENT FORM

CRAZY HORSE SCHOOL IS REQUESTING FOR YOUR PERMISSION TO USE YOUR CHILDS PHOTOGRAPH AND/OR VIDEO FOR THE PUPOSE OF:
NEWSLETTERS, BULLETIN BOARDS, DOCUMENTARY PUBLICATIONS, LOCAL NEWSPAPERS (For Accomplishments), SCHOOL CHANNEL 92 & SCHOOL WEBSITE (With NO names being used).

I understand the above, being requested to be used for Crazy Horse School.

I give CHS my consent for my Child,_____ grade_____ for Video/Picture consent.

Signed:_____ Date:_____
(Parent/Guardian)

Cc: Student File

2016-2017 Application for Free or Reduced Price Meals

☐ New Applicant ☐ Previous Applicant

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

STEP 1: **List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are needed 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 Meals for more information.

Child's Name (First, MI, Last)	**Age**	**Write in Name of Child's School or else "not in school"**	**If a student, write in the 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?** Circle one: **Yes / No**

If you answered NO > Complete STEPS 3 and 4.

If you answered YES > Write your 9-digit SNAP or TANF, or the FDPIR case number here then go to STEP 4. If you get Medicaid or WIC skip STEP 2 and complete STEPS 3 and 4.

Case Number: ____________

Write only one case number in this space.

STEP 3: **Report Income for ALL Household Members** (Skip this STEP if you answered Yes and provided a Case Number in STEP 2.)

Please read How to Apply for Free and Reduced Price Meals for more information. The Sources of Income for Children section will help you with the Child Income section. The Sources of Income for Adults section will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn income. Please include the TOTAL income earned by all the children listed in STEP 1 to the right. →

Child Income	Weekly	Bi-Weekly	2x Month	Monthly	Child Income	Weekly	Bi-Weekly	2x Month	Monthly
$	O	O	O	O	$	O	O	O	O

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 for each source in whole dollars 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	Farming/ Pensions/ Retirement/ and All Other Income	How Often? Weekly	Bi-Weekly	2x Month	Monthly	Yearly
	$	O	O	O	O	$	O	O	O	O	$	O	O	O	O	O
	$	O	O	O	O	$	O	O	O	O	$	O	O	O	O	O
	$	O	O	O	O	$	O	O	O	O	$	O	O	O	O	O
	$	O	O	O	O	$	O	O	O	O	$	O	O	O	O	O
	$	O	O	O	O	$	O	O	O	O	$	O	O	O	O	O

Total Household Members (Children and Adults): ____

Write only the last 4 digits of the 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. SIGNATURE IS REQUIRED**

* I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws.*

Mailing Address ____ Apt. # ____ City ____ State ____ Zip ____ Daytime Phone and Email (if available) ____

Printed Name of Adult Completing the Form ____ Signature of Adult Completing the Form (REQUIRED) ____ Today's Date ____

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 ○ White
○ Black or African American ○ Native Hawaiian or Other Pacific Islander

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 on Indian Reservations (FDPIR) case number or other DFPIR 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:

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

(2) Fax: (202) 690-7442; or

(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

FOR SCHOOL/CENTER USE ONLY

Total Income & How Often: _____ / _____

Household size: _____

Other Notes:

SNAP / FDPIR / TANF or other eligible program household categorically eligible free: ☐ Yes ☐ No

Number of foster children eligible free _____

Eligibility classification: ☐ Free Rate ☐ Reduced Price Rate ☐ Paid Rate

Date notification sent: _____ Date withdrawn or transferred: _____

Signature of Determining Official: _____ Date: _____

Signature of Confirmation Official: _____ Date: _____

DELTA DENTAL

Delta Dental Mobile Dental Programs
Patient Information Form

mil WITH PRIDE

A

Please fill out this form completely. If you have questions, please ask a Dakota Smiles staff member. Thank You!

Patient's Legal Name _____ **Birth Date** (mm/dd/yyyy) _____

Patient's Social Security Number _____ - _____ - _____

School Attending _____ **Grade** _____ **Age** _____ **Sex** (circle) M F

Ethnicity: (circle) *White* *Black or African American* *Asian* *American Indian* *Hispanic/Latino* *Other*

Home Address _____
Street Address City State Zip

Phone Numbers: Home (____) _____ Work (____) _____

Cell (____) _____

Parent/Guardian Name _____

Note: Dental visits should start at first tooth.

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (____) _____

Income: Which of these best represents your annual household income? (circle one)

Less than $10,000 *$10,000-20,000* *$20,000-30,000* *More than $30,000*

Household Size: How many children less than 21 years of age live in your household? _____

Dental History	Yes	No	
Is this the patient's first dental visit? Past or current dentist name_____			If no, how long has it been? (√) ___less than 13 months ___less than 2 years ___more than 2 years
Does the patient brush daily?			
Does the patient floss?			
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			
Does the patient drink milk daily?			
Has dental pain caused you or your child to miss school and/or work in the last year?			If "yes", circle – school work both How many times?
Has the patient visited the ER/hospital for dental pain in the last year?			If "yes", how many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____			Date of last medical exam (mm/yy) _____
Does the patient have a current medical condition?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Is the patient current on immunizations?			
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism			
Is patient pregnant?			

Reason for Visit: Check any that apply (√)

☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else
☐ Toothache/mouth pain/face swelling ☐ Other (specify)_____

Has the patient had a history of or had difficulty with the following? Check any that apply (√)

☐ Latex allergy	☐ Asthma	☐ Diabetes	☐ Liver disease
☐ AIDS / HIV	☐ Birth defects	☐ Fainting	☐ Mono
☐ Epilepsy/ seizures	☐ Cancer	☐ Heart problems	☐ Rheumatic fever
☐ Excessive bleeding	☐ Cerebral Palsy	☐ Hepatitis	☐ Tuberculosis
☐ Anemia	☐ Convulsions	☐ Kidney disease	☐ Other _____

Please explain "yes" answers: _____

Behavioral Issues	Yes	No	
Is the patient using tobacco products (cigarettes, chewing tobacco)?			
Does anyone smoke in the household?			
Is the patient using alcohol and/or drugs?			

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided. **MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.**

Medicaid/ SCHIP **Private DENTAL Insurance** (please provide copy of card) **IHS** **None**

Medicaid Number/ Policy Number _____ Reservation (IHS) _____

Dental Ins. Name: _____ policy #_____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

B

Treatment Consent and Agreement

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)

give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Each item needs to be answered in order to receive dental care.

Yes	No	
		Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment. (Circle of Smiles provides preventive services only)
		Dentist Exam (including dental x-rays)
		Restorative Services: fillings, stainless steel crowns, pulpotomy. Anesthesia is used for these procedures.
		Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Anesthesia is used for these procedures.
		I have received and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices
		I consent to share my or my child's health care records with other health care providers or agencies as needed.
		I consent to the use of pictures, video or audio recordings of myself or my child for program promotion.

Parent/Legal Guardian signature _____ Date _____

BUREAU OF INDIAN EDUCATION
McKinney-Vento Enrollment/Referral Form

The purpose of this form is to address the requirements of the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. This document 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.

1. Is your current address a temporary living arrangement? YES _____ NO _____

2. Is your temporary address due to loss of housing or economic hardship? YES _____ NO _____

If answer to both questions is "YES", PLEASE CONTINUE, otherwise STOP HERE. Thank you!

STUDENT INFORMATION

Student Name(s) _____
Age(s) _____
Parent/Guardian Name(s) _____
School Site(s) _____
Grade Level(s) _____
Parent/Guardian/Youth Phone Number _____
_____ Cell Phone _____ Work Phone _____ Shelter Phone _____ Family/Friends residence

RESIDENCY INFORMATION

Are you a high school student who is currently living on your own? YES _____ NO _____
Where does the student stay at night? ____Shelter ____ Temporary Housing ____ Other_____
Address/Directions _____

Shelter Contact Person _____

The family/youth has been residing within the school district boundaries and intends to stay. _____
Please initial

Does the student wish to continue at school of origin? YES _____ NO _____

- Is the school of origin a boarding school? YES _____ NO _____
- If present school is a boarding school, will student be enrolled in the dorm? YES _____ NO _____

AGREED UPON SERVICES

Education Services: (Description) _____
_____
After-school Services: (Description) _____
_____
Transportation Services:
Pick up location _____
Drop off location (if different) _____
Health Services:
Immunizations _____
Dental _____
Food/Clothing _____
Free lunch _____
Counseling _____

The parent/guardian/youth understand that the agreed upon services are supplemental to the regular instructional day and will be re-evaluated to determine which needs to be continued. In the event that the family/youth residency changes, it is their responsibility to notify the MIS Building Principal at their respective building.

_____ _____
Parent/Guardian/Youth Date Building Principal Date

South Dakota Immunization Information System (SDIIS)
Access Agreement

To ensure the South Dakota Department of Health is aligning with the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule, a School Health Official must obtain parent, guardian or legal representative agreement before accessing a student's immunization record in the South Dakota Immunization Information System (SDIIS). No student record shall be accessed by a School Representative in the SDIIS without parent, guardian or legal representative agreement.

Student Last Name _____ First Name _____

I give permission to _____
(School)

access the above child's immunization record in the South Dakota Immunization Information System.

Date_____ Signature_____
(Parent, Guardian or Legal Representative)

****

In lieu of written consent, verbal consent was obtained from_____

Date_____ Signature_____
(School Official)

NETWORK AND INTERNET USE POLICY

In this regard, the School has made available to staff; network, electronic mail and the Internet. Students have access to the network and Internet. To gain access to the network and the Internet, all students under age of (18) must obtain parental permission and sign and return a parental permission form to the School district. Students over (18) can sign their own forms. Access to the network and the internet will enable students to explore thousands of libraries, databases and bulletins. Families should be warned that some material accessible via the Internet may contain items that are illegal, defamatory, inaccurate, or potentially offensive to some people. While it is possible for students to access inappropriate material and otherwise misuse the system, it is the intent of the School District that internet access should only be used to further the educational goals and objectives set out for each student. It is the policy of this School District to try to educate our students using modern technology which the students will need to be familiar with in order to be successful in their subsequent careers. However, in order to utilize this modern technology, it will ultimately be the responsibility of parents and guardians of minors to set and convey standards to their children which they will follow while utilizing this technology. To that end, the School District will support and respect each family's right to decide whether or not to apply for access.

With proper signed permission forms, a student may use the district network and the Internet to:

1. Research assigned classroom projects/emails/Odyssey Ware, Online Classes

Network storage areas are not to be considered private or personal property of students. They are learning areas subject to review by Administrators and teaching staff. Any files and communications may be reviewed by the Administration staff to maintain system integrity and to ensure that users are using the system responsibility. Users should not expect that files stored on District servers will be private. The district reserves the right to limit disk storage space on the network. **Users will not be allowed to load software on the network. Unauthorized software will be deleted without notice**. While school teachers of younger students will generally guide them toward appropriate materials, older students (18) and students utilizing the system outside of regular school hour will need to be directed by families in the same manner they direct their children's use of television, telephones, movies, radio, and other potentially offensive media.

The following conduct and utilizations of the Internet is NOT permitted:

1. Sending or displaying offensive messages or pictures;
2. Using abusive, objectionable or obscene language;
3. Searching for, down loading, or otherwise reviewing any type of sexually explicit, obscene material or other information for any non-instructional or non-educational purpose; harassing, insulting or attacking other;
4. Damaging computers, computer systems, or computer networks;

INTERNET PHOTO AND INFORMATION RELEASE/DISTRICT NETWORK TERMS AND CONDITIONS/USER AGREEMENT AND PARENTAL PERMISSION FORM

Crazy Horse School has a website (crazyhorse.k12.sd.us) featuring the school as well as news and information pages. It is our desire to include student work, photographs and information about our students on these web pages, with your permission and it will be accessible via internet and to print in connection with school news. As the parent and legal guardian of the student signing this form; Your son/daughter to access the network for computer services and the internet. I understand that individuals and families may be held liable, defamatory, inaccurate or potentially offensive to some people and I accept responsibility for guidance of internet use, including setting and conveying acceptable standards for my son/daughter to follow when selecting, sharing or exploring information on the CHS network. We do hereby release the School District, its School Board, staff and agents from the liability of any kind arising out of our son's or daughter's use of the computer/Internet system at the school. I understand that I will be notified if my son or daughter is found accessing questionable material.

SIGNED:

_____ _____

STUDENT SIGNATURE ***DATE***

_____ _____

PARENT/GUARDIAN SIGNATURE ***DATE***

_____ _____

PRINCIPAL SIGNATURE ***DATE***

DENTAL PATIENT MEDICAL HIS')RY

Please complete the PATIEN DENTIFICATION Section at the bottom ..er to update our records.
Your Social Security Number is not required.

If you are unsure of how to answer any of the following questions, *please ask the dental staff for help.*

Are you a registered patient at this clinic? Yes ☐ No ☐
Are you registered at other clinics? Yes ☐ No ☐
What is the reason for your visit to the dental clinic? _____
What is the name of your medical doctor? _____
What is the date of your last physical examination? _____
Has there been any change in your general health this past year? Yes ☐ No ☐
List any medication (pills or drugs) you are currently taking: _____

Please check:	Yes	or	No
1. Do you have a toothache now?	☐		☐
2. Have you received medical care in the past two years?	☐		☐
3. Have you ever been hospitalized?	☐		☐
4. Have you taken medication in the last two (2) months?	☐		☐
5. Are you allergic to or made sick by any medicine such as penicillin, aspirin, or codeine?	☐		☐
6. Have you ever had a bleeding problem that needed medical treatment?	☐		☐
7. Do you have chest pains?	☐		☐
8. Do you use alcohol or other drugs?	☐		☐
If yes, do you want to quit?	☐		☐
9. Do you use tobacco products?	☐		☐
If yes, do you want to quit?	☐		☐
10. Do you have reason to believe you have been exposed to AIDS or HIV?	☐		☐
11. Do you or does anyone in your family have diabetes?	☐		☐

Have you ever had the following?	Yes	or	No
12. Hepatitis	☐		☐
13. Heart murmur	☐		☐
14. Heart attack	☐		☐
15. High blood pressure	☐		☐
16. Rheumatic fever	☐		☐
17. Heart valve or pacemaker	☐		☐
18. Artifical joint	☐		☐
19. Anemia	☐		☐
20. Stroke	☐		☐
21. Ulcers	☐		☐
22. TB or lung disease	☐		☐
23. Asthma	☐		☐
24. Sinus trouble	☐		☐
25. Cancer or tumors	☐		☐
26. Epilepsy or seizures	☐		☐
27. Arthritis / rheumatism	☐		☐
28. Blood transfusions	☐		☐
29. Sexually Transmitted Disease	☐		☐
30. Kidney problems	☐		☐
31. Liver problems	☐		☐
32. Nervous or mental disorders	☐		☐
FEMALES ONLY - Are you:			
1. Pregnant?	☐		☐
2. Taking birth control pills?	☐		☐
3. Currently nursing?	☐		☐

Do you have any disease, condition, or problem not listed? Yes ☐ No ☐ (If yes, specify) _____

Do you have concerns about receiving dental treatment? Yes ☐ No ☐ (If yes, specify) _____

IMPORTANT!

These answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns, and local anesthesia by signing below.

	(Signature)	*(Date)*
Patient or Parental Consent		
Dentist		

NOTES: *(For dental staff use)* _____

_____ Tobacco Use Status: 1 2 3 4 5 L M H

PATIENT IDENTIFICATION:

Name: _____ Health Record No. _____
Date of Birth: _____ Soc. Sec. No. *(optional)* _____
Community where you live _____
Phone No: Home (___) _____ Work (___) _____
Mail Address: _____
City: _____ State: _____ Zip Code: _____

PROVIDER REVIEW

	(Date)	*(Initials)*

CRAZY HORSE SCHOOL

RELEASE OF RECORDS FORM
2017-2018 SY

P.O Box 260
245 Crazy Horse School Drive
Wanblee, SD 57577
Elementary (605) 462-6808 **FAX** (605) 462-6349
Middle/High School Office (605) 462-6816 **FAX** (605) 462-6083
Special Ed. Dept. (605) 462-6807 **FAX** (605) 462-6293

PERSON WHOSE RECCORDS ARE REQUESTED (Please print Clearly)

(Student)_____(Grade)_____(Birth Date)_____

PREVIOUS SCHOOL HISTORY-Please fill out the information and be specific on the days attended

(School Name)_____

(Address)_____

(City, State & Zip Code)_____

(Dates Attended)_____

Fill out if your Child Did NOT Attend CHS last Year or last Semester

PLEASE FORWARD THE FOLLOWING DEPARTMENT: ELEMENTARY or MS/HS

- Cumulative Records
- Behavioral Records
- Medical & Health History Records
- All Special Education Records (Current I.E.P, Case History, Evaluations Etc..)
- Transcript/Last Report Card
- BIRTH CERTIFICATE & TRIBAL ENROLLMENT

Please FAX & Mail to the above forwarding Address Requesting

Requested
By:_____Title:_____Date:_____

This is to certify that I completed this form and that the information above is accurate. I understand that all records will be released to the person/school named above for purposes stated above. Any records received that are not required will be returned to the parent/guardian and/or shredded by Crazy Horse School.

_____ _____
Parent/Guardian Signature **Date**

1st Request _____ 2nd Request_____ 3rd Request_____