SCHOOL YEAR 2022-2023

ST. STEPHENS INDIAN SCHOOL
128 MISSION ROAD/P.O. BOX 345
ST. STEPHENS, WY 82524
PHONE: 307.856.4147
K-8 (Ext. 210), HS (Ext. 199)

ALL STUDENTS: Registration packets are available **May 2, 2022.**
Priority will be given to returning students.
Students will only be allowed to begin school following formal acceptance.

PARENTS/GUARDIANS OF STUDENTS: You must bring the following for registration:

1. **Immunization Record (copy)**
2. **Complete Physical Form (Grades 5-12) if Participating in Sports**
3. **Any New & Updated Guardianship Papers Regarding Student(s)**

You will also be required to fill out a 506 form for each child and a health consent form.
HS students will not be considered for admission after the first month of the school year (9/9/22 @ 8:00 a.m.).

St. Stephens Indian School, in accordance with Federal law, does not discriminate on the basis of race, color, national origin, sex, age, or disability.

2022-2023 school year starts AUGUST 8, 2022.

Enrollment will be determined after a completed application packet is received and the application is reviewed and approved by administration. Students will not start class until the application is reviewed and approved by the administration.

***** Staff members will not pick up students who miss the bus. *****

OMB Control No. 1076-0122
Expires: 05/31/2023

STUDENT ENROLLMENT APPLICATION
FOR STUDENTS ENROLLED IN BUREAU-FUNDED SCHOOLS

Name of School: ST. STEPHENS INDIAN SCHOOL

Type:		Funding:	
Day School	(X)	Pub. Law 100-297 Grant	( )
Boarding School	( )	Pub. Law 93-638 Contract	(X)
Peripheral Dormitory	( )	BIA Operated	( )

1. IDENTIFICATION

Name of Student:

(Last) (First) (Middle)

Physical Address:
City: State: Zip Code:
Mailing Address:
City: State: Zip Code:
Miles from home to school: HS Student will drive to school: Yes No

Date of Birth: Place of Birth:
Month Day Year

Sex: Male ( ) Female ( )

Tribal Affiliation: Degree Indian:
Enrollment Number: Home Agency:

1. Which language did your child learn when they first began to talk?
2. Which language does your child most frequently speak at home?
3. Which language do you (the parents/guardians) use more often when speaking with your child?

2. FAMILY INFORMATION

Father (if living with): Address: Tribal Affiliation: Home Agency: Enrollment Number: Living: ( ) Dead: ( ) Occupation (Optional): Employer: Home Phone: Work Phone: Emergency: Other (specify)	Mother (if living with): Address: Tribal Affiliation: Home Agency: Enrollment Number: Living: ( ) Dead: ( ) Occupation (Optional): Employer: Home Phone: Work Phone: Emergency: Other (specify)

STUDENT ENROLLMENT APPLICATION (CONTINUED)

Legal Guardian (if not mother or father): Address: Tribal Affiliation: Home Agency: Enrollment Number: Occupation (Optional): Employer:	Other (group home, etc) (if applicable): Address: Telephone: Student Lives With: Telephone Home: Work: Emergency: Other (specify)

3. SCHOOL(S) PREVIOUSLY ATTENDED:

School Name: Address: City / State:	Dates Attended: Reasons for Leaving:	Grades Completed:
School Name: Address: City / State:	Dates Attended: Reasons for Leaving:	Grades Completed:
School Name: Address: City / State:	Dates Attended: Reasons for Leaving:	Grades Completed:

I am legally responsible for this student and hereby apply for his/her admission to this school. I understand that additional information may be requested by the school before the student is enrolled.

_____ _____
Signature of Parent/Legal Guardian/Adult Student Date

FOR OFFICE USE ONLY - DO NOT FILL OUT
Day School Enrollment:
Approved: Not Approved:

Principal_____ Date _____

U.S. DEPARTMENT OF EDUCATION
OFFICE OF INDIAN EDUCATION
WASHINGTON, DC 20202

TITLE VII STUDENT ELIGIBILITY CERTIFICATION

Parents: Please return this completed form to your child's school. In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program**. This form will become part of your child's school record and will not need to be completed every year.** This form will be maintained at the school and information on the form will not be released without your written approval.

Definition: Indian means any individual who is (1) a member (as defined by the Indian tribe or band) of an Indian tribe or band, including those Indian tribe or bands terminated since 1940, and those recognized by the State in which the tribe or band reside; or (2) a descendent in the first or second degree (parent or grandparent) as described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an Eskimo or Aleut or other Alaska Native; or (5) a member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Name of Child _____ Date of Birth _____
(as shown on school enrollment records)

School Name _____ Grade _____

NAME OF TRIBE, BAND OR GROUP_____

Tribe, Band or Group is: (check one)

_____ Federally Recognized, Including Alaska Native _____ State Recognized _____ Terminated _____ Organized Indian Group Meeting #5 of the Definition Above

Name of individual with tribal membership: _____

Individual named is (check one): _____ Child _____ Child's Parent _____ Child's Grandparent

Proof of membership, as defined by tribe, band, or group is:

A. Membership or enrollment number (if readily available) _____ OR
Other (explain) _____

Name and address of organization maintaining membership data for the tribe, band or group:
_____

I verify that the information provided above is accurate:

PARENT'S SIGNATURE _____ DATE _____

Mailing Address _____ Telephone _____

Notice: Public Reporting Burden Notice on Reverse Side

PAPERWORK BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. **If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:** U.S. Department of Education, Washington, D.C. 20202-4651. **If you have comments or concerns regarding the status of your individual submission of this form, write directly to:** Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3E200, Washington, D.C. 20202-6335.

Wind River Family and Community Healthcare

S.T.A.R.S (Students That Are Receiving Services Program)

Arapahoe • Ethete • Riverton

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

According to law, parents or legal guardians must provide consent for their child to participate in preventative screenings and treatment provided by Wind River Family and Community Healthcare Center for all American Indian/Alaskan Native children who qualify under PL 93-638 and choose to participate at: (please circle one)

School **WRFCHC Site** **Tele-medicine**

School Name _____ School Year _____

Location:

511 N. 12th E Street Riverton, WY 82501	14 Great Plains Road Arapahoe, WY 82510	707 Blue Sky HWY 132 Ethete, WY 82520

Wind River Family and Community Healthcare Center may utilize healthcare professionals in training, working under the supervision of licensed WRFCHC or other healthcare professionals under contract with WRFCHC to administer dental, optometry, well-child, behavioral, all telehealth, and public health services. I understand that telemedicine/telebehavioral health is the use of electronic information and communication by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to WRFCHC providing telehealthcare services to patients via telemedicine. All WRFCHC healthcare professionals are subject to federally-mandated background checks and determination of suitability pursuant to the WRFCHC Child Background and Character Investigation Policy and Procedure. Parent/guardian or legal caregiver will receive an information sheet of rendered services containing assessment and examination results with the listed recommendations as to continuing needs and/or treatment referrals. Contact information for providers, and follow-up instructions for care and treatment including what to do in case of a need for urgent or emergency response.

I, _____, give permission for my child, _____

(parent/legal guardian print name) (print child's name)

who was born on _____ to be screened and treated by WRFCHC.

(date of birth)

Phone number of Parent/Guardian ( ) _____-_____.

Please mark all programs that you do give consent for your child to participate in:

- ☐ Telemedicine
- ☐ Dental
- ☐ Optometry
- ☐ Well-Child
- ☐ Behavioral Health/Tele-Behavioral Health
- ☐ Immunizations -COVID 19 Vaccination
- ☐ Occupational/Physical Therapy
- ☐ Population Health- Public Health Nurse, Patient Navigator, Trauma Services, Strengthening Generations, Family Spirit, Maternal Child Health, Fitness Coordinators

_____ _____

(parent/legal guardian signature) (date)

COPY 1 (WRFCHC RECORD)

OMB Control No. 1076-0122
Expires: 05/31/2023

Medical History Information
School Year 2022-2023

Student Name: _____ Gender:_____ Grade:_____

Date of Birth:_____ Age: _____ School attended last year:_____ * **See Note**

Parent/Guardian Name:_____ Phone: _____ Other Phone:_____

●Please be sure to keep the school updated on any phone number changes ●

Emergency contact if parent/guardian cannot be reached: Name:_____

Relationship to student:_____ Phone: _____ Other Phone:_____

Emergency contact address:_____

Physician: _____ Dentist:_____ Eye Doctor: _____

Date of Last – Physical exam_____ Dental Exam: _____ Eye exam: _____

My child has (circle all that apply): Glasses Contacts Braces Hearing aids Orthopedic brace

* **Note**: If your child is a new student at St. Stephens, you will need to provide an up-to-date vaccine record.

Does your child have any of the following health conditions? NO YES – place an X in front of each health condition:

o Asthma – list triggers:_____ Treatment?_____
o Diabetes – describe treatment:_____ Date of onset:_____
o Allergies, to what?_____ Treatment?_____
o Diet Restrictions – explain:_____ * **See Note**
o Seizures – describe:_____ Treatment?_____ Date of last seizure:_____
o Heart Condition – describe:_____ Treatment?_____
o Urinary/Kidney Problems – describe:_____ Treatment?_____
o Stomach/Bowel Problems – describe:_____ Treatment?_____
o Muscle/Joint/Bones Problems – describe:_____ Treatment?_____
o Activity Restrictions – describe:_____ * **See Note**
o Emotional Issues – describe:_____Treatment?_____
o Ear/Hearing Problems – describe:_____ Treatment?_____
o Eye/Vision Problems – describe:_____ Treatment?_____
o Dental problems – describe:_____ Treatment?_____
o Surgeries/Hospitalizations – what & when?_____
o Other Health Problems – describe problem(s) & treatment(s):_____
_____

* Note - **P**hysician documentation required prior to implementing restrictions at school.

Does your child take medication(s)? NO YES – check all that apply

o Uses an inhaler – child will need inhaler at school? NO YES – child will carry their inhaler? NO YES – ** **See Note**
o Takes medication(s) at home – list medications:_____
o Will need medication(s) at school – list medication(s):_____

** **Note** – Complete a "Prescription Medication Authorization" form for each prescription medication your child will be taking at school. Complete an "Inhaled Asthma Medication Authorization" form if your child will be using an inhaler at school or during school activities.

I will not hold St. Stephen's Indian School financially responsible for emergency care or transportation for my student.

Parent/Guardian Signature:_____ Date:_____

OMB Control No. 1076-0122
Expires: 05/31/2023

PRESCRIPTION MEDICATION AUTHORIZATION

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

Medications that need to be administered at school longer than two weeks, need to have the top portion of this form completed and signed by the child's physician. Prescription medications needing to be administered less than two weeks, will not require a physician's signature. This form is designed to be used for only **one** prescription medication.

Physician Signature Required

This section is to be completed and signed by the prescribing PHYSICIAN if the prescription medication needs to be administered at school longer than two weeks.

Diagnosis and symptoms:_____

Medication:_____ Dose:_____
Route:_____

Frequency:_____
Duration:_____

Adverse Reactions/Side Effects:_____

Additional Instructions? NO YES – explain:_____

Physician's Name (Printed):_____ Office Phone:_____

Physician's Signature:_____ Date:_____

The following section must be completed by a parent/guardian.

Please initial in front of each of the following statements to verify understanding:
_____ I understand that medications brought to school need to remain in their original container with the prescription label intact, and

_____ My child and I understand that medication is to be brought promptly to the nurse's office and will be kept in a locked cabinet during school hours.

_____ I hereby grant permission to St. Stephens Indian School and its designees to assist in the administration of above prescribed medication during school and/or school sponsored activities.

_____ I understand the law provides protection from liability of civil damages to school personnel administering medication in accordance with a signed medication consent.

_____ I understand the school shall incur no liability, and I will hold the school harmless against any claims related to self-administration of asthma medications.

Parent/Guardian's Name (Printed):_____ Phone: _____
Parent/Guardian's Signature:_____ Date: _____

St. Stephens Consent Forms (2022-2023)

PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL ASSISTANCE

I hereby authorize _____St. Stephens_____ School District and its faculty members in charge of my child named below to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed physician and/or medical personnel to render necessary medical treatment to my child.

Student's Name _____ Work Phone Number; Father_____
Address _____ Mother _____
_____ Home Phone Number _____

INSURANCE INFORMATION: Company _____ Policy # _____
Insured Person _____
Policy Holder's Social Security Number _____

Signature acknowledges that we have read and understand the above warning and we give consent for emergency assistance that might be needed.

Date _____ Signature of Parent/Guardian _____

STUDENT/PARENT/GUARDIAN INFORMED CONSENT

Participation in all activities requires the acceptance of risk of possible serious injury. The risk can be minimized by following your coaches' rules and procedures, by familiarizing yourself with the rules of the activity, and by following the specific rules issued by manufacturers for the safe use of your activity equipment. The risk is always there, but you can help minimize it by making safety a shared responsibility. When you make the decision to participate in an activity, you are assuming the shared responsibility of following the activities rules, the coaches'

rules, and the equipment manufacturer's rules. You, as a participant, can help make the activity safer by not intentionally using techniques which are illegal and which can cause serious injury.

Your signature below indicates that you have been informed about the importance of following rules in activities participation; and you realize that there is a risk of being injured that is inherent in all activities. You realize that the risk of injury may be severe, including the risk of fractures, brain injuries, paralysis or even death.

Activity programs specifically excluded: _____

Date _____ Signature of Student _____

Signature of Parent _____

Student Name _____ Grade _____

Suspicion of Drug/Alcohol Use Form

We at St. Stephens believe that our students and campus should be drug free. Any possession or use of alcohol or drugs on school grounds is strictly prohibited. As such, we reserve the right to test any student that we suspect may be under the influence of alcohol or other drugs. If a student is suspected to be under the influence of alcohol the school nurse will perform a breathalyzer test. If the student is suspected to be under the influence of drugs a urinalysis test will be performed.

Drug Testing

As a student and parent/guardian:

- We hereby acknowledge that the student named on this form may undergo a urinalysis test or breathalyzer test if a staff member has reasonable suspicion that the student is under the influence of alcohol or drugs.

- We understand that a qualified health professional (School Nurse) will oversee the collection process, and that a health professional will analyze the results. The health professional will follow a strict code of confidentiality.

- We understand that the health professional selected by St. Stephens School will release all results of these tests to the school administrators. We understand positive test results will require guardians to be notified and action taken by the school.

- Students may voluntarily undergo a urinalysis or breathalyzer test to validate their claim of compliance.

_____	_____
Student Signature	Date
_____	_____
Parent/Guardian Signature	Date

ST. STEPHENS INDIAN SCHOOLS COMMUNICATION SHEET

Please fill out all sections of this form.
Name: _____
Grade: _____ **D.O.B.** _____
Parent/Guardian: _____
Physical Address: _____
Phone: _____ **Home:** _____ **Cell:** _____

Who is authorized to check out student:
_____ _____
_____ _____
_____ _____

Emergency Contact (if parent cannot be reached):
Name: _____
Physical Address: _____
Cell: _____

***** Please Print**

****** These cards will be on file all school year. If you should have any changes, please notify the school *as soon as possible.***

St. Stephens Indian School
Acknowledgement and Receipt of
Student & Parent Handbook

The SSIS Student & Parent Handbook can be viewed on the school's website (st-stephens.net) under the "Parents" feather. Also, copies can be requested at either building.

***** Return this sheet to the office by August 8th *****

Our signatures below reflect that my child and I have read and discussed the information included in the student-parent handbook. I have been given the opportunity to ask for clarification and ask questions regarding the discipline and conduct procedures of the school. I understand I can call the school for more information.

_____ _____

Parent/Guardian Signature Date Student Signature Date

St. Stephens Indian School
Acknowledgement and Receipt of
Athletic Handbook

The SSIS Athletic Handbook can be viewed on the school's website (st-stephens.net) under the "Parents" feather. Also, copies can be requested at either building.

***** Return this sheet to the office by August 8th *****

Our signatures below reflect that my child and I have read and discussed the information included in the athletic handbook. I have been given the opportunity to ask for clarification and ask questions regarding the discipline and conduct procedures of the school. I understand I can call the school for more information.

If your student will not be involved in sports, please disregard this page.

_____ _____

Parent/Guardian Signature Date Student Signature Date