



STUDENT ENROLLMENT FORM

Student Information:

INSTRUCTIONS: Complete the entire form. Please print legibly.

Student's Legal Last Name		First Name		Middle Name	
Grade Applying For:		Date of Birth (mm/dd/yyyy)		Sex (Select one): <input type="checkbox"/> Male <input type="checkbox"/> Female	
State of Birth	Day or Dorm Student	Wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Chapter Name: _____		
Student's Mailing Address (include Bldg./Apt.#)			Race (Check all that apply)		
City, State, ZIP			<input type="checkbox"/> Asian or Indian Subcontinent <input type="checkbox"/> White: European, North African, Middle East <input type="checkbox"/> American Indian/Alaskan Native: Tribe: _____ <input type="checkbox"/> Black/African <input type="checkbox"/> Native Hawaiian/Other Pacific Islander		
Phone Number (Including area code) *This number receives absence calls*		Parents/Guardian(s) Email Addresses (You will receive pertinent info.)		Parents/Guardian(s) Name, Employer Name and Phone Number	
1. ()		1.		1. ()	
2. ()		2.		2. ()	
Student's Previous School Information:					
Last School Attended: _____ Date: _____					
State and/or Country located: _____ Previous Grade: _____					
Please check any special services previously received:			*Please provide current IEP		
<input type="checkbox"/> Special Education <input type="checkbox"/> 504 Accommodation <input type="checkbox"/> Gifted/Talented <input type="checkbox"/> English Language Learner (ELL) <input type="checkbox"/> Other (concerns, Meetings i.e. Child Study Team, Services Received i.e. Early Intervention, Walk in Beauty etc.): _____					
Is the above named student:					
Suspended or expelled from any school or district? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Being Considered for disciplinary action, suspension, or expulsion? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Previously retained? <input type="checkbox"/> Yes <input type="checkbox"/> No					



STUDENT ENROLLMENT FORM

PARENT/GAURDIAN INFORMATION:

Please List Adults (18 and older) Responsible for Student and Relationship to Student as Indicated Here (if more than five (5) please list on back of sheet):

Father, Mother, Stepfather, Stepmother, Guardian, Self (Emancipated, Married, In Transition) or write in Other.

Provide complete first and last name	Relationship to student	Physical Address (include Hwy#, Country Road #, SR#, RA# and description of home)	Other phone numbers and type (work, message, cell) include area code	Check applicable Boxes Below:
				<input type="checkbox"/> Lives With <input type="checkbox"/> Educational Rights <input type="checkbox"/> Can Check out student from School <input type="checkbox"/> Has Custody <input type="checkbox"/> Mailings Allowed
				<input type="checkbox"/> Lives With <input type="checkbox"/> Educational Rights <input type="checkbox"/> Can Check out student from School <input type="checkbox"/> Has Custody <input type="checkbox"/> Mailings Allowed
				<input type="checkbox"/> Lives With <input type="checkbox"/> Educational Rights <input type="checkbox"/> Can Check out student from School <input type="checkbox"/> Has Custody <input type="checkbox"/> Mailings Allowed
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STUDENT ENROLLMENT FORM

TRANSPORTATION

Circle most frequently used:

Morning: Bus Rider (if pick up is different than home address, please write a physical address)

Afternoon: Bus Rider (if pick up is different than home address, please write a physical address)

LANGUAGE

What is the language most frequently spoken at home? _____

What language did your child learn when he/she first began to talk? _____

What language does your child most frequently speak at home? _____

What language do you most frequently speak to your child? _____

What is the language most frequently spoken at with adults? _____

What is the language most frequently spoken at home with grandparents? _____

INTERNET

Do you have a computer at home? Yes No Is it less than 5 years old? Yes No

If yes, do you have internet access? Dial Up Cable Modem DSL Satellite Dish

Other _____

HEALTH INFORMATION

List any current medical condition, injury, illness, disease, or surgery.

Does your child have food, insect, drug, or latex allergy? _____ If yes, please explain: _____

*What medications required for allergic reaction? _____

Does your child have Asthma? _____ if yes, does your child require access to an inhaler: _____

Does your child routinely take medication? _____ If yes, please list: _____

We the undersigned have answered the above questions to the best of our ability. The information given is true. We understand that the school personnel will rely on the information provided and if there are any changes, it is my responsibility to inform the school in writing.

PARENT/GAURDIAN SIGNATURE _____ DATE: _____

REGISTRAR: _____ DATE: _____

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal MembershipThe individual with Tribal membership is the (select only one): child child's parent child's grandparentIf the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- Federally Recognized Tribe
- State Recognized Tribe
- Terminated Tribe
- Alaska Native
- 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.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- Membership or enrollment number establishing membership (if readily available) or
- Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____



PO BOX 649 FORT DEFIANCE, AZ 86504 PHONE: 928.729.8010 FAX: 928.729.8019 WEBSITE: WWW.FDIHB.ORG
A FACILITY OF FORT DEFIANCE INDIAN HOSPITAL BOARD, INC.

Student Name: _____ **DOB:** _____

Dear Parent/Guardian,

Your state recommends certain health screenings, by grade, which may include vision, hearing, height/weight, and blood pressure. The Public Health Nursing staff of Fort Defiance Indian Hospital, Inc. coordinates these screenings each fall. The health information collected during this screening will be recorded in your child's Fort Defiance Indian Hospital record and your child's school health record. You will be notified of any unusual findings. Your student's information will only be shared in the event that he/she is referred for further evaluation.

Additionally, Public Health Nursing will conduct an immunization record review to ensure that your student is adequately protected from preventable illnesses. You will be notified if your child is due for any vaccines.

Enclosed, you will also find a health history update. Please complete this form. It will be placed in your child's school health record.

As the parent or legal guardian of the student named above, I hereby consent to have Fort Defiance Indian Hospital, Inc. staff provide the state recommended health screenings for my child: **Yes** **No**

Does your child have a chart with FDIH? **Yes** **No**
For the purpose of recording your child's information, please provide the number: _____

I understand that these health care services are non-invasive and are only screenings. The FDIHB Public Health Nurses will make recommendations if needed, for follow-up with a Medical Provider.

Signed: _____ **Date:** _____
Parent or legal guardian Valid for 1 year

---PLEASE RETURN THIS FORM TO THE SCHOOL---

STUDENT HEALTH HISTORY

FORT DEFIANCE SERVICE UNIT

TO BE FILLED OUT AND SIGNED BY PARENTS

Student's Name _____ Birthday _____ Sex _____

School _____ City _____ Grade _____

Parent/Guardian Name _____

Address _____

City _____ Telephone # _____ State _____ Zip _____

Family Physician/Clinic _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Family Dentist Name _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Has your child ever had or now have?					
	Details	Year		Details	Year
Allergy	Yes No	_____	Joint Pain	Yes No	_____
Anemia	Yes No	_____	Kidney Trouble	Yes No	_____
Arthritis	Yes No	_____	Menstrual Cramps	Yes No	_____
Asthma	Yes No	_____	Migraine Headaches	Yes No	_____
Back Pain	Yes No	_____	Knocked Out	Yes No	_____
Concussion	Yes No	_____	Knee Injury	Yes No	_____
Loss of Consciousness	Yes No	_____	Rheumatic Fever	Yes No	_____
Diabetes	Yes No	_____	Scoliosis	Yes No	_____
Eczema (skin rash)	Yes No	_____	Spine Injury	Yes No	_____
Emotional Problems	Yes No	_____	Sinus Trouble	Yes No	_____
Epilepsy (seizures)	Yes No	_____	Sore Throats (chronic)	Yes No	_____
Fainting	Yes No	_____	Tuberculosis	Yes No	_____
Hearing Trouble	Yes No	_____	Neck Injury	Yes No	_____
Heart Murmur	Yes No	_____	Wrist Injury	Yes No	_____
Hepatitis	Yes No	_____	Elbow Injury	Yes No	_____
Hernia (rupture)	Yes No	_____	Surgical procedure (Operation)	Yes No	_____
Ankle Injury	Yes No	_____	Other	Yes No	_____
Elbow Injury	Yes No	_____			

1. During the past 12 months was your child hospitalized? Yes () No ()
3. During the past 12 months did your child have any injuries requiring medical attention or is he/she now under a physician care? Yes () No ()
4. During the past 12 months did your child have any illness lasting more than one week? Yes () No ()
5. Does your child take any medication regularly? Yes () No ()
6. Do you feel that there should be limits on your child's participation in activities because of symptoms of illness, injury, or abnormalities of family history known to you or your Physician? Yes () No ()
7. During the past 12 months has your child had any fractures, sprains/dislocations? Yes () No ()
Explain: _____
8. Does your child have any allergies to medications, plants, foods, etc? Please list. Yes () No ()

9. Medications Now Taking: _____
10. Does your child wear prescription glasses? Yes () No ()
11. Does your child have a diagnosed hearing condition? Yes () No ()
Has she/he been followed by an audiologist? Yes () No ()
12. Please explain any "yes" answers

We the undersigned, have answered the above questions to the best of our ability. The information given is true. We understand that school personnel will rely on the information provided.

If emergency service involving medical action or treatment is required and neither the parents nor guardians can be contacted, I hereby consent for the student named above to be given medical care at the facility selected by the school.

Signature of parent or guardian _____

Date _____
(permission valid for 365 days unless rescinded)

Revised 8/30/04

HUNTERS POINT BOARDING SCHOOL, INC.

SY 2023-2024 SCHOOL COMPACT

STUDENT AGREEMENT

- 1) I will attend school every day
- 2) I will come to school well rested and attentive
- 3) I will be responsible for learning
- 4) I will be responsible for all in-class assignments and homework assignments
- 5) I will come to school prepared
- 6) I will abide by all school/campus policies as stated in Student Handbook
- 7) I will respect all teachers, classmates and support staff at Hunters Point School

Student: _____ Date: _____

PARENT/GUARDIAN AGREEMENT

I will encourage and motivate my child to succeed in education by doing the following:

- 1) I will support my child's education with a positive attitude
- 2) I will abide by the school policies and procedures
- 3) I will assist my child to complete homework as assigned
- 4) I will attend all Parent/Teacher conferences with my child
- 5) I will attend Parent Meetings, Family Learning Night and Annual Parent Orientation at least two (2) times in one school year.

PARENT: _____ Date: _____

Primary Home Language Other Than English (PHLOTE) Home Language Survey

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

1. **What is the primary language used in the home regardless of the language spoken by the student?** _____
2. **What is the language most often spoken by the student?** _____
3. **What is the language that the student first acquired?** _____
4. **Is there another language spoken in the home?** _____

Student Name _____

Date of Birth _____

Parent/Guardian Signature _____ Date _____

School _____

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

**Hunters Point Boarding School
2023-2024**

Student Housing Questionnaire

The answers to the following questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act 42 U.S.C. 11435. The McKinney-Vento Act provides services and supports for children and youth experiencing homelessness. (Please see reverse side for more information)

If you own/rent your own home, you do not need to complete this form.

If you do not own/rent your own home, please check all that apply below.

- | | |
|---|--|
| <input type="checkbox"/> In a motel | <input type="checkbox"/> A car, park, campsite or similar location |
| <input type="checkbox"/> In a shelter | <input type="checkbox"/> Transitional Housing |
| <input type="checkbox"/> Moving from place to place/couch surfing | <input type="checkbox"/> In a residence with inadequate facilities (no water, heat, electricity, etc.) |
| <input type="checkbox"/> In someone else's house or apartment with another family | <input type="checkbox"/> Other: Other details |

Name of Student: _____ Date of Birth: _____ Age: _____

Name of School: _____ Grade: _____ Gender: _____

- Student is unaccompanied (not living with a parent or legal guardian)
- Student is living with a parent or legal guardian

Address of current residence: _____

Phone number or contact number: _____

Name of Parent(s)/Legal Guardians(s) or unaccompanied youth: _____

*Signature: _____

* I declare under penalty of perjury under the laws of the State of Washington that the information provided here is true and correct.

Parent Signature: _____ Date: _____

For School Personnel Only: For data collection purposes and student information system coding

- (N) Not Homeless (A) Shelters (B) Doubled-Up (C) Unsheltered (D) Hotels/Motels