Flandreau Indian School

1132 N. Crescent St. ~ Flandreau, SD ~ 57028
605-997-3773 ~ 1-800-942-1647

Application for Admission

2024-2025

Dear Parents:

Thank you for your interest in Flandreau Indian School as a potential choice to educate your student. The admissions application checklist is to be used as a guide, to provide the information the school needs to review your student's application.

The deadline for submitting applications is **August 30, 2024.** **Only applications accompanied with required documents will be date stamped and reviewed for admissions.** Required documents are listed on the bottom half of page 2. **Please only send copies of your Certificate of Indian Degree of Blood, Birth Certificate, Social Security Card and Medical Card. Keep your originals for your files.**

The following decisions are possible:
1. Accepted
2. Denied

These items are the most difficult to obtain and will hold up the process of your application.

1. COPY of Certified Degree of Indian Blood (**Tribal Membership cards are not accepted**)
2. Contact your current school's registrar (before they close for the summer) to get an official transcript or a certificate of 8th grade completion and achievement test scores.
3. **Physical Exam is REQUIRED for all new and reapplying students and must be completed after MAY 1, 2024, see pages 16-22.** Students should start calling now for a physical exam appointment.
4. Students interested in participating in competitive athletics may be required to complete an application for hardship for the SDHSAA. Application for hardship **does not** guarantee eligibility. Eligibility is determined solely by the SDHSAA. See attached Sports Eligibility Checklist.
5. **STUDENTS INTERESTED IN PARTICIPATING IN SPORTS AT FIS MUST BE ON CAMPUS AUGUST 14th, the first day of school, TO PARTICIPATE IN SPORTS. If student is not here on the first day of school they will have to wait 45 days to participate in any sports. NO EXCEPTIONS.**

FIRST DAY OF SCHOOL—AUGUST 14, 2024. TRAVEL ARRANGEMENTS WILL BE MADE BY THE FLANDREAU INDIAN SCHOOL AT OUR EXPENSE. IF YOU DO NOT TRAVEL WHEN IT IS PROVIDED FOR YOU, YOU WILL BE RESPONSIBLE FOR YOUR OWN TRANSPORTATION TO SCHOOL.

When the application is completed, please mail to:
Only complete applications will be reviewed.

Flandreau Indian School
Admissions
1132 N. Crescent St.
Flandreau, SD 57028

2024-2025

Flandreau Indian School Admissions Application Checklist

ALL APPLICATIONS MUST HAVE THE FOLLOWING LIST OF DOCUMENTS

THE ADMISSIONS COMMITTEE WILL NOT REVIEW INCOMPLETE APPLICATIONS

STUDENT:_____ Grade applying for:_____

DATE:_____ School year: _____

Student Enrollment Application

Pg. 1	Letter to parents
Pg. 2	Admissions application check list
Pg. 3	Student Information Form
Pg. 4	Family/Guardian Information Form—MAKE SURE TO SIGN THIS FORM
Pg. 5	Additional Information/Criteria for Boarding Schools Form
Pg. 6	Education and Social Information Form
Pg. 7 and 8	Family Educational and Privacy Letter (FERPA)
Pg.9	No Child Left Behind Act of 2002
Pg. 10	Admissions and Continuing Enrollment Criteria
Pg. 11	Individual Education Programs (If receiving services include a copy of your IEP)
Pg. 12	Gifted and Talented Program
Pg. 13	BIE McKinney– Vento Form
Pg. 14	Consent for Group Counseling & Therapeutic Programs
Pg. 15	Language Survey
Pg. 16	Consent for Medical Information Form HIPAA
Pg. 17 & 18	Authorization for disclosure of Medical Information
Pg. 19	Consent for Medical Treatment
Page 20	Medications Prescribed and/or over the counter
Page 21	Health History Form
Page 22	Flandreau Indian School Physical Examination Form

Following documents are required before the application can be processed

	Copy of State Issued Birth Certificate		Copy of Social Security Card
	Copy of Certified Degree of Indian Blood (Tribal Membership card not accepted)		Copy of Health/Medical Insurance Cards
			Immunization record/2nd MMR
	Flandreau Physical Form		Parent/Guardian signatures
	ALL students must provide reports cards showing completion of grade 8th through December and **FINAL** grades in May Students applying for grades 10-12 must **ALSO** provide transcript with GPA		

COURT APPOINTED PARENT OR LEGAL GUARDIAN MUST PROVIDE LEGAL DOCUMENTATION. An application signed by the student as parent or legal guardian will not be accepted, even if The student is 18 years of age or older.

Date/Time Rec'd
Initials:

United States Department of Interior
Bureau of Indian Education

Student Enrollment Application
For Bureau Funded Schools and Federal Boarding Schools

2024—2025

DATE:_____

Name of School: FLANDREAU INDIAN SCHOOL Grade Applying for: _____

Day Student ( ) Dorm Student ( )

(PLEASE PRINT OR TYPE)

I. **IDENTIFICATION** Social Security Number: _____

Name of Student: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Student Cell phone # (if applicable): _____

Date of Birth: ___/___/____ Hospital or Clinic Used: _____ Chart#: _____

Place of Birth: _____ Sex: Male ( ) Female ( )

Student resides with: Mother ( ) Father ( ) Legal Guardian ( ) other ( )_____

Tribal Affiliation: _____ Degree Indian: _____

Enrollment Number: _____ Home Agency: _____

Dominant Language: _____

Student attended FIS previously? Yes ( ) No ( )
If yes, please list dates_____

Siblings attending FIS presently or previously? _____

_____

Student's Name: _____

FAMILY AND BACKGROUND INFORMATION: (PLEASE PRINT OR TYPE)

IMPORTANT - PLEASE NOTIFY THE ADMISSIONS OFFICE IMMEDIATELY IF ADDRESS OR PHONE NUMBERS CHANGE!

CIRCLE ONE: - Parent(s) OR Legal Guardian(s)

Father: _____
Address: _____
_____
Tribal Affiliation: _____
Occupation: _____
Employer: _____
Phone: Work _____
Home _____
Cell _____
Email _____

Mother: _____
Address: _____
_____
Tribal Affiliation: _____
Occupation: _____
Employer: _____
Phone: Work _____
Home _____
Cell _____
Email _____

If you are the court appointed custodial parent, you must attach appropriate documentation (if parents do not live in the same house, please indicate if non-custodial parent can receive mailings by completing ad-

GUARDIAN INFORMATION: (IF OTHER THAN PARENT) MUST PROVIDE APPROPRIATE LEGAL DOCUMENTATION

If the student does not live with either parent, complete the following information on the guardian. If the student is a ward of the court, attach documentation and provide information on the person(s) responsible for the applicant who will be the primary contact person. A STUDENT MAY NOT LIST HIMSELF/HERSELF AS GUARDIAN EVEN IF HE/SHE IS 18 YEARS OF AGE OR OLDER.

Name: _____
Address: _____
_____
_____

Telephone: Work _____
Home _____
Cell _____
Email _____

PARENT/LEGAL GUARDIAN SIGNATURE BELOW:

X _____

******Parent or Legal Guardian MUST sign this page.******

Student's Name: _____

IN CASE OF EMERGENCY, WHOM COULD WE CONTACT (**OTHER THAN PARENT/GUARDIAN**)

Name: _____ Cell: _____

Home phone: _____ Work phone: _____ Relationship _____

Email address: _____

TRIBAL EDUCATION OFFICE: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

TELEPHONE NUMBER: _____

CRITERIA FOR BOARDING SCHOOL:

Favorable action is recommended upon this application because this case confers to the following criteria for boarding school or out of boundary enrollment. If this application is for an off-reservation boarding school and for social reason, a social summary should accompany this application.

Check all applicable criteria (At least one must be checked)

Educational Factors

Federal/Public Schools near students home:

( ) grade level not offered
( ) are severely overcrowded
( ) exceed 1 1/2 mile walking distance to school or bus route.
( ) do not offer special vocational/preparatory training necessary for gainful employment
( ) do not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences.
( ) receiving school offers special program needed by student

Social Factors

In his/her family environment, the student:

( ) was rejected or neglected
( ) does not receive adequate parental supervision.
( ) well being was imperiled due to family.
( ) has behavioral problems too difficult for or local resources.
( ) has siblings or other close relatives enrolled who would be adversely affected by separation.

Flandreau Indian School

Information Form

Student Name:_____

EDUCATIONAL INFORMATION

1. List school previously attended:_____
2. Previous school contact number: _____
2. Reason for leaving: _____
3. Did student miss 15 or more days in the last school year? Yes ( ) No ( )
4. Has student ever been suspended? Yes ( ) No ( ) Expelled? Yes ( ) No ( )
   If yes, date and reason **must** be given_____
5. **Will your student participate in Sports at Flandreau Indian School? Yes ( ) No ( ) If Yes, MUST BE PRESENT ON CAMPUS THE FIRST DAY OF SCHOOL OR WILL NOT BE ELIGIBLE TO PLAY SPORTS FOR 45 DAYS. NO EXCEPTIONS.**
6. Do you have a computer, tablet or iPad at home? Yes ( ) No ( )
7. Do you have internet at home? Yes ( ) No ( )

SOCIAL INFORMATION

1. Is student a ward of the court? Yes ( ) No ( ) If yes, a copy of the court order must be submitted.
2. Has student ever been arrested? Yes ( ) No ( ) If yes, what was/were the violation(s)?_____
   _____
3. Has student ever been in jail or a detention center? Yes ( ) No ( ) If yes, how many times?
   _____
4. Does student have a probation officer? Yes ( ) No ( )
   Name_____
   County_____
   Phone_____
5. Has student ever received counseling? Yes ( ) No ( )
   Name_____
   Phone_____

I, the parent/legal guardian of the above mentioned student hereby certify that the information provided is true and accurate to the best of my knowledge and I understand that Flandreau Indian School will verify all information. **Any false statement or misrepresentation or omission of required information in application will result in denial of application.**

I understand that additional information may be requested to complete my student's records. Such as: School records, counseling records, and behavior records.

_____ _____

Student Signature Parent/Legal Guardian Signature

PARENT or LEGAL GUARDIAN & STUDENT MUST SIGN FORM

Flandreau Indian School

1132 N. Crescent St. ~ Flandreau, SD ~ 57028
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Everall Fox
Chief School Administrator

David Flammond
Acting Assistant Principal

The Family Educational Rights and Privacy Act (FERPA), a Federal law, requires that Flandreau Indian School, with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, Flandreau Indian School may disclose appropriately designated "directory information" without written consent, unless you have advised the District to the contrary in accordance with District procedures. The primary purpose of directory information is to allow the Flandreau Indian 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 programs; and
- 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's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. 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 parents have advised the school that they do not want their student's information disclosed without their prior written consent.

If you do not want Flandreau Indian School disclose directory information from your child's education records without your prior written consent, you must notify the school in writing. Flandreau Indian School designated the following information as directory information:

- Student's name, address, telephone listing, Photograph, Date and place of birth, Electronic mail address.
- Participating in officially recognized activities and sports, weight and height of member of athletic teams
- Degrees, honors, and awards received, Major field of study
- Dates of attendance, Grade level, the most recent educational agency or institution attended

If there are questions about your or your student's (18 or older) rights under FERPA, you may contact the office at Flandreau Indian School.

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 Flandreau Indian School.

Flandreau Indian School

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.

[ ] I do not want **any** Directory Information regarding _____
(Student Name)
(Nothing will be disclosed without written Permission)

OR

I, do not want **the following** directory information regarding my student _____
(Student Name)
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. [ ] Electronic mail address
7. [ ] Photograph
8. [ ] Degrees, honors, and awards received
9. [ ] Date and place of birth
10. [ ] Major field of study
11. [ ] Dates of attendance
12. [ ] Grade level

I am the parent or legal guardian of: _____

I am an eligible student (18 years old or older) _____

_____ _____

Signature **Date**

Flandreau Indian School

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Everall Fox
Chief School Administrator

David Flammond
Acting Assistant Principal

"No Child Left Behind Act of 2002"

Parents,

The "No Child Left Behind Act of 2002", SEC.9528, Armed Forces Recruiter Access to Student and Student Recruiting Information, provides for schools to provide, on request made by military recruiters or an institution of higher education, access to secondary school student names, addresses, and telephone listings. As a school, we are required to comply with this law. You as a parent, however, have the right to request that the school not release that information to these agencies. If you wish to not have your child's information released, please indicate below. If you have any questions about the "No Child Left Behind Act of 2002" please contact Flandreau Indian School.

_____I do wish to have my child's information released.

_____I do not wish to have my child's information released.

_____ _____

Signature of Parent/Legal Guardian Date

PARENT or LEGAL GUARDIAN MUST SIGN FORM

Flandreau Indian School
Admission and Continuing Enrollment Criteria

Student's Name: _____

- Students **must be making academic progress** throughout the school year at Flandreau Indian School. Students failing to make academic progress will be placed on academic probation. Grades will be reviewed at the end of each semester to determine progress. The student will be given until the end of the next semester to make improvements.
- Students may not miss more than 3 unexcused days of school per academic year.

ICU Academic Program

The ICU program allows students more practice time for completing their assignments. ICU is during the student's lunch and study hall as well as after school. During ICU the student can get one on one help with a teacher or an education technician to complete their class work. You will be contacted when your child is placed on the ICU list.

Contact Information

PARENT CELL NUMBER: _____

PARENT EMAIL ADDRESS: _____

STUDENT CELL NUMBER: _____

STUDENT EMAIL ADDRESS: _____

I, _____ (parent) agree for reasonable cause and essential to assuring the health and safety of all students at the Flandreau Indian School, staff, acting in attendance in loco parentis, may at their discretion exercise search, seizure, and drug testing while my student is in attendance at Flandreau Indian School. Such activities shall be in compliance with 25CFR-part 42.3, (b), (Rights of the Individual Students) and 34 CFR-part 86.200 (b-e) (Drug Free) School and Campuses).

CELLPHONES

Use of **cell phones** and personal electronic devices is restricted to before school, after school, and during lunch while in the dining hall unless requested and approved by the classroom teacher for an educational activity.

MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN INFORMED OF THE POLICIES:

_____ _____

Student Signature **Date**

_____ _____

Parent/Legal Guardian Signature **Date**

INDIVIDUAL EDUCATIONAL PROGRAMS

Student participated in Special Education: YES _____ NO _____

Student was on a 504 Plan: YES _____ NO _____

Student participated in Gifted and Talented: YES _____ NO _____

Student participated in LEP: YES _____ NO _____

Has your student ever been on an Individual Education Plan (IEP) for Special Education? If yes, please indicate your child's disability:

_____ Cognitive Impairment

_____ Emotional Disturbance

_____ Learning Disability

_____ Speech or Language Impairment

_____ Other Health Impairment

Please contact the school that last implemented your child's IEP and have them forward the Special Education Records to the Flandreau Indian School. This is extremely important. It will assist the staff in planning an appropriate program for your student.

I am legally responsible for this student and hereby understand that additional information may be requested by the Exceptional Education Department concerning my child's Individual Education Program or 504 Plan.

_____

Parent/Legal Guardian Signature

The Flandreau Indian School, in cooperation with the Bureau of Indian Education (BIE) funded schools, will ensure that a free and appropriate education and a full educational opportunity is provided in the least restrictive environment to all children with disabilities, grades 9 through 12.

Flandreau Indian School

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Gifted and Talented Education Program

Parental Consent for Testing/Evaluation

Dear Parents/Guardian,

This letter is to inform you that _____, your child could be referred/nominated to be assessed for the Flandreau Indian School Gifted and Talented Program. Your parental consent for testing and evaluation will be required. Although, a test or an evaluation will be administered, any other available supporting data will need to be submitted. These documents will be utilized to screen your child and to determine their eligibility for placement within the program. To qualify for the gifted and talented program for academic aptitude, the student has to score in the eighty-sixth percentile or higher nationally on the Northwest Evaluation Association assessment.

If your child qualifies for the Gifted and Talented Program, they will be provided weekly Gifted and Talented services, The Gifted and Talented Program is designed to challenge and strengthen the academic and creative needs of your son/daughter.

You have the option to have your child tested and evaluated. Please check the appropriate statement below and sign this form:

_____ Yes, I give my parental consent for my child to be tested, evaluated and documents collected to determine eligibility for the Gifted and Talented Program. I also give my parental consent to place your son/daughter in the Gifted and Talented Program at the Flandreau Indian School.

_____ No, I do not give my parental consent for my daughter to be tested and evaluated for the Gifted and Talented Program.

PARENT/GUARDIAN: _____ Date:_____

Flandreau Indian School

McKinney-Vento Act

Student Residency Questionnaire

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

Name of Student: _____ **Gender:** Male ____ Female ____

Please check only **ONE** that best describes where the student is presently living (Please specify name of hotel, shelter, or organization providing the transitional housing)

- O In my own home or apartment.
- O In the home of a friend or relative because I lost my housing. (fire, flood, lost job, divorce, domestic violence, kicked out by parents, parent in the military was deployed, parent/s in jail). Name, address of person with whom you live with (full name required) _____
- O In a shelter because I do not have permanent housing. (living in a family shelter, domestic violence shelter or children/youth center). Name, address and phone number of the shelter _____
- O In Transitional housing. (housing that is available for a specific length of time only and is partly or completely paid by a church, a nonprofit organization or some other organization). Name, address and phone number of housing program and organization providing housing _____
- O In a hotel or motel. (because of economic hardship, eviction, cannot get deposits for permanent housing). Name of hotel or motel, address and phone number of where you are staying _____
- O In unsheltered care. (living in a car, park or campground). Provide where you are living such as where your car is parked _____
- O In housing that does not have plumbing, electricity or heat. (circle which is missing).
- O Awaiting foster care placement.
- O None of the above describes my current living situation. Briefly describe your situation: _____

_____

Name of parent/guardian or person who student resides: _____

Address _____ **City** _____ **State** _____ **Zip**_____

Cell # _____ **Work #** _____ **Shelter #** _____ **Friend #** _____

_____ _____

Parent/guardian signature **Date**

OFFICE USE ONLY: _____Does Qualify under McKinney-Vento Act _____Does NOT Qualify

_____ _____

McKinney-Vento Liaison Signature Date

Flandreau Indian School

Consent for Group Counseling & Therapeutic Programs

Note: This form is not needed if this specific group counseling and/or therapeutic programs have already been consented to through an IEP or 504 plan or another consent form approved by FIS Administration.

Student Name_____Date of Birth____/____/_____

Parent/Guardian Name _____

Contact Phone No. _____-_____-_____

Groups and Therapeutic Programs: Group and Individual counseling, Virtual counseling services, Life skills programs, Healthy Relationships, Prevention Programs (Suicide Awareness, Drugs and Alcohol, etc)

The school counselor, psychologist, contract mental health providers, or social worker can provide group counseling and therapeutic programs to students with permission from the parent(s) or guardian(s). These counseling sessions and programs are designed to teach skills to help students be more successful in their academic and social environment. Many students may improve their school performance, attendance, and attitude towards school by taking part in group counseling sessions and therapeutic programs. Self-help issues developed in these counseling groups often include coping strategies, stress management, problem solving, and social skills.

Students will be strongly advised to keep the information shared by others during the groups and therapeutic programs confidential. Information disclosed by the students during group sessions is typically not revealed to anyone else by the group leader, except under certain circumstances (for example, evidence that a student is a threat to themselves, others or property). The leader will limit the sharing of information to FIS administrators or other FIS staff as necessary for student well-being and to support student success. In addition, information must be shared if legally required to do so. Otherwise, all material discussed will be confidential.

Please sign and return this consent form. This consent for group counseling and therapeutic programs is valid for one school year. Student participation in counseling is strictly voluntary and consent may be withdrawn by the student's parent(s)/guardian(s) at any time (or by an eligible student).

Parents are encouraged to contact the school counselor, psychologist, or social worker to keep informed about the student's progress.

□ I **do** give permission for _____ to receive Group counseling and Therapeutic services. (Name of Student)

□ I **do not** give permission for _____ to receive Group counseling services. (Name of Student)

Student (Signature) _____Date____/____/_____

Parent/Guardian (Signature)_____Date____/____/____

Flandreau Indian School Student and Family Language Survey

Student Name_____ Grade_____

Gender: Female_____ Male_____ Date of Birth _____

Parent/Guardian's Name _____

Parent/Guardian's Name _____

Select all of the races that apply to the student

_____ Native American _____Caucasian _____Hispanic _____Asian

_____ Native Hawaiian/Pacific Islander

Registered Tribal Member of _____ Other Tribe(s)_____

What was student's first language?_____

Is a language other than English used in the home? ____Yes ____No

If so, what language? _____

Does the student **speak** any languages other than English? _____ Yes _____No

If so, what language and at what level? Language _____

_____ Beginning, few words and phrases _____Intermediate, conversational

_____Advanced, comprehends commonly used terms _____ Fluent

If a second language is not spoken in the home, has the student been regularly exposed to a second language by a family member? If so, how would you describe the student's exposure to the language? Consistent, occasional, rare? Please describe.

_____

_____

What relation is this family member who exposes the student to a language other than English? (grandparent, great-grandparent, aunt, uncle, etc.)

_____

Did your child attend a language immersion school prior to this year? If so, where and for how long? What language?

_____

Can you provide any additional information about your child's second language skills?

_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Student Name: _____ Date of Birth: _____

1. I authorize the use or disclosure of the above-named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam Information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.

2. The information identified above may be used by or disclosed to the school nurse, Athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.

3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand the revocation will not apply to information that has already been released I response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire when student graduates.

6. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need Not sign this form to ensure healthcare treatment.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____

SIGNATURE OF STUDENT (IF OVER 18) DATE

This form must be completed annually and must be available for inspection at the school.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: December 31, 2026
See OMB Statement on Reverse.

Complete all sections, date, and sign

I. AUTHORIZATION

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Other *(Specify)*
☐ Personal Use ☐ Disability ☐ Research ☐ Health Information Exchange *(IHS/Other)*

V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, 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 my signature unless a different expiration date or expiration event is stated.

(Specify new date or expiration event (mm/dd/yyyy))

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose 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 USC 552a(i)(3)).

(continued on next page)

PATIENT IDENTIFICATION

	NAME *(Last, First, MI)*	
	ADDRESS	
	CITY/STATE	
	DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

Instructions for Completing IHS Form 810
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Section III, provide the name of the person, facility, and address that will receive the information.
    a. If the information is being disclosed to prevent multiple enrollments in a withdrawal management or maintenance treatment program, please provide the name of each central registry, withdrawal management, and maintenance treatment program to which disclosure may be made OR state "any withdrawal management or maintenance treatment program within 200 miles of [IHS Facility permitted to make the disclosure]".
4. Section IV, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE, as well as the name or general designation of the HIE participants who may access your records (e.g., a specific provider(s) or "my current and future treating providers").
5. Section V, check the appropriate box as applicable.
    a. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.
    b. **Only the period of events from** – specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.
    c. **Other (specify)** – e.g., Purchased Referred Care (PRC), Billing, Employee Health.
    d. **Entire Record** – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).
    e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES *MUST* BE CHECKED BY THE PATIENT.**
    f. **Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES (which are separate from progress notes and contain the therapist's impressions and the content of psychotherapy conversations), ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**
    IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.
6. Section VI, if a different expiration date or event is desired, please specify. When you opt-in to share information through the HIE, an expiration date must be entered; it is recommended that a date five (5) years into the future be entered to provide for continuity of care.
    a. If authorizing the release of records for court-ordered substance use disorder treatment, the expiration date/event must be no later than the final disposition of the criminal proceeding.
7. Section VI, Please sign (or mark) and date.
8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

FOR ALL MEDICAL ENTITIES and FLANDREAU INDIAN SCHOOL
DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICES

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON WITH PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD (Person is defined as one who in the absences of the parent or legal guardian provides a home for the child such as next to kin)

Name of Student: _____ Date of Birth:_____
Students' Social Security Number: _____ (send copy of SS Card)
Address:

_____

Phone Number for Parent/Guardian: _____
Name of Emergency Contact: _____ Phone Number: _____

ALL MEDICAL PROCEDURES
ALL LAB AND RADIOLOGY TESTS
ALL IMMUNIZATIONS AND VACCINES
ALL DENTAL CARE
SURGICIAL CARE AS NEEDED
EMERGENCY SERVICES
MENTAL AND PSYCHOLOGICAL CARE
TRANSPORTATION SERVICES AS APPROVED BY SCHOOL
PRESCRIPTIONS/ADMINISTER OF MEDICATIONS
(Please submit a list of current medications or complete a list on the next page)
USE OF INSURANCE FOR PAYMENT (Include copy of insurance card)

INSURANCE COMPANY: _____ POLICY #:_____
GROUP #_____
For Medicare Holders: Claim # _____ Effective Date: _____

Flandreau Indian School administration/staff will make every effort possible to contact you in case of an emergency.

All Flandreau Indian School staff are authorized to act in Loco Parentis for the students at the Flandreau Indian School. The FIS staff has authority to sign all paperwork required for emergency, medical or hospital care at any medical facility.

Definition - In Loco Parentis
In loco parentis is a term used in situations where another individual or agency is acting in place of a parent on behalf of a minor. The term is used in legal settings to assign the rights, duties and responsibilities of a parent to another person or agency. Alternatively, the term has been used in less formal references to describe the role played by an educational institution, such as a boarding school, college, or university in supervising minors and young adults.

I have read and give Consent for the Healthcare Provider and Flandreau Indian School staff to arrange for or to provide the above health services for this child while attending the Flandreau Indian School during school and/or on a school sponsored outing or activity.

PARENT/GUARDIAN SIGNATURE: _____
RELATIONSHIP TO STUDENT: _____
DATE _____ VALID Throughout School Enrollment.

MEDICATIONS PRESCRIBED AND/OR OVER THE COUNTER TAKEN BY STUDENT

Name of Student: _____

List any chronic meds/long term medications your child is currently taking:

Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____

List any over the counter medications your child is currently taking:

Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____
Medication: _____ Dose_____ # of pills_____
Taken for: _____

List **Food Allergies**(fruit, nuts, dyes, lactose, gluten): _____
Reaction: _____
Uses medication for reaction: _____
List **Medication Allergies**: _____ Reaction: _____
Uses medication for reaction: _____
List **Other Allergies**: _____ Reaction: _____
Uses medication for reaction: _____

Copy to: Nurse, Academic & Home Living (dorms)

SDHSAA HEALTH HISTORY FORM - To be completed (with parent/guardian if student is under 18) in years when a physical exam is given, prior to the exam.

Name: _____ **Date of Birth:** _____

Date of Exam: _____ **Sports:** _____

List all past and current medical conditions:	
Have you ever had surgery? If Yes, list all procedures:	
List all prescriptions, over-the-counter meds or supplements you currently take:	
Do you have any allergies? If Yes, Please list them here:	

Over the last two weeks, how often have you been bothered by the following problems? (Circle Response)

	Not At All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest in pleasure or doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes				

ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR" & EXPLAIN ANY YES ANSWERS ON THE BACK OF THIS SHEET:

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns you'd like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illnesses?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? (Example: electrocardiography or echocardiography)		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before 35 years of age (including drowning or unexplained car crash)		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS) short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CVPT)?		
13. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or a game?		

BONE AND JOINT QUESTIONS, CONTINUED:	Yes	No
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
21. Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to, or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet, or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
29. Have you ever had COVID-19?		
FEMALES ONLY	**Yes**	**No**
30. Have you ever had a menstrual period?		
31. How old were you when you had your first period?		
32. When was your most recent period?		
33. How many periods have you had in the past 12 months?		

CERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct:

Signature of Athlete: _____

Signature of parent/guardian (if under 18): _____

Date: _____

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FLANDREAU INDIAN SCHOOL
PHYSICAL EXAMINATION

NAME:_____Other names_____

Date of Birth:_____ Sex:_____ Age:_____ Height:_____ Weight: _____

Parent or Legal Guardian:_____

Normal	Abnormal	Not Evaluated	
			Eyes
			Ears
			Teeth
			Glands
			Heart
			Lungs
			Abdomen
			Genitals
			Posture

Physical findings which are of significance to **the School:**

Recommendations and Restrictions:

_____ Pulse _____Blood Pressure Eye Screening: L____ R ____

List allergies(food, medications, other):_____
Type of reaction:_____ Treat reaction with: _____
If student uses an EpiPen or Benadryl they **MUST** bring updated medication to school with them.

Immunizations: Record any immunizations given at this office visit – list type and date:

Attach a copy of immunization record(s) for review – MUST show documentation of 2 MMRs.

Date of last eye exam by an optometrist: _____ The Flandreau Tribal Clinic does not provide contact exams or contacts.
Uses glasses: _____ Contacts: _____

Significant Personal Medical History with dates: (Current medications/diagnosis, asthma, anemia, birth control, h/o fractures/plates or pins, surgeries, hospitalizations, concussions, prosthetic). You **MUST** bring current medications to school.

Social/Behavioral Health History: (Current medications/diagnosis, ADD/ADHD, anxiety, insomnia, dates of Behavioral hospitalizations or CD treatment). You **MUST** bring current medications to school.

SPORTS PARTICIPATION RECOMMENDED FOR:

____ Cleared for ALL (collision, contact/endurancesports, and other sports
____ Cleared only for contact/endurance sports and other sports
____ Cleared only for other sports

Definition: (Collison=Football and Wrestling);(Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance); (Other Sports=Golf)

____ Cleared for ALL , but with recommendations for further evaluation or treatment of: _____
____ Above clearance to be granted only after _____
____ **Clearance cannot be given at this time because** _____

Signature of Examining Physician_____ Date_____
Medical Facility_____
Address/City/State_____ Phone: _____