FLANDREAU INDIAN SCHOOL

1132 N. Crescent St., Flandreau, SD 57028
(605) 997-3773 Ext. 2121

RETURNING STUDENTS

Welcome Back!

We are excited that your student is planning to return to Flandreau Indian School for the 2026–2027 school year. To prepare for the upcoming school year, please complete and return all forms included in this packet as soon as possible. Updated information is required each year to help us:

- Ensure your student's health and safety
- Support a smooth and successful transition to campus
- Coordinate travel arrangements

Important Information:

- All required documents must be fully completed and submitted before enrollment can be finalized.
- Travel arrangements will be scheduled **only after** all paperwork has been received and approved.
- Once final approval is granted, our Travel Office will contact you with next steps and details regarding travel.

We appreciate your continued partnership and look forward to welcoming your student back to campus for another successful school year at FIS!

Contents with a (*) MUST BE SIGNED

- **COURT APPOINTED PARENT OR LEGAL GUARDIAN MUST PROVIDE LEGAL DOCUMENTATION.** Applications signed by the student as parent or legal guardian will not be accepted, even if the student is 18 years of age or older.
- **MUST** have an **emergency contact** & **Email address** listed for the application to be complete.

INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED – ALL FORMS MUST BE FILLED OUT COMPLETELY

FLANDREAU INDIAN SCHOOL
Residential Checklist

Dear Parent/Guardian(s),

The Flandreau Indian School asks that students attending the current school year bring only what they can take back with them at the end of the school year. We highly advise students not to accumulate additional belongings while in attendance, as FIS **will not** ship excess baggage or belongings home. Please ensure that all clothing is clearly labeled with the student's name and write down the serial numbers for any electronic devices and take a picture for your records. Please review the lists below. If you have any questions about an item not listed, feel free to contact the school for guidance.

Thank you for helping us maintain a safe, respectful and well-organized school environment. If you have any questions about this list or need clarification on a specific item, please do not hesitate to contact the school office.

*Items in **BOLD** are provided by FIS*
**Items must be checked in with staff immediately upon arrival*

BED & BATH

- **Pillows**
- **Bedding (sheets, blanket, pillowcases)**
- **Towels & Washcloths**
- **Shower Shoes**
- **Shower Caddy**
- **Plastic Clothes Hangers**

LAUNDRY SUPPLIES

- **Laundry Detergent**
- **Dryer Sheets**
- Fabric Softener
- **Laundry Bag/Basket**

PERSONAL SUPPLIES/TOILETRIES

- **Shampoo**
- **Conditioner**
- **Body Wash**
- **Toothpaste**
- **Toothbrush**
- Mouthwash – *non-alcohol*
- **Deodorant*** - *aerosol cans must be checked in with staff*
- **Pads/Tampons**
- Hair Products* - *aerosol cans must be checked in with staff*
- Perfume / Cologne*****
- Makeup / Skin Care
- Nail Polish*****

INDENTIFICATION / MONEY

- ATM Card
- Cash *(can be locked with Home Living staff)*
- Identification
  - State Issued Driver's License
  - State Issued ID
  - Photo Tribal ID Card

ELECTRONICS

~FIS is not responsible for theft or loss of electronic devices~

- Alarm Clock
- Camera
- Music Player
- Personal Cell Phone
- Gaming System(s) – *only permitted in TV room*

OTHER ITEMS

- Power Strip or Mult-outlet plug-in
- LED lights
- Snacks – *must be stored in a personal container*
- Hair clippers*****
- **School Backpacks**
- **School Supplies** – provided by FIS *(may bring own supplies)*
- Razors*****
- Nail Clippers/ Files*
- Curling irons/ hair straightener/ hair dryer*****

***Medication:** All over the counter (OTC) and prescription (Rx) medications must be unopened, labeled, and accompanied by a doctor's script. ALL medications must be submitted to staff immediately upon arrival.

Non-Allowable Items

- × **Alcohol Products**
- × **Christmas Lights or any non-LED string lights**
- × **Coffee Pots/ Microwaves/ Refrigerators**
- × **Energy Drinks / Performance-enhancing supplements**
- × **Heaters or Heating Pads**
- × **T.V.'s / Projectors**
- × **Zyn Nicotine Pouches, Chewing Tobacco, Cigarettes, Vaping Products, Zigzags**
- × **Boom Boxes / Large Speakers / Wireless Speakers**
- × **Candles or Fragrance Warmer**
- × **Extension Cords and Lamps**
- × **Permanent Markers**
- × **Piercing Kits**
- × **Punching Gloves/Boxing Gloves**
- × **Gang-related colors or items (e.g., excess clothing in one color, bandanas)**

FIS STUDENT TRAVEL INFORMATION

Flandreau Indian School provides transportation to students during the designated travel times listed below:

- August Travel (Home to School – One Way)
- Dec/Jan Travel (Christmas Break Home – Round Trip)
- May Travel (School to Home – One Way)

Each student is allowed to bring two (2) checked bags up to 50lbs each for the airline, bus, or SUV and 1 carry-on item. FIS will NOT cover overweight or excess baggage. Additional travel information will be sent closer to travel dates, please contact the travel coordinator with any questions.

Travel Coordinator Phone: 605-997-3773 ext. 2147 Travel Cell: 605-864-0571 call/text

Please Note: Beginning May 7, 2025, if you plan to use your state-issued ID or license to fly within the U.S., make sure it is REAL ID compliant. If you are not sure if your ID complies with REAL ID, check with your state department of motor vehicles.

**** Please send student with a valid ID (Tribal ID, State Issued ID, State Issued Driver's License, Passport) ****

STUDENT INFORMATION

Student Name: _____
Last *First* *Middle*

City: _____ State: _____

Date of Birth: _____ Gender: Male Female

Siblings/ Relatives:
**Please list any siblings or relatives that should travel together:* _____

TRAVEL INFORMATION

Depending on location, your student will be transported to FIS via airline flight, bus or school SUV. Travel itinerary will be sent to you after review of travel information.
Please indicate if you will need school provided transportation or will be arriving via personal transportation.

Transportation Method *(circle one)*: FIS Bus/SUV FIS Flight Personal Travel

Closest airport to your residence (City, State): _____
~Tickets will only be rebooked one (1) time for flights missed without prior notification to travel department. Rebooking flights will be subject to administrative decision~

Is your student a first-time flyer? YES NO

Will your student be under the age of 15 as of August 1 of this year? YES NO
Students under 15 that will be flying are required to fly as an Unaccompanied Minor (UM), see the following information on UM flyers:

- An airport escort to help your child to the gate for flight connections
- Escorting the child to the authorized adult picking them up when they land

We are required to submit the following information to the airline at the time of booking, if you know your child will be under 15 at the time of the flight, please fill out the information below:

Drop-off Person Name (as appears on ID): _____

Address (as appears on ID): _____

Phone Number: _____

ACKNOWLEDGEMENT OF OFFICAL TRAVEL

I (parent/ guardian) understand that FIS will only pay for official travel times listed above. ALL other travel at any other time is at the expense of the student's family. Students who are withdrawn from enrollment by the parents are responsible for travel expenses for returning home. FIS Will provide transport to and from the Sioux Falls, SD Airport.

_____ **Please initial here indicating that you have read and understand the above statement regarding paid travel and responsibilities of the student's family.**

PERMISSION FOR STUDENT CHECKOUT

Bureau of Indian Education (BIE), policy prohibits students from leaving campus with anyone other than the parent/guardian unless written consent is on file, and only under the following conditions:

- A student may be released to immediate family* only who are: 25 years or older, with written parental/guardian permission; and administrative approval.
- Students will not be released to ANYONE under the influence of drugs or alcohol.

**Immediate family is defined as mother, father, legal guardian, sister, brother, grandparent, aunt or uncle.*

Individuals wanting to checkout a student must physically appear on campus and will be asked to present a valid driver's license, state, or tribal ID for identification purposes. Students will only be released for checkout if a valid licensed driver is present, and the driver is following the FIS checkout policy. If checkout occurs during instructional time, it may be considered an unexcused absence, which might affect the grade/performance of the student. Individuals checking out students over the weekend must return students to the dorm by 9:00 PM on the evening before school resumes.

FIS will not be held responsible for:

- Any legal problems/expenses, health care expenses, or CHS (contract health service) expenses incurred by the student when checked out will be the responsibility of the parent/guardian.

STUDENT INFORMATION

Student Name: _____ **Grade:** _____
Last *First*

Guardian Name: _____ **Date:** _____
Last *First*

AUTHORIZED CHECKOUT PERSONS

Name & Age *(must be 25+ yrs. Old)*	**Relationship** **Immediate Family Member*	**Address**	**Phone Number**

FIS STAFF CHECKOUT PERMISSION:

☐ YES, I give permission for my student to be checked out by FIS Staff after school or on the weekend.
(Staff are not allowed to check out students overnight)

FIS CHAPLAIN CHECKOUT PERMISSION:

☐ YES, I give permission for my student to be checked out by FIS Chaplain after school or on the weekend.
(Chaplain is not allowed to check out students overnight)

UNAUTHORIZED CHECKOUT PERSONS

~Please include any proper documentation if an individual is not allowed to have contact with a student~

Name: _____
Relationship: _____
Reason for denied checkout (if applicable):
_____

Name: _____
Relationship: _____
Reason for denied checkout (if applicable):
_____

_____ **Nobody has permission to check out my student at this present time**

Permission will remain in effect until cancelled by the undersigned parent/ guardian in writing or based upon Administration decisions.

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

CONSENT FOR COUNSELING (INDIVIDUAL & GROUP) AND THERAPEUTIC PROGRAMS
On and Off Campus Services

Student Name: _____ Date of Birth_____/_____/_____

Parent/Guardian Name: _____

Contact Phone No. _____-_____-_____ Contact Email: _____

Group and Individual counseling, Virtual counseling services, Life skills programs, Healthy Relationships, Prevention Programs, Behavioral Health Services, Peer Support, Referrals to Indian Health Service-Behavioral Health.

The school counselor, psychologist, contract mental health providers, or social worker can provide Individual and group counseling sessions 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, emotion regulation, problem solving, and social skills.

Information disclosed by the students during individual and group sessions is typically not revealed to anyone else by the facilitator, except under certain circumstances (for example, evidence that a student is a threat to themselves, others or property). The group facilitator 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. Disclosure of abuse and/or neglect will be reported per mandatory reporting guidelines.

☐ **YES**, I do give permission for _____ to receive Group Counseling and Therapeutic Services. *(Name of Student)*

☐ **NO**, I do not give permission for _____ to receive Group Counseling Services. *(Name of Student)*

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

FIS NURSE INFORMATION LETTER

Dear Parents, Guardians, and Students,

Welcome to the 2026-2027 school year at Flandreau Indian School!
You can reach the nursing staff at extension 2168 at FIS. We look forward to caring for your students so that they can succeed this school year.
The nurse's office is in the home-living building on campus where we are equipped with supplies to care for your child's needs. If your child's needs exceed what we can provide, they will be sent to the closest medical facility in Flandreau. Hospital or emergency room services may be used in cases of emergency. Our goal is to communicate all concerns, treatments, illnesses, or medication changes that your child may need, and we will do our best to request your consent for such changes. In the case that we are unable to reach a child's guardian, and medical treatment is deemed necessary, we will act under the loco parentis act. Please read the following notices and sign below.

Medication and Health Services Notice:

- Students may bring prescription medications to campus; however, all medications must be immediately reported and turned into staff for inspection and evaluation by nursing staff. Once verified, medications will be administered by staff as prescribed.
    - IHS pharmacies do not transfer prescriptions or refills to the Flandreau Santee Sioux Tribal (FSST) Clinic pharmacy without a request. Students must have a current prescription on file before medication can be administered. Prescriptions must be sent directly to the FSST pharmacy by a healthcare provider, and families are responsible for ensuring prescriptions are submitted for any medications their student takes.
- Each medication requires **Attachment A (pg. 10)** completed and signed by both the guardian and prescriber (one form per medication). This includes all prescribed medications, over-the-counter medications (OTC), vitamins, supplements, and herbal remedies.
    - Students requiring emergency rescue medications (e.g., EpiPen, rescue inhaler, seizure rescue medication) must also have a **Student Medical Action Plan (pg. 11)** completed and signed by both the guardian and medical provider.
- Students may not bring any performance enhancers, pre-workouts, or other body-enhancement vitamins or supplements to campus. Any such items will be confiscated by staff and returned when the student goes home.
- When students depart campus, medications may be sent home sealed in a tamper-proof bag and in their original packaging (which may not be child-proof).
- FIS provides a **Sick Bay** near the Nurse Office during school hours (Monday–Friday). This shared space is available for students unable to attend class due to illness or injury. It includes 9 beds, clean bedding, meals as needed, and OTC medications as appropriate. Nurses and authorized staff monitor Sick Bay every 30 minutes.
- **No Electronics Policy:** Electronics are not allowed in Sick Bay to encourage rest and recovery. Families will be notified if their child is placed in Sick Bay.

I have read and understand the above notice: _____(signature)

For more information on recommended vaccines scan the QR code at the bottom of this page. Please make sure all medical forms for your student are well filled out so that we can best care for your child.

Thank you for your commitment to your child's education, health, and wellness. We look forward to supporting your child this year!

Kind Regards,

FIS Nursing Staff

Student Name: _____

STUDENT AND FAMILY MEDICAL HEALTH AND HISTORY

Please fill in the STUDENT and FAMILY history as able. Check the box for **YES** if the student or an *immediate family member has ever received the listed diagnosis below. Leave box unchecked for **NO** leave blank if not applicable.
Please leave a comment of explanation for all "YES" answers, if further explanation is needed, please provide proper documentation. If not applicable, please leave blank or write "N/A".
**Immediate family member is defined as biological mother, father, siblings, grandparent, aunt, uncle*

Please request a copy of a recent History & Physical and medication list from student's primary physician/doctor and include in the application packet if able.

Diagnosis	Student	Family History	Diagnosis	Student	Family History
Acne	☐	☐	Hearing Impairment	☐	☐
ADHD	☐	☐	Heart Murmur	☐	☐
Allergies	☐	☐	Heart Palpitations	☐	☐
Anemia	☐	☐	Heart Abnormalities or Problems	☐	☐
Anxiety or Panic Disorders	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Hypoglycemia	☐	☐
Autism	☐	☐	Immunosuppressant condition or medication	☐	☐
Autoimmune Disease	☐	☐	Kidney Problems	☐	☐
Behavioral Health Hospitalization	☐	☐	Liver/Gallbladder problems	☐	☐
Bipolar Disease	☐	☐	Mental Illness	☐	☐
Birth Defects	☐	☐	Migraines	☐	☐
Bleeding Disorders	☐	☐	Organ Transplant	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Pacemaker	☐	☐
Cancer	☐	☐	Pneumonia	☐	☐
Chemical Dependency or Substance Abuse	☐	☐	Pregnancy	☐	☐
Congestive Heart Failure	☐	☐	Schizophrenia	☐	☐
COPD	☐	☐	Self-Harm or harm to others	☐	☐
Cystic Fibrosis	☐	☐	Skin abnormalities	☐	☐
Depression	☐	☐	Smoking	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Dizzy or fainting spells	☐	☐	Suicidal Attempt/ Ideation *(if yes please explain)*	☐	☐
Eating Disorder	☐	☐	Surgery	☐	☐
Eczema	☐	☐	Thyroid Problems	☐	☐
Epilepsy or Seizure Disorder	☐	☐	Upper Gastrointestinal Disease (ulcer, hernia, reflux)	☐	☐
Fracture	☐	☐	Visual impairments	☐	☐

If yes to any of the above, please explain: _____

_____

_____

Has student ever been hospitalized for any reason? ☐ **YES** ☐ **NO** **If YES, please explain:**

_____

_____

_____

Does student have any other medical conditions not listed above? ☐ **YES** ☐ **NO** **If YES, please explain:**

_____

_____

_____

Student Allergies (REQUIRED- if none put "none"):

_____

_____

STUDENT AND FAMILY MEDICAL HEALTH AND HISTORY - *Continued*

Primary Care Provider Information *REQUIRED*

Primary Physician/Doctor: _____

Primary Clinic (city/state/phone): _____

Primary Pharmacy and location (city/state):

_____

Please list all current prescription and over the counter medications your child is taking:

Medication Name	Dose	Frequency	Purpose

OVER-THE-COUNTER MEDICATIONS

At Flandreau Indian School we offer the following **Over the Counter (OTC)** medications as needed. Please sign at the bottom if you consent to your child receiving the following as needed. These are distributed and documented by nursing and authorized staff.

- **Acetaminophen/Tylenol** – 1000 mg by mouth every 8 hours as needed for pain/fever
- **Benadryl/generic** – 25mg by mouth every 4-6 hours as needed for cough or congestion
- **Bisacodyl/Dulcolax** – 5mg by mouth daily as needed for constipation
- **Cetirizine/Zyrtec** – 10mg daily as needed for allergies, runny nose, cold symptoms, rash, or hives (if patient does not have as scheduled med)
- **Cough drops** – 1 drop every 2 hours as needed for cough or sore throat
- **Ibuprofen/Motrin** – 400mg by mouth every 8 hours as needed for pain/fever
- **Midol** – two tabs by mouth every 8 hours as needed for menstrual cramps (biological females only)
- **Mylanta One** – 1 tablet as needed for heartburn, sour stomach, bloating and gas.
- **Pepto-Bismol/generic brand** – 524 mg by mouth per hour as needed for upset stomach/diarrhea, up to 4200mg in 24-hour period
- **Refresh Plus/Generic Brand** – 1-2 drops in affected eye as needed up to 4x daily for dry eyes.
- **Robitussin OM/generic brand** – 1 tablet every 4 hours as needed for cough or congestion

☐ **YES**, I do give consent for my student to receive **Over the Counter (OTC)** medications as needed.

☐ **NO**, I do not give consent for my student to receive **Over the Counter (OTC)** medications as needed.

Parent/Guardian Consent

The above medical health and history is completed to the best of my knowledge. I understand that if there are health and safety concerns that exceed what Flandreau Indian School can provide, my child may be sent home for health and safety reasons.

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

MEDICAL CONSENTS & INSURANCE INFORMATION

IN LOCO PARENTIS PERMISSION

I, _____, give consent, for reasonable cause and assurance for the health and safety of all students, all Flandreau Indian School staff may act *In Loco Parentis,* in the best interest of my student, _____, in authorizing medical care or mental health care for him/her. Care to be rendered to the above-named minor under supervision and upon the advice of a qualified health care provider, emergency and acute health care for accidents or illnesses, mental or psychological/ behavioral care, dental and optical care. The FIS Staff have the authority to sign all paperwork required for emergencies, 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.

_____

Address *City* *State* *Zip*

_____

Home Phone Number *Cell Phone Number* *Work Phone Number*

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

**This permission shall remain in effect throughout the student's enrollment at FIS.*

HEALTH INSURANCE INFORMATION

Medical / Pharmacy Private Insurance: YES NO Medicaid: YES NO IHS: YES NO

Name of Insurance Company: _____

Insurance Company Address: _____

Name of Policy Holder: _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Group Number: _____ ID Number: _____

Dental Private Insurance: YES NO Medicaid: YES NO IHS: YES NO

Name of Insurance Company: _____

Insurance Company Address: _____

Name of Policy Holder: _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Group Number: _____ ID Number: _____

Vision Private Insurance: YES NO Medicaid: YES NO IHS: YES NO

Name of Insurance Company: _____

Insurance Company Address: _____

Name of Policy Holder: _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Group Number: _____ ID Number: _____

ATTACHMENT A

BUREAU OF INDIAN EDUCATION

AUTHORIZATION TO ADMINISTER PRESCRIBED/OVER-THE-COUNTER MEDICATION

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize designated and properly instructed school personnel to administer prescribed medication as directed by the prescribing physician or other duly licensed provider (PART II below). I certify that I have legal authority to consent to the administration of prescribed medication following the provider's order. I understand additional prescriber/parent authorizations will be necessary for each medication to be administered, and if the dosage of the medication is changed. If necessary, I authorize **the designated school health care official to communicate with the prescriber or the student's health care provider as allowed by HIPAA.**

STUDENT INFORMATION

Student Name _____ **Date of Birth** _____ **Gender M** ___ **F** ___
Last First MI

School _____ **Grade**_____ **School Year**_____ **Height (inches)** _____ **Weight (lbs)** _____

List all medication(s) student is taking, including over-the-counter medication(s):

_____

_____

List any known drug allergies/reactions: _____

Parent/Guardian Signature _____ **Date** _____

Contact Number(s): _____ **(Day)** _____ **(Evening)**

PART II—TO BE COMPLETED BY THE PRESCRIBER

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ **Diagnosis:** _____

Dosage: _____ **Time(s)/Frequency to be given:** _____

Route of Administration: _____ **PRN (as needed)** ___**Yes** ___**No** **If PRN, (signs/symptoms):** _____

_____

Side Effects: _____

Begin Medication: _____ **Stop Medication:** _____
Date Date

Special Instructions:
Refrigeration required? ____Yes ___No
Is medicine a controlled substance? ____Yes ___No
Is this an emergency self carry/self administration medication? ___Yes ___No
Has student been instructed in the proper self administration of medicine? ___Yes ___No

Prescriber's authorization for self carry/self-administration of emergency medication: _____
Signature Date

Prescriber's Name/Title: _____ **Phone**_____
(Type or Print)

Address:_____ **Fax**_____

Prescriber's signature: _____ **Date**_____

PART III—TO BE COMPLETED BY School Nurse/Other Duly Licensed Health Care Provider

- ☐ Parts I and II above are completed, including signatures.
- ☐ Prescription medication is properly labeled by a pharmacist and within the expiration date.
- ☐ Medication label and prescriber order are consistent.
- ☐ Over-the-counter medication is in an original container with manufacturer's dosage label intact.

Principal/Authorized School Personnel Signature _____ **Date**_____

Release #16-4, Issued: 11/04/15
New

STUDENT MEDICAL ACTION PLAN

This section applies only if your student has any emergency or as-needed medications (such as an EpiPen, rescue inhaler, anti-epileptic medication, etc.). This form must be completed and signed by a licensed medical doctor.

***If your student does not require these, please skip to the next section.**

Student Name: _____ DOB: _____/_____/_____

Allergies (list all that apply): _____

_____

Guardian Name: _____ Relationship: _____

Cell: _____ Home: _____ Work: _____ Other: _____

Emergency Contact: _____ Relationship: _____

Cell: _____ Home: _____ Work: _____ Other: _____

MEDICATIONS

Medication: _____

Dose: _____ Frequency: _____

Medication: _____

Dose: _____ Frequency: _____

HEALTH DIAGNOSES

1. _____
2. _____

ACTIONS TO BE TAKEN

1. _____
2. _____
3. _____
4. _____

SIGNATURES

This action plan will remain in effect for the currently enrolled school year or until terminated by medical physician or with written notification from the parent/guardian on file.

Parent/Guardian: _____ Date: _____

Physician: _____ Date: _____

FIS Nurse: _____ Date: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

- I authorize the use or disclosure of the above-named individual's health information including History and Physical Exam Information, student and family medical history, medication history and current usage pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored events and FIS sponsored events. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
- The information identified above may be used by or disclosed to the FIS school nurse, Athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
- 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.
- 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.
- This authorization will expire when a student graduates or withdraws.
- 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.
- 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.

Parent/Guardian

(Signature)_____ **Date**_____/_____/_____

Student (*if over 18*)

(Signature)_____ **Date**_____/_____/_____

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

TRIBAL HEALTH CENTER
605-997-2642
FSST-NSN.GOV
P.O. BOX 329, 403 W. BROAD AVE | FLANDREAU, SD 57028

New Patient Registration Packet Checklist

Welcome to our clinic! Below you will find a checklist to help you complete the registration packet and ensure that you will have everything you need to bring to your first appointment. The registration packet will only be considered complete when all verifications are provided.

Verifications Needed

- ☐ Identification Card (ID)
- ☐ Insurance Cards
- ☐ Proof of Tribal Enrollment (If Applicable)
- ☐ Birth Certificate(s) to enrolled member if lineal descent

Forms to Complete

- ☐ Patient Registration
- ☐ Patient Insurance & Assignment of Benefits
- ☐ Health Center Policies, PRC Basics & Communication
- ☐ Patient Consent & Limits of Confidentiality
- ☐ Health History
- ☐ Authorized Communication Form
- ☐ Release of Information Form
- ☐ Consent for the Treatment of a Minor
- ☐ Patient Bill of Rights
- ☐ Patient Responsibilities
- ☐ Behavioral Health - Informed Consent for Therapy
- ☐ Behavioral Health - Client Rights and Responsibilities - SUD

TRIBAL HEALTH CENTER

Patient Registration Form
Please fill packet out completely if something does not apply to you write N/A for not applicable

Shaded Boxes for Office Staff Use Only
(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	Suffix: (Circle) JR / SR / I / II / III
Date of Birth:	Birth Sex: ☐ Female ☐ Male ☐ Unknown	Social Security Number:	***Health Record Number:***
Place of Birth [City]:	Place of Birth [State]:	Primary Language:	Preferred Language:

PATIENT CONTACT INFORMATION

Current Street Address:	City:	State:	
Zip Code:	Residence Phone:	Cell Phone:	Work Phone:
Other Phone:	Date Moved:	Current Community:	
Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-employed ☐ Retired ☐Active Military ☐Unknown		Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Never Married ☐ Separated ☐ Unknown	
Employer:	Spouse Employer:	Religious Preference:	

TRIBAL INFORMATION

Tribe of Membership:	Indian Blood Quantum:	Tribal Quantum:
Tribal Enrollment Number:	***Eligibility Status:***	***Classification/Beneficiary:***

OTHER INFORMATION

Ethnicity:	Race:	***Notice of Privacy Practices:***	***Received by Patient:***
Migrant Worker: ☐ Yes ☐ No ☐ Migrant Agricultural Worker ☐ Seasonal Agricultural Worker		Homeless: ☐ Yes ☐ No ☐ Homeless Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other ☐Unknown	

VETERAN/MILITARY INFORMATION

Veteran: ☐ Yes ☐ No	Service Branch:	Service Entry Date:	Service Separation Date:
Vietnam Service Indicated: ☐ Yes ☐ No ☐ Unknown	Service Connected: ☐ Yes ☐ No	Valid VA Card: ☐ Yes ☐ No	***Date VA Card Copy Obtained***
Description of VA Disability:			

EMAIL/INTERNET/COMMUNICATION		
Email Address:	Permission to Send Generic Information: ☐ Yes ☐ No	Preferred Method of Communication ☐Phone ☐Email ☐Letter ☐Do not Notify
Can you Access the Internet? ☐ Yes ☐ No ☐ Unknown	Internet Access From: ☐ Home ☐ Work ☐ School ☐ Health Care Facility ☐ Library ☐ Tribe/Community Center ☐ Mobile Device	

EMERGENCY CONTACT			
Emergency Contact Name:		Relationship:	
Street Address:	City:	State:	Zip Code:
Phone Number:		Work/Other Phone Number:	

NEXT OF KIN INFORMATION			
Next of Kin Name:		Relationship:	
Street Address:	City:	State:	Zip Code:
Phone Number:		Work/Other Phone Number:	

FAMILY INFORMATION		
Father's Name:	Father's Birth Date:	Father's Employer:
Father's Phone:	Father's Other Phone:	Father's Email:
Mother's Name:	Mother's Birth Date:	Mother's Employer:
Mother's Phone:	Mother's Other Phone:	Mother's Email:
Spouse's Employer:	Number in Household:	Total Household Income: Weekly Bi-weekly Monthly Annual

PREFERRED/OTHER NAMES

First Name Only:

***** OPTIONAL: SEXUAL ORIENTATION /GENDER IDENTIFICATION (SO/GI)*****

Pronouns:

Legal Sex: ☐ Female ☐ Male ☐ Unknown	Legal Document: ☐ Court Order ☐ State ID ☐State Birth Certificate ☐ Physician State Specific Declaration ☐ State Driver's License	Effective Date:
Gender Identity: ☐ Declined to Answer ☐Identifies as Female ☐ Identifies as Male ☐ Nonconforming Gender ☐ Other ☐ Transgender Female ☐ Transgender Male ☐ Do Not Know		Sexual Orientation: ☐ Bisexual ☐ Something Else ☐Declined to Answer ☐Lesbian/Gay/Homosexual ☐Straight/Heterosexual ☐ Do Not Know

TRIBAL HEALTH CENTER

Patient Insurance & Coverages

Third Party Coverage is not only a federal requirement, but it is critical for the FSST Health Center to be able to offer a variety of services with high quality and compassionate care.

PATIENT INFORMATION

Patient's Last Name	First Name:	Middle:	Date of Birth

INSURANCE INFORMATION

Do you currently have any insurance coverage? ☐ Yes ☐ No

If No, do you need assistance in applying for coverage? ☐ Yes ☐ No

Would you like to setup an appointment with our Patient's Benefits Coordinator? ☐ Yes ☐ No

I understand the Flandreau Santee Sioux Tribal Health Center is funded by Indian Health Service (IHS) where IHS is the payor of last resort. Thereby the use of alternate resources is required when such resources are available and accessible to the individual in accordance with The Indian Health Care Improvement Act Amendments (P.L. 100-713) and CRF 42-136
https://www.ihs.gov/prc/eligibility/requirements-alternate-resources/

**** Please give ALL your insurance card(s) to staff or provide a copy of the front and back of the card(s) if mailing****

MEDICAL INSURANCE

Insurance Company: _____

Policy Holder Name: _____Birth Date: _____

Policy Holder Employer: _____

Policy/Member ID #: _____

Group #: _____

DENTAL INSURANCE

Insurance Company: _____

Policy Holder Name: _____Birth Date: _____

Policy Holder Employer: _____

Policy/Member ID #: _____

Group #: _____

VISION INSURANCE

Insurance Company: _____

Policy Holder Name: _____Birth Date: _____

Policy Holder Employer: _____

Policy/Member ID #: _____

Group #: _____

MEDICAID

State regulations require you to present a current identification card every time you are admitted or receive services. Every patient without insurance is required to submit an application for Medicaid if referred by a Physician, Benefits Coordinator, Purchased Referred Care Service or other Provider. Lack of compliance with the Medicaid application process may result in denial from Purchased Referred Care Service until an application is completed.

Medicaid Household Income Guidelines - South Dakota expanded as of July 1, 2025

Household Size	Maximum Gross Monthly Income	Household Size	Maximum Gross Monthly Income
1	$ 1,835	5	$ 4,448
2	$ 2,488	6	$ 5,102
3	$ 3,142	7	$ 5,755
4	$ 3,795	8	$ 6,407

If you think you may be eligible or would help applying for Medicaid, please make an appointment with our Patient Benefits Coordinator.

Flandreau Santee Sioux Tribal Health Center

This form serves as a record of consent for the Flandreau Indian School (FIS) student listed below to receive the following vaccinations from the Flandreau Santee Sioux Tribal Health Center (FSST HC) during the 2026-2027 school year, based on the latest national guidelines and eligibility.

- I acknowledge that Flandreau Santee Sioux Tribal Health Center (FSST HC) provided me and I have been afforded the opportunity to read the CDC Vaccine Information Statement for the vaccine(s) linked with the QR code found here → or found at https://www.cdc.gov/vaccines/hcp/current-vis/index.html.
- I understand that the student will be screened for eligibility prior to receiving any vaccine dose based on the recommended vaccine schedule by the National Advisory Committee for Immunization Practices (ACIP).
- I understand that vaccinations may take place on FIS grounds during vaccine clinics administered by FSST HC staff or at FSST HC during a scheduled appointment time.
- I understand that after giving consent, if I change my mind and do not want to have my student complete the vaccination or vaccination series, that I may call FIS nursing staff or FSST HC Public Health.
- I understand I am able to contact FIS nursing staff @ 1-605-997-3773 or FSST HC Public Health @ 1-605-997-2642 with any questions or concerns regarding the vaccines listed below or the vaccination process.

Vaccine	Consent (Circle Yes or No)
Seasonal Influenza (Flu)	☐ Yes ☐ No
Meningococcal (MenACWY)	Yes No
Meningococcal B Series	☐ Yes ☐ No
HPV Series (Human Papillomavirus)	☐ Yes ☐ No

- I consent to the vaccine(s) selected above as indicated by circling "Yes" option to be given to the student listed .

Student's Full Name (Print) _____ Student's Birthdate _____

Printed Name of Legal Guardian _____

Signature of Legal Guardian _____ Date &Time _____

HIPAA - Notice of Privacy Practices

The below acknowledgement provides information regarding how medical information about you may be used and disclosed, and what your patient rights are.

PATIENT INFORMATION			
Patient's Last Name:	First Name:	Middle:	Date of Birth:

HIPAA - Notice of Privacy Practices Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health Information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Office at the Flandreau Santee Sioux Tribal Health Center.

Flandreau Santee Sioux Health Center is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Flandreau Santee Sioux Tribal Health Center, OCHIN supplies information technology and related services to Flandreau Santee Sioux Tribal Health Center and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Flandreau Santee Sioux Tribal Health Center with other OCHIN participants or health information exchange only when necessary for medical treatment or for the health care purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent; however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided with a list of entities to which your information has been disclosed.

By signing this form, you acknowledge that you have received a copy or have been offered a copy of our Notice of Privacy Practices dated 07/01/2025.

_____	_____	_____
Name of Patient (or Guardian) *(print)*	Signature	Date

TRIBAL HEALTH CENTER

Consent for Treatment of Minor - FIS

The treatment of a minor requires coordination between the healthcare provider and child's parent or guardian. The provider's role is to ensure that the parent or guardian is aware of and agrees with the care plan.

PATIENT INFORMATION			
Patient's Last Name:	First Name:	Middle:	Date of Birth:

AUTHORIZATION & CONSENT FOR THE TREATMENT OF A MINOR

The parent or legal guardian authorizes consent for Flandreau Santee Sioux Tribal Health Center to arrange for or provide the following services:

1. **Healthcare** including medical examinations, routine laboratory studies, x-ray procedures and skin tests
2. **Dental** care including dental examinations, preventative use of fluorides, and necessary emergency care
3. **Mental Health** services including evaluation and treatment as necessary
4. **Transportation** of the child to and from another Health Facility for these services

Exceptions or special instructions:

_____

_____

_____

PROXY AUTHORIZATION FOR OTHERS TO CONSENT OR BE INVOLED IN CARE

As the parent/legal guardian of the above minor patient authorize Flandreau Indian School (FIS) staff as a proxy who will be able to bring my child to his/her visit(s) and to give consent in person for the health care of my minor child. This person may also sign any necessary consents or acknowledgments on my behalf, including responsibility for payment. I further state that there are no Court Orders now in effect in any jurisdiction that would prohibit me from exercising the power I now seek to authorize. I understand that protected health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making. In the event FSST HC or FIS is unable to reach me for non-routine care as described below that FIS staff can invoke "In Loco Parentis" for the immediate healthcare needs as recommended by a medical provider.

ACKNOWLEDGMENT & AGREEMENT

I hereby give consent for all of the above services. This authorization shall remain effective for one year from the date signed, unless revoked sooner in writing by parent or legal guardian and delivered to Flandreau Santee Sioux Tribal Health Center. This authorization is given pursuant the provisions of South Dakota Codified Law 20-9-4.2.

To revoke this authorization, please send written notice to Flandreau Santee Sioux Tribal Health Center 403 West Board, PO Box 329 Flandreau, SD 57028.

Valid: Throughout School Enrollment Year 2026-2027

_____	_____	_____	
Name of Parent/Legal Representative *(print)*	Signature	Date	MRN #

Last Update: 2/27/2026

DEFINITIONS

1. HEALTH CARE:

Health care is the provision of health services of preventive, diagnostic, therapeutic and/or rehabilitative nature that do not involve major surgical procedures.

The purpose of medical examination is to appraise the child's health and physical condition. The medical examination consists of two parts: in the first part, questions are asked relative to the health, present and past, of the child and his/her parents; in the second part, a thorough examination is made of the child's body, including weight, height, blood pressure, vision, and hearing.

Laboratory studies include tests of urine and blood.

X-rays are taken when necessary to see if there is any abnormality within the body.

A skin test consists of the injection into the skin of about a drop of a substance such as "tuberculin" or "coccidioidin." By means of these tests and x-rays of the chest, the physician determines whether the patient has or has had tuberculosis or valley fever.

2. DENTAL CARE:

Dental care begins with the dental examination, which consists of (a) examining tooth, gums, tongue and other parts of mouth with dental mirror and explorer (probe) and (b) taking dental x-rays as needed.

Routine dental care includes those services necessary to prevent the loss of teeth, such as cleaning the teeth, applying fluoride to the teeth, filling decayed teeth, and pulling teeth in order to prevent infection or clear up existing infection.

Necessary emergency dental care consists of those services that cannot be deferred without endangering the child's health or life, such as the relief pain, the cleaning up of infection, and the control of bleeding.

3. MENTAL HEALTH SERVICES:

Mental health services include psychological and psycho-educational testing, psychiatric evaluation and consultation or assessment by mental health professionals. The information obtained is used to determine if it is appropriate or necessary to develop a treatment program for the child.

4. EMERGENCY HEALTH CARE:

Emergency health care includes surgical and/or non-surgical procedures that cannot be deferred without endangering the child's health or life, surgical procedures that can be deferred are not authorized by the consent in this form. In such cases, the specific authorization for surgery from the parent or legal guardian is required.

TRIBAL HEALTH CENTER

Authorized Communication

Please list any family members or others who may be involved in coordinating care or payment for care. Please indicate what type of information may be shared

PATIENT INFORMATION			
Patient's Last Name:	First Name:	Middle:	Date of Birth:

FAMILY MEMBERS OR OTHERS INVOLVED IN CARE

This authorization allows our staff to speak only with the individual(s) you designate you are not able to be reached or you have an adult help coordinate your medical care. As part of out our commitment to Patient Privacy, we will not discuss your health information with any other person unless you specifically authorize below.

☐ I do **NOT** authorize anyone to receive information regarding my medical care

☐ I authorize my provider and employees of FSST HC to speak with:

Individual: **Relationship:** **Phone:**

☐Appointments ☐Insurance/Bill ☐Lab Results ☐Test results ☐Medical Care ☐Treatment ☐All

Individual: **Relationship:** **Phone:**

☐Appointments ☐Insurance/Bill ☐Lab Results ☐Test results ☐Medical Care ☐Treatment ☐All

Individual: **Relationship:** **Phone:**

☐Appointments ☐Insurance/Bill ☐Lab Results ☐Test results ☐Medical Care ☐Treatment ☐All

SPECIFIC INSTRUCTIONS OR LIMITATIONS:

EXPIRATION OF AUTHORIZATION

This authorization is valid for 1 year from the date of signature, unless otherwise noted below.

Expiration Date: **May 5th, 2027**

VALIDATION CODE

If you would like to require a validation code to any individual authorized above as part of coordinating care or payment for you, please provide below. The individual will be asked for this code before information can be released. In absence of a custom code, date of birth will be used.

Validation Code: _____

REVIEW & CONSENT

We will continue to use the information on this form when communicating with family members or others involved in your care unless you make changes. Promptly notify our office staff if you wish to alter any of the above designations. To revoke this authorization, please send written notice to 403 West Broad Ave, Flandreau SD 57028.

_____ _____ _____

Signature of Patient (Parent or Guardian) Relationship to Patient Date

TRIBAL HEALTH CENTER

Behavioral Health Authorized Communication

Please list any family members or others who may be involved in coordinating care or payment for care. Please indicate what type of information may be shared

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	Date of Birth:

FAMILY MEMBERS OR OTHERS INVOLVED IN CARE

This authorization allows our staff to speak only with the individual(s) you designate you are not able to be reached or you have an adult help coordinate your medical care. As part of out our commitment to Patient Privacy, we will not discuss your health information with any other person unless you specifically authorize below. This is for Behavioral Health Information only.

☐ I do **NOT** authorize anyone to receive information regarding my medical care

☐ I authorize my provider and employees of FSST HC to speak with:

Individual:	**Relationship:**	**Phone:**	
☐Scheduling/Appointments ☐Insurance/Billing ☐Referrals ☐Mental Health ☐Substance Use/Treatment			☐All BH
Individual:	**Relationship:**	**Phone:**	
☐Scheduling/Appointments ☐Insurance/Billing ☐Referrals ☐Mental Health ☐Substance Use/Treatment			☐All BH

SPECIFIC INSTRUCTIONS OR LIMITATIONS:

EXPIRATION OF AUTHORIZATION

This authorization is valid for 1 year from the date of signature, unless otherwise noted below.

Expiration Date: _____

VALIDATION CODE

If you would like to require a validation code to any individual authorized above as part of coordinating care or payment for you, please provide below. The individual will be asked for this code before information can be released. In absence of a custom code, date of birth will be used.

Validation Code: _____

REVIEW & CONSENT

We will continue to use the information on this form when communicating with family members or others involved in your care unless you make changes. Promptly notify our office staff if you wish to alter any of the above designations. To revoke this authorization, please send written notice to 403 West Broad Ave, Flandreau SD 57028.

_____ _____ _____

Signature of Patient (Parent or Guardian) Relationship to Patient Date

Behavioral Health

CLIENT RIGHTS AND RESPONSIBILITIES - SUD

As a client of the Flandreau Santee Sioux Tribal Health Center Behavioral Health department, your rights include, but not limited to the following:

- The right to confidentiality and privacy of all medical/counseling records and information given in treatment.
- The right to confidentiality to all record, correspondence and information relating to assessment, diagnosis and treatment in accordance with 42U.S.C. 290 dd-3 and ee-33 and 42 Code of Federal Regulations, part 2 and Indian Health Service Notice of Privacy Practices, HIPAA-Health Insurance Portability and Accountability Act. Exceptions to this include:
    - a.) The client consent in writing; or
    - b.) The disclosure is mandated by court order; or
    - c.) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
    - d.) The client commits or threatens to commit a crime either at the program or against any person who works for the program; or
    - e.) Program personnel have reason to believe that the client is a threat or harm to self or other people
    - f.) We may disclose limited protected health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness or missing person;
    - g.) If you are believed to be victim of a crime, a law enforcement official requests information about you and we are unable to obtain your agreement because of in capacity or other emergency circumstances, we may disclose the requested information
      if we determine that such disclosure would be in your best interests;
    - h.) We may use or disclose protected health information as we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person;
    - i.) We may use or disclose protected health information in the course of judiciary and administrative proceedings if required or authorized by law;
    - j.) We may use or disclose protected health information to report a crime committed on IHS health facility premises or when HIS is providing emergency health care; and
    - k.) We may make any other disclosures that are required by law.

- The right to be treated with respect and dignity.
- The right to be free of any exploitation or abuse; including, for example, any financial or sexual relationship with any agency personnel or any member of the governing board.
- The right to receive treatment which is sensitive to you as an individual in a non-discriminatory manner.
- The right to actively participate in your treatment plans as well as any modification of that plan to ensure your understanding and agreement with this plan.
- The right to know the reasons why a particular treatment is considered appropriate.
- The right to refuse any proposed treatment or medication unless in an emergency.
- The right to receive an explanation of diagnosis of prescribed medications and any side effects.
- The right to locate alternative sources of assistance.
- The right to be informed of the volunteer or student status of a therapist, or therapist process in gaining licensure.
- The right to review your case records unless conditions arise as specified by South Dakota Codified Law.
- The right to assert grievances if your rights are violated.
- The right to have access to advocacy services at any time.
- The right to explanation if you are terminated for services or suspended from services for specified period of time.

To maximize beneficial client outcome, clients should be aware of their responsibilities. The client is responsible for:

- Following recommended and agreed upon treatment plan. Punctuality of appointments and notification to FSST HC Behavioral Health if unable to attend a session prior to appointment.
- Consideration of the rights of the staff and other clients
- Being respectful of the property of others
- Maintain cleanliness and order
- Providing accurate medical and personal information.
- No use of obscene language or disruptive behaviors.
- Parents will take responsibility for their child's appointments and transportation needs.
- Advising the FSST HC Behavioral Health department on changes in residence or work hours that may interfere with appointments.
- Adults take full responsibility for their transportation to treatment.
- Upon receipt of court order for a substance evaluation, immediately set appointment due to the lengthy process of the completion of this document. Evaluations are completed in 2-3 weeks. The

FSST HC Behavioral Health will note write letters notifying the court that you have an appointment scheduled because you failed to get your evaluation done in a timely manner.

- If you are referred to inpatient treatment and discontinue or are discharged, you are responsible for your actions and the consequences. The FSST HC Behavioral Health will not write letters to the Court on your behalf.
- If you do not attend an inpatient treatment program because you choose not to, the FSST HC Behavioral Health will not prioritize you ahead of other clients we are assisting.
- If you are eligible and services are paid for by the FSST for Keystone Treatment, you will be responsible for the financial agreement if you do not complete Aftercare with the FSST HC Behavioral Health.

_____ _____ _____

Clients' Name & Signature **DOB** **Date**

_____ _____

Counselor Signature **Date**

Updated: 01/21/2026

Behavioral Health
INFORMED CONSENT FOR THERAPY

INTRODUCTION

The Flandreau Santee Sioux Tribal Health Center (FSST HC) would like to welcome you to our mental health and substance abuse services. For you to make an informed decision about the type of care and services you desire, it's important to be familiar with the specific therapeutic and case management services that we offer. PLEASE read this information carefully and ask any questions that you may have about the services or about how you will be provided with the care/treatment that you want or need.

COUNSELING RISKS AND BENEFITS

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

PATIENT RIGHTS

During your involvement with our facility, you have the following right(s) to:

- Be informed about the treatment planned, including benefits expected, risks involved, and participation in the development of your treatment plan.
- Refuse treatment.
- Reserve confidentiality.
- Be treated with full recognition of your personal dignity, individuality, and need for privacy.
- Receive services in adequate facilities.
- Know the qualifications of the counselor providing you service
- Receive a written explanation, stating your right for appeal (if any), if you are found ineligible for services.

CONFIDENTIALITY

- The Health Information Portability Act (HIPPA) requires that your information and records are kept protected and confidential unless you sign a Release of Information (ROI) asking for your records, information, or updates to an outside agency. This request may be revoked at any time.
- All interactions with the Flandreau Santee Sioux Tribal Health Behavioral Health Clinic, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. The behavioral health team works as an interdisciplinary team that may include Case Management, Social Services, and Medical Providers employed by the FSST. If you have questions or concerns your therapist can provide answers for each individual case. The information shared with the team is based on a 'Need To Know' basis.

EXCEPTIONS TO CONFIDENTIALITY

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities and/or a Qualified Mental Health Professional responsible for ensuring safety. Therapists have a legal duty to warn any individual who may be in imminent danger.
- The law requires that any Flandreau Santee Sioux Behavioral Health staff who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age to report this information to child protection services.
- The law requires that any Flandreau Santee Sioux Behavioral Health staff who have knowledge or reasonable suspicion of abuse, neglect or exploitation of elders and adults with disabilities to adult protective services.
- Insurance companies may review information solely for the purpose of payment for services. Please refer to your insurance carrier for detailed information.

GRIEVEANCE PROCESS

The Flandreau Santee Sioux Tribal Health Center (FSST HC) strives to provide quality services which are monitored on-going through weekly staff meetings, case management reviews, and quarterly reports. If you have a complaint about our service or providers, you can address it by visiting the FSST HC Behavioral Health Director who may ask you to submit it in writing. The FSST HC will consult with the Flandreau Sioux Tribe Health Administrator for investigation and resolution.

STATEMENT OF AGREEMENT

In signing below, I acknowledge that I fully understand what I have read and have discussed this document with my counselor or psychiatrist. I have had an opportunity to ask questions, and I consent to (or on behalf of my minor child or guardian) participate in counseling with the Flandreau Santee Sioux Tribal Health Center.

_____	_____	_____
Client/Minor's Printed name	Client/Minor's Signature	Date
_____	_____	_____
Parent/Guardian's Printed Name (If client is a minor child)	Parent/Guardian's Signature (If client is a minor child)	Date
_____	_____	_____
Counselor/Psychiatrist's Printed Name	Counselor/Psychiatrist's Signature	Date

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 Flandreau Santee Sioux Tribal Health Center
ADDRESS	ADDRESS 403 W Broad Ave
CITY/STATE	CITY/STATE Flandreau,SD Phone# (605) 997-2642 Fax# (605) 997-9940

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 (mm/dd/yyyy) or expiration event)

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

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 Flandreau Santee Sioux Tribal Health Center	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS 403 W Broad Ave	ADDRESS
CITY/STATE Flandreau, SD Phone# (605) 997-2642 Fax# (605) 997-9940	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 (mm/dd/yyyy) or expiration event)

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

South Dakota High School Activities Association

Pre-Participation Form Packet

2026-27 School Year

Last Updated: March 17, 2026 by Dan Swartos

Within this packet, you will find the following forms and information to be distributed to participants in SDHSAA Activities for the 2026-27 School Year in accord with local and SDHSAA Policy:

- SDHSAA Pre-Participation Exam Bylaw information (information only)

- SDHSAA PARENTAL CONSENT & PERMIT FORM – to be completed EVERY year, regardless of whether or not the athlete is having a physical exam.

- SDHSAA CONSENT FOR MEDICAL TREATMENT FORM – to be completed EVERY year, regardless of whether or not the athlete is having a physical exam.

- SDHSAA CONTENT FOR RELEASE OF MEDICAL INFORMATION (HIPAA) FORM – to be completed every year, regardless of whether or not the athlete is having a physical exam.

- SDHSAA CONCUSSION FACT SHEETS – to be completed EVERY year, regardless of whether or not the athlete is having a physical exam. Return to the school.

- SDHSAA SUDDEN CARDIAC ARREST INFORMATION- Does NOT need to be returned to the school, it is simply information for parents and students.

- SDHSAA INTERIM PRE PARTICIAPTION FORM – to be completed only in years when a physical exam is not being given (biennial/triennial).

- SDHSAA HEALTH HISTORY FORM – to be completed only in years when an actual physical exam is being given (annual/biennial/triennial).

- SDHSAA PREPARTICIPATION PHYSICAL EXAM FORM – to be completed as the record of the physical examination, when prescribed.

2026-27 SDHSAA PARTICIPATION FORM GUIDELINES

By SDHSAA Bylaws, the following applicable responsibilities exist for the respective parties:

School Boards/Districts:

1. Each School Board and/or governing body shall determine the frequency of physical examinations. Per the SDHSAA and the American Academy of Pediatrics, et. al. 2019, Physical Examinations of High School athletes should be completed at a minimum of once every three years.
2. All student health information must be handled and stored according to HIPAA and FERPA regulations.

Member Schools Athletic/Activities Departments:

1. Each member school shall provide copies of blank forms as sufficient so that all students may complete them prior to participation.
2. Member schools must keep on file each of the forms as listed on the previous page.
3. Member schools may allow physical exams to be completed after April 1 of the previous school year to apply to the ensuing school year.
4. All student health information must be handled and stored according to HIPAA and FERPA regulations.

Medical Professionals:

1. The certification of forms requiring a medical professional are specific to those individuals who are a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Physician Assistants or Nurse Practitioners (South Dakota Codified Law). Stamping the name of a clinic or association is not acceptable – all forms must be signed by authorized medical professionals where applicable.

2. The medical history forms must be made present to the person conducting the physical exam at the time of the examination.

SDHSAA CONSENT FOR PARTICIPATION IN ACTIVITIES

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

School Year: 2026-27 School Year **Place of Birth:** _____

Name of High School: _____

The parent and student, by signing this form, hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.

2. Understand and agree that:
   (a) By this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation;
   (b) Participation in any athletic activity may involve injury of some type;
   (c) The severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death;
   (d) Even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility; and;
   (e) By signing this form, I/we give our consent for the listed student to compete in SDHSAA approved athletics for the school year as listed on this form. Further, I/we give our permission for our child to participate in organized high school athletics, realizing that such activity involves the potential for injury and harm which exists as an inherent element in all sports.

3. Understand, consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and

4. Understand, consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. If I/we do not wish to have any or all such information disclosed, I/we must notify the above-mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.

_____ _____

Signature of Parent **Date**

_____ _____

Signature of Student **Date**

SDHSAA CONSENT FOR MEDICAL TREATMENT FORM

Student Name: _____ Date of Birth: _____

The SDHSAA recommends that all member schools receive consent from all students and parent/guardians prior to activities, to ensure that medical care can be provided to the student during any activity away from home. This form should be kept both on-file at the school, as well as in the possession of a student's coach/sponsor authorizing as below:

CONSENT FOR MEDICAL TREATMENT (for those children 18 and under at any time during the 2026-27 school year):

I, _____, am the (circle one) Parent or Legal Guardian, of _____, who participates in activities and/or athletics for _____ High School. I hereby consent to necessary medical services that may be required while said child is under the supervision of an employee of the fore-mentioned high school while on a school-sponsored activity, and hereby appoint said employee to act on behalf of myself in securing medical services from any duly licensed medical provider. Signatures on this form do not constitute consent for vaccinations of any kind.

_____ _____

Signature of Parent **Date**

CONSENT OF PARTICIPANT (for all students to complete):

I, _____, have read the above consent for medical treatment form signed above, or, as an individual of majority age, consent to those same medical services and actions as indicated above on this form.

_____ _____

Signature of Student **Date**

SDHSAA CONSENT FOR MEDICAL RELEASE FORM (HIPAA)

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

I/We the undersigned do hereby:

1. 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 for the purposes of evaluating, observing, diagnosing and creating treatment plans for injuries that occur during the time period covered by this form, or, from pre-existing conditions that require care plans pertaining to participation during the time period covered by this form.

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 medical care of this student.

3. This information for which I/we are 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 that the revocation will not apply to information that has already been released in 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 on July 1, 2027.

6. I understand that once the above information is disclosed, there is potential for it to be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Schools, School districts and school personnel must uphold the bounds of FERPA. As such, disclosure and re-disclosure by schools or school employees must be done in compliance with FERPA guidelines.

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	**Date**
Signature of Student (if over 18 or turning 18 before July 1, 2027)	**Date**

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

SDHSAA CONCUSSION FACT SHEET FOR STUDENTS-

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should I do if I think I have a concussion?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow you coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

IT IS BETTER TO MISS ONE GAME THAN A WHOLE SEASON – SEE SOMETHING – SAY SOMETHING!!!

Student's Name (Please Print)	**Date**
Signature of Student	**Date**
Parent's Signature	**Date**

SDHSAA CONCUSSION FACT SHEET FOR PARENTS-

What is a concussion?

A concussion is a traumatic brain injury that interferes with the normal function of the brain.

What are the signs and symptoms?

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
• Dazed, vacant, or stunned appearance • Is confused about assignment or position • Forgetfulness • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Shows mood, behavior, or personality changes • Can't recall events prior to or after hit or fall	• Headache or "pressure" in head • Neck pain • Nausea • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your child has a concussion?

If your child sustains a head injury, it is good to be aware of the signs and symptoms of a concussion. If you suspect an athlete has a concussion, the athlete must be removed from activity. Do not allow the athlete to drive until symptoms have resolved. Continuing to participate in a contact or collision sport while experiencing concussion symptoms can lead to worsening of symptoms, increased risk of further injury, and sometimes death.

Parents and coaches should not make the diagnosis of a concussion. Any athlete suspected of having a concussion should be evaluated by a medical professional trained in the diagnosis and management of concussions.

WHEN IN DOUBT, SIT THEM OUT!

Parent's Name	**Date**
Signature of Parent	**Date**
Student's Name	

Sudden Cardiac Arrest

Information for Parents and Students

What is Sudden Cardiac Arrest? The leading cause of death in young athletes while training or participating in sports, Sudden cardiac arrest is caused by a malfunction in the electrical system of the heart that occurs suddenly and often without warning. The malfunction may be caused by an abnormality in the heart at birth, a virus in the heart, or a hard blow to the chest. Survival depends on quick action, including calling 911, starting CPR, and the use of an AED.

What are the warning signs and risk factors?

- Fainting or seizure during or following exercise
- Racing or fluttering heart palpitations
- Excessive shortness of breath during exercise
- Frequent dizziness/lightheadedness
- Chest pain with exercise
- Excessive fatigue during or after exercise
- Family history of heart abnormalities or sudden death before age 50.

How can I protect my student's Heart?

- Know the warning signs and follow up with your doctor if your student is having any warning signs or risk factors above
- Answer the Pre-Participation History questions dealing with heart health and family heart health (questions 4-13) truthfully, and follow up with your doctor during the athletic physical
- Encourage your child to speak up if they are having any symptoms
- Help fund or find grant programs to get more AED's in your student's school

What can schools do to be prepared for sudden cardiac arrest events?

- Have a well-developed, well-rehearsed emergency action plan
- Ensure that AEDs are readily available, along with people trained on their use
- Practice response drills with school personnel, medical personnel, and EMS
- Ensure that AEDs are functioning with appropriate batteries and pads

Information in this sheet adapted from keeptheirheartinthegame.org, the Eric Paredes Save a Life Foundation, and the American Heart Association.

SDHSAA INTERIM PRE PARTICIPATION HEALTH HISTORY FORM -- Complete & Sign this form (with parents if younger than 18) in years when no physical is given to the student.

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?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first period?		
31. When was your most recent period?		
32. How many periods have you had in the past 12 months?		

RECERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct & the above named student is physically fit to participate in interscholastic athletics for the current school year, including those areas marked 'yes' above:

Signature of Athlete: _____

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

Date: _____

SDHSAA PREPARTICIPATION PHYSICAL EXAM FORM

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

Date of Exam: _____ **Annual/Biennial/Triennial:** _____

Physician Reminders:

1. **Consider additional questions on more sensitive issues:**
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, vaping, chewing tobacco, snuff or dip?
   - Over the past 30 days, have you used chewing tobacco, snuff or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seatbelt or helmet?
2. **Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)**

EXAMINATION		
Height:	Weight:	BP:
Pulse:	Vision: R 20/ L 20/	Corrected?:

MEDICAL	**Normal**	**Abnormal Findings**
Appearance		
Head/Mouth		
Eyes, ears, nose and throat - Pupils equal & Hearing		
Lymph Nodes		
Heart* -Heart sounds, murmurs, pulse, rhythm, auscultation		
Lungs		
Abdomen - Liver/Spleen, masses		
Skin - HSV, Lesions, Staph, MRSA, etc.		
Neurological		
MUSCULOSKELETAL	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, Hand and Fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional • Double-leg squat test, single-leg squat test, box drop or step drop test		

***** *Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination*

Sports Participation Recommended for (Mark One):

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendation for further evaluation or treatment of: _____

☐ Medically eligible for certain sports (list here): _____

☐ Not medically eligible pending further evaluation: _____

☐ Not medically eligible for any sports: _____

Name of Examiner: _____

Signature of Examiner: _____

Date of Exam: _____

Note: SDCL allows Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Licensed Physician Assistant and Licensed Nurse Practitioners as those that can provide this recommendation.