Ch'ooshgai Community School
"Home of the Broncos"
P.O. Box 321
Tohatchi, New Mexico 87325
Phone# (505) 733-2700

Ch'ooshgai Community School is accepting Enrollment Application for School Year 2026/2027.

*Student Name :*_____ *Grade:*_____

Dear Parents/Guardians:

WELCOME! Thank you for choosing Ch'ooshgai Community School for SY-2026/2027. We look forward to working with you and your child(ren). Each student's success in school will be a result of their efforts and your support. To enroll your child, please complete the attached forms and return them to the Academic Department. Any questions, please call (505)733-2700 or 2707.

NEW STUDENTS, the following documents are required:

Check List:	**Office Use Only:**
___ Completed Enrollment Packet SY-2026/2027	
___ Birth Certificate	(CCS staff initial:_____)
___ Certificate of Indian Blood	(CCS staff initial:_____)
___ Immunization Records (**Printed Current Year 2026**)	(CCS staff initial:_____)
___ IEPs (Individualized Education Plan	(CCS staff initial:_____)
___ Previous school report card for SY-2025/26.	(CCS staff initial:_____)

___ Legal Court Documents for Guardianship Decree or Power of Attorney, ***if you are enrolling a child and you are not the biological parent.*** (CCS staff initial: _____)

****** Only the parent or legal guardian are allowed to enroll a child ******

Other Forms Available:

___ Residential Packet SY-2026/2027 ___ NMAA Sports Physical Form

Completed enrollment packets and all required documents must be on file during enrollment.

Ch'ooshgai Community School upholds **Suspensions/Expulsions** of other schools. Any student that has been on suspension or expulsion from their prior schools must be cleared and approved with the Ch'ooshgai Community School Principal, this includes students that didn't completed the school year 2025/26.

CH'OOSHGAI COMMUNITY SCHOOL
BOARD OF EDUCATION, INC.

OMB No. 1076-0122
CCS, Revised: 3/2011
ID# D36N03

STUDENT ENROLLMENT APPLICATION SY-2026/2027

Grade Applying For: _____ (Check One): Day Student _____ Dorm Student _____

Returning Student ( ) New Student ( ) Previous CCS Student ( ) _____
Date last attended at CCS

STUDENT INFORMATION:

Name of Student: _____
Last First Middle

Address: _____ City: _____ State/Zip: _____

Physical Address (Location of Home) _____

Date of Birth: _____ - _____ - _____.
Month Day Year

Gender: Male ( ) Female ( )

Census Number: _____

Hospital #: _____

Tribal Affiliation: _____

Home Agency: _____

Degree Indian: _____

Community: _____

SCHOOL PREVIOUSLY ATTENDED

School Name: _____ Grade Completed: _____

Address: _____ City: _____ State/Zip: _____

Dates Attended: _____ Reason for Withdrawing: _____

Have you been expelled? YES___ NO___ Suspended? YES___ NO___ Reason: _____

Student Participated in Special Education Program: Yes ( ) No ( )

Student Participated in Gifted and Talented Program Yes ( ) No ( )

Student Participated in the Section 504 Plan under the Americans with Disabilities Act: Yes ( ) No ( )

Reason for choosing to attend Ch'ooshgai Community School: _____

_____

LANGUAGE SPOKEN AT HOME

1). _____

2). _____

WHATS YOUR CHILD IS CLAN:

1.) _____ (Maternal/Mom)

2.) _____ (Paternal/Father)

FAMILY AND BACKGROUND INFORMATION:

Child Lives With: _____Both Parents _____Father _____Mother _____Legal Guardian

(Father/Guardian): _____ **(Mother/Guardian):** _____

Census #: _____ Census #: _____

Telephone Number: _____ Telephone Number: _____

Employer: _____ Employer: _____

Occupation: _____ Occupation: _____

Work Number: _____ Work Number: _____

Email Address: _____ Email Address: _____

In case of emergency contact (only if parents cannot be contacted)

Name: _____ Relationship: _____

Phone #: _____ Work #: _____

List Names of Sibling attending Ch'ooshgai Community School: Brothers/Sisters only, no cousins.

1. _____ 2. _____

The following (8) individuals have my permission to check out my child during the school year.
They must be 18 years old and older. (Changes can only be done in person by legal parent/guardian.)

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

I hereby authorize that I am legally responsible for the above listed child and hereby apply for his/her admission to this school. I understand that the school may request additional information before the student is enrolled. The above information is true and correct to the best of my knowledge. I understand that if any of his/her information changes or is determined to be inaccurate. I am responsible for informing the school immediately.

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

FOR SCHOOL USE ONLY!!

The student has been approved for enrollment for SY-2026/2027

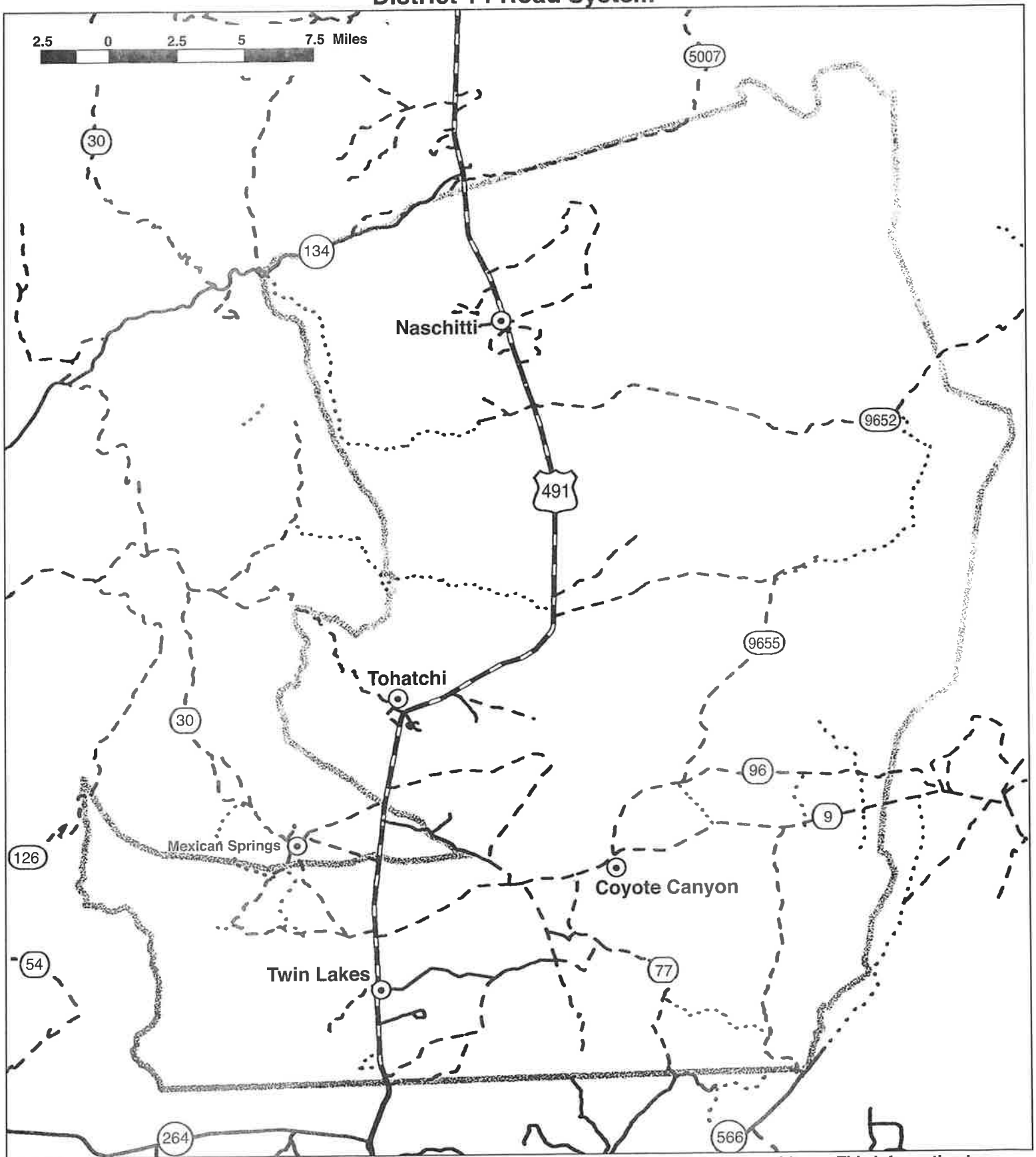
_____ _____

Signature of CCS Principal Date

_____ _____

Signature of Approving BIE Official Date

District 14 Road System



Please mark a large X in red ink on the District 14 Road Map to verify the exact location of student residency. This information is important for Audit Purpose.

Physical Address: _____

House # _____ Color: _____ (Circle One) House / Trailer

Student Name: _____ Parent/Guardian Signature: _____

WHITE • Enrollment Record CANARY • Residential Record

BIE Home Language Survey
School Year _____

First Name: **Last Name:**

Federal Code: 25: CFR 32.3 & Revised CFR 30.109

"It's the responsibility of the federal government to provide comprehensive education programs and services for Indians and Alaska Natives."

Federal requirements direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. BIE has contracted with WIDA (World Class Instructional Design and Assessment) to provide English Learner Assessments and Supports identified in this Home Language Survey.

BIE Mission Statement:
"Provide quality education opportunities from early childhood through life in accordance with the Tribes' needs for cultural and economic well-being..."

Purpose: The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order that the school to provide adequate instructional programs and services. As parents or guardians your cooperation is requested in complying with these requirements.

Please respond to each of the questions listed as accurately as possible.

For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered.

If you have any questions you have the right to share them before your student's English proficiency is assessed.

1. **Which language did your child learn when they first began to talk?**

2. **Which language does your child most frequently speak at home?**

3. **Which language do you (the parents/guardians) use more often when speaking with your child?**

4. **Which language is spoken more often by other adults in the home?**

5. **Do you believe your child might need additional support learning the academic language for math, science, reading, or writing related to other languages within the home or school?**

Additional Information (Optional)

Please sign and date this form in the spaces provided below, then return this form to your child's school. Thank you for your cooperation.

Signature of Parent or Guardian _____

Date _____ **School Official Verification** _____

Criteria for Screening

If a language other than English is identified for any of the primary language questions above, your child will be recommended for screening.

***** Please Note: SOME items in this template can be modified to represent specific needs of LEAs in efforts to better gain knowledge of student EL status. Questions 1-3 are not negotiable and must remain as stated per federal requirements. Additionally, the Federal Code, BIE Mission Statement, and Purpose sections remain as stated. Thank you.**

BIE Form HLS, Updated April 2023

Ch'ooshgai Community School

2026-2027 HEALTH AUTHORIZATION FORM

PURPOSE: To enable parents/guardians to **AUTHORIZE** emergency treatment for a child who becomes ill or injured while under school authority, when parents cannot be reached. Upon completion, this form must be returned to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent/guardian.

PLEASE COMPLETE ALL THREE SECTIONS.

Student's Last Name:	Student's First Name:	Middle:	Gender:	D.O.B

SECTION ONE-STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or the ER, the school health office will always attempt to reach the Parent/Guardian listed below FIRST. Secondary contacts will be called if the parent/guardian cannot be reached. PLEASE KEEP THESE NUMBERS CURRENT!

Parent/Guardian Name: *_____ Relationship: _____	Address:	Phone #1: Phone #2: Phone #3:
Parent/Guardian Name: *_____ Relationship: _____	Address:	Phone #1: Phone #2: Phone #3:

	Emergency Contact List	Relationship	Phone #1	Phone #2
1.				
2.				
3.				
4.				

SECTION TWO-STUDENT HEALTH HISTORY-PLEASE CHECK APPROPRIATE BOX

☐ **My child has NO health conditions including those listed below**

☐ Allergies ☐ Seasonal	☐ Food Allergy (List):	☐ Other Allergy (List):	☐ Has Epi-Pen Prescription ☐ Needs at School: Y or N
☐ ADHD/ADD Needs meds at school: Y or N	☐ Migraines	☐ Stomach/GI	☐ Dental/ Braces
	☐ Asthma Needs inhaler at school: Y or N	☐ Long Term Medication(s) (list):	☐ Eye/Vision Wears glasses/contacts: Y or N
☐ Bladder/GU	☐ Dermatologic/Skin	☐ Musculoskeletal	☐ Cardiovascular
☐ Any Other Health Conditions:			

SECTION THREE-INSURANCE INFORMATION

Student's Insurance:	Subscribers Name:	ID#

TO GRANT CONSENT

In case of an emergency involving my child **AND I CANNOT BE REACHED.** I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:
Dentist:	Phone:
Hospital:	Phone:

If, for any reason, **NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED,** I understand that appropriate transport and medical care of my child will be arranged to **ANY** appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this form will be shared with appropriate personnel on an as-needed basis only. I, also understand health screenings (including vision, hearing, weight, and lice check) may be done by school health personnel unless I provide the school health office with written notification requesting exclusion from these screenings. **Ch'ooshgai Community School is not Authorized to Administer Medication without a Doctor's Authorization Form.**

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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www.ccsbroncos.org

Kenneth Toledo, *Principal*
Ch'ooshgai Community School
Board of Education:
Willis Nez, President
Raymond Barney, Vice-President
Benjenita K. Bates, Secretary
Treva M. Roanhorse, Member
Vacant, Member

Field Trip Permission Form for School Year 2026/27

Student's Name:_____ Age:_____ Grade:_____

I/We give permission for my/our child to participate in field trips and school activities sponsored by Ch'ooshgai Community School during the 2026-2027 School Year.

The parent/guardian is reminded that every reasonable precaution will be taken to provide for the safety and care of the student. In the event of an accident, which requires emergency care, every effort will be made to contact the parent/guardian.

If the parent/guardian cannot be contacted, if there is an accident or illness, permission is hereby granted to the teacher in charge to authorize any necessary medical treatment or hospitalization thought to be in the best interest of the above-named student. (A copy of this permission form will be filed in the school office and a copy will accompany this trip sponsored).

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

_____ _____
Home Phone # Work Phone #

_____ _____
Emergency Contact Person Emergency Contact Number

List any prescribed medication your child must take, or any medical problem(s) of which the teacher or trip sponsor should be aware.

Medication Prescription: State any medical condition or physical restriction: _____

_____

xc: Student File - Original
Homeroom Teacher

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Media Release Form

Dear Parent/Guardian:

During the School Year 2026/27, we take photographs and videos of school activities involving students to
share the school's updates. By which incidentally, some photographs may capture your child's participation, directly or indirectly.

These photos may be published through our website, social media pages, news bulletins, billboards, and ads.

With this, we seek for your consent in allowing us to publish photos or videos which may involve your child to the said platforms.

Please do provide your response by selecting your choice below and submitting this form.

Photo Release Consent (Check a box):

- ☐ **I hereby allow** the reproduction and publication of my child's photograph(s) and video(s)
- ☐ **I do not allow** the reproduction and publication of my child's photograph(s) and video (s)

Student Name: _____ Grade: _____

Parent Name (Print/Sign): _____ Date: _____

Contact Number: _____ Email: _____

Address: _____

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Technology Agreement for SY-2026/2027

Terms and Conditions

Acceptable use. Each User Must:

- Use the Electronic Communication Device (ECD) to support personal educational objectives consistent with the educational goals and objectives of CCS.
- Agree not to submit, publish, display or retrieve any defamatory, inaccurate, abusive, obscene, profane, sexually oriented, threatening, racially offensive, or illegal material.
- Abide by all copyright and trademark laws and regulations.
- Not reveal home addresses, personal phone numbers, or personally identifiable data unless authorized to do so by designated school authorities.
- Understand that electronic mail or direct electronic communication is not private and may be read and monitored by school employed persons.
- Not use the network in any way that would disrupt the use of the network by others.
- Not attempt to harm, modify add/or destroy software or hardware nor interfere with system security.
- Understand that inappropriate use may result in cancellation of permission to use the ECD and appropriate disciplinary action up to and including expulsion for students.

Chromebook or iPad is subject to the terms and conditions set forth in this agreement.

- I understand the device is only available to students enrolled at Ch'ooshgai Community School for the 2025-2026 School year.
- I agree not to remove or alter any CCS identification labels attached to or displayed on the device or tamper with the device in any way.
- I agree to report a theft, loss, or damage to the device to CCS immediately.
- I understand that there will be internet filtering on my assigned device in addition to filtering of the student Chromebook.
- I understand that my use of the devices is subject to CCS Student Internet Use Policy and Agreement.
- I agree to follow all CCS regulations and policies governing the use of the device as well as all applicable State and Federal laws including copyright and intellectual property law pertaining to software and information.
- I understand that CCS is not responsible for any files, data or personal information accessed, transmitted, lost or damaged while accessing the Internet via this device.

By signing below, I accept the terms and conditions of the Agreement described herein and state that I am responsible for the use of technology devices with Ch'ooshgai Community School.

Student's Name (print): _____ Grade: _____

Student's Signature: _____ Date: _____

Parent/Guardian Name (print): _____ Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

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Transportation Bus Form School Year – 2026/2027

Student Name(s): _____ **Grade Level:** _____

Dad Cell Phone: _____ **Mom Cell Phone:** _____

Physical Address: _____
****EXACT HOME LOCATIONS** (Directions should be clear.)**

Provide a map with directions to your home. If PM route is different from AM route, provide PM route with directions on the back.
****

Residence/Route (be specific) ** Identify any visible factors that will give direction to your home. List any road numbers or rural addresses. Home location directions: _____

Color of home: _____ Color of roof: _____

Distance from School: _____ Type of home: _____

-
-
-
-
–
-
-
011
-
-
-
-

***IN CASE OF EMERGENCY CONTACT*:**

Name: _____ **Relationship:** _____

Telephone # _____

Day Bus Route (Monday—Friday)

_____ Bus 1 (Billie **South 491, Red Mesa Store, Tohlakai Road, and Johnson Road.**

_____ Bus 2: (Cohoe) North Naschitti and Sheep Springs (NHA Housing)

_____ Bux 3:(Williams) Mexican Springs Cotton Wood Village, Deer Springs Road and Loop

_____ Bux 4:(Jackson) Tohatchi Area and Buffalo Springs

_____ Bux 5:(Begay) Coyote Canyon Nizhoni & Dibe Lichee Housing and Coal Mine Loop, 491 (3 miles South MM19)

_____ Parents/Guardians Pickup at Academic Building.

_____ Other Transportation Route: _____

Parent/Guardian Signature: _____ Date: _____

Division of Performance and Accountability
Supplemental Education Programs
McKinney-Vento Education for Homeless Children & Youth Program
HOUSING QUESTIONNAIRE

*This questionnaire is intended to help determine eligibility for services under the federal McKinney-Vento Act. The information provided is **confidential** and protected by the Family Educational Rights and Privacy Act (FERPA). Information may be shared with the designated homeless liaison to determine eligibility and provision of services.*

School: _____ Date: _____

Student Name: _____ • Male • Female • Non-binary

Last School attended: _____ Current Grade: _____

Birth Date: _____

Address of where the student slept last night: _____

Parent/Guardian/Adult Caring for Student: _____ Relationship: _____

Main Contact Phone Number: _____ Email, if available: _____

Is the student's address a temporary living arrangement? • Yes • No

Note: If you checked "No," you may STOP here. Thank you.

If temporary, is this living arrangement due to loss of housing or economic hardship? • Yes • No

Please "X" all boxes below that best describes where the student sleeps at night, leave those blank that do not apply:

☐ **Doubled-up** – staying with a friend or relative because of loss of housing, economic hardship or similar reason (ex: eviction, foreclosure, fire, flood, lost job, divorce, domestic violence, kicked out by parents, ran away from home)

☐ In a **hotel**/motel (Name of hotel/motel): _____

☐ In a **shelter** or transitional housing program (name of shelter or program): _____

☐ In an **unsheltered** location such as: Tent, Car/Truck/Van, abandoned building, streets, campground, park, bus/train station, or another similar place.
- In a house that DOES NOT have water, or electricity, or heat, or DOES HAVE an infestation of rodents, or mold, or insects

☐ With an adult that is not a parent or legal guardian, or alone without a parent.

List all other children (infants/toddlers/school-aged children through age 21) that stay in the same location; even if they are not yet in school or have withdrawn from school:

Last Name	First Name	Grade	School

The undersigned certifies that the information provided above is accurate.

_____ _____

Child's Name _____ Teacher _____

Dear Parents/Guardians,

Our school is involved with The Community Pantry in the Food for Kids Program (FFK). The FFK program is able to offer a backpack of food to a child who may need the extra food while school is not in session on the weekends. Your child's name was nominated for this program. This year there are many community families who are facing difficult times. The Pantry has other programs which provide food for families in need. I encourage you to check out those resources as well.

If you do not feel your child needs this service of receiving food for the weekend, check the "NO" box and we will remove your child's name from consideration. If you would like your child to participate, check the "YES" box and complete the appropriate information. Please complete and return the attached form as soon as possible. Decisions as to who will participate in the FFK program will be made by next week and a waiting list may be established.

These guidelines must be followed for your child to participate in the FFK backpack program:

1. Your child (and younger children in the household) should be eating the snacks provided by FFK. If there is a food item which they will not eat, please return it unopened. Please do not throw any items away or feed to livestock. These items can be redistributed to other FFK individuals who can use them.
2. Do not sell the food. (This is not provided for you to profit financially.) If your child/family cannot use the food, please return it to the school for redistribution.
3. Students will be asked to write/draw 1 thank you letters to be sent to the sponsoring FFK donors. (First letter due at beginning of May)
4. If your circumstances change and you do not want your child to continue with the FFK program, please let me know immediately. There are students on a waiting list for this program.

Thank you for your time and consideration of this important matter. If you have any questions, please contact Geremiah C. Begay, Student- Parent Liaison at (505)733-2733 or gbegay@ccsbroncos.org

Sincerely,

(Please return to Geremiah C. Begay's Office)

The Community Pantry's Food For Kids (FFK) Backpack Program

Child's Complete Name: _____ Grade/Teacher: _____

☐ **NO**. My child will not participate in FFK this school year. _____ **Parent Signature**

☐ **YES.** My child will be able to participate in FFK this school year. I have read the requirements and will follow the rules while my child is in the FFK program. _____ **Parent Signature**

Please list all children in your household that are school age or younger. (Newborn to high school or college)

Complete Name	Age/School/Grade/ Teacher's Name	Food Allergies (if any)

Please list all adults (not in college) that are living in your home and their relationship to student.

Complete Name	Age/ Relationship to child	Work Status

_____ _____

Signature of Parent/Guardian Parent/Guardian PRINTED Name

_____

Home Phone Number Cell Phone Number Work/Business Phone Number

_____

Mailing Address and/or Email Address

_____

DEPARTMENT OF HEALTH HUMAN SERVICES

PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

Navajo Area Indian Health Service
GALLUP INDIAN MEDICAL CENTER
516 East Nizhoni Boulevard
P.O. Box 1337
Gallup, New Mexico 87301-1337

AUTHORIZATION TO FURNISH INFORMATION AND ASSIGNMENT OF BENEFITS

I. Private Insurance

The Indian Health Service (IHS) may disclose all or any part of the patient's records to any person or corporation which is or may be liable under a contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charge, including but not limited to, hospital or medical services companies, insurance companies, workmen's compensation carriers, welfare funds or the patient's employer.

I hereby assign to the IHS such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the IHS. I authorize payment of such benefits directly to IHS. I understand that this assignment applies to hospital, physician services and supplies furnished to me, covers previous visits and will continue in effect until revoked.

II. Medicare/Medicaid

I hereby assign to the Indian Health Service such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the IHS during the period_____ to _____I authorize payment of such benefits (if any) directly to the IHS. I understand that this assignment applies only to medical services and supplies furnished to me during the period designated. Release of clinical information required to substantiate appropriate insurance claims is authorized.

NOTIFICATION OF NEW MEXICO REVIEW ASSOCIATION OF CASE REVIEW

This is notification that your admission may be subject to the NMRA case review for compliance of the Medicare standards. The New Mexico Medical Review Association has a contract with the Health Care Financing Administration (HCFA) that oversees the Medicare Program to perform reviews for compliance on the Medicare standards.

Addressograph

Patient signature:_____

Date:_____

Clerk signature:_____

PATIENT INFORMATION SHEET

PATIENT INFORMATION (It is important the information collected is accurate and complete. Thank you.)

FIRST NAME	MIDDLE NAME	LAST NAME		CHART NUMBER
SOCIAL SECURITY NUMBER (SSN)	DATE OF BIRTH (DOB)	PLACE OF BIRTH (CITY & STATE)		MALE / FEMALE
MAIDEN NAME OR ALIAS	TRIBAL ENROLLMENT	CENSUS NUMBER	BLOOD QUANTUM	RELIGIOUS PREFERENCE
MAILING ADDRESS (PO BOX or STREET, CITY, STATE, ZIP CODE)				PHONE NUMBER
LOCATION OF HOME (PHYSICAL ADDRESS)		COMMUNITY		STATE
EMPLOYER/SCHOOL	ADDRESS (CITY & STATE)			EMPLOYER PHONE NUMBER
HEALTH COVERAGE (Medicaid, Medicare, or other Health Insurance)		MEMBER NUMBER		INSURER PHONE NUMBER
VETERAN STATUS _____ YES _____ NO	SERVICE BRANCH	SERVICE ENTRY DATE		SEPARATION DATE

SPOUSE INFORMATION

SPOUSE'S FULL NAME	DOB	SSN
EMPLOYER/SCHOOL	ADDRESS (CITY & STATE)	EMPLOYER PHONE NUMBER
HEALTH COVERAGE	MEMBER NUMBER	INSURER PHONE NUMBER

MOTHER'S INFORMATION

MOTHER'S FULL MAIDEN NAME	PLACE OF BIRTH (CITY & STATE)	DOB	SSN
EMPLOYER/SCHOOL	ADDRESS (CITY & STATE)		EMPLOYER PHONE NUMBER
HEALTH COVERAGE	MEMBER NUMBER		INSURER PHONE NUMBER

FATHER'S INFORMATION

FATHER'S FULL NAME	PLACE OF BIRTH (CITY & STATE)	DOB	SSN
EMPLOYER/SCHOOL	ADDRESS (CITY & STATE)		EMPLOYER PHONE NUMBER
HEALTH COVERAGE	MEMBER NUMBER		INSURER PHONE NUMBER

EMERGENCY CONTACT **NEXT OF KIN**

EMERGENCY CONTACT'S FULL NAME	RELATIONSHIP	NEXT OF KIN'S FULL NAME	RELATIONSHIP
MAILING ADDRESS	PHONE NUMBER	MAILING ADDRESS	PHONE NUMBER