UNITED STATES DEPARTMENT OF THE INTERIOR
Bureau of Indian Education

Student Enrollment Application

For Students enrolled in Bureau-Funded School

Name of School: **JOHN F. KENNEDY DAY SCHOOL**

Grade Applying for: ______________________

IDENTIFICATION: SOCIAL SECURTIY #______________________

NAME OF STUDENT:______________________, ______________________ ______________
LAST FIRST MIDDLE

ADDRESS:

P.O. Box ____________ City:____________________ STATE:__________ ZIP CODE:____________

PHYSICAL ADDRESS
(911):____

COMMUNITY YOU RESIDE:______________________________ HOUSE #:________________

DIRECTIONS:____

____

EMAIL ADRESS:____

DATE OF BIRTH:______________________________ SEX: MALE ( ) FEMALE ( )

PLACE OF BIRTH:______________________________

TRIBAL AFFILIATION:______________________________ DEGREE INDIAN:______________

CENSUS NUMBER:______________________________ HOME AGENCY:________________

Family and Background Information:

Parents or Legal Guardian (circle one) — If Guardian Please put Guardian Information:

Father:__________________________

Address:__________________________

____

Tribal Affiliation:__________________

Home Agency:_____________________

Enrollment NO:____________________

Occupation(optional)__________________

Employer:________________________

Telephone Number:

Home: (928)_________________

Work: (928)_________________

Cell: (928)_________________

Emergency Number:

Name:______________________

Home:______________________

Work:______________________

Mother____________________________

Address:__________________________

____

Tribal Affiliation:__________________

Home Agency:_____________________

Enrollment NO:____________________

Occupation(optional)__________________

Employer:________________________

Telephone Number:

Home: (928)_________________

Work: (928)_________________

Cell: (928)_________________

Emergency Number:

Name:______________________

Home:______________________

Work:______________________

The following three (3) adults have my permission to check out my child out of school:

Name:______________________________Relationship to student:______________________

Name:______________________________Relationship to student:______________________

Name:______________________________Relationship to student:______________________

The persons listed above must be over 21 years of age. Any adult listed above will have permission to check out the Student. All names should be single names *(not Mr. & Mrs., etc.)*

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

____

Signature for parent/legal guardian

____

Date

JOHN F. KENNEDY SCHOOL
Consent Form

Consent of Guardian who has primary responsibility for the care of the child.

Name of Student:______________________________ Grade:__________
D.O.B.___________

I (we) have read the Consent Form for Health services for my child:

If you don't want your child to receive these, please cross them out.

1. Emergency health care for accidents or illness.
2. Transportation of child to Health Facility for services
3. Vision and Hearing examinations yearly.
4. The office will have the following medications available for illness: Tylenol, Extra Strength Tylenol, Bacitracin Ointment.

I give my consent for the above services:

Signature:______________________________ Date:_______________

Exceptions or Special Instructions:____
____
____

EMERGENCY PHONE NUMBERS

Mother's Name:________________________________
Work Phone#:________________________ Home Phone#:______________
Father's Name:________________________________
Work Phone#:________________________ Home Phone#:_____________
(in the event, neither parent can be reached , call)
Name:____
Phone#:______________________________
Relationship to student:___________________________

The Smiles Movement

PO Box 767
Camp Verde, AZ 86322

Ph: 928-567-1832
Fax: 928-567-6500

thesmilesmovement@gmail.com

Please return this form to the school!

DEAR CONCERNED PARENT:

Dental disease is the #1 reason children miss school. The Smiles Movement has been providing care for your children for over 30 years at no charge to you. You have a choice; you can choose to go through the process at IHS, or enjoy the convenience of having our experienced doctors care for your child at their school. We thank you for once again choosing our practice that over the years has served thousands of children. To participate, your child must be enrolled in an appropriate AHCCCS program which is easily done at most IHS facilities.

IF YOU CHOOSE TO HAVE YOUR CHILD CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name______________________________ Male_____ Female_____

Child's Social Security Number______________________ Date of Birth____/____/____

Emergency Contact______________________________ Phone #__________________

School Name____________________ Teacher's Name__________________ Grade____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Has your child had?	NO	YES
Allergy to medication	___	___
Rheumatic Fever	___	___
Psychiatric Treatment	___	___
Seizure Disorder	___	___
Diabetes	___	___
AIDS/HIV Positive	___	___
Hospitalizations	___	___
Vision or speech problems	___	___
Could your child be pregnant?	___	___

	NO	YES
Heart Murmur	___	___
Bleeding Disorders	___	___
High Blood Pressure	___	___
Asthma	___	___
Hepatitis/Jaundice	___	___
Anemia	___	___
Latex Allergy	___	___
Other Serious Illness	___	___

Is your child under a Physician's care? NO____ YES____
Is your child taking any medication? ____ ____
Any problems with local anesthetic? ____ ____

PLEASE EXPLAIN ANY "YES" ANSWERS:____

What is your primary concern for your child's oral health?__________________________

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME
- WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME

CONSENT FOR TREATMENT AND AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1.______ YES. I give permission for my child to receive necessary treatment!

2.______ No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.

3.______ I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.

4.______ I consent to the sharing of this information with the IHS Dental program.

I understand that I may refuse to sign this Consent and Acknowledgement.

X______________________________________ Date____________________

Parent or Guardian

Please print your name______________________________________

If you have any questions, please call our office at 928-567-1832

PLEASE TURN OVER AND COMPLETE

Eye Exams And Glasses...

...AT SCHOOL!

Letters on an eye chart can look like this "O N R K D" or like this "● ● ● ● ● " to your student and both would be recorded as 20/20!

Between 70% and 80% of learning happens through the visual *system*. Because sight and vision are so important to learning, your students' vision needs to be as efficient as possible. His/Her eye health, eye sight, and other necessary visual skills used for learning can be conveniently examined at school using computerized, state of the art equipment.

By having your child's eyes examined at school, he or she will miss little class time and travel time away from school will not be an issue. Dr. Charles Ferrin, O.D. has received permission to examine students at John F. Kennedy School.

Comprehensive eye exams and glasses (if needed) are offered as a convenience to you and your child. Because there is **no charge** to the parents, family, or school, the exam and glasses are limited to students with *active* and verified I.H.S insurance only.

Please neatly complete and include all necessary insurance information so proper authorization and verification can be obtained quickly.

Childs Name ______________________________ (Boy/Girl) Birthday__________
Please Print clearly First Last **(Must be correct)**

Address: ______________________________ City ______________ State: Arizona

Zip: ______ Phone: ______________ Grade ______

AHCCCS ID # ______________________ **Childs SS#** ______________________
(Please look this number up and include) **(Important for finding insurance eligibility)**
(Please look this number up and include) **(Used only to help find insurance eligibility)**

I authorize Dr. Ferrin to examine my child, provide glasses if needed and bill my child's insurance at no charge to me.

____
(Parent/Guardian signature)

Office (800) 874-4895 FAX (928) 428-0563

HIPPA Notice: All information is held in total confidence. Your information may only be used to communicate with your insurance company to process an insurance claim or to another healthcare provider only for further medical or optometric care, or the school to complete their records.

Whiteriver Service Unit
Consent Form Children Vaccinations
(<18 years of age)

Dear Parents/Guardians:

The Whiteriver IHS Hospital is working with **John F Kennedy School** to update your child's vaccines (shots) during the **2020-2021 school year.** We will hold vaccination clinics during the year, and your child's school will let you know the specific dates. There will be no cost to you for this vaccine, whether or not your child is Native American.

The vaccine consent form includes the option to accept vaccination for your child by signing the consent form. If you do not wish for your child to be vaccinated, do not sign the form and vaccinations will not be given to your child during the clinic.

To give consent for your child to receive vaccines while at school:

- Sign and date the consent form to accept vaccination for your child.
- Return the consent form to the school.
- If you accept vaccination, the vaccine will be given to your child during the vaccination clinic.
- If, at any time, you change your mind about having your child vaccinated, you can contact the Whiteriver IHS Immunization Outreach team at 928-594-5228 or email megan.dill@ihs.gov.

Please visit the CDC's vaccination web site at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html and also https://www.cdc.gov/vaccines/parents/index.html for more information. If you do not have internet access and would like more information or a printed copy of the Vaccine Information Sheet, please contact us. Your child's health care provider can also answer your questions about any shots your child is due for and give the shots as well.

The Arizona State vaccine record (ASIIS) as well as your child's chart at the hospital will be used to screen for vaccines that are due. We will screen for any vaccines given at other locations (within Arizona) as well as any medical conditions/medications that may affect if your child is eligible for certain vaccines.

Sincerely,

Whiteriver IHS Hospital Immunization Outreach Team
LCDR Megan Dill, Hospital Immunization Clinical Coordinator (acting)
LCDR Anna Kit, LT Kristen Parker, Clinical Staff Pharmacists

Please answer all of the following questions. The answers are important to us, so we can be sure to give the right vaccines. By signing this form, you are giving consent for Whiteriver Service Unit to administer all recommended immunizations by the Advisory Committee on Immunization Practices (ACIP) during the **2020-2021 school year** at **John F Kennedy School** and acknowledging receipt of the Vaccine Information Statements (VIS) which can be found at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.

CONSENT FOR CHILD'S VACCINATION:

By signing below, I give consent to the WHITERIVER INDIAN HEALTH SERVICE HOSPITAL and its staff for my child named on this form to be vaccinated during the vaccination clinic. (If this consent form is not signed, then your child will not be vaccinated).

Parent/ Legal Guardian Name: ______________________ **Date:** __________

Signature of Parent/Legal Guardian: ______________________

Child's Name: ______________________ **Chart # or Birthday:** ______ **Age:** ______

	YES	NO
1. Is your child Native American/ Alaska Native?		
2. Does your child have any serious allergies? If so, what? ______________		
3. Has your child ever had a serious reaction to a vaccine? If so, what? ______________		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Does your child have any of the following: asthma, cancer, diabetes (or other type of metabolic disease), or disease of the immune system, lungs, heart, kidneys, liver, nerves, or blood? If so, what?: ______________		
6. Has your child taken cortisone, prednisone, any other steroid, anticancer drug, antiviral drug or had radiation treatment in the past 3 months? If so, explain: ______________		
7. Has your child received a transfusion of blood or a blood product, or been given immune (gamma) globulin in the past year? If so, explain: ______________		
8. If the child is a baby, have you ever been told that he/she had Intussusception (the telescoping of one portion of the intestine into another)?		
9. Is your child pregnant?		
10. Has your child received vaccines anywhere else OTHER THAN Whiteriver Hospital? If so, where? ______________		

To make sure that we have all information needed to vaccinate your child, please completely fill out the information in the boxes. This includes your name and signature, child's name and birthday/ chart number, and answers to all questions.