**SAN ILDEFONSO DAY SCHOOL**
**STUDENT RE-REGISTRATION FORM**
**SY 2023-2024**

STUDENT NAME: _____

D.O.B.: _____ GENDER: _____ GRADE: _____

ADDRESS: _____

_____

**MOTHER'S CONTACT INFORMATION:**

MOTHER'S NAME: _____

ADDRESS: _____

CELL PHONE: _____

WORK NUMBER: _____

E-MAIL ADDRESS: _____

**FATHER'S CONTACT INFORMATION**

FATHER'S NAME: _____

ADDRESS: _____

CELL PHONE: _____

WORK NUMBER: _____

E-MAIL ADDRESS: _____

**PLEASE NOTE: We must have contact numbers in case of an emergency. If numbers or contact(s) change throughout the year, please contact the school.**

**EMERGENCY CONTACTS**

NAME: _____ PHONE #: _____

NAME: _____ PHONE#: _____

NAME: _____ PHONE#: _____

Parent Signature: _____

Principal Signature: _____ Approved: _____ YES _____ NO

SAN ILDEFONSO DAY SCHOOL
MEDICAL EMERGENCY INFORMATION

Grade: Kindergarten { } First { } Second { } Third { } Fourth { } Fifth { } Sixth { }

*(It is very important that all numbers are current, Please notify school of any changes)*

Student Name: _____ DOB _____ SEX _____ GRADE: _____

Home Mailing Address: _____ City _____ State _____ Zip _____

Lives with: ___ Mother ___ Father ___ Both ___ Guardian ***MAIL SHOULD BE SENT TO:*** ___Mother ___Father ___ Both ___ Guardian

Mother's Name _____ HM/CELL PH: _____ WK PH: _____
Last First

Father's Name _____ HM/CELL PH: _____ WK PH: _____
Last First

Guardian's Name _____ HM/CELL PH: _____ WK PH: _____

***(List three contacts) Local relative or friend to be called in case parents/guardian cannot be reached;***

1. _____
Last First (Relationship) Phone/Cell

2. _____
Last First (Relationship) Phone/Cell

3. _____
Last First (Relationship) Phone/Cell

List persons **NOT** authorized to pick up your children: _____

Does your child **CURRENTLY** have any of the following:

| | | | | | |
|---|---|---|---|---|---|
| ASTHMA | ___ | TIRES EASILY | ___ | HEPATITIS (TYPE) | ___ |
| MEDICATION ALLERGIES | ___ | BLEEDING DISORDERS | ___ | SHORTNESS OF BREATH | ___ |
| FOOD ALLERGIES | ___ | PNEUMONIA | ___ | FREQUENT STREP THROAT | ___ |
| SEASONAL ALLERGIES | ___ | FREQUENT COLDS | ___ | FREQUENT NOSEBLEEDS | ___ |
| DIABETES | ___ | FREQUENT COUGH | ___ | VISION PROBLEMS | ___ |
| CEREBRAL PALSY | ___ | RHEUMATIC FEVER | ___ | DIZZINESS OR FAINTING | ___ |
| FREQUENT STYES | ___ | HEARING PROBLEMS | ___ | FREQUENT STOMACH ACHES | ___ |
| SPEECH DIFF | ___ | FREQUENT URINATION | ___ | KIDNEY/BLADDER PROB. | ___ |
| GLASSES OR CONTACTS | ___ | BLOOD PRESSURE | ___ | EMOTIONAL PROBLEMS | ___ |
| HEADACHES | ___ | MENINGITIS | ___ | WEIGHT PROBLEMS | ___ |
| FREQUENT EYE INFECTION | ___ | OTHER | _____ | | |

- Is your child on any medication at this time? ____ YES ____ NO
- Medication Name & Dose _____
- Medication is for _____

PLEASE NOTE: If your child requires medication at school, both a parent must complete a medical consent form and doctor before medication can be administered.
** Due to restrictions in the nurse practice act, WE ARE NOT ABLE to give students under age 18 any medication at school.

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*HOSPITAL NUMBER (IHS):* _____

Are there any other health issues you would like to discuss with the Teacher or school? _____

_____

Are there any restrictions in physical activity? _____

When was your child's last physical exam? _____

When was your child's last vision exam? _____

DOCTOR'S OFFICE OR CLINIC WHERE YOU'RE CHILD LAST RECEIVED IMMUNIZATIONS:
NAME: _____ PHONE: _____ CITY _____ STATE: _____
COMMENTS. _____

**TO GRANT CONSENT**

IN CASE OF AN EMERGENCY INVOLVING MY CHILD AND I CANNOT BE REACHED, I HEREBY GIVE CONSENT TO TRANSPORT MY CHILD TO THE FOLLOWING MEDICAL CARE PROVIDER AND HOSPITAL TO GIVE ANY REASONABLE AND CUSTOMARY MEDICAL AND HEALTH CARE DEEMED NECESSARY:

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Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Hospital: _____ Phone: _____

IF, FOR ANY REASON, THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I AUTHORIZED APPROPRIATE TRANSPORT AND MEDICAL CARE OF MY CHILD TO ANY APPROPRIATE MEDICAL CARE PROVIDER, HOSPITAL, OR MEDICAL FACILITY. THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS ONE OTHER DOCTOR OR 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.

_____

(Parent/Guardian Signature) (DATE)

***URGENT NOTE: IF ANY INFORMATION CHANGES WITHIN THE SCHOOL YEAR, PLEASE CALL OR SEND THE INFORMATION WITH YOUR CHILD TO THE PRINCIPAL'S OFFICE AS SOON AS POSSIBLE.***

# Student Emergency Contact Information

## SY 23-24

**(Your child can only be picked up by these listed family members)**

Emergency Contact #1: Name:_____

Relationship: _____

Phone Number: _____

Emergency Contact #2: Name:_____

Relationship: _____

Phone Number: _____

Emergency Contact #3: Name:_____

Relationship: _____

Phone Number: _____

Emergency Contact #4: Name:_____

Relationship: _____

Phone Number: _____

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Doctor:_____ Phone Number:_____

Medical Considerations/Allergies:_____

Medications:_____

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the closest medical care providers and /or hospital, and authorize these providers and hospital to give reasonable and customary medical and health care deemed necessary. If for any reason, the above medical care providers or hospital cannot be reached, I authorize appropriate transportation and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor concurs to the need. Nothing in the section shall be construed to impose liability on any school official or employee who in good faith attempts to comply with above instructions. It is understood that I will be financially responsible for all emergency care and transportation.

Signature of Parent/Guardian:_____Date:_____

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

**The information on this form is required to meet The Education for Homeless Children and Youth (EHCY) program, authorized under Title VII-B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.), also known as the McKinney-Vento Act. Information on this form is confidential.** False claims about living situations may affect enrollment.

**School:** SAN ILDEFONSO DAY SCHOOL **Date:** _____

**Last School attended:** _____ **Current Grade:** _____

**Student Name:** _____ ☐ Male ☐ Female

**Birth Date:** _____ **Do you have more children?** ☐ Yes ☐ No

**Address of where the student sleep last night:** _____

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

**Telephone:** _____ **Email Address:** _____

**Is the student's address a temporary living arrangement? ☐ Yes ☐ No**
**NOTE: ** If You Checked NO, you many 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 **motel**/hotel (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.
___ With an adult that is not a parent or legal guardian, or alone without a parent.
___ None of the above (Please explain):

_____

List all other children that stay in the same place

| Last Name | First Name | Grade | School |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

*The undersigned certified that the information provided above is accurate.*

_____ _____
**Signature of Person Providing Information** **Date**
**Parent/Legal Guardian/Caregiver/Unaccompanied Student**

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*For School Use Only*
***Housing type-Check all that apply and date***:
___ Doubled-up ___ Sheltered ___ Unsheltered ___ Motel/hotel

1 )Unaccompanied youth: ☐ Yes ☐ No 2) Transportation needed: ☐ Yes ☐ No

Do not make copies of this form. If "yes" is checked for "Is the student's address a temporary living arrangement?" forward form to Local Homeless Liaison. A copy should not be placed in the student's cumulative file.

**School Personnel Who Enrolled the Student:** _____

# Release Form

**U.S. Department of the Interior**
**Bureau of Indian Education**
1849 C Street N.W.
Washington, DC 20240

***Permission to Photograph / Video / Audio Record***

Subject _____

Location _____

I grant to the U.S. Department of the Interior, Bureau of Indian Education, its representatives and employees, the right to take photographs / video / audio recording of me and my property in connection with the above identified subject. I authorize the U.S. Department of the Interior, Bureau of Indian Education, its assign and transferees to copyright, use and publish the same in print and / or electronically.

I agree that the U.S. Department of the Interior and the Bureau of Indian Education may use such photographs / video / audio recording of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, social media and web content.

***I have read and understand the above:***

Signature _____

Printed name _____

Organization Name (if applicable) _____

Address _____

Date _____

Signature of parent or guardian _____
(if under age 18)

DEPARTMENT OF HEALTH & HUMAN SERVICES

**Public Health Service**

Santa Fe Indian Hospital
1700 Cerrillos Road
Santa Fe. New Mexico 87501

Dear Parents and Legal Guardians,

The Santa Fe Service Unit Public Health Nurse would like to provide an oral health screening and a fluoride application for your student at your school this year.

Fluoride varnish makes your child's teeth stronger and protects against cavities. In order to make the fluoride varnish effective, your child should receive fluoride varnish **at least** twice a year. It can prevent cavities from growing bigger.

In order to provide these services, we will need your written consent. If you would like your child to receive these services, please sign where indicated below. With signed consent, these routine services may be provided without you having to be present.

☐ Yes, I do give permission for my child _____ to receive

Date of Birth: _____ Chart #: _____ Classroom: _____

- Dental Screening & Fluoride Varnish
-

☐ No, I do not wish to give permission for my child _____ Classroom: _____

to receive any services.

_____ _____

**Parent/ Legal Guardian Signature** **Date**

Revised March 2019

# MEDICAL HISTORY

**Please read carefully, this form must be completed prior to treating your child.**

Child's Name: _____

Date of Birth: _____ Hospital Chart #: _____

Which PHS Indian Hospital Dental Clinic does your child have dental care provided?

_____

Has your child EVER had:

| | | | | | |
|---|---|---|---|---|---|
| Allergies | Yes | No | Liver Disease/ Hepatitis | Yes | No |
| If yes, to what? _____ | | | Bleeding Tendencies | Yes | No |
| Heart Murmur | Yes | No | Heart/ Vascular Disease | Yes | No |
| Seizures | Yes | No | Asthma | Yes | No |

Please explain any "yes" answers:

_____

_____

Is your child under the care of a Doctor at this time? Yes No

If yes, for what? _____

Name of Doctor (MD): _____ Phone #: _____

Is your child taking any medication (prescription or over the counter)? Yes No

If yes, please list medication: _____

Any other information we should be aware of? Yes No

If yes, please be explain:

_____

By signing, I attest that all the information given regarding my child is true and accurate.

_____ _____

Signature of Parent/ Guardian Date