UNITED STATES DEPARTMENT OF THE INTERIOR
Bureau of Indian Education

San Ildefonso Day School
36 Tunyo Po
Santa Fe, New Mexico 87506

Dear Parent(s)/Guardians:

We are excited to have your child enroll with us at San Ildefonso Day School. We strive to provide excellent educational programs and create partnerships with community programs with the best interest of our students and families.
In order to enroll your child at San Ildefonso Day School, The Bureau of Indian Education has established the following required documents for new students entering San Ildefonso Day School.

Students must have the following documents on file at the school:

1. **A Certified State Birth Certificate**: It is mandated to have vital statistics in students' cumulative files for audit and funding purposes.
2. **CIB (Certificate of Indian Blood).** This form may be requested from your Tribal Office. Parents CIB is valid if child does not yet have a CIB. Student must have ¼ or 25% Blood Quantum.
3. **Physical Exam and Immunization Records:** These documents are required by the State of New Mexico Health Department.
4. **Social Security Number**
5. **Registration Packet:** Forms that provides us with contact and emergency information and other necessary information that provides both permissions and protections for the children.
6. **Kindergarten students must be 5 years of age prior to September 1, 2023.**
7. Parent consent to release school records from last school attended. (Transfer students).

All documents listed above are necessary to complete your child's/children's enrollment at San Ildefonso Day School. All documents are reviewed by our Educational Line Office for funding purposes.

We look forward to working with you and your child/children. Please do not hesitate to contact us if you need any assistance in this process. The school telephone number is 505-455-2366. I may be contacted at 505-690-9358 by phone or text. Please leave a message if the phone is not answered.

Respectfully,

Julianna Trujillo
Principal

2023-2024

STUDENT ENROLLMENT APPLICATION
FOR STUDENTS ENROLLED IN BUREAU-FUNDED SCHOOLS

Name of School: **SAN ILDEFONSO DAY SCHOOL** **Grade** _____

Type:		Funding:	
Day School	(X)	Pub. Law 100-297 Grant	()
Boarding School	()	Pub. Law 93-638 Contract	()
Peripheral Dormitory	()	BIE Operated	(X)

1.IDENTIFICATION

Name of Student: _____
(Last) (First) (Middle)

Address: P.O. Box_____ Street: _____

City: _____ State: _____ Zip Code_____

Miles from home to school: _____

Date of Birth: _____ Place of Birth: _____
Month Day Year

Sex: Male () Female () Verified by: _____

Tribal Affiliation: _____ Degree Indian: _____

Enrollment Number: _____ Home Agency: _____

Dominant language spoken in the home:
(1)_____ (2) _____

2. FAMILY INFORMATION

Father: _____

Address: _____

Tribal Affiliation: _____
Home Agency: _____
Enrollment Number: _____
Living: () Dead: ()
Occupation (Optional): _____
Employer: _____

Telephone Home: _____
Work: _____
Emergency: _____
Other (specify)

Mother: _____

Address: _____

Tribal Affiliation: _____
Home Agency: _____
Enrollment Number: _____
Living: () Dead: ()
Occupation (Optional): _____
Employer: _____
Telephone Home: _____
Work: _____
Emergency: _____
Other (specify)

Legal Guardian: _____ Address: _____ _____ Tribal Affiliation: _____ Home Agency: _____ Enrollment Number: _____ Occupation (Optional): _____ Employer: _____	Other (group home, etc.): _____ Address: _____ _____ Telephone: _____ Student Lives With: _____ Telephone Home: _____ Work: _____ Emergency: _____ Other (specify)_____

3. SCHOOL(S) PREVIOUSLY ATTENDED:

School Name: _____ Dates _____ Grades _____
Attended: _____ Completed: _____
Address: _____ Reasons for Leaving: _____
City / State:_____

School Name: _____ Dates _____ Grades _____
Attended: _____ Completed: _____
Address: _____ Reasons for Leaving: _____
City / State: _____

School Name: _____ Dates _____ Grades_____
Attended: _____ Completed: _____
Address: _____ Reasons for Leaving: _____
City / State:_____

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 of Parent/Legal Guardian/Adult Student Date

_____ _____

Day School Enrollment: _____

Approved: _____ Not Approved: _____ _____
Principal Date

4. CRITERIA FOR BOARDING OR OUT OF BOUNDARY ENROLLMENT:
Favorable action is recommended upon this application because this case conforms to the following criteria for boarding school or out of boundary enrollment. If this application is for an off-reservation boarding school and for social reasons, a social summary is to accompany this application.

Education Factors	Social Factors
Federal/Public schools near student's home:	In his/her environment, the student:
() Do not offer grade level.	() Was rejected or neglected.
() Are severely overcrowded.	() Does not receive adequate parental. supervision
() Do not offer student's grade.	
() Exceed 1½ miles walking distance to school or bus route.	() Wellbeing was imperiled due to family behavioral problems.
() Do not offer special vocational/ preparatory training necessary for gainful employment.	() Has behavioral problems too difficult for solution by family or local resources
() Do not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences.	() Has siblings or another close relative enrolled who would be adversely affected by separation.
() Receiving School offers special academic program needed by student.	
Approved: Date: In Boundary	Approved: Date: Out-of- Boundary
(signature & title of approving official)	(signature & title of approving official)
Off-Reservation Boarding School	
(signature & title of approving official)	

Privacy Act Statement: This information is collected as provided by 5 U.S.C. 552A. The Office of Indian Education Programs is authorized to collect this information in accordance with Public Law 95-561; 98-511;99-89; and 100-297. The information will be used to determine the level of funding to be distributed by formula to BIA funded elementary and secondary schools. Weighted student units, the value of basic and specialized instructional and residential programs, are used to calculate the distribution of funds. The information may be disclosed to appropriate Department of the Interior and Congressional Offices for policy and budgetary purposes.

Paperwork Reduction Act Statement: This information is collected to identify each student's instructional and residential program classification. It will be used to allocate appropriated funds on a weighted student unit formula. The information is supplied by the respondent to obtain or retain a benefit, that is, to provide appropriate schooling and the needed funding. It is estimated that this form will take an average of 15 minutes to complete. This includes the amount of time it takes to gather the information and fill out the form. If you wish to make comments on the form, please send them to Attn: Information Collection Clearance Officer – Indian Affairs, 1849 C Street, NW, MS-4141, Washington, DC 20240. The control number and expiration date are at the top right corner of the form. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless there is a valid OMB control number.

Instructions for Completing the Student Enrollment Application Form

1. IDENTIFICATION	
Name:	Enter the name of the student by last, first, and middle. Example: Green, Frances Jean
Address:	Enter the address where student receives mail.
Date of Birth:	Enter the student's date of birth.
Verified by:	The school is responsible for filling in this section. Verification of birth date may be done by birth certificate, affidavit, baptismal record, etc.
Place of Birth:	Enter the location, name of city or town, and state where the student was born.
Sex:	Indicate whether the student is male or female.
Tribal Affiliation:	List the tribe(s) in which the student is enrolled.
Degree Indian:	Indicate such as: 4/4, 3/4, ½, 1/4, etc.
Census Number:	Enter the census number or roll number assigned to the student by the governing Tribe or Agency in which he/she is a member/enrolled.
Home Agency:	Enter the name of government office which has the responsibility or list of enrolled members which includes the student's name.
Dominant language spoken in the home:	Enter dominant language spoken in the home.

2. FAMILY AND BACKGROUND INFORMATION	
Parents' Name	
Father's Address:	Enter father's address if different from students.
Tribal Affiliation:	Enter father's Tribe.
Home Agency:	Enter Agency where father is enrolled.
Census Number:	Enter father's census number.
Living / Deceased:	Indicate whether father is alive or deceased, entering date if deceased.
Occupation (Optional):	Enter father's occupation.
Employer:	Enter the name of father's employer or where he works.
Telephone Numbers:	Please list father's home telephone, work number, an emergency number or other numbers where father can be reached, in case of an emergency. If other, indicate friend, aunt, uncle, etc.
Mother:	Same instructions as above.
Legal Guardian:	Same instructions as above.
3. SCHOOLS PREVIOUSLY ATTENDED: List the names, addresses, dates, grades completed and reasons for leaving all the schools the student previously attended. Please fill out as accurately as possible.	
4. FOR BUREAU USE ONLY: Self-Explanatory.	

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.

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:

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: _____

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:_____

BIE Home Language Survey

Student Full Name: _____

Federal Code: 25: CFR 32.3

"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..."

School Mission Statement:

"The San Ildefonso Day School will provide opportunities to inspire educational success!"

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 for 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 following 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?** _____

Additional Information (Optional)

_____

_____

_____

Criteria for Screening - If a language other than English is identified for any of the primary language questions #1-4 above, your child will be recommended for screening.

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/Guardian _____ **Date** _____

FOR SCHOOL USE ONLY	
Reviewed by:	Received on:

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

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