

CHOCTAW TRIBAL SCHOOLS

MISSISSIPPI BAND OF CHOCTAW INDIANS
PO BOX 6008
CHOCTAW, MS 39350
PHONE (601) 650-7302
FAX (601) 656-9454

Student Enrollment Application 2020-21

School: _____

NASIS ID: _____

Student ID: _____

OMB: 1076-0122
EXPIRES 03/31/2021

Student's Full Name: _____ Suffix: _____

Preferred Name: _____ Sex: _____ Grade: _____ Date of Birth: _____

Lives With: _____ Home Phone: _____

Address: _____

street apt/lot# city state zip

Mother/Guardian Cell PH: _____ Work PH: _____ ext: _____

Mother/Guardian Place of Employment: _____ Dept: _____

Mother/Guardian Email Address: _____

Father/Guardian Cell PH: _____ Work PH: _____ ext: _____

Father/Guardian Place of Employment: _____ Dept: _____

Father/Guardian Email Address: _____

EMERGENCY CONTACT

Emergency Contact: (Name, Relationship, Phone) _____

Dr. Contact/Phone: _____

INTENSE BILINGUAL

Language First Learned By Student _____

Language Spoken in Home _____

Language Most Often Spoken By Student _____

Mother/Guardian Signature _____ Date _____

Father/Guardian Signature _____ Date _____

Principal _____ Date _____

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Student's Full Name: _____ Grade: _____

Names of Brothers and Sisters:

Name _____ M ___ F ___ Grade ___ School _____ DOB _____

Name _____ M ___ F ___ Grade ___ School _____ DOB _____

Name _____ M ___ F ___ Grade ___ School _____ DOB _____

Name _____ M ___ F ___ Grade ___ School _____ DOB _____

Has your child attended any previous school? Yes ___ No ___ Please give the name, address of all schools attended, grades attended and reason for leaving:

Student participated in special education program: Yes ___ No ___

Student participated in gifted and talented program: Yes ___ No ___

Student placed in an alternative education program: Yes ___ No ___

Other information we may need to know to better serve your child:

TRANSPORTATION INFORMATION

(check all that apply)

_____ Student will ride bus to school from home each morning

_____ Student will ride bus home each afternoon

_____ Student will be dropped off at school by _____

_____ Student will be picked up at school by _____

_____ High School Students ONLY – Student will apply for a parking decal to park on campus.
See handbook for required documentation.

I understand that if I change transportation plans for my child, I must notify the school of the changes in writing and follow the handbook policy regarding bus privileges.

Parent/Guardian Signature _____

Date _____

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School _____

Student Check Out Permission **SY20-21**

The safety and security of your child are vitally important to us in the Choctaw Tribal Schools. Please complete this form so we can be certain of who has your permission to pick up your child from school.

In addition to myself, **ONLY** the following persons have my permission to check out my child, _____, from any Choctaw Tribal School during the school day for the 2020-21 school year.

| | NAME | RELATIONSHIP | PHONE |
|-------------|-------|--------------|-------|
| Sign Out #1 | _____ | _____ | _____ |
| Sign Out #2 | _____ | _____ | _____ |
| Sign Out #3 | _____ | _____ | _____ |
| Sign Out #4 | _____ | _____ | _____ |
| Sign Out #5 | _____ | _____ | _____ |
| Sign Out #6 | _____ | _____ | _____ |

I realize that the school will **NOT** release the above child to anyone unless their name is on this form. I also understand that it is my responsibility to let the school know in writing when there is to be a change in those persons who have permission to check out my child and that the school reserves the right not to release this child to the persons above if they are under the age of 18, or if the safety and welfare of the child is at stake. If there is a restriction or a custody alert, papers **MUST** be on file in the school office.

Student Name: _____ Grade: _____

Parent/Guardian Name: _____ Daytime Phone: _____

Parent/Guardian Signature: _____ Date: _____

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School _____

Corporal Punishment
SY20-21

Please check the following statement that applies to your child.

Student's Full Name: _____ Grade: _____

This form will be kept on file at the school for the school year.

_____ Corporal punishment or paddling MAY be used as a disciplinary measure for my child.

_____ Corporal punishment or paddling MAY NOT be used as a disciplinary measure for my child.

I understand that if corporal punishment is refused, then in-school or out-of-school suspension is a mandatory requirement.

Parent/Guardian Signature _____ Date: _____

Phone number: _____

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Official Medical Consent SY20-21

MEDICAL CONSENT FOR:

Student's Full Name: _____

NASIS ID: _____ Sex: _____ Grade: _____ Date of Birth: _____

My CHILD IS ALLERGIC TO:

** Please list all medicine, food, materials, animals, etc.

**I (We) hereby grant consent/permissions/authorization to Choctaw Tribal Schools for the following:
(CIRCLE any for which you DO NOT grant consent/permission/authorization).**

1. Authorize release of medical records at Choctaw Health Center to Choctaw Tribal School nurses. If this authorization has not been revoked earlier, it will terminate one year from the date of my signature.
2. Physical examination (done by an outside provider) for special education office, sports, and annual Medicaid screening, including laboratory procedures, skin tests for tuberculosis, stool examinations, and treatment for parasites (worms, etc.). A copy of the exam will be released to the Choctaw Health Center and filed there in the student's medical records.
3. All necessary immunizations, including diphtheria, whooping cough, tetanus, lockjaw, polio, measles and rubella (as required by law), plus influenza, mumps, and typhoid when indicated.
4. Dental screening, individual emergency dental care and fluoride swish.
5. Any necessary dental treatment (children 17 or younger), including x-ray, fillings, local anesthetic, fluoride or nitrous oxide analgesia.
6. Diabetic education/screening provided by Choctaw Health Center staff.
7. Emergency Medical care ONLY for accidents or illness occurring during school hours, including transporting my child to and from emergency health care providers.
8. Administer medication from the school principals' and nurses offices, either according to routine standing orders from the Doctor, or medicine brought by parent/guardian with a note.
9. Treatment for head lice and scabies if necessary.
10. Health counseling/education to fifth through twelfth graders on pregnancy prevention and sexually transmitted diseases (STDs) including HIV/AIDS. All students may receive health counseling/education on any health problem that occurs during the school year.

Parent/Guardian Signature _____ Date: _____

Phone number: _____

Medical History SY20-21

Student's Full Name: _____

NASIS ID: _____ Sex: _____ Grade: _____ Date of Birth: _____

Please provide a current health history for your child. This allows us to help your child gain the most from his/her school experience.

1. With whom does the child live? Both parents _____ Mother _____ Father _____
Other (Explain) _____

2. When did your child last have a physical exam? _____ Clinic: _____
Purpose of exam: Routine checkup _____ Illness/Injury _____

3. Does your child take medication? _____ Name of medication(s) _____
Frequency taken _____

4. Does your child have a health problem? Check where appropriate:
_____ Asthma _____ Diabetes _____ Vision _____ Injury _____ Allergies
_____ Anemia _____ Hearing _____ Heart _____ Seizures/Convulsions
Other (Explain): _____

5. During the pregnancy with this child, did the mother have any medical problems? (e.g., high blood pressure, kidney problems, diabetes, other)?
Explain: _____

6. Has this child been hospitalized for any reason since birth? Explain _____

7. Do any close relatives have a history of any of the following illnesses? (check and indicate relationship to this child)

| | |
|---------------------------|---------------------------------|
| _____ Seizures _____ | _____ Anemia _____ |
| _____ Diabetes _____ | _____ Cancer _____ |
| _____ Heart Disease _____ | _____ High Blood Pressure _____ |
| _____ Birth Defect _____ | _____ Learning Problem _____ |
| _____ Other _____ | |

8. Is your female child pregnant: Yes _____ No _____ Don't know _____

9. Does your child have any children? _____ If so, what are their ages? _____

10. Are there any problems at home that might affect your child's learning? Comments _____

11. Has your child ever had a bleeding problems that needed medical treatment? _____

12. Do you have reason to believe that your child has been exposed to HIV/AIDS? _____

13. Is there anything more about your child's health that you think is important for us to know?

The answers I have given are true to the best of my knowledge.

Parent/Guardian Signature _____ Date: _____