Required Documents for All New Students

- Birth Certificate
- Blood Degree (Student/Parent)
- Updated Immunizations
- Title 19/Health Insurance

2024 - 2025
PORCUPINE SCHOOL
PAHIN SINTE OWAYAWA
STUDENT REGISTATION FORM

STUDENT INFORMATION

Has the student named below ever register with Pahin Sinte Owayawa? ☐Yes ☐ No		
Students Legal Name:		
First:	Middle Name:	Last:

Grade:	Social Security Number:
Date of Birth:	Gender: ☐Male ☐ Female
Place of Birth:	Is student enrolled in a Tribe? ☐Yes ☐ No
Name of Tribe:	Enrollment number:

TRANSPORTATION

The Pahin Sinte Owayawa will provide transportation in accordance of policy. The bus driver will wait precisely **three** minutes for each stop for your child/children at designated location. If your child/children miss the bus, we will not send another bus driver out to pick him/her up. It will be the responsibility of the Parent/Guardian to get the child to school.

It is also your responsibility to notify the school if your child/children will be getting on or off at a different location with a written note or you can call the school at (605) 867-5588. **NO Later than 1:00 pm.**

Student Name:	Parent/Guardian Name:	
Home #:	Work #:	Cell #:
List student Siblings whom will be attending Porcupine School:		

Please check the box for your child/children pick up and drop off location:

☐ Evergreen	☐ Pine Ridge/ Wounded Knee	☐ Sharps Corner	☐ Martin
☐ Off Road North	☐ Off Road South	☐ East of Porcupine	☐ Other

Is the drop off location different from the pick-up location? ☐Yes ☐ No

If yes, please specify:

Directions to your house:

CUSTODY OR GUARDIANSHIP

Is there a custody order or any other legal document governing the custody or guardianship of your child?

☐ Yes ☐ No

If yes, a copy or the most recent custody document must be placed in the student record. ☐ Attach copy

Please Remember Parents/Guardians can check out their child unless there is a custody statement on file.

Parent Signture	**Date**

PARENT/GUARDIAN INFORMATION

This information must be provided. Please provide a minimum of **TWO** emergency contacts.

1 ☐ Mother ☐ Father ☐ Grandparent ☐ Stepmother ☐ Stepfather ☐ Other	**2** ☐ Mother ☐ Father ☐ Grandparent ☐ Stepmother ☐ Stepfather ☐ Other
First Name: Email:	First Name: Email:
Last Name:	Last Name:
☐ Sole Custody ☐ Shared/Joint custody ☐Guardian	☐ Sole Custody ☐ Shared/Joint custody ☐Guardian
Is this person an Emergency contact? ☐ YES ☐ No	Is this person an Emergency contact? ☐ YES ☐ No
Name of Tribe:	Name of Tribe:
Tribal Enrollment number:	Tribal Enrollment number:
Address: Physical Address:	Address: Physical Address:
City: State: Zip Code:	City: State: Zip Code:
Home Phone #:	Home Phone #:
Work #:	Work #:
Cell #	Cell #:
Has authorization to check out student? ☐ Yes ☐ No	Has authorization to check out student? ☐ Yes ☐ No
Would you be willing to sub at Porcupine School? ☐Yes ☐ No	Would you be willing to sub at Porcupine School? ☐Yes ☐ No

ONLY individuals stated on the student check list will be allowed to check out student.

EXCEPTIONAL CHILD PROGRAM

Has your child, ever received or is presently receiving any of the following Special Education Services, Counseling, or Health Concerns: ☐ Yes ☐ No	☐ Counseling ☐ Special Education Services ☐ Speech/Language ☐ Physical Therapy ☐ Occupation Therapy ☐ Behavior Issues ☐ Individual Education (IEP)
If so what School?	Name of School(s):
Phone #: Fax #:	Address of School:
Are there possibly any other concerns? ☐ Yes ☐ NO	If yes, please specify:

Is your child fully vaccinated for COVID - 19 Yes ☐ No ☐

(Please provide document if you haven't already)

STUDENT RECORDS REQUEST

Student's Name:	Date of Birth:
Current Grade:	Start Date:
School Transferring From:	Address:
Last Grade Completed:	
Phone:	Fax:

Please indicate which records are to be released by checking box:

☐ Transcripts ☐ Immunizations ☐ Withdrawal of grades ☐ Birth Certificate ☐ Tribal Enrollment
☐ Standard Tests ☐ Attendance ☐ Enrollment History ☐ Cumulative Folder
☐ Behavior ☐ Special Education

Federal Law 99.31: No parent signature is required for education records to be sent to another education agency.

We require a current Report Card; Birth Certificate; Immunization Record; Parent/Guardian/Student degree of Indian Blood to enroll into School.

Person requesting records:

Title:

Pahin Sinte Owayawa
Porcupine School
P.O Box 180
101 School Drive
Porcupine, South Dakota
Phone: (605) 867-5588
Fax: (605) 867-5480

Date requesting records:

_____ _____ _____
Parent/Guardian (Please print) Relationship of student Date

PARENT/GUARDIAN CONSENT

I, , give my consent for my child to participate in all school affiliated activities including field trips. The school personnel will do within their power to safeguard the health and wellbeing of the said student but, NOT BE RESPONSIBLE FOR ACCIDENTS BEYOUND THEIR CONTROL.

Parent/Guardian Signature _____ Date _____

I, , give the Pahin Sinte Owayawa (Porcupine School) rights to use my son/daughter's pictures on the website or any other usage the school deems necessary.

Parent/Guardian Signature _____ Date _____

MEDICAL INFORMATION

In case of any accident or illness while student is participating or enroute to participate in a school activity, I give permission to emergency medical care, including emergency dental and minor surgery, if such procedure becomes necessary, while the student is under jurisdiction of the Porcupine School. I also give the proper authorities/personnel of Porcupine School the authority to acquire all the necessary documents from the various departments/agencies that are required to attend the Porcupine School.

Parent/Guardian Signature _____ Date _____

If the student's attendance at Porcupine school may be affected by an existing medical or physical condition, it is your responsibility to submit the student's medical records from his/her pediatrician.

Does your child have any medical or physical conditions that may affect his/her attendance at school?
☐ Yes ☐ No
If yes, please give a brief description:

Is there anything the school should know about the health of your child, such as prescription medicine, physical disabilities, or other health conditions? ☐ Yes ☐ No
If yes, please give a brief description:

Are there any specific procedures to follow? ☐Yes ☐ No
If yes, please explain step by step:

Does student have health insurance? ☐Yes ☐ No

If yes, name of service provider:

If provider is Medicaid, what is Student's Medicaid number? ☐ Attach copy of card

Is your child current and up to date on his/her immunization's? ☐ Yes ☐ No ☐ Attach records

Student Name: _____

Grade: _____

DOB: _____

Student health plan

This information must be provided:

Pahin Sinte Owayawa
School Health Plan and Routine Medical Care

I give my permission for Porcupine School; Indian Health Service clinics; Indian Health Service Emergency room; and Indian Health Mobile clinic permission to see my child for any health care issues and for any of the following treatments deemed necessary.

1. Soak/ Cleaning body parts that have sores; wounds and abrasions on students while in school. Also, and not limited to applying non-prescription topical Ointment/ Creams/ Solutions as well as the application of dressing to wounds.
2. Check and cleansing heads that are infested and/ or infected.
3. The use of non-prescription medications for minor complaints by students while in school.
4. Taking their temperature to determine the presence of fever in students while in school.
5. Update all necessary immunizations per state and school policies.
6. Specialty programs coordinated through the student health clinic that are held at the porcupine school which include "School Wide Health Screenings" for early detection of Diabetic; Asthma; High blood pressure; Dental; Eyes; and Hearing on students.
7. Possible transporting students Via school vehicles to appointments for Emergencies to the Indian Health Services; and other health factors not described above.
8. Also, if your child is allergic to any foods or Medications; Please fill out the attached paper work and send these all back to the school nurse. Please list the foods and the medications.

The school health plan is to assist families in procuring and maintaining wellness for their child. However, the school assumes no responsibility for injuries or illness which occur at home.

☐ In my absence I give my permission for my child to receive these services necessary at Porcupine School.

☐ I Do Not want my child to receive these services at Porcupine School and preferred called and will assume care of my child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Pahin Sinte Owayawa School Nurse Date

Project AWARE

Counseling Center

Informed Consent

Introduction Pahin Sinte Owayawa will be offering Mental Health Counseling services for Pahin Sinte Owayawa Students that are experiencing problems coping in the school environment or with personal issues that keep them from fully engaging in their education. It is important for you to know the services that we can provide so that you can make an informed decision about your child receiving care from this program.

Please read, ask the counseling or staff any questions or concerns you may have about what you have read of your child's care at the counseling center.

Program Services Counseling/Wellness program will provide a variety of services to students based on the individual needs (counseling/assessment/referral). The main purpose of our services to students is to treat their individual needs. The counseling services are to identify the student's concerns, to prevent the identified concerns from becoming more serious, and to provide students with an established treatment plan or a referral to I.H.S. Behavior Health or other Agencies/Programs for more intensive therapy. In addition, traditional Lakota ceremonies include Inipi, smudging, and songs as part of the therapeutic process. Services provided; triage mental health needs, counseling (individual, family, group), Mind Body Medicine skills (meditation, breathing, body scan, autogenic), assessments, case management and referral.

Services are limited to those students in the capacity to treat safely in the school setting. Individuals who are an imminent risk to harm self or others results in referral to the I.H.S. Health Center or other Public Safety Agencies.

Hours of Operation Pahin Sinte Owayawa Counseling Center will follow the school's regular school hours.

Treatment Pahin Sinte Owayawa Counseling Center will create a protective environment for our students to promote physical, social, and psychological safety. Student referral for services to the counseling center will include, and not be limited to an Intake Interview, assessment to determine appropriate treatment, and/or referral. Parents/guardians are notified daily of services.

Goals and Benefits To address situations of heightened feelings; sadness, anger, shame, pain, etc., and to discuss painful or embarrassing subjects in a non-judgmental & understanding environment, requiring the integration of mind body medicine skills for the reduction and management of care. The benefits are to establish a knowledge base of available resources for help and safety, enhance personal choice of practicing self-care, and find resolution for continuous care.

Confidentiality & Limits to Confidentiality Trust and honesty are crucial to the development of client counselor relationships. Counselors are required to abide by a confidential code of ethics. This service follows and abides by the legal and ethical requirements of the Pahin Sinte Owayawa, Oglala Sioux Tribe Law & Codes, and the State of South Dakota & National CACREP standards. There may be conditions in which it is necessary for counselors to discuss information about care with other professionals.

- Danger of self-harm, or threats to harm others, and the incapacity of caring for self,
- Suspicion of abuse; children, elderly or disabled persons, sexual, physical, mental or emotional,
- Upon request, records are released without the client consent to the FBI, or BIA Criminal Investigators,
- When a crime is investigated records are released when court ordered only after a patient or guardian consents by signing a release of information,
- Necessary to obtain professional consultation in regards to the course of your care. Consultation regarding the case may be required periodically with supervisor and other colleagues when needed. Counselors will inform you when determination of consultation is necessary. Your identity may or may not be disclosed when this occurs.

Client Responsibilities A client and his/her guardian shall have certain responsibilities while receiving counseling; attending scheduled appointments, asking questions for clarification, concerns, and/or recommendations, complying with self-care, treatment, and therapy sessions.

Statement of Agreement I acknowledge that I fully understand what I have read. I give consent for my child to participate in counseling with the staff at the Pahin Sinte Owayawa.

☐ I consent for my child's participation in Lakota Ceremonies; Inipi, smudging/songs.

☐ I DO NOT GIVE CONSENT FOR MY CHILD TO PARTICIPATE IN LAKOTA CEREMONIES.

_____ _____

Student Name Grade

_____ _____

Parent/Guardian Date

_____

Counselor *UD 5/18*

Staff Contact Information **Main Office - (605) 867-5588 ext.227**

Project Manager - (605) 454-1199

Project Aware Counselor - (605) 454-1342

Project Cultural mentor -(605)867-5588

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUPLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

Student Name: _____

Date of Birth: _____ Grade: _____

Medicaid#: _____

I have read the consent form for the Indian Health Services to arrange for or to provide the following health services for my child:

1. Health care including medical examinations, routine laboratory studies, x-ray procedures and skin tests.
2. Dental care including dental examinations, preventive use of fluorides and necessary emergency dental procedures.
3. Mental health services including evaluations, referrals and treatment as necessary.
4. Transportation of the child to and/ or from another health facility for these services.

O I hereby give consent for all of the above services.

O Exceptions or special instructions: _____

_____

_____

Parent/Guardian Signature:

_____

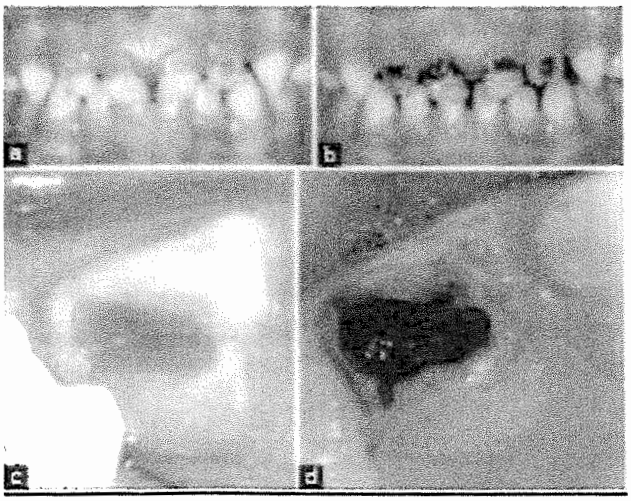
Date: _____

Valid until: _____

Pine Ridge Dental Service Unit Silver Diamine Fluoride (SDF) Consent

Facts for consideration:

- Silver Diamine Fluoride (SDF) is an antibiotic liquid used on cavities to help stop the cavity process within the enamel (white part of tooth) and treat tooth sensitivity.
- Additional SDF application may be recommended.
- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.
- **The affected area will stain black permanently, this is an indication SDF is working.** Healthy tooth structure will not stain.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Color changes on the surface can normally be polished off. The edge between a tooth and filling may keep the color.
- If SDF gets on skin or gums, a harmless brown or white stain may appear and will disappear in 1-3 weeks.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied.
- **If allergic to SILVER SDF isn't a therapeutic option.**



DELTA DENTAL

Delta Dental Mobile Program
Patient Information Form

Please fill out this form completely. If you have questions, please ask a Delta Dental staff member. Thank You!

Patient's Legal Name _____ Birth Date (mm/dd/yyyy) _____

School Attending _____ Grade _____ Age _____ Sex (circle) M F

Ethnicity: (circle) *White* *Black or African American* *Asian* *American Indian* *Hispanic/Latino* *Other*

Home Address _____
Mailing Address City State Zip

Phone Numbers: Home (_____) _____ Work (_____) _____

Cell (_____) _____

Parent/Guardian Name _____ Relation to patient _____

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (_____) _____

Income: Which of these best represents your annual household income? (circle one)

☐ *Less than $10,000* ☐ *$10,000-20,000* ☐ *$20,000-30,000* ☐ *More than $30,000*

Household Size: How many children age 21 or younger live in your household? _____

Dental History (Note: Dental visits should start at first tooth.)	Yes	No	
Is this the patient's first dental visit? Past or current dentist name_____			If no, how long has it been? (√) ☐ less than 2 years ☐ more than 2 years
Has the patient visited the ER/hospital for dental pain in the last year?			If "yes", how many times?
Has dental pain caused you or your child to miss school and/or work in the last year?			If "yes", circle - school work both How many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____ Date of last medical exam (mm/yy) _____			
Does the patient have a current medical condition?			
Is the patient taking any medications?			
Has the patient ever been hospitalized or had surgery?			
Does the patient have any allergies?			
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism			
Is patient pregnant?			

Has the patient had a history of or had difficulty with the following? Check any that apply (√)

☐ AIDS / HIV	☐ Cerebral Palsy	☐ Fainting	☐ Liver disease
☐ Anemia	☐ Diabetes	☐ Heart problems	☐ Mono
☐ Asthma	☐ Epilepsy/ seizures	☐ Hepatitis	☐ Rheumatic fever
☐ Birth defects	☐ Excessive bleeding	☐ Kidney disease	☐ Tuberculosis
☐ Cancer	☐ Other _____		

Please explain your answers: _____

Reason for Visit: Check any that apply (√)

☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else

☐ Toothache/mouth pain/face swelling ☐ Other (specify)_____

Patient Behavior	Yes	No	
Does the patient brush daily?			
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?			
Is the patient using tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			
Does anyone in the household use tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?			

Insurance: Please circle any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided.

MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.

Medicaid/ SCHIP Private DENTAL Insurance (please provide copy of card) None ☐

Medicaid Number/ Policy Number _____

Dental Ins. Name: _____ policy #_____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

Treatment Consent and Agreement

I, _____ (print parent/legal guardian name), as a legally responsible guardian of _____ (print child's name) give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular dental exams by a dentist. Each item needs to be answered in order to receive dental care.

Yes	No	
☐	☐	Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
☐	☐	Dentist Exam (including dental x-rays)
☐	☐	Restorative Services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.
☐	☐	Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.
☐	☐	The use of nitrous oxide (laughing gas) may be used as deemed necessary.
☐	☐	I have been offered and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices.

Parent/Legal Guardian signature _____ Date _____

BIE McKinney-Vento Enrollment/Referral

The purpose of this form is to address the requirements of the McKinney-Vento Act, Title X, Part C of the No Child Left behind Act. This document wilt be used to share with school staff and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

1. Is your current address a temporary living arrangement? Yes___ No___
2. Is your temporary address due to loss of housing or economic hardship? Yes___ No___

If answer to both questions is, "YES", please continue, otherwise stop here. Thank you!

Student Information

Student Name(s) _____

Age(s) _____

Grade Level(s) _____

School Site(s) _____

Parent/Guardian Name(s): _____

Parent/Guardian/Youth phone number: _____

○ Cellular phone ○ Work Phone ○ Shelter Phone ○ Family/Friends Residence

Residency Information

Are you a high school student who is currently living on your own? Yes___ No___

Where does the student stay at night?

☐ Shelter ☐ Temporary Housing ☐ Other: _____

Address/Directions: _____

_____

Shelter Contact Person: _____

The family/youth has been residing within the school district boundaries and intend to stay. (Please initial) _____

Does the student wish to continue at school of origin? Yes___ No___

- Is school of origin a boarding school? Yes___ No___
- If present school is a boarding school, will student be enrolled in residential dorm? Yes___ No___

Agreed Upon Services

Educational Services Description: _____

_____

After-school Services Description: _____

_____

Transportation Services

Pick-up Location: _____

Drop-off Location (if different): _____

Health Services

Immunizations: _____

Dental: _____

Food/Clothing: _____

Free Lunch: _____

Counseling: _____

The parent/guardian/youth understand that the agreed upon services are supplemental to the regular instructional day and will be re-evaluated to determine which need to be continued. In the event that the family/youth residency changes, it is their responsibility to notify School Liaison/Designee immediately.

_____ _____

Parent/Guardian/Youth Date School Liaison/Designee Date

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

_____ _____

Signature of Person Providing Information **Date**

Parent/Legal Guardian/Caregiver/Unaccompanied Student (Circle one)

If student is an unaccompanied youth, please provide contact information for a caregiver or other adult that can be notified in the event of an emergency: _____ _____ _____

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

Name **Phone contact** **Relationship to student**

For School Use Only

Note: Upon enrollment, the school registrar or other designated staff is responsible for inputting required student-level data into NASIS including housing type (Primary Nighttime Residence).

Housing type (Primary Nighttime Residence)-Check all that apply and date:

☐ Doubled-up: _____ ☐ Sheltered: _____

☐ Hotel/Motel: _____ ☐ Unsheltered: _____

1)**Unaccompanied youth**: ☐ Yes ☐ No

2) **Transportation needed**: ☐ Yes ☐ No

Select all that apply: ☐ Special Education ☐ English Learner ☐ Migrant

Resources and Services
Must be reviewed with parent/guardian/unaccompanied homeless youth in a manner and form that is understandable, including if necessary and to the extent feasible, in the native language:

☐ McKinney-Vento rights reviewed (Immediate enrollment, Rights to attend school of origin, Transportation, Free school meals/fees waived)

☐ Community resources available and information shared (Food and clothing, Affordable permanent housing, Emergency shelter, Mental health services, Employment, Domestic abuse resources, Medical, dental, and other health services, Seasonal/holiday)

☐ School staff confidentially received student information (Food services, Registration/enrollment, Transportation department, Building school counselor or school social worker, Building principal)

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.

Local Homeless Liaison: _____ **Date:** _____

Internet Acceptable Use Policy Agreement

Students, Faculty, Staff and administrators at Pahin Sinte Owayawa have access to the Internet. Internet access will help promote educational excellence in schools by facilitating student research, resource sharing, searching and technology techniques and utilization, and internal and external communication. The internet is an electronic network of computer networks connecting millions of computers and hundreds of million of people all over the world. The following services are available to our students, faculty, staff and administrators.

1. Electronic mail (email)
2. World Wide Web Access

Pahin Sinte Owayawa has taken precautions to restrict access to conversational materials. However, it is impossible to control all materials and block materials that may be inappropriate for school use. Pahin Sinte Owayawa believes that valuable information and communications accessible through the Internet far outweighs the possibility that users may come access inappropriate information. The following guidelines are provided as a framework for proper Internet use in Pahin Sinte Owayawa. Any violation of any of he provisions stated here may cause the Pahin Sinte Owayawa Administration to terminate or restrict the users account and access may be permanently denied. The signature(s) on this document is (are) legally binding and indicates the party (parties) who signed has (have) read and understand the terms and conditions herein.

Internet: Terms and Conditions of Use:

1.Privileges-The use of the Internet is a privilege, not a right, and inappropriate use will result in a cancellation of this privilege

2. Acceptable Use-The use of the Internet privileges must be in support of education and research and consistent with the educational objectives of the Pahin Sinte Owayawa. Transmission of any material in violation of any national or state regulation is prohibited. This includes, but is not limited to: copyrighted material; threatening, harassing or obscene email, social media or material; or material protected by trade secret or other laws.

3. Network Etiquette-You are expected to follow generally accepted rules of Internet etiquette. General rules include (but are not limited) to the following:

- Do not reveal your personal address or phone numbers of students or colleagues.
- Do not give out your password to anyone.
- Use appropriate language. Remember that the Internet is not private and anything you say may be resent and reposted.
- Do not participate in illegal activities.
- Be polite in all your writing. Remember that words are easily misunderstood.

- Email is private. System operators and authorities have access to all communications.
- Do not forward other email without their express permission.
- Use your email and web privileges for the benefit of your education and the mission of Pahin Sinte Owayawa only.

4. **Pahin Sinte Owayawa** makes no direct or implied warranties for any of the services it may provide Pahin Sinte Owayawa will not be responsible for any damages suffered directly or indirectly by the user. This will include access or lack of access to email, material, or data and/or loss of service or electronic data and communications.

5. **Security**-Security is of vital importance to Pahin Sinte Owayawa. We will do everything in our power to make sure that the network is secure. Since technology and humans are not perfect, lapses in security may occur; Pahin Sinte Owayawa is in no way responsible for this and shall be held harmless.

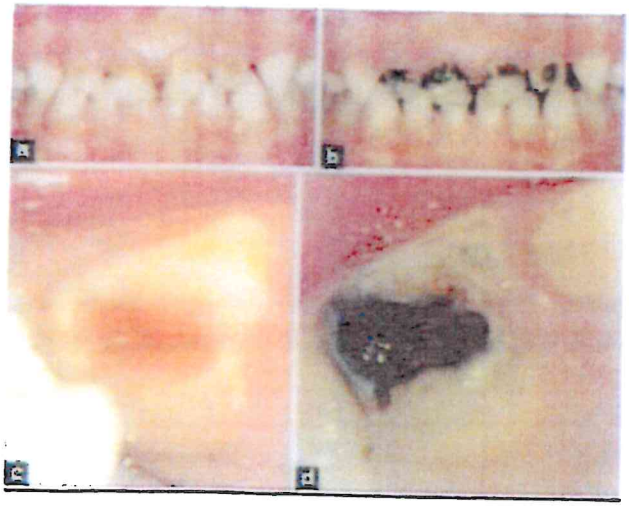
6. **Vandalism**-Vandalism will not be tolerate and is a reason for immediate suspension of privileges.

Parent/Guardian Signature _____ Date _____

Pine Ridge Dental Service Unit Silver Diamine Fluoride (SDF) Consent

Facts for consideration:

- Silver Diamine Fluoride (SDF) is an antibiotic liquid used on cavities to help stop the cavity process within the enamel (white part of tooth) and treat tooth sensitivity.
- Additional SDF application may be recommended.
- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.
- **The affected area will stain black permanently, this is an indication SDF is working.** Healthy tooth structure will not stain.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Color changes on the surface can normally be polished off. The edge between a tooth and filling may keep the color.
- If SDF gets on skin or gums, a harmless brown or white stain may appear and will disappear in 1-3 weeks.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied.
- **If allergic to SILVER SDF isn't a therapeutic option.**



Pine Ridge Dental Service Unit School Sealant Program Consent Form

Dear Families,
A free dental program will be in your child's school. Your child will receive preventative dental services that include a dental screening, tooth cleaning, sealants, fluoride varnish, silver diamine fluoride and tips on how to care for their teeth.

Name:_____ Date of Birth:_____Sex: M/F
School:_____ Grade:_____ Teacher: _____
Address: _____ City/State/Zip: _____
Parent/Guardian: _____ Cell Phone: _____
Email: _____ Home: _____Work: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Health History	Yes	No	
Allergies			Reaction Type
Medications			
Past Surgeries			
Pregnant			
Heart Conditions			

Condition	Yes	No	Explanation
Asthma			
HIV			
Hepatitis			Type:
Gastrointestinal			
Diabetes/Type			
Seizures			
Joint Replacement			
Hospitalizations			

CoVID 19 Screening	Yes	No
Tested positive for COVID 19		
Loss of taste or smell		
Cough		
Shortness of Breath		
Muscle Pain/Body Aches		
Nausea/Vomiting/Diarrhea		
Headache		
Fever/feverish		

	Yes	No
Are you experiencing any tooth pain?		
Is this your first dental visit?		
Does anyone smoke in the home?		
Do you brush your teeth daily?		

Dental Insurance	
Medicaid ID	
Private	
IHS	

Consent

Yes	No	Procedures
		Dental screening, teeth cleaning, sealants, fluoride varnish
		Silver diamine fluoride (will turn area of tooth with cavity black, see attachment, baby teeth only)
		Dental exam, x-rays, nitrous oxide, fillings and extractions

Signature _____ **Date** _____
Provider _____ **Date** _____

First Name: Last Name:

BIE Home Language Survey
2023-2024 School Year
Pahin Sinte Owayawa
Porcupine School

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 mission of the Porcupine School is to provide a quality education for children of the Lakota Nation which promotes the culture and prepares them for success in the future."

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 questions listed as accurately as possible.

First Name: **Last Name:**

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)

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.

Pahin Sinte Owayawa
Transportation
Bus Policy 2024/2025

- **Parents are required** to have their child ready prior to the bus arriving at their scheduled stop.
- Bus Drivers are required to wait **3 minutes** at each bus stop.
- If a student misses his or her bus ride or other school transportation, the parent is responsible to providing transportation to school on that day.
- On days which inclement weather has made off roads muddy and undriveable, students will be excused for that day. Parents can also bring their child to the pavement of the road to board the bus. School vehicles will not be traveling on muddy undriveable roads due to getting stuck or vehicle damage.
- Students will be transported home during an emergency or early closing of the school.

Signature_____ **Date**_____

OGLALA LAKOTA COUNTY SCHOOL
DISTRICT 65-1
P.O. BOX 109, BATESLAND, SD 57716

2024-2025 School Year Survey Form

Dear Parents / Guardians:
The Oglala Lakota County School District 65-1 is eligible to receive Impact Aid funding (Federal funds, which are paid in lieu of taxes on trust lands). In order for the school your child is attending to receive i mpact aid funds we must have the following information.

1. Name of Child: _____
   First Middle Last
2. Child's Date of Birth: _____ Female or Male
3. School _____ Teacher _____ Grade _____
4. Town of Residence of Child on Survey Date _____
   City State
5. Child's Enrollment # _____ with the _____ Tribe.
6. Exact Physical Location of child's residence - housing name, house number, how many miles and direction from mailing address. (Please be as specific as you can with your directions)

   _____

   _____
7. The following land description is **absolutely necessary** regarding where you live. Call BIA Reality office at 867-1001

Range Unit # _____ Township # _____ Section # _____ Tract# _____

8. Do you pay property taxes to the county for the land you live on? Yes____ No_____
9. Name and mailing address of Parents or Guardians on date of survey.

   Name and mailing address of Parents or Guardians' Employer on date of survey.
10. Parent's occupation on survey date: _____

Student Social Security Number:

_____
Signature of Parent/Guardian