

# Lower Kuskokwim School District

## Bethel Schools Enrollment

Date: \_\_\_\_\_

- |                       |                             |      |                |
|-----------------------|-----------------------------|------|----------------|
| <input type="radio"/> | Mikelnguut Elitnaurviat     | K-2  | (907) 543-2845 |
| <input type="radio"/> | Gladys Jung Elementary      | 3-6  | (907) 543-4440 |
| <input type="radio"/> | Ayaprun Elitnaurvik         | K-6  | (907) 543-1645 |
| <input type="radio"/> | Bethel Regional High School | 7-12 | (907) 543-3957 |
| <input type="radio"/> | Kuskokwim Learning Academy  | 9-12 | (907) 543-5610 |

Student Legal Last Name		First	MI	Social Security Number	
Grade	Gender <input type="radio"/> Male <input type="radio"/> Female	Birthdate: month/day/year		Mother's Maiden Name	
Ethnic Origin <input type="radio"/> Alaska Native <input type="radio"/> Hispanic <input type="radio"/> Caucasian <input type="radio"/> American Indian <input type="radio"/> African American <input type="radio"/> Mixed Ethnicity <input type="radio"/> Asian/Pacific Islander			Mailing Address (PO Box)		City
			Physical Address (House and Street)		Zip Code
Mother/Guardian			Father/Guardian		
Home Phone Number		Mother's Cell Phone	Father's Cell Phone	Student's Cell Phone	
Mother's Employer		Mother's Business Phone	Father's Employer	Father's Business Phone	
e-mail			e-mail		

### Previous School:

Name of School:			
Address:		Date last attended:	

To which phone numbers/email would you prefer automated school messages be sent? (home phone is default)

- |  |   |
|--|---|
| <input type="checkbox"/> Home Phone    | <input type="checkbox"/> Mother's email |
| <input type="checkbox"/> Mother's Cell | <input type="checkbox"/> Father's email |
| <input type="checkbox"/> Father's Cell |   |

In addition, the following forms must be submitted with a new student enrollment:

- |  |   |
|--|---|
| <input type="checkbox"/> Transcripts / Grades from previous school | <input type="checkbox"/> Up-to-date shot records            |
| <input type="checkbox"/> Income Survey for Title I (attached)      | <input type="checkbox"/> Demographic Information (attached) |
| <input type="checkbox"/> Indian Education 506 Form                 | <input type="checkbox"/> Birth Certificate                  |

\_\_\_\_\_  
Parent/Guardian Signature

**HEALTH SHEET  
STUDENT INFORMATION**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Emergency contact (if you cannot be reached at above numbers)

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Many times during the school year, students will come to the front office with a sore throat, headache, or other aches and pains. Most times, a non-aspirin pain reliever or other over the counter medication would take care of the symptoms. At times we may not have a nurse, so we need your permission to allow them to self-administer a non-aspirin pain reliever (such as Tylenol or Ibuprofen), and/or cough drops. Please fill in and sign the form below if you choose to give this permission. If your child has specific medical needs, or may need to take prescription drugs during the school day, please notify us.

☐ I give permission for my child to self-administer a non-aspirin pain reliever, and/or cough drops when deemed prudent to the best interests of my child.

Parent/Guardian Signature: \_\_\_\_\_

**STUDENT HEALTH HISTORY**

Please fill in the following questionnaire. This information will be used to better the healthcare of our students.

(Please circle your answer)

1. Does your child have allergies? YES NO  
Allergic to: \_\_\_\_\_
2. Does your child take medication regularly? YES NO  
Name of medication, and reason taken: \_\_\_\_\_
3. Are your child's physical activities limited? YES NO  
How, and for what reason? \_\_\_\_\_
4. Does your child have other health problems that the school should be aware of? (i.e. asthma, migraines.....)

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*11<sup>th</sup> and 12<sup>th</sup> GRADE STUDENTS ONLY\*\*\***

**2023-2024**

**BRHS Off-Campus Behavior Contract**

**Student Commitment**

I am a Junior or Senior at Bethel Regional High School (BRHS) with good citizenship standing. I agree to follow the BRHS behavior code while I am off-campus during my lunch period. I understand my freedom to leave campus during my lunch may be revoked if I am late to class after lunch, if I offer transportation to leave campus to any ineligible student, or if I break the BRHS behavior code.

---

Student Printed Name

Student Signature

Date

**Parent/Guardian Consent for Off-Campus  
Privileges**

My student, \_\_\_\_\_, of Junior or Senior standing, has my permission to leave campus during the high school lunch period. I understand that my child may ride in vehicles driven by other eligible students during their open campus lunch period. By signing this agreement, I agree not to hold Bethel Regional High School responsible for my child during open campus lunchtime. I also understand my student may lose this privilege of open campus lunch if he or she violates the above signed contract.

---

Printed Parent/Guardian Name

Signature

Date

## AUTHORIZATION FOR RELEASE OF IMMUNIZATION / TB RECORDS TO COMPLY WITH ALASKA'S "NO-SHOTS NO-SCHOOL" LAW

The purpose of releasing this information is to allow schools, childcare facilities and other centers that house school-age children to comply with Alaska's "No-Shots No-School" law. In many cases, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires written authorization before personal medical information can be released by a health care provider or health care organization. This form authorizes only the release of immunization records and/or confirmation of tuberculosis screening. **I understand that this does not authorize release of any other personal medical information.**

Name of child / student: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Name of parent / guardian: \_\_\_\_\_

Health care provider / organization releasing information: PUBLIC HEALTH NURSING - STATE OF AK

School / organization requesting information: BETHEL REGIONAL HIGH SCHOOL

Description of information to be released (check one or both):

- ☐ Immunization records
- ☐ Tuberculosis screening and results

I hereby authorize the disclosure of immunization records and / or tuberculosis screening information as described above. I understand that this authorization is voluntary. I understand that a health care provider may not condition treatment on whether I sign this authorization. I understand that if the person(s) or organization(s) authorized to receive this information is not a health plan or health care provider, the released information *may* no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may revoke this authorization at any time by notifying the organization releasing this information in writing. If I do revoke this authorization, I understand it won't affect actions taken before my revocation was received. I understand that I may request a copy of this authorization.

Please check **ONLY** one:

- ☐ I additionally authorize the re-disclosure of immunization records and/or tuberculosis screening information to other school or health care authorities should my child move to another school or school district AND I understand that this authorization to re-disclose will expire when the student reaches the age of majority or when this authorization is revoked.
- ☐ I DO NOT authorize further re-disclosure of this information and request that this authorization expire:
  - \_\_\_ When student moves or graduates from the school or organization listed above or when this authorization is revoked.
  - \_\_\_ Other (specify date): \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Printed name of parent or guardian: \_\_\_\_\_

Today's date: \_\_\_\_\_



Lower  
Kuskokwim  
School  
District

## Parental Media Release Form

I certify that I am the parent and/or guardian of \_\_\_\_\_,  
a student in the Lower Kuskokwim School District (LKSD).

I give the LKSD the right and permission to use and/or edit any

- Photographs
- Videos/films
- Audio recordings
- Student name
- Works, projects, and art
- Awards/recognitions of the above named student in the following ways:
  - In school settings
  - During out-of-school student activities
  - On LKSD webpages
  - At workshops or conferences
  - In public media such as radio, television, and newspaper
  - In LKSD publications such as ELICAQ, Student of the Month, and advertisements

These photographs, videos, films, audio recordings, student name, works, projects, art, awards/recognitions will be used for the purpose of representing LKSD in a positive and beneficial manner. They will not be used for commercial purposes or profit.

I hereby consent to the above named uses and release LKSD, its employees, Board members and agents from any and all claims resulting from such use.

I hereby decline permission to the above named uses

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Student Printed Name

# BRHS Cell Phones/Portable Electronic Device Policy

## Cell Phones/Portable Electronic Devices:

### Conditions of Use

1. The use of cell phones during class is prohibited.
2. All Portable Electronic Devices should be stored inside of a bag or pocket.
3. Cell phones can be used before school starts, upon dismissal, and during lunch.
4. The District assumes no responsibility for loss or damage to personal property of students, including all portable electronic devices, whether in the possession of students or if confiscated by school personnel pursuant to this policy.
5. Repeated violations will be regarded as willful disobedience as disciplined as according to the discipline rubric.
6. The contents of a cellular phone, camera, or any other PED may be searched to determine ownership, to identify emergency contacts, or upon reasonable suspicion that a school or District rule or the law has been violated.

**Prohibited Conduct:** The following actions involving portable electronic devices are not allowed and will result in disciplinary action:

- Using a portable electronic device, including any type of camera, in a restroom or locker room.
- Calling, texting or otherwise communicating with students in another classroom during scheduled class time, unless specifically directed to do so by school personnel.
- Behaving in a manner that is disruptive, rude, or lewd.
- Sending any form of text, photo, or other communication that harasses, intimidates, threatens, bullies, or discriminates against another individual or group.

If a parent needs to contact their student during class, please contact the front office.

Failure to comply with cell phone policy may result in being ineligible to participate in extracurricular activities.

First Offense	Second Offense	Third Offense
1 day confiscation and returned to student at the end of the day - parent phone call home	Confiscate until student and parent meeting (release device to parent) Detention	Device released only to parent- ineligible for student activities for that week, disciplined as according to willful disobedience

**Earbuds:** Earbuds and similar devices may not be used during instruction. Repeated violations will be regarded as willful disobedience.

I HAVE RECEIVED AND UNDERSTAND THE BRHS CELL PHONE/PORTABLE ELECTRONIC DEVICE POLICY.

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STUDENT SIGNATURE

DATE

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PARENT/GUARDIAN SIGNATURE

DATE

**\*\*\*PLEASE KEEP THIS PAGE FOR YOUR REFERENCE\*\*\***



# School-Parent Compact

**Bethel Regional High School**

**School Year 2023-2024**

**Revised 07/31/23**

Dear Parent/Guardian:

BRHS students participating in the Title I, Part A program, and their families, agree that this compact outlines how the parents, the entire school staff, and the students will share the responsibility for improved student academic achievement. This compact also describes how the school and parents will build and develop a partnership that will help children achieve the challenging State academic standards.

## Jointly Developed

We believe that families, students, and school staff should work in partnership to help each student reach his/her potential.

## School Responsibilities

**Bethel Regional High School will:**

1. Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables the participating children to meet the challenging State academic standards as follows:

The Mission of Bethel Regional High School is to provide an education that promotes skill mastery, content knowledge, life-long learning, and accountability in a safe learning environment that fosters respect, trust, character development, civil-mindedness, and acceptance of cultural diversity.

2. Hold parent-teacher conferences during which this compact will be discussed as it relates to the individual child's achievement. Specifically, those conferences will be held:

Twice a semester, usually about midway through each quarter. BRHS will give notice ahead of time to notify parents/guardians the specific dates and times.

3. Provide parents with frequent reports on their children's progress. Specifically, the school will provide reports as follows:

Progress will be presented to parent/guardians at parent-teacher conferences or mailed home if not picked up. Report cards will be mailed home after each quarter ends and grades have been stored in PowerSchool.

4. Provide parents reasonable access to staff. Specifically, staff will be available for consultation with parents as follows:

Teacher emails are listed in the Student Handbook as well as in PowerSchool on the student's schedule.

Parents/guardians can also leave a message at the Front Office for a teacher to call them.

5. Provide parents opportunities to volunteer and participate in their child's class, and to observe classroom activities, as follows:

BRHS welcomes parent/guardian visits. Please make arrangements ahead of time with the staff you are planning to meet with.

6. Ensure regular two-way, meaningful communication between family members and school staff. Specifically, the school will ensure meaningful communication as follows:

School staff will make it a priority to communicate regularly via email, phone calls, letters home, and social media to help keep parents/guardians informed with the most recent updates regarding our school and students.

## Parent Responsibilities

We, as parents and guardians, will support our children's learning in the following ways:

- Talk to my child regularly about the value of education.
- Talk to my child about their goals and interests for after high school. Encourage goal setting and encourage my child to challenge him/herself.
- Communicate with the school when I have a concern.
- Provide a time and place for studying or doing homework.
- Encourage reading and discourage excessive TV viewing and electronics play.
- Make sure that my child attends school every day, on time, and with homework completed.
- Support the school's discipline code.
- Monitor my child's progress in school.
- Make every effort to attend school events, such as parent-teacher conferences, or orientations. Ensure that my child gets adequate sleep, regular medical attention, and proper nutrition.
- Participate in shared decision making with school staff and other families for the benefit of students.
- Respect the school, staff, students, and families.

## Student Responsibilities

We, as students, will share the responsibility to improve our academic achievement and achieve the State's high standards. Specifically, we will:

*Describe the ways in which students will support their academic achievement, such as:*

- Believe that I can learn and will learn.
- Make school attendance a priority and target a personal attendance rate of 95% or better.
- Come to class ready to learn, give my best effort, participate, and work cooperatively.
- Set aside time every day to complete my homework and return homework on-time.
- Read for at least 30 minutes, five days a week. This can be a great work of fiction, or careful textbook reading. Reading is a powerful way to learn and must be practiced.
- Know and follow the school and class rules.
- Regularly talk to my parents and my teachers about my progress in school.
- Ask for help when I need it.
- Respect my school, classmates, staff, and family.



Lower Kuskokwim School District

**High School  
ONLY**

**Military or College Recruiters  
Parent Request to Withhold Release of Information**

To: Parents

The **Every Student Succeeds Act of 2015** requires that school districts provide military recruiters and institutions of higher education access to secondary school students' names, addresses, and telephone listings. Parents have the right to withhold the release of this directory information from these organizations.

If you **DO NOT** want your child's directory information released to the military and/or college recruiters, please complete the following:

Student Name: \_\_\_\_\_ School: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ **Do not** release my child's directory information to military recruiters.

\_\_\_\_ **Do not** release my child's directory information to colleges, universities, or other institutions of higher learning.

Parent Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

OR

Eligible Student Signature \_\_\_\_\_ Date: \_\_\_\_\_  
(18 years or older)

*Thank you*

**Please return the completed form to your child's school by September 30.**

## Lower Kuskokwim School District

### **Family Educational Rights and Privacy Act (FERPA) Parent Request for Non-Disclosure of School Directory Information**

The **Family Educational Rights and Privacy Act (FERPA)**, a Federal law, requires that LKSD, with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, LKSD may disclose appropriately designated "directory information" without written consent, unless you have advised the District to the contrary in accordance with District procedures. The primary purpose of directory information is to allow LKSD to include this type of information from your child's education records in certain school publications.

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks.

The Lower Kuskokwim School District has designated the following information as directory information:

- Student's Name
- Participation in officially recognized activities and sports
- Address
- Telephone listing
- Weight and height of members of athletic teams
- Electronic mail address
- Photograph
- Degrees, honors, and awards received
- Date and place of birth
- Dates of attendance
- Grade level

If you **do not** want LKSD to disclose directory information from your child's education records without your prior written consent, you must notify the district in writing by September 30. The form is located on the back on this sheet.

Lower Kuskokwim School District

**Family Educational Rights and Privacy Act (FERPA)  
Parent Request for Non-Disclosure of School Directory Information**

To: Parents of K-12 Students

If you **do not** want your child's directory information released, please complete the following:

Student Name: \_\_\_\_\_ School: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ **Do not** release my child's directory information.

Parent/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

Eligible Student

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Thank you*

**Please return this form to your child's school by September 30.**



# YUKON-KUSKOKWIM HEALTH CORPORATION

## Bethel Regional High Health Center PARENT/GUARDIAN CONSENT AND INSURANCE INFORMATION SHEET

Students Name \_\_\_\_\_ DOB \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Insurance Information: Medicaid, other insurance \_\_\_\_\_  
Insurance name \_\_\_\_\_ Policy Holder \_\_\_\_\_  
Policy number or ID number \_\_\_\_\_ Group Number \_\_\_\_\_  
Parent's Employer \_\_\_\_\_ Effective date \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFIT:** *I assign the Yukon-Kuskokwim Health Corporation, all benefits due and payable to me under insurance policies by virtue of my treatment. I authorize insurance company to deduct payments from its obligations to me for benefits provided under my policy. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I understand that I remain financially responsible to YKHC for charges not met by the proceeds of this assignment, if I am not IHS eligible. I agree to pay all charges for all services rendered to me during my treatment at YKHC that are not paid in full by any third party payers.*

**AUTHORIZATION TO RELEASE INFORMATION FOR BILLING PURPOSES:** *I authorize Yukon-Kuskokwim Health Corporation to disclose medical information i.e. diagnosis, discharge summary, doctors' orders, progress notes and other related documents to the extent required to assure payment to any agency, who is liable. This would include the diagnosis, or treatment received during the course of this treatment.*

**PRIVACY ACT:** *I understand that the information given by me and/or collected and stored in my health record or any portion of my health record may be shared with other service providers within YKHC and as necessary to ensure the highest quality of services available for my health and wellbeing. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person without my signed consent, unless the disclosure is permitted by federal/state laws and regulations. (Notice of privacy practices is available upon request or you can download a copy at YKHC.org)*

This form makes it possible for your child to receive health services through the Bethel Regional High Health Center until they are 18 years old. All direct care is provided by a YKHC or Bethel Public Health Center provider. We are providing these services to improve access to care for teens in the community.

This consent form provides you with two options:

**I acknowledge that I have read this agreement and understand its purpose and contents.**

### **I. I PROVIDE MY CONSENT.**

I am the parent or legal guardian of the minor individual whose name is stated above. I hereby give my consent to the Bethel Regional High Health Center to provide health and counseling services to my child throughout the school year.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_  
Printed name: \_\_\_\_\_ Date \_\_\_\_\_

-----OR-----

**I acknowledge that I have read this agreement and understand its purpose and contents.**

### **II. I WITHHOLD MY CONSENT. \*\***

I am the parent or legal guardian of the minor individual whose name is stated above. I do not give my consent to the Bethel Regional High Health Center to provide health and counseling services to my child.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_  
Printed name: \_\_\_\_\_ Date \_\_\_\_\_

Note: You may submit a new form if you decide at a later date to provide consent.

If you provided your consent please provide the following information:

Name of Child's regular physician: \_\_\_\_\_  
Past or present chronic illness if any: \_\_\_\_\_  
Allergies or reactions to medications if any: \_\_\_\_\_

**\*\* Alaska law AS 09.65.100(4) states that a minor may give consent for diagnosis, prevention or treatment of pregnancy, and treatment of venereal disease. No parental consent is required for these services.**



**Yukon-Kuskokwim  
HEALTH CORPORATION**

## **BRHS Dental Clinic**

*Dear Parent or Guardian,*

*YKHC Dental is expanding our service to provide dental care services the Bethel Regional High School (BRHS) Clinic for current students. This program will be run by various dental providers throughout the year.*

*If you are interested in having your child scheduled for a dental exam, cleaning, and/or fillings during school hours at the BRHS clinic, please complete the bottom of this form **and** the Dental Patient History form (front and back). Both of these need to be completed in entirety for your child to be scheduled.*

*As part of this clinic, we will provide the following services your child:*

- *Dental Exams*
- *Fluoride varnish and iodine applications*
- *Sealants*
- *Dental Prophylaxis (teeth cleaning)*
- *Protective Restorations (temporary fillings)*
- *Silver Diamine Fluoride (This WILL TURN CAVITIES BLACK, but will help kill the bacteria to stop the cavity from growing)*
- *Fillings under Local Anesthesia (getting teeth and surrounding areas numb)*

*If you have any questions, please contact:*

Name: Dr. David Humphrey Title: Doctor of Dental Surgery Phone: 907-543-6229

### **Consent Form for Services Offered by YKHC Dental Community Outreach Program**



**Student's Name:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

**Student's Medicaid/Denali Kid Care Number:** \_\_\_\_\_

**Student's Insurance Plan name/number:** \_\_\_\_\_

I give my permission for my child to receive preventative services, (fluoride varnish and iodine, sealants, teeth cleaning, protective restorations, SDF & oral hygiene instructions, local anesthesia (*getting teeth and surrounding areas numb*), and fillings from the Dental Provider. As well as, the school to give my child's name and contact information to YKHC Dental for the purpose of follow-up and billing.

**Parent or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

"I affirm that I have correctly translated this document from English to Yupik/Cupik for \_\_\_\_\_ and I believe they understand the information on this page." **Translator:** \_\_\_\_\_



# Yukon-Kuskokwim HEALTH CORPORATION

## Consent and Insurance Information Sheet

Patient Name: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Insurance Plan / Medicaid #: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Dependent	Birth Date	Dependent	Birth Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

- ☐ I consent to the following routine dental procedures: x-rays, cleanings, fillings, crowns, local anesthesia and topical fluoride application.
- ☐ I give permission to YKHC Dental to photograph me for medical/dental purposes only and for the sole use of the medical/dental clinic.
- ☐ I understand that I will be requested to provide consent to procedures beyond routine care and the risks, benefits and options related to those procedures will be explained to me.
- ☐ I have reviewed the treatment plan. I authorize release of any information relating to this claim.
- ☐ I hereby authorize payment directly to the Yukon-Kuskokwim Health Corporation.

_____	_____	_____	_____
Patient's Signature	Printed Name	Date	Time AM/ PM

Why does the YKHC Dental Department wish to bill your insurance company?

Two reasons:

1) Regulations state that payment for health services must be sought when Alaskan Natives have "alternate resources" (like insurance companies) – Chapter 42 CFR 36.12/36/23.

2) Payment for your dental services by this "alternative resource" will allow more dental services to be provided to all the people of the Yukon-Kuskokwim Delta.

☐ Check if NO Insurance or Medicaid

### Guarantor of Payment — NO PROOF OF INSURANCE

I understand that **failure** to provide Yukon-Kuskokwim Health Corporation with **proof** of insurance upon registration has made me **financially responsible** for all charges.

I understand that if I provide proof of insurance at a later time, I will be held liable for all charges excluded from coverage of my policy. This authorization is valid for this visit only.

I understand that I am financially responsible for all charges incurred for this visit date.

_____	_____	_____	_____
Patient's Signature	Printed Name	Date	Time AM/ PM

### Broken Appointment Policy

To increase services to all patients the following policy is in effect. You can be rescheduled only twice. If you are credited with one broken appointment you **WILL NOT BE SCHEDULED FOR ANOTHER APPOINTMENT FOR AT LEAST THREE MONTHS**. You will be charged with a broken appointment when:

- You do not come to the dental clinic for your appointment.
- When you sign in at the dental clinic 5 minutes or more after your appointment time.
- When you do not cancel your appointment at least 1 day (24 hours) before your appointment time.
- You do not notify the YKHC Dental department of a weather delay 2 hours prior to your appointment.

I understand the Broken Appointment Policy.

_____	_____	_____	_____
Patient, Parent or Guardian Signature	Printed Name	Date	Time AM/ PM



# Yukon-Kuskokwim HEALTH CORPORATION

P.O. Box 528 • Bethel, Alaska 99559 • 907-543-6000

## Dental Patient History - Medical

Your health information will be used to provide care, treatment and services to you, and will not be disclosed without your authorization.

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ DOB: \_\_\_\_\_ ☐ M ☐ F

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Name of Physician and their specialty \_\_\_\_\_

Most recent physical examination \_\_\_\_\_ Purpose \_\_\_\_\_

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

### DO YOU HAVE or HAVE YOU EVER HAD:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. hospitalization for illness or injury.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. an allergic reaction to   |                          |                          |
| <input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine    |                          |                          |
| <input type="checkbox"/> penicillin                                    |                          |                          |
| <input type="checkbox"/> erythromycin                                  |                          |                          |
| <input type="checkbox"/> tetracycline                                  |                          |                          |
| <input type="checkbox"/> sulfa   |                          |                          |
| <input type="checkbox"/> local anesthetic                              |                          |                          |
| <input type="checkbox"/> fluoride                                      |                          |                          |
| <input type="checkbox"/> metals (nickel, gold, silver, _____)          |                          |                          |
| <input type="checkbox"/> latex   |                          |                          |
| <input type="checkbox"/> other _____                                   |                          |                          |
| 3. heart problems, or cardiac stent within the last 6 months....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. history of infective endocarditis.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. artificial heart valve, repaired heart defect (PFO).....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. pacemaker or implantable defibrillator.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. orthopedic implant (joint replacement).....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. rheumatic or scarlet fever .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. high or low blood pressure.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. a stroke (taking blood thinners) .....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. anemia or other blood disorder.....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. prolonged bleeding due to a slight cut (INR>3.5) .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. emphysema, shortness of breath, sarcoidosis .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. tuberculosis, measles, chicken pox.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. asthma .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus).... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. kidney disease .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. liver disease.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. jaundice .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. thyroid, parathyroid disease, or calcium deficiency .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. hormone deficiency.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. high cholesterol or taking statin drugs .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. diabetes (HbA1c = _____).....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. stomach or duodenal ulcer .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. digestive disorders (i.e. celiac disease, gastric reflux).....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. osteoporosis/osteopenia (i.e. taking bisphosphonates).....         | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 27. arthritis .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. autoimmune disease                                  |                          |                          |
| (i.e. rheumatoid arthritis, lupus, scleroderma) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. glaucoma .....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. contact lenses.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. head or neck injuries.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. epilepsy, convulsions (seizures) .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. neurologic disorders (ADD/ADHD, prion disease)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. viral infections and cold sores.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. any lumps or swelling in the mouth.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. hives, skin rash, hay fever .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. STI / STD / HPV .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. hepatitis (type____) .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. HIV/ AIDS.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. tumor, abnormal growth .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. radiation therapy.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. chemotherapy, immunosuppressive medication .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. emotional difficulties .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. psychiatric treatment.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. antidepressant medication.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. alcohol / recreational drug use.....                | <input type="checkbox"/> | <input type="checkbox"/> |

### ARE YOU: .....

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 47. presently being treated for any other illness.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. aware of a change in your health in the last 24 hours  |                          |                          |
| (i.e. fever, chills, new cough, or diarrhea).....          | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. taking medication for weight management .....          | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. taking dietary supplements .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. often exhausted or fatigued .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. experiencing frequent headaches.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. a smoker, smoked previously or use smokeless tobacco.. | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. considered a touchy / sensitive person.....            | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. often unhappy or depressed .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 56. FEMALE - taking birth control pills.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. FEMALE - pregnant / nursing .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. MALE - prostate disorders.....                         | <input type="checkbox"/> | <input type="checkbox"/> |

Do you feel safe at home? ..... ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) \_\_\_\_\_

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS

_____ Patient/Guardian Signature	_____ Printed Name	_____ Date & Time	AM/ PM
_____ Provider Signature	_____ Printed Name	_____ Date & Time	AM/ PM



# HOME LANGUAGE SURVEY

SCHOOL DISTRICT LOWER KUSKOKWIM SCHOOL DISTRICT

Dear Parents/Guardians:

To make sure that all students receive the education services they need, the law requires us to ask questions about students' language backgrounds. The answers to Section A below will tell us if a student's proficiency in English should be evaluated and help us to ensure that important opportunities to receive programs and services are offered to students who need them. The answer to Section B below will help us communicate with you regarding the student and all school matters in the language you prefer.

## STUDENT INFORMATION:

Student Name: \_\_\_\_\_ Sex: ☐ Female ☐ Male Alaska Student #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Month Day Year

Place of Birth: \_\_\_\_\_ Participating in a student exchange program? ☐ Yes ☐ No

Has the student received formal education outside of the US? ☐ Yes ☐ No

If yes, circle grades completed outside of the US: K 1 2 3 4 5 6 7 8 9 10 11 12

If yes, what was the Language of Instruction? \_\_\_\_\_

## SECTION A: LANGUAGE BACKGROUND

1. What is the primary language used in the home (*regardless* of the language spoken by the student)?

☐ English ☐ Other \_\_\_\_\_

2. What is the language most often spoken by this student?

☐ English ☐ Other \_\_\_\_\_

3. What is the first language this student learned to speak?

☐ English ☐ Other \_\_\_\_\_

## SECTION B: COMMUNICATION PREFERENCES

1. In which language do you prefer to receive school communication?

☐ English ☐ Other \_\_\_\_\_

## PARENT/GUARDIAN SIGNATURE

Parent/Guardian Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Information about schools' civil rights obligations to English learner students and limited English proficient parents can be found on USED's Office for Civil Rights webpage ([www2.ed.gov/about/offices/list/ocr/ellresources.html](http://www2.ed.gov/about/offices/list/ocr/ellresources.html)). If you have questions about this form or about services available to your child, please contact your district or school at: \_\_\_\_\_

**For Parent/Guardians:**

**Definitions:**

Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, Aleut, or other Alaska Native; or (5) A member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect on October 19, 1994.

**Student Information:** Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

**Tribal Membership:** Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

**Attestation Statement:** Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

**Paperwork Burden Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

**ED 506 Form**  
**Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program**

**Parent/Guardian:** This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

**Student Information**

Name of the Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade level \_\_\_\_\_

Name of School \_\_\_\_\_ School District \_\_\_\_\_

**Tribal Membership**The individual with Tribal membership is the (select only one): ☐ child ☐ child's parent ☐ child's grandparentIf the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: \_\_\_\_\_Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

The Tribe or Band is (select only one):

- ☐ Federally Recognized Tribe
- ☐ State Recognized Tribe
- ☐ Terminated Tribe
- ☐ Alaska Native
- ☐ Member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ☐ Membership or enrollment number establishing membership (if readily available) or
- ☐ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). \_\_\_\_\_

**Attestation Statement**

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_

# LKSD MIGRANT EDUCATION PROGRAM

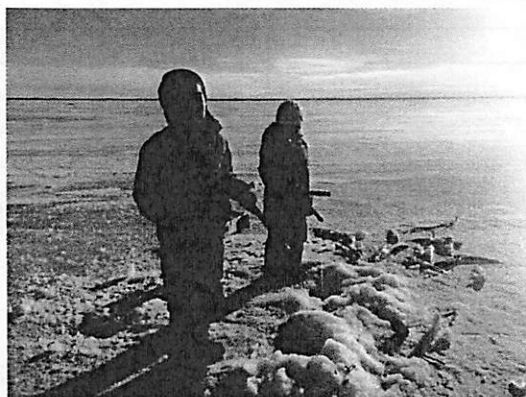
Coordinator: Delilah Hodge -delilah\_hodge@lksd.org (543-4854)

Jazzmin LaVale -jazzmin\_lavalle@lksd.org

Rachel DeHaan -rachel\_dehaan@lksd.org (543-4869)

*The primary goal of the Alaska Migrant Education Program is to ensure that all migrant students reach challenging academic standards & graduate with a high school diploma that prepares them for responsible citizenship, further learning, & productive employment, while supporting a subsistence lifestyle.*

**Please fill out the survey on the back of this sheet & return to your child's school office.**



*Your child(ren) may qualify for the Migrant Education Program if they:*

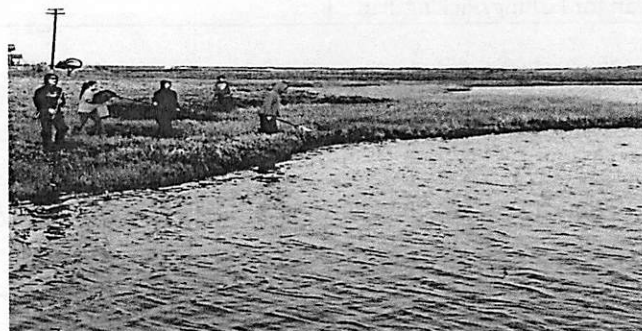
- Travelled more than 20 miles to a fish camp or berry camp or for commercial logging
- Stayed at camp for a total of **7 nights or more** within a year (doesn't have to be consecutive)
- Relies on subsistence fish &/or berries to get through the year

*After returning this survey, you may be called by recruiter for a short interview for details about your children's trips.*

**\* Children do not have to be in school to qualify.**

*Some of the services we can provide include (after school or weekends):*

- Tutoring
- Credit Recovery
- Family Nights
- Book & School Supply Distributions
- Summer Camps
- First Aide/CPR Training
- Hunter Safety Training
- Swimming Lessons + pool access
- Enrichment Activities
- Safety Gear



**PLEASE FILL OUT THIS SURVEY  
& RETURN IT TO YOUR CHILD'S SCHOOL**

TO SEE IF YOU QUALIFY. COMPLETE ONE SURVEY PER FAMILY.

DO include kids not in school yet &amp; those at Mt. Edgecumbe/GILA/dropped out (label).

Child's Full Name (list youngest 1st) *Children do not have to be in school to qualify.	Birthdate	Grade	Twin?

Parent Names	Phone Number	Physical Address (not PO box)	e-mail please

**REQUIREMENTS TO APPLY**

- Children must travel over 20 miles from home & stay at least one night per trip.
- A total of 7 nights or more. (They can take several trips to total the 7+ nights.)  
Please list specific location names & dates. If you can provide a map, that's great!

- Fishing & berry picking trips only. Commercial logging counts also.

- NO HUNTING please, unless they picked berries, plants, &/or fished as well. (state rule, not LKSD's)

**\*EXAMPLE**

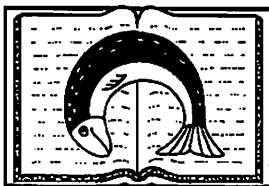
Location of Fishing/Picking Trip	Tunt. Fish Camp, upriver from Tunt.
Dates of Overnight Trips	06/05/23 - 07/01/23 ... .. We <u>DO</u> need the month & days or a good guess.
Type of Gear/Activity and Type of Catch	Drift Net-Salmon (reds, chum, silvers) + salmon berries (5 gal.)
Guardian for Fishing/Picking Trip	Grandma Sally

Location of Fishing/Picking Trip	
Dates of Overnight Trips	Only DAY trips?
Type of Gear/Activity and Type of Catch	
Guardian for Fishing/Picking Trip	

Location of Fishing/Picking Trip	
Dates of Overnight Trips	Only DAY trips?
Type of Gear/Activity and Type of Catch	
Guardian for Fishing/Picking Trip	

1. Are fish and berries a financial necessity for your family? YES / NO (circle one)
2. What will happen if your family does not gather fish or berries? \_\_\_\_\_
3. How do you use the food? How often do you eat fish &/or berries? \_\_\_\_\_
4. How much food do you store for the winter? \_\_\_\_\_

**RETURN TO:** Rachel (Swiggum) DeHaan [rachel\\_dehaan@lksd.org](mailto:rachel_dehaan@lksd.org) or fax 543-4902 or your school secretary



# Income Survey for Title I & E-rate 2023-2024

Lower Kuskokwim School District  
PO Box 305, Bethel Alaska 99559

Dear Parent/Guardian,

The following information is needed by our school. This information will be used for the E-rate program to determine our school discount for telephone and Internet. It is also needed to meet federal and state laws for Title I-A, and may be used to qualify for additional grants. (This table is from the Alaska Income Eligibility Guidelines for Free and Reduced Meals, but does **not** determine Free and Reduced Lunch eligibility.)

Please check the row that best describes your family's annual income level (including all taxable income).

## Yearly Income

<input type="checkbox"/>	\$33,689 or less
<input type="checkbox"/>	\$33,690-\$45,584
<input type="checkbox"/>	\$45,585- \$57,480
<input type="checkbox"/>	\$57,481- \$69,375
<input type="checkbox"/>	\$69,376- \$81,271
<input type="checkbox"/>	\$81,272- \$93,166
<input type="checkbox"/>	\$93,167- \$105,062
<input type="checkbox"/>	\$105,063- \$116,957
<input type="checkbox"/>	more than \$116,957

Number of people who live in your household: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Children enrolled in school (please include all children in schools in the district):

Name (last, first)	Grade	School

**This information is confidential and individual family data will not be reported.**

Please return this survey to \_\_\_\_\_ BRHS \_\_\_\_\_ by this date: 08/18/23 .

Thank you.