Theodore Roosevelt School
PO Box 567
Fort Apache, AZ 85926
Phone (928) 338-4464

Returning Student Enrollment Forms

School Year 2025-2026

"Intelligence plus Character is the good of Education"

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Please remember***, before*** accepting a student to attend Theodore Roosevelt School the following documents ***must*** accompany the enrollment packet, and proper procedures must be followed.

_____ Updated Immunization record (According to the Arizona Revised Statute S15-871-874; and Arizona Administrative Code R-9-6-701-708; students must have proof of all required immunizations, or a valid exemption form, to attend school.

_____ Legal Documentation. If you are not the legal guardian or custodial parent of the student, we ***require*** one of the following documents for enrollment:

- Court sanctioned custody documents
- Social Services placement letter
- Power of Attorney form signed and notarized

_____ Completed Enrollment Packet. ***If you are not the custodial parent, do not sign***. Legal or temporary guardianship documents must be attached before signature is valid.

_____ Student Interview (If student had behavior issues at previous school)

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A Bureau Funded Day/Boarding School

Please submit the application to Theodore Roosevelt School for review and approval. The school will review the application and render a decision. All highlighted sections ***must*** be signed.

STUDENT INFORMATION

Grade applying for _____ Check One: Dorm Student ____ Day Student ____

Name _____
First Middle Last

Physical Address _____

Mailing Address _____

Date of Birth _____ Gender ____ Male ____ Female

Tribal Affiliation _____

Social Security Number _____-_____-_____

Child lives with ____ Both parents ____ Mother ____ Father ____ Other _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian's Name (1) _____
(First) (Last)

Home Address _____

Phone (Home) _____ (Work) _____

Email Address _____

Parent/Guardian's Name (2) _____
(First) (Last)

Home Address _____

Phone (Home) _____ (Work) _____

Email Address _____

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EMERGENCY CONTACT IF UNABLE TO REACH PARENT(S)/GUARDIAN(S)

Name _____
(First) (Last)

Relationship to Student _____

Phone (Home) _____ Phone (Cell) _____

School Check-out List

ONLY the following individuals have my permission to check my/our child out of school:
Note: The persons listed below **must** be at **least** 18 *years old*. (All names must be printed)

1. _____ Relationship _____ Phone _____
2. _____ Relationship _____ Phone _____
3. _____ Relationship _____ Phone _____
4. _____ Relationship _____ Phone _____
5. _____ Relationship _____ Phone _____

Signature of Parent/Guardian _____ Date _____

Theodore Roosevelt School

OVER THE COUNTER MEDICATION CONSENT FORM

Student Name_____ Grade_____

Over the counter (OTC) medications are drugs that do not require a prescription and are purchased "over the counter". OTC medications may at times need to be administered. This form is ***required before*** OTC medications can be administered at school.

PLEASE CHECK OFF EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

__Antibiotic cream (i.e., Bacitracin Cream, Antiseptic)
__Hydrocortisone cream
__Chapstick
__Lubricant eye drops
__Cough drops/throat lozenges
__Cough medicine
__Imodium
__Pepto Bismol
__Antacid (i.e., Mylanta)
__Ibuprofen
__Acetaminophen (Tylenol)
__Antihistamine(i.e., Benadryl, Diphenhydramine)

I authorize the administration of the medications listed above to my student. I understand that these medications may be given without the supervision of medical personnel. Additionally, I consent to any necessary first aid treatment being provided as needed.

Does your student have any known allergies? ___No ___Yes

If yes, please list: _____

If yes, ***complete* Allergy Action Plan & Medication Consent Form (If needed) **

Does your student take any prescription medication on a regular basis? __No __Yes
If yes, ***complete* Medication Consent form**

Does your student have asthma? __No __Yes
If yes, ***complete* Medication Consent form**

Does your student have any current health conditions? __No __Yes
If yes, please list: _____

_____ _____
(Parent/Guardian Print Name) (Parent/Guardian Signature)

_____ _____
(Parent/Guardian Phone Number) DATE

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

Consent of Parent/Legal Guardian or other person who has primary responsibility for the care of the child.

Name of Student _____ SSN# _____

Birthdate _____ Tribe _____

I (we) have read the consent form from Indian Health to arrange for, or to provide the following health services for this child:

1. Healthcare including medical examinations, routine laboratory studies, x-ray procedures, and skin tests.
2. Dentalcare including dental examinations, preventive use of fluoride, and any necessary emergency dental care.
3. Mental Health services include treatment when necessary.
4. Emergency Healthcare for accidents and illnesses.
5. Transportation of the child to and from another health facility for these services:

❒ I hereby give consent for all services.

❒ Exceptions or special instructions: _____

_____

❒ I hereby give consent for reasonable cause and essential need to assure the health and safety of my child to Theodore Roosevelt School staff while my child is in attendance.

Parent/Guardian signature _____

Printed Name _____

Address _____

City/State/Zip Code _____

Relationship _____

Phone# _____ Alternate# _____

Date _____ Valid until _____

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Field Trip Permission

I, _____, parent/guardian of _____
Name of Parent/Guardian Student's name

hereby grant permission for the 2025-2026 school year to Theodore Roosevelt School to allow my child to participate in any school-sponsored field trips, under the supervision of the school personnel with the following conditions:

_____ permission is granted, if school vehicles are used for transportation.

_____ permission is granted when the student walks from school to the site of the field trip.

Signature of Parent/Guardian _____ Date _____

Daily Transportation

I, _____, parent/guardian of _____
Name of Parent/Guardian Student's name

give permission for the 2025-2026 school year for my child to: (Must choose ***ONE*** option.)

_____ always ride the bus/school vehicle, unless checked out or changes are made before noon with the front office.

_____ always a parent drop-off/pickup, unless changes are made before noon with the front office.

Signature of Parent/Guardian _____ Date _____

Parent Waiver

I hereby release Theodore Roosevelt School of all liability if my child refuses to board the designated school bus or vehicle for transportation home or to a scheduled event as part of a trip.

I understand it is not the responsibility of the TRS Staff but the decision of my child to board and ride any of the school vehicles when told to do so. Furthermore, it is the sole decision of my child to refuse to board or ride in any school vehicle when told to do so. If my child refuses to board the bus or vehicle it is my responsibility to transport my child.

Signature of Parent/Guardian _____ Date _____

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Parental Consent for Counseling

Name of Student _____ DOB _____

I hereby give my permission for my child to receive any counseling with the School Counselor for the 2025-2026 school year.

Signature of Parent/Guardian _____ Date _____

Media Release Form

Theodore Roosevelt School believes in recognizing student accomplishments by sharing them with the community which will include:

- Releasing student names and/or photographs to local media
- Posting on our school website and/or social media
- Displaying student names and/or photographs on the school bulletin boards

If you agree to allow TRS to publish, post, distribute and/or display your child's name and/or photograph or other information related to his/her achievements for the 2025-2026 school year, please sign below.

I/we agree to grant permission for my child's name and/or photograph to be published, posted, distributed, and/or displayed in any or all platforms listed above.

Signature of Parent/Guardian _____ Date _____

Certification

I certify, under perjury by the law, that the information provided anywhere in this enrollment form is true, correct, and complete, to the best of my knowledge and belief. I am responsible for _____, and hereby apply for his/her admission to
(Name of Student)
Theodore Roosevelt School. I understand that, if the school requires additional information, I will provide the information requested.

Signature of Parent/Guardian _____ Date _____

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Parent/Student Responsibilities

I support and encourage my child's education. In order to be successful at Theodore Roosevelt School, I agree that my child has the following responsibilities:

1. Attending all classes regularly except when ill or properly excused. Meet all class requirements and school obligations.
2. Following school rules and policies that govern daily school attendance, behavior, discipline, academic requirements, including possession, use, and distribution of illegal substances, drug paraphernalia and weapons.
3. The responsibility to respect the privacy and space of others.
4. The responsibility to live in peace and harmony with fellow students and school employees, respecting the privacy and space of others.
5. The responsibility to make decisions that will not infringe on the rights, health, and safety of others or be disruptive to the educational process.
6. Respect the rights of others to express their freedom of religion and culture.
7. Expressing opinions and ideas respectfully so as not to slander, defame, or use abusive language against others. Express one's self in such a way as not to be disruptive or use abusive language to others or be disruptive to the educational process or classroom procedures.
8. May write my opinions and ideas but may not write them if they are not true, or if they hurt another person or group.
9. Respect the rights of the other students and person in regard to the rights of the person included in this code or as guaranteed by law.
10. Schedule a meeting so as not to disrupt the educational process nor interfere with approved school activities.

In addition, I understand that if my inappropriate behaviors should result in any damage or vandalism of school and other people's property that I am subjecting myself to consequences that may require monetary payment(s) by me and/or my parents.

I understand that I am here to learn and to develop positive self-worth and should I choose to defy the rules and authority, my consequences are at the discretion of the disciplinary team or administration which may include: dismissal, suspension, or expulsion from the school.

_____ _____

Student's Signature Date

As a parent, I will encourage my child to attend school daily and to follow the school rules and policies.

_____ _____

Parent/Guardian Signature Date

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Home Language Survey

2025-2026 Academic Year
Bureau of Indian Education

Student's Name: _____

Instructions

This survey is to be completed by the parent or legal guardian of the student enrolling in **Theodore Roosevelt School**. Completion of this survey is optional, although it may lead to additional resources or support being provided to assist in your child's education. Please circle or write the answer requested.

Student Languages

1. What was the first language your child learned?

   English Another Language (list) _____

2. What language is the one that is primarily spoken by your child in the home?

   English Another Language (list) _____

3. Do you believe your child might need additional help with the English language to learn other academic areas such as math, science, social studies, reading, or writing? Yes No

Adult Languages

4. How many adults live in your home? _____
5. How many of these adults primarily speak a language, other than English, in the home? _____
6. What languages, other than English, are spoken in the home?

   _____ _____

7. Do you or the other adults in your home need translated documents for the school to provide information to you concerning your student? Yes No
8. Do you or the other adults in your home require a translator to discuss your student's academic progress with educators at the school? Yes No

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: _____ _____ _____
Name **Phone contact** **Relationship to student**

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

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:**_____

CONSENT FORM FOR HEALTHCARE SERVICES

Your child may be eligible for healthcare services at a free school-based health clinic (Healthcare Clinic) offered by Indian Health Services. The Healthcare Clinic may provide some or all of the following services:

1. Preventive healthcare screenings
2. Physical examinations for school and sports participation
3. Immunizations
4. Diagnosis and treatment of health problems
5. Counseling for health maintenance and health risk behaviors
6. Assessment for mental health referrals
7. Dental services

If you would like your child to receive healthcare services, please complete, sign and return this Consent Form for Healthcare Services. If you have questions about the services available or treatment that is being provided to your child, please contact the Healthcare Clinic personnel directly at 928 338 4911 x3633. Please note that the Healthcare Clinic is operated entirely by Indian Health Services and not by the Whiteriver Unified School District.

_____ _____

Name of Child Name of Parent/Guardian

CONSENT:

I hereby give permission for my child to receive healthcare services at the Healthcare Clinic that is located at my child's school. I understand that the Healthcare Clinic is operated by Indian Health Services and is not operated by the Whiteriver Unified School District. I understand I have the right to revoke this consent at any time by giving written notice of such revocation to Healthcare Clinic personnel.

_____ _____

Parent or Guardian Signature Date

Whiteriver Service Unit
Consent Form Children Vaccinations
(<18 years of age)

Dear Parents/Guardians:

The Whiteriver IHS Hospital is working with **Theodore Roosevelt School** to update your child's vaccines (shots) during the **2025-2026 school year.** We will hold vaccination clinics during the year, and your child's school will let you know the specific dates. There will be no cost to you for this vaccine, whether or not your child is Native American.

The vaccine consent form includes the option to accept vaccination for your child by signing the consent form. If you do **not** wish for your child to be vaccinated, please sign here:

I, _____ **do NOT** authorize immunizations for my child, _____

Signature_____ Date_____

To give consent for your child to receive vaccines while at school, please refer to reverse side of this form:

- Sign and date the consent form to accept vaccination for your child.
- Return the consent form to the school.
- If you accept vaccination, the vaccine will be given to your child during the vaccination clinic.
- If, at any time, you change your mind about having your child vaccinated, you can contact the Whiteriver IHS Pharmacy Outreach team at 928-338-3504 or email Leanna.Asante@ihs.gov or Shane.Hillman@ihs.gov

Please visit the CDC's vaccination web site at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html and also https://www.cdc.gov/vaccines/parents/index.html for more information. If you do not have internet access and would like more information or a printed copy of the Vaccine Information Sheet, please contact us. Your child's health care provider can also answer your questions about any shots your child is due for and give the shots as well.

The Arizona State vaccine record (ASIIS) as well as your child's chart at the hospital will be used to screen for vaccines that are due. We will screen for any vaccines given at other locations (within Arizona) as well as any medical conditions/medications that may affect if your child is eligible for certain vaccines.

Sincerely,
Whiteriver IHS Hospital Pharmacy Outreach Team
LCDR Leanna Asante, Hospital Immunization Clinical Coordinator
Shane Hillman, Director of Pharmacy Outreach

****Please Review Both Sides of this Document****

Please answer all of the following questions. The answers are important to us, so we can be sure to give the right vaccines. By signing this form, you are giving consent for Whiteriver Service Unit to administer all recommended immunizations by the Advisory Committee on Immunization Practices (ACIP) during the **2024-2025 school year** at **Theodore Roosevelt School** and acknowledging receipt of the Vaccine Information Statements (VIS) which can be found at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.

CONSENT FOR CHILD'S VACCINATION:

By signing below, I give consent to the WHITERIVER INDIAN HEALTH SERVICE HOSPITAL and its staff for my child named on this form to be vaccinated during the vaccination clinic. (If this consent form is not signed, then your child will not be vaccinated).

THIS CONSENT INCLUDES AUTHORIZATION TO ADMINISTER BOTH INFLUENZA AND COVID-19* VACCINES

If you choose to decline either vaccine, please indicate so by checking the box

□ Influenza vaccine declined **□ Covid Vaccine declined**

Parent/ Legal Guardian Name: _____ **Date:**_____

Signature of Parent/Legal Guardian: _____

Child's Name: _____ **Chart # or Birthday:** _____ **Age:**_____

	YES	NO
1. Is your child Native American/ Alaska Native?	□	□
2. Does your child have any serious allergies? If so, what?	□	□
3. Has your child ever had a serious reaction to a vaccine? If so, what?	□	□
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	□	□
5. Does your child have any of the following: asthma, cancer, diabetes (or other type of metabolic disease), or disease of the immune system, lungs, heart, kidneys, liver, nerves, or blood? If so, what?:	□	□
6. Has your child taken cortisone, prednisone, any other steroid, anticancer drug, antiviral drug or had radiation treatment in the past 3 months? If so, explain:- _____	□	□
7. Has your child received a transfusion of blood or a blood product, or been given immune (gamma) globulin in the past year? If so, explain: _____	□	□
8. If the child is a baby, have you ever been told that he/she had Intussusception (the telescoping of one portion of the intestine into another)?	□	□
9. Is your child pregnant?	□	□
10. Has your child received vaccines anywhere else OTHER THAN Whiteriver Hospital? If so, where?	□	□

To make sure that we have all information needed to vaccinate your child, please completely fill out the information in the boxes. This includes your name and signature, child's name and birthday/ chart number, and answers to all questions.

The Smiles Movement

PO Box 767
Camp Verde, AZ 86322

Ph: 928-567-1832
Fax: 928-567-6500

thesmilesmovement@gmail.com

Please return this form to the school!

DEAR CONCERNED PARENT:

Dental disease is the #1 reason children miss school. The Smiles Movement has been providing care for your children for over 30 years at no charge to you. You have a choice; you can choose to go through the process at IHS, or enjoy the convenience of having our experienced doctors care for your child at their school. We thank you for once again choosing our practice that over the years has served thousands of children. To participate, your child must be enrolled in an appropriate AHCCCS program which is easily done at most IHS facilities.

IF YOU CHOOSE TO HAVE YOUR CHILD CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name_____Male_____Female_____

Child's Social Security Number_____Date of Birth____/____/____

Emergency Contact_____Phone #_____

School Name_____Teacher's Name_____Grade____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Has your child had?	NO	YES
Allergy to medication	___	___
Rheumatic Fever	___	___
Psychiatric Treatment	___	___
Seizure Disorder	___	___
Diabetes	___	___
AIDS/HIV Positive	___	___
Hospitalizations	___	___
Vision or speech problems	___	___
Could your child be pregnant?	___	___

	NO	YES
Heart Murmur	___	___
Bleeding Disorders	___	___
High Blood Pressure	___	___
Asthma	___	___
Hepatitis/Jaundice	___	___
Anemia	___	___
Latex Allergy	___	___
Other Serious Illness	___	___

Is your child under a Physician's care? NO___YES___
Is your child taking any medication? ___ ___
Any problems with local anesthetic? ___ ___

PLEASE EXPLAIN ANY "YES" ANSWERS:_____

What is your primary concern for your child's oral health?_____

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- **HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME**
- **WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME**

CONSENT FOR TREATMENT AND AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1._____ **YES. I give permission for my child to receive necessary treatment!**
I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.
I consent to the sharing of this information with the IHS Dental program.

2._____ **No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.**

I understand that I may refuse to sign this Consent and Acknowledgement.

X_____**Date**_____
Parent or Guardian

Please print your name_____

If you have any questions, please call our office at 928-567-1832

PLEASE TURN OVER AND COMPLETE