FLANDREAU INDIAN SCHOOL

1132 N. Crescent St., Flandreau, SD 57028
(605) 997-3773 Ext. 2121

APPLICATION FOR ADMISSION

2025 - 2026

Dear Parents:

Thank you for your interest in Flandreau Indian School as a potential choice to educate your student. The admissions application checklist is to be used as a guide, to provide the information the school needs to review your student's application.

The deadline for submitting applications is **FRIDAY, JANUARY 9th, 2026. Only applications accompanied with required documents will be date stamped and reviewed for admissions.** Required documents are listed at the bottom half of page 2. **Please only send copies of your Certificate of Indian Blood, Birth Certificate, Social Security Card and Medical Insurance Cards.** *Keep your originals for your files.*

The following decisions are possible:

1. **ACCEPTED**
2. **DENIED**

These items are the most difficult to obtain and will hold up the process of your application:

- **COPY** of Certified Degree of Indian Blood **(Tribal Membership Cards are not accepted)**
- Contact your current school's registrar to get an official transcript and achievement test scores.
- **Physical Exam is REQUIRED for all new and reapplying students and must be completed after MAY 1, 2025 (see pages 29-30).**
- Students interested in participating in competitive athletics may be required to complete an application for hardship for SDHSAA. Application for hardship **does not** guarantee eligibility. Eligibility is determined solely by the SDHSAA. (See attached Sports Eligibility Checklist.

FIRST DAY OF SCHOOL - WEDNESDAY, JANUARY 7th, 2026

TRAVEL ARRANGEMENTS WILL BE MADE BY THE FLANDREAU INDIAN SCHOOL AT OUR EXPENSE. IF YOU DO NOT TRAVEL WHEN IT IS PROVIDED FOR YOUR STUDENT(S), YOU WILL BE RESPONSIBLE FOR YOUR OWN TRANSPORTATION TO SCHOOOL.

WHEN THE APPLICATION IS COMPELTED, PLEASE MAIL OR FAX TO:

~ONLY COMPLETE APPLICATIONS WILL BE REVIEWED~

Flandreau Indian School Attn: Applications/Registrar
1132 N Crescent St.
Flandreau, SD 57028
Fax: 605-997-2601
To send by email or for questions, please call:
605-997-3773, Ext. 2121

School Year 2025 - 2026

FLANDREAU INDIAN SCHOOL

FLANDREAU, SOUTH DAKOTA

ADMISSIONS APPLICATION CHECKLIST

Received:

Thank you for applying to the Flandreau Indian School. We have provided a check-off list to ensure you are sending in a complete application. The admissions committee **WILL NOT** review incomplete applications.

Contents with a (*) MUST BE SIGNED

Page #	Contents	Complete
1	Letter to Parents	
2	Admissions Application Check List	
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11	***The Family Educational Rights and Privacy Act (FERPA)**	
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13	***Individual Education Programs** (Provide copy of IEP)	
14	***Gifted and Talented Program**	
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19	**BIE Behavioral Health and Wellness Program Information**	
20	***Consent for Counseling (Individual & Group) and Therapeutic Programs On and Off Campus Services**	
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22-23	***STUDENT AND FAMILY MEDICAL HEALTH AND HISTORY**	
24	**OVER-THE-COUNTER MEDICATIONS**	
25	***MEDICAL CONSENTS & INSURANCE INFORMATION**	
26	***CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)**	
27-34	***FLANDREAU SANTEE SIOUX TRIBAL HEALTH CENTER MEDICAL FORMS**	
35	***FIS – STUDENT MEDICAL ACTION PLAN**	
36	***ATTACHMENT A – AUTHORIZATION TO ADMINISTER PRESCRIBED/OTC MEDICATION**	
37-39	***Authorization for Use or Disclosure of Protected Health Information**	
40-41	**SDHSAA Health History Form –** *Both forms must be filled out by Medical Provider* **SDHSAA Physical Evaluation –** *date of physical must be within the last 6 months* *Please request recent copy of H&P with current medication list from provider if able*	

The following documents are required before the application can be processed:

- ☐ Copy of State Issued Birth Certificate
- ☐ Copy of Certificate of Indian Blood (CIB) – *Tribal membership cards are NOT accepted*
- ☐ Copy of Social Security Card
- ☐ Copy of Health/Medical Insurance Cards
- ☐ Copy of Official/Unofficial transcript and achievement test scores
- ☐ Health & Physical Form
- ☐ Immunization Record/ Proof of two (2) MMR Vaccines
- ☐ Guardianship documents
- ☐ Final 8th grade report card (incoming Freshman ONLY)

INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED – ALL FORMS MUST BE FILLED OUT COMPLETELY

Bureau of Indian Education - SY 2025-2026 Student Enrollment Application

ENROLLMENT INFORMATION

Name of School: *Flandreau Indian School* *1132 N Crescent St.* *Flandreau, SD 57028*	Grade Applying for (*final determination dependent on prior credit earned*): **9** **10** **11** **12**
Semester Applying For: **Fall (AUG)** **Spring (JAN)**	Student will be a: **Dorm Student** **Day Student**

STUDENT INFORMATION

SOCIAL SECURITY NUMBER _____ - _____ - _____

Full Name: _____
Last *First* *Middle*

MAILING Address: _____

Street Address (if different): _____

City: _____ State: _____ Zip: _____

Student Email: _____ Student Cell Phone: _____

Date of Birth: _____ **Gender:** Male Female Non-Binary Other (*please specify*): _____

Tribal Affiliation: _____ Degree Indian: _____

Enrollment Number: _____ Home Agency: _____

Student attended FIS previously: YES _____ NO _____ If yes, please list dates: _____

Sibling(s) attending FIS presently or previously:

_____

PARENT OR LEGAL GUARDIAN INFORMATION
(WHO STUDENT LIVES WITH OR IS AUTHORIZED TO HAVE INFORMATION)

FATHER: _____

Address: _____

_____

Phone: _____
HOME *CELL* *WORK*

Email: _____

Tribal Affiliation: _____

Has legal custody of student: YES NO Lives with Student: YES NO

Enrollment, grades, behavior, attendance and medical can be discussed with this person: YES NO

MOTHER: _____

Address: _____

_____

Phone: _____
HOME *CELL* *WORK*

Email: _____

Tribal Affiliation: _____

Has legal custody of student: YES NO Lives with Student: YES NO

Enrollment, grades, behavior, attendance and medical can be discussed with this person: YES NO

Student Name: _____

EMERGENCY CONTACT INFORMATION *(person who does not reside with the student)*

Contact 1: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Contact 2: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

LEGAL CUSTODY INFORMATION

Legal Guardian Information (if not parent listed above): *If you are the court appointed custodial parent, you must attach appropriate documentation. If the student does not live with either parent or is a ward of the court, attach documentation and provide information on the person(s) responsible for the applicant who will be the primary contact person. A student may not list himself/herself as guardian even if he/she is 18 years of age or older.*

Name: _____

Adress: _____

Phone: _____ Email: _____

Do **BOTH** parents listed on page 1 have legal physical custody of the student? YES NO ***If NO, please provide documentation***

Is student a ward of the court or in state/tribal custody? YES NO ***if YES, please provide documentation***

Is there a restraining order in place? YES NO ***if YES, please provide documentation***

Has student ever been arrested or placed in Juvenile Detention Center? YES NO ***If YES, please provide violation:*** _____

Is student currently on probation? Yes No ***if YES, please provide documentation***

Probation officer: _____

Address: _____

City *State* *Zip*

Office Phone: _____ Email: _____

Does Student have a case worker? YES NO ***if yes, please provide documentation***

Case Worker: _____ Agency: _____

Address: _____

City *State* *Zip*

Office Phone: _____ Email: _____

TRIBAL EDUCATION OFFICE

Education Contact: _____

Address: _____

City *State* *Zip*

Office Phone: _____ Email: _____

SIGNATURE

I am legally responsible for this student and herby apply for his/her admission to the Flandreau Indian School. I understand that the Flandreau Indian School may request additional information before the student is admitted.
I understand that if any of the above information changes during my student's enrollment at the Flandreau Indian School, I am required to provide accurate and updated information and/ or documentation (if applicable).

X

Signature of Parent / Legal Guardian Date

Student Name: _____

CRITERIA FOR BOARDING SCHOOL

Favorable action is recommended upon this application because this case confers to the following criteria for boarding school or out of boundary enrollment. If this application is for an off reservation boarding school and for social reasons, a social summary should accompany this application.

Check all applicable criteria (At least one must be checked):

EDUCATIONAL FACTORS Federal/Public Schools near student home:	**SOCIAL FACTORS** In his/her family environment, the student:
☐ grade level not offered ☐ are severely overcrowded ☐ exceeds 1 ½ mile walking distance to school or bus route ☐ does not offer special vocational/preparatory training necessary for gainful employment ☐ does not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences ☐ receiving school offers special program needed by student	☐ was rejected or neglected ☐ does not receive adequate parental supervision ☐ well-being was imperiled due to family ☐ have behavioral problems been too difficult for home, school, and/or local resources ☐ has a sibling(s) or other close relatives enrolled at FIS who would be adversely affected by separation.

EDUCATIONAL INFORMATION

Previously School: _____

Previous School Contact Number: _____

Reason for Leaving: _____

Did student miss fifteen (15) or ore days in the last school year? YES☐ NO ☐

Has student ever been suspended? YES☐ NO ☐ Expelled? YES☐ NO ☐

If YES, date and reason MUST be given: _____

Will your student participate in sports at Flandreau Indian School? YES☐ NO ☐

***MUST BE PRESENT ON CAMPUS THE FIRST DAY OF SCHOOL OR WILL NOT BE ELIGIBLE TO PLAY SPORTS FOR FORTY-FIVE (45) DAYS. NO EXCEPTIONS.*

SOCIAL INFORMATION

Is student a ward of the court? YES☐ NO ☐ *If yes, a copy of the court order must be submitted.*

Has student ever been arrested? YES☐ NO ☐

If yes, what was/were the violation(s)? _____

Has student ever been in jail or a detention center? YES☐ NO ☐ If yes, how many times? _____

SIGNATURE

I, the parent/legal guardian of the above-mentioned student hereby certify that the information provided is true and accurate to the best of my knowledge and I understand that Flandreau Indian School will verify all information.

Any false statement or misrepresentation or omission of required information in application will result in denial of application.

I understand that additional information may be requested to complete my student's records. *Such as: School records, counseling records, and behavior records.*

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

Student (Signature)_____ **Date**_____/_____/_____

Student Name: _____

FIS ADMISSION AND CONTINUING ENROLLMENT CRITERIA

- Students must be making academic progress throughout the school year at Flandreau Indian School. Students failing to make academic progress will be placed on academic probation. Grades will be reviewed at the end of each semester to determine progress. *The student will be given until the end of the next semester to make improvements.*
- Students may not miss more than 3 unexcused days of school per academic year.

CREDIT RECOVERY PROGRAM

The Missing Assignments - Power of ICU program allows students more practice time for completing their assignments. ICU is during the students' lunch and study hall as well as after school. During Missing Assignments - Power of ICU the student can get one-on-one help with a teacher or an education technician to complete their class work. You will be contacted when your child is placed on the Missing Assignments - Power of ICU list.

Contact Information

PARENT CELL NUMBER: _____

PARENT EMAIL ADDRESS: _____

STUDENT CELL NUMBER: _____

STUDENT EMAIL ADDRESS: _____

I, _____ (parent)agree for reasonable cause and essential to assuring the health and safety of all students at the Flandreau Indian School, staff, acting in attendance in loco parentis, may at their discretion exercise search, seizure, and drug testing while my student is in attendance at Flandreau Indian School. Such activities shall be in compliance with 25CFR-part 42.3, (b), (Rights of the Individual Students) and 34 CFR-part 86.200 (b-e) (Drug Free) School and Campuses).

CELLULAR PHONE/PERSONAL ENTERTAINMENT DEVICE POLICY FIS06-P15

Cellular phones and personal entertainment devices; these items may be used before school begins and during the noon hour. These items must be turned off, put away and unavailable during all other school hours. (Lockers and cell phone classroom lockers will be made available for students and staff use). The school will strongly encourage students to utilize school or personal computers for education purposes during their time at FIS. However, the school will closely monitor all Internet activity. Any student who visits an inappropriate site will be subject to discipline action. Violators of this rule will have their items confiscated and the student subject to disciplinary consequences. As a consequence of cell phone misuse, the device may be confiscated for the remainder of the year or sent home to their guardian. Cell Phones may be used in the dorms in accordance with dorm policy.

SIGNATURE

MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN INFORMED OF THE POLICIES:

Parent/Guardian
(Signature)_____ **Date**_____/_____/_____

Student
(Signature)_____ **Date**_____/_____/_____

FIS STUDENT TRAVEL INFORMATION

Flandreau Indian School provides transportation to students during the designated travel times listed below:

- August Travel (Home to School – One Way)
- Dec/Jan Travel (Christmas Break Home – Round Trip)
- May Travel (School to Home – One Way)

Each student is allowed to bring two (2) checked bags up to 50lbs each for the airline, bus, or SUV and 1 carry-on item. FIS will NOT cover overweight or excess baggage. Additional travel information will be sent closer to travel dates, please contact the travel coordinator with any questions.

Travel Coordinator Phone: 605-997-3773 ext. 2147 Travel Cell: 605-864-0571 call/text

Please Note: Beginning May 7, 2025, if you plan to use your state-issued ID or license to fly within the U.S., make sure it is REAL ID compliant. If you are not sure if your ID complies with REAL ID, check with your state department of motor vehicles.

**** Please send student with a valid ID (Tribal ID, State Issued ID, State Issued Driver's License, Passport) ****

STUDENT INFORMATION

Student Name: _____
Last *First* *Middle*

City: _____ State: _____

Date of Birth: _____ Gender: Male Female

Siblings/ Relatives:
**Please list any siblings or relatives that should travel together:* _____

TRAVEL INFORMATION

Depending on location, your student will be transported to FIS via airline flight, bus or school SUV. Travel itinerary will be sent to you after review of travel information.
Please indicate if you will need school provided transportation or will be arriving via personal transportation.

Transportation Method *(circle one)*: FIS Bus/SUV FIS Flight Personal Travel

Closest airport to your residence (City, State): _____

~Tickets will only be rebooked one (1) time for flights missed without prior notification to travel department. Rebooking flights will be subject to administrative decision~

Is your student a first-time flyer? YES NO

Will your student be under the age of 15 as of August 1 of this year? YES NO

Students under 15 that will be flying are required to fly as an Unaccompanied Minor (UM), see the following information on UM flyers:

- An airport escort to help your child to the gate for flight connections
- Escorting the child to the authorized adult picking them up when they land

We are required to submit the following information to the airline at the time of booking, if you know your child will be under 15 at the time of the flight, please fill out the information below:

Drop-off Person Name (as appears on ID): _____

Address (as appears on ID): _____

Phone Number: _____

ACKNOWLEDGEMENT OF OFFICAL TRAVEL

I (parent/ guardian) understand that FIS will only pay for official travel times listed above. ALL other travel at any other time is at the expense of the student's family. Students who are withdrawn from enrollment by the parents are responsible for travel expenses for returning home. FIS Will provide transport to and from the Sioux Falls, SD Airport.

_____ **Please initial here indicating that you have read and understand the above statement regarding paid travel and responsibilities of the student's family.**

Student Name: _____

PARENTAL CONSENT FORM

Initial Each Box for Consent	Activity
	FIELD TRIPS – I (we) hereby grant permission for the above student to participate in any organized school sponsored activity trip as approved by Flandreau Indian School Administration. I (we) understand the student will be properly chaperoned and all precautions will be taken to ensure his/her safety.
	COMPETATIVE SPORTS – I (we) hereby grant permission for the above-named student to participate in the competitive sports sponsored by the Flandreau Indian School
	AUDIO | VISUAL | ELECTRONIC BILLBOARD RELEASE – I (we) hereby grant permission to the Flandreau Indian School and the Bureau of Indian Education, for use of the above student's photograph and name for public information or exhibit purposes and deemed appropriate by representatives of the Flandreau Indian School or Bureau of Indian Education. This included Flandreau Indian School Yearbooks, announcements, web page Internet displays, electronic school billboard and local newspapers for promotional purposes in the community.
	HEALTH EDUCATIONAL EVENTS – I (we) hereby grant permission for the above-named student to participate in opportunities such as, local health fair events sponsored by the Flandreau Indian School and/or the Flandreau Santee Sioux Tribal Health Center.
	R-RATED MOVIE – During this school year at Flandreau Indian School, we may choose to use films as learning tools. As part of your child's educational experience in learning about history, politics, economics, and culture in Social Studies, it would be helpful for him/her to see some selections from historically based movies and/or other films related to the curriculum. Some of the films we will be showing may be R-rated, although they will be appropriate and relevant to the learning process. (Example: Flags of our Fathers, Windtalkers, Killer of the Flower Moon, etc.) *All movies shown will have a follow-up assignment and a discussion.*

SPECIAL PERMISSIONS –

Initial each activity that your student has permission to participate in while attending the Flandreau Indian School:

SWEAT LODGE –

- All students who use the sweat lodge must have written permission from their legal guardian. These signed slips must be on file in the Home Living office. This will eliminate any students or staff from proselytizing a student without permission, and restrain those with physical conditions such as asthma, high blood pressure, etc. from using the sweat lodge.
- The Sweat Lodge is for the Flandreau Indian School community only. This includes students and staff. The Flandreau Indian School cannot be responsible for anyone than the students and staff of the Flandreau Indian School.

Flandreau Indian School recognized that the students pursuing their education on this campus are not own sons and daughters. Every effort will be made to avoid any negative incidences that would offset the positive nature of the sweat lodge.

****for complete information, please see the FIS-02-01 Sweat Lodge Policy in the FIS Policy Index****

☐ **YES, my student may participate in Sweat Lodge ceremonies**

HAIRCUTS –

On occasion FIS will bring in a licensed individual to provide student haircuts. This does not include any chemical processing to hair (hair dye, perms, relaxers, etc.)

☐ **YES, my student may have a school sponsored Haircut**

Parental Consent for Child Participation in the Evaluation of Sexually Transmitted Infections and Teen Pregnancy Prevention Initiative (STITPPI)

TITLE:	STI TPPI Program Evaluation
PROJECT DIRECTOR:	Kelley LeBeaux, MA, Senior Director Health Promotion and Disease Prevention Programs
PHONE NUMBER:	605-721-1922

WHAT IS THE PURPOSE OF THIS STUDY?
Your child is being asked to take part in an evaluation of the STITPPI program. The purpose is to see how the program is working. The program is aimed to prevent sexually transmitted infections, teenage pregnancies, and prepare them for adulthood. The evaluation will be done through surveys. Your child was chosen as a participant because he/she is receiving the implemented curriculum.

HOW MANY PEOPLE WILL PARTICIPATE?
Along with your tribal community, up to 17 other tribal communities will be sites for the program and evaluation. Potentially 500+ unduplicated youth at schools and after school programs will participate in the evaluation over all years of the evaluation of the STITPPI program.

HOW LONG WILL I BE IN THIS STUDY?
Your child will fill out a survey twice, once at the beginning of the program (entry survey) and once at the end (exit survey). The surveys will last about 30 minutes each.

WHAT WILL HAPPEN DURING THIS STUDY?
The entry/exit-surveys will include questions for your child to answer about demographics, knowledge about setting limits, sexual behaviors, and opinions about the program.

Your child does not have to respond to any question they do not want to.

WHAT ARE THE RISKS OF THE STUDY?
There may be some risks from being in this study. Some questions might make your child feel uncomfortable due to the sensitive nature of the questions. Your child can stop answering questions at any time or choose not to answer a question. STITPPI program staff, teachers, counselors and other appropriate staff will be available to talk to your child should they become upset. This study is not considered to have more than "minimal risk." If any referrals are needed you are responsible for paying for any medical services.

The survey will not have your child's name on it.

WHAT ARE THE BENEFITS OF THIS STUDY?
Your child will not directly benefit from being in this study. However, we hope that other youth might benefit from this study because it will help continue to improve the program.

WHAT ARE THE ALTERNATIVES TO PARTICIPATING IN THIS STUDY?
Other arrangements will be made for your child's class time (e.g., study hall) if they choose not to participate in the entry/exit-surveys.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?
Your child will not have any costs for being in this research study, aside from their time.

WILL I BE PAID FOR PARTICIPATING?
You or your child will **not** be paid for being in this research study. However, he/she can withdraw their participation anytime.

WHO IS FUNDING THE STUDY?
The U.S. Department of Health and Human Services (DHHS), Tribal Personal Responsibility Education Program (PREP), Family and Youth Services Bureau, and the Administration for Children and Families is funding this program. This means that Great Plains Tribal Leaders' Health Board and its partners are receiving funding from DHHS to support the activities that are required to conduct the study. No one on the team will receive a direct payment or an increase in salary from DHHS for conducting this study.

ARE MY RECORDS CONFIDENTIAL?
The records of this evaluation will be kept confidential to the extent permitted by law. In any report about this study that might be published, the study results will be described in a summarized manner so that your child cannot be identified. Data will be stored in secure share drives and locked cabinets.

IS THIS STUDY VOLUNTARY?
Your child's participation is voluntary. Your child may choose not to participate, or your child may discontinue participation at any time. They will not be penalized or lose benefits to which he/she is otherwise entitled. You and your child's decision whether or not to participate will not affect your or your child's current or future relations with Great Plains Tribal Leaders' Health Board, evaluators at Lost&Found, the school, or other organizations.

WHOM MAY I CONTACT IF I HAVE QUESTIONS?
You and your child may ask any questions you have now or later. The lead researcher conducting this study is Kelley LeBeaux from Great Plains Tribal Leader's Health Board. You can reach her at **605-721-1922** or kelley.lebeaux@gptchb.org.

If you have questions regarding your child's rights as a research subject, you may contact Great Plains IHS IRB at 866-331-5794. An IRB is a group of people who review the research to protect your rights and welfare. You can call this number about any problems, complaints, or concerns you have about this research study. You may also call the numbers of the IRB if you cannot reach the research staff, or you wish to talk with someone who is independent of the research team.

Child's Name: _____
Please Print

_____ _____
Signature of Person Authorized to Provide Permission for the Child Date

_____
Relationship to Child

Student Name: _____

THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

The Family Educational Rights and Privacy Act (FERPA), a Federal law, requires that Flandreau Indian School, with certain exceptions, obtain your written consent prior to the disclosure of personally identifiable information from your child's education records. However, Flandreau Indian School 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 the Flandreau Indian School to include this type of information from your child's education records in certain school publica-tions. Examples include:

- A playbill, showing your student's role in a drama production;
- The annual yearbook; Honor roll or other recognition lists; Graduation programs; and
- Sports activity sheets, such as for wrestling, showing weight and height of team members

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, com-panies that manufacture class rings or publish yearbooks. In addition, two federal laws require local education agencies receiving assistance under the Elementary and Secondary Education Act of I 965 (ESEA) to provide military recruiters, upon request, with three directory information categories-names, addresses and telephone listings - unless parents have advised the school that they do not want their student's information disclosed without their prior written consent.

If you do not want Flandreau Indian School disclose directory information from your child's education records without your prior written consent, you must notify the school in writing. Flandreau Indian School designated the following information as directory information:

- Student's name, address, telephone listing, Photograph, Date and place of birth, Electronic mail address.
- Participating in officially recognized activities and sports, weight and height of member of athletic teams
- Degrees, honors, and awards received, Major field of study
- Dates of attendance, Grade level, the most recent educational agency or institution attended

If there are questions about your or your student's (18 or older) rights under FERPA, you may contact the office at Flandreau Indian School.

If you do not wish directory information about your student to be disclosed, please indicate on the attached form and return that form to the Flandreau Indian School.

Everall Fox
Chief School Administrator

David Flammond
Acting Assistant Principal

Family Educational Rights and Privacy Act (FERPA)

I have received information about my rights under FERPA and understand my right to request that any of the items listed below not be disclosed as Directory Information to any outside group, other than those having a legal right to the information, without my written permission. Those having legal rights might include fed-eral auditors, those having oversight responsibilities, circumstances regarding health and safety, emergencies or other similar entities.

_____ I do not want any Directory Information regarding _____

Student Name - Nothing will be disclosed without written permission

_____**OR**_____

I do not want the following directory information regarding my student _____
Disclosed without my permission: *Student Name*

CHECK ALL THAT APPLY:

1. ☐ Student's Name
2. ☐ Participation in officially recognized activities and sports
3. ☐ Address
4. ☐ Telephone listing
5. ☐ Weight and height of members of athletic teams
6. ☐ Electronic mail address (e-mail)
7. ☐ Photograph
8. ☐ Degrees, honors, and awards received
9. ☐ Date and place of birth
10. ☐ Major field of study
11. ☐ Dates of attendance
12. ☐ Grade level

I am the parent/ legal guardian of: _____

I am an eligible student (18 years of age or older): _____

(Signature)_____ **Date**_____/_____/_____

Student Name: _____

NO CHILD LEFT BEHIND ACT OF 2002

Everall Fox
Chief School Administrator

David Flammond
Acting Assistant Principal

"No Child Left Behind Act of 2002"

Parents,

The "No Child Left Behind Act of 2002", SEC.9528, Armed Forces Recruiter Access to Student and Student Recruiting Information, provides for schools to provide, on request made by military recruiters or an institution of higher education, access to secondary school student names, addresses, and tel-ephone listings. As a school, we are required to comply with this law. You as a parent, however,
have the right to request that the school not release that information to these agencies. If you wish to not have your child's information released, please indicate below. If you have any questions about
the "No Child Left Behind Act of 2002" please contact Flandreau Indian School.

☐ YES, I do wish to have my child's information released.

☐ NO, I do not wish to have my child's information released.

Parent/Guardian

(Signature)_____**Date**_____/_____/_____

Student Name: _____

INDIVIDUAL EDUCATION PROGRAMS

- Student participated in Special Education: YES ☐ NO ☐
- Student was on a 504 Plan: YES ☐ NO ☐
- Student participated in Gifted and Talented: YES ☐ NO ☐
- Student participated in LEP: YES ☐ NO ☐

Has your student ever been on an Individual Education Plan (IEP) for Special Education?
YES ☐ NO ☐
If yes, please indicate your child's disability: _____

- ☐ Cognitive Impairment
- ☐ Emotional Disturbance
- ☐ Learning Disability
- ☐ Speech or Language Impair

Please contact the school that last implemented your child's IEP and have them forward the Special Education Records to the Flandreau Indian School.

This is extremely important

It will assist the staff in planning an appropriate program for your student.

SIGNATURE

I am legally responsible for this student and hereby understand that additional information may be re-quested by the Exceptional Education Department concerning my child's Individual Education Program or 504 Plan.

Parent/Guardian
(Signature)_____ **Date**_____/_____/_____

The Flandreau Indian School, in cooperation with the Bureau of Indian Education (BIE) funded schools, will ensure that a free and appropriate education and a full educational opportunity is provided in the least restrictive environment to all children with disabilities, grades 9 through 12.

Gifted and Talented Questionnaire

Student Name: _____ Grade: _____ Date: _____

Student's Teacher: _____ School: _____

Circle who filled out form:
Teacher ☐ Parent ☐ Student ☐ Other: _____

Check the following items as best describes your child or student as you see him/her:

	Occasionally	Often	Most Often
1. Has advance vocabulary, uses unusual words for his /her age.	☐	☐	☐
2. Knows a lot more about some topics than do other children his/her age.	☐	☐	☐
3. Has quick recall of information; immediately remembers facts, series of numbers, words from songs or plays, or parts of conversations heard earlier).	☐	☐	☐
4. Is observant; never misses anything; knows what is going on around him/her.	☐	☐	☐
5. Has lots of ideas to share.	☐	☐	☐
6. Has different ways of solving problems.	☐	☐	☐
7. Wants to know how and why.	☐	☐	☐
8. Asks a lot of questions about a variety of subjects.	☐	☐	☐
9. Makes up stories or plays and has ideas that are unique.	☐	☐	☐
10. Likes to plan and organize activities.	☐	☐	☐
11. Works well with others.	☐	☐	☐
12. Has a sense of humor.	☐	☐	☐
13. Often likes to play or work on his or her own.	☐	☐	☐
14. Often get engrossed in projects.	☐	☐	☐
15. Shows strong abilities in; Circle: art, writing, crafts, music, acting, sports, other _____	☐	☐	☐
16. Shows leadership abilities	☐	☐	☐
17. Shows imagination, originality, creativity.	☐	☐	☐
18. Likes to play organized games (football, soccer, baseball) and is good at them.	☐	☐	☐
19. Sets high standards for himself/herself.	☐	☐	☐
20. Understands things well enough to teach others. (e.g. teaches others how to do things; explains things so others can understand; explains areas of interest to adults)	☐	☐	☐

Please circle the area(s) in which you think the individual is gifted/talented:

☐ Language Arts ☐ Math ☐ Science ☐ Social Studies ☐ Creativity

☐ Leadership ☐ Art ☐ Music ☐ Dance ☐ Drama

FIS STUDENT AND FAMILY LANGUAGE SURVEY

Student Name: _____ Grade: _____

Date of Birth: _____ Gender: Male ☐ Female ☐

Parent/Guardian's Name: _____

Parent/Guardian's Name: _____

Select all of the races that apply to the student:

☐ Native American ☐ Caucasian ☐ Hispanic ☐ Asian

☐ Native Hawaiian/Pacific Islander

Registered Tribal Member of: _____

Other Tribe(s): _____

What was the student's first language? _____

Is a language other than English used in the home? ☐ Yes ☐ No

If so, what language? _____

Does the student speak any language other than English? ☐ Yes ☐ No

If so, what language and at what level? Language: _____

☐ Beginning, few words and phrases ☐ Intermediate, conversational

☐ Advanced, comprehends commonly used terms ☐ Fluent

If a second language is not spoken in the home, has the student been exposed to a second language by a family member? If so, how would you describe the student's exposure to the language? Consistent, occasional, rare? Please describe below:

_____

_____

What relation is this family member who exposes the student to a language other than English? (grandparent, great-grandparent, aunt, uncle, etc.)

_____

_____

Did your child attend a language immersion school prior to this year? If so, where and for how long? What language?

_____

_____

Can you provide any additional information about your child's second language skills?

_____

_____

Student Name: _____

PERMISSION FOR STUDENT CHECKOUT

Bureau of Indian Education (BIE), policy prohibits students from leaving campus with anyone other than the parent/guardian unless written consent is on file, and only under the following conditions:

- A student may be released to immediate family* only who are: 25 years or older, with written parental/guardian permission; and administrative approval.
- Students will not be released to ANYONE under the influence of drugs or alcohol.

**Immediate family is defined as mother, father, legal guardian, sister, brother, grandparent, aunt or uncle.*

Individuals wanting to checkout a student must physically appear on campus and will be asked to present a valid driver's license, state, or tribal ID for identification purposes. Students will only be released for checkout if a valid licensed driver is present, and the driver is following the FIS checkout policy. If checkout occurs during instructional time, it may be considered an unexcused absence, which might affect the grade/performance of the student. Individuals checking out students over the weekend must return students to the dorm by 9:00 PM on the evening before school resumes.

FIS will not be held responsible for:

- Any legal problems/expenses, health care expenses, or CHS (contract health service) expenses incurred by the student when checked out will be the responsibility of the parent/guardian.

STUDENT INFORMATION

Student Name: _____ **Grade:** _____
Last *First*

Guardian Name: _____ **Date:** _____
Last *First*

AUTHORIZED CHECKOUT PERSONS

Name & Age *(must be 25+ yrs. Old)*	**Relationship** **Immediate Family Member*	**Address**	**Phone Number**

FIS STAFF CHECKOUT PERMISSION:

☐ YES, I give permission for my student to be checked out by FIS Staff after school or on the weekend.
(Staff are not allowed to check out students overnight)

FIS CHAPLAIN CHECKOUT PERMISSION:

☐ YES, I give permission for my student to be checked out by FIS Chaplain after school or on the weekend.
(Chaplain is not allowed to check out students overnight)

UNAUTHORIZED CHECKOUT PERSONS

~Please include any proper documentation if an individual is not allowed to have contact with a student~

Name: _____
Relationship: _____
Reason for denied checkout (if applicable):
_____

Name: _____
Relationship: _____
Reason for denied checkout (if applicable):
_____

_____ Nobody has permission to check out my student at this present time

Permission will remain in effect until cancelled by the undersigned parent/ guardian in writing or based upon Administration decisions.

Parent/Guardian
(Signature)_____ **Date**_____/_____/_____

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

_____ _____

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

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**

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)

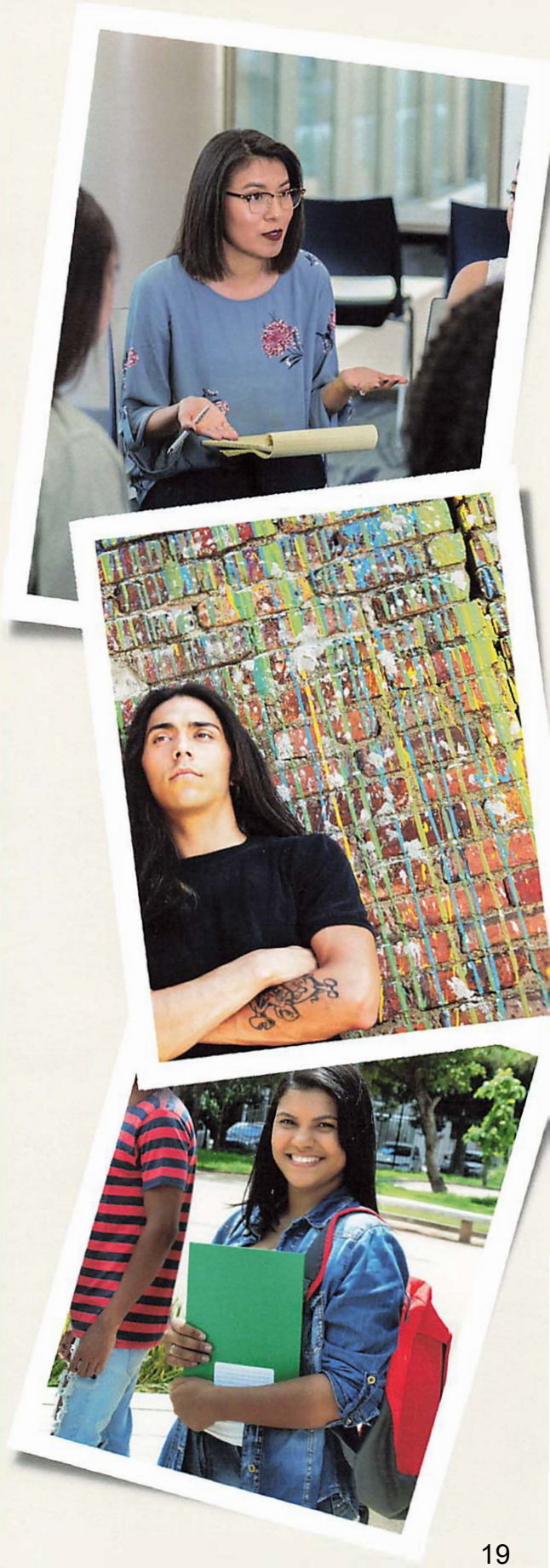
☐ School staff confidentially received student information (Food services, Registration/enrollment, Transportation department, Building school counselor or school social worker, Building principal)

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:** _____

Bureau of Indian Education

Behavioral Health and Wellness Program



IMMEDIATE INDIVIDUAL CRISIS SUPPORT

24/7 Call Line - Option 1

The 24/7 BIE BHWP Call Line, Option 1, Immediate Individual Crisis Support, is live for students and staff at all entities and programs funded by BIE.

Behavioral Health Support

Immediate Individual Crisis Support connects students and staff to a trained crisis professional who can help with behavioral health-related distress such as thoughts of suicide, substance abuse crisis and emotional distress such as feelings of panic, persistent sadness, flashbacks or relationship problems.

Call Today

Dial the 24/7 BIE BHWP Call Line **1-844-ASK-BHWP (1-844-275-2497)** and select Option 1 to access Immediate Individual Crisis Support.

- ☑ 24/7
- ☑ Confidential
- ☑ Free
- ☑ Indigenous Lens

CONSENT FOR COUNSELING (INDIVIDUAL & GROUP) AND THERAPEUTIC PROGRAMS
On and Off Campus Services

Note: *This form is not needed if this specific group counseling and/or therapeutic programs have already been consented to through an IEP or 504 plan or another consent form approved by FIS Administration.*

Student Name: _____ Date of Birth_____/_____/_____

Parent/Guardian Name: _____

Contact Phone No. _____-_____-_____ Contact Email: _____

FIS Individual & Group counseling and Therapeutic Programs

Group and Individual counseling, Virtual counseling services, Life skills programs, Healthy Relationships, Prevention Programs, Behavioral Health Services, Peer Support, Referrals to Indian Health Service-Behavioral Health.

The school counselor, psychologist, contract mental health providers, or social worker can provide Individual and group counseling sessions and therapeutic programs to students with permission from the parent(s) or guardian(s). These counseling sessions and programs are designed to teach skills to help students be more successful in their academic and social environment. Many students may improve their school performance, attendance, and attitude towards school by taking part in group counseling sessions and therapeutic programs. Self-help issues developed in these counseling groups often include coping strategies, stress management, emotion regulation, problem solving, and social skills.

Information disclosed by the students during individual and group sessions is typically not revealed to anyone else by the facilitator, except under certain circumstances (for example, evidence that a student is a threat to themselves, others or property). The group facilitator will limit the sharing of information to FIS administrators or other FIS staff as necessary for student well-being and to support student success. In addition, information must be shared if legally required to do so. Otherwise, all material discussed will be confidential.

Parent/Guardian Consent

☐ **YES**, I do give permission for _____ to receive Group counseling and Therapeutic services.
(Name of Student)

☐ **NO**, I do not give permission for _____ to receive Group counseling services.
(Name of Student)

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

Student Name: _____

FIS NURSE INFORMATION LETTER

Dear Parents, Guardians, and Students,

Welcome to the 2025–2026 School Year at Flandreau Indian School!
We're pleased to introduce our nursing staff, Marquelle Edlund and Tara Rodriguez, who can be reached at extensions 2168 and 2150. We look forward to caring for your students and supporting their success this school year. Our office, located in the Home Living Building, is equipped to meet most student health needs. If care beyond our capabilities is required, students will be referred to the nearest medical facility in Flandreau. In emergencies, hospital or ER services may be utilized. Our goal is to communicate all health concerns, treatments, illnesses, and medication updates with parents/guardians whenever possible. If we are unable to reach a guardian and medical care is necessary, we will act under the loco parentis act to ensure your child's well-being.
Please read the following notice and sign below.

Medication and Health Services Notice:

- Students may bring prescription medications to campus; however, all medications must be immediately reported and turned into staff to be properly inspected and evaluated by the nursing staff. Once prescriptions are verified, medications will be administered by staff as scheduled.

Please note that IHS (Indian Health Service) pharmacies do not transfer prescriptions or refills to the local Flandreau Santee Sioux Tribe (FSST) Pharmacy. Because of this, students must have a current prescription on file before any medication can be administered. The FSST Pharmacy will only fill prescriptions that are sent directly to them by a healthcare provider. Families are responsible for ensuring new prescriptions are submitted for any medications their student is currently taking.

- Each medication must have **Attachment A (pg. 36)** completed and signed by both the guardian and prescriber—one form per medication. This includes all prescription medications, over-the-counter (OTC) medications, vitamins, supplements, and herbal remedies.
    - Students requiring emergency rescue medications (such as an EpiPen, rescue inhaler, or seizure rescue medication) must also have a Student Medical Action Plan (pg. 35) completed and signed by both the guardian and provider.
- Students may not bring any performance enhancers, pre-workouts, or other body-enhancement vitamins or supplements to campus. If such items are brought, they will be confiscated by staff and returned to the student upon return home.
- When students depart campus, they may be sent home with their medications, which will be sealed in a tamper-proof bag and sent in their original packaging (which may not be child-proof).
- At FIS, we offer a Sick Bay located near the Nurse's Office, available during school hours Monday through Friday. This shared space provides care for students who are unable to attend classes due to illness or injury. There are nine beds available, with clean bedding, meals as needed, and OTC medications provided when appropriate. Nurses and authorized staff monitor Sick Bay every half hour to ensure student comfort and safety.
    - *Please note, there is a no-electronics policy in Sick Bay to encourage students to rest and recover. We will make every effort to notify families if their child is placed in Sick Bay.*

I have read and understand the above notice: _____(signature)

For more information on recommended vaccines, scan the QR code below. Please ensure all medical forms are fully completed so we can provide the best care for your child. Thank you for your partnership in supporting your child's health and education this year!

Kind Regards,

Marquelle Edlund, Registered Nurse
Tara Rodriguez, Registered Nurse

Student Name: _____

STUDENT AND FAMILY MEDICAL HEALTH AND HISTORY

Please fill in the STUDENT and FAMILY history as able.
Check the box for YES if the student or an *immediate family member has ever received the listed diagnosis below. Leave box unchecked for NO or comment N/A.
Please leave a comment of explanation for all "YES" answers, if further explanation is needed, please provide proper documentation. If not applicable, please leave blank or write "N/A".
**Immediate family member is defined as biological mother, father, siblings, grandparent, aunt, uncle*

Diagnosis	Student	Family History	Comments	Diagnosis	Student	Family History	Comments
Acne	☐	☐		Hearing Impairment	☐	☐	
ADHD	☐	☐		Heart Murmur	☐	☐	
Allergies	☐	☐		Heart Palpitations	☐	☐	
Anemia	☐	☐		Heart Abnormalities or Problems	☐	☐	
Anxiety or Panic Disorders	☐	☐		High Blood Pressure	☐	☐	
Asthma	☐	☐		Hypoglycemia	☐	☐	
Autism	☐	☐		Immunosuppressant condition or medication	☐	☐	
Autoimmune Disease	☐	☐		Kidney Problems	☐	☐	
Behavioral Health Hospitalization	☐	☐		Liver/Gallbladder problems	☐	☐	
Bipolar Disease	☐	☐		Mental Illness	☐	☐	
Birth Defects	☐	☐		Migraines	☐	☐	
Bleeding Disorders	☐	☐		Organ Transplant	☐	☐	
Bowel/Bladder Abnormalities	☐	☐		Pacemaker	☐	☐	
Cancer	☐	☐		Pneumonia	☐	☐	
Chemical Dependency or Substance Abuse	☐	☐		Pregnancy	☐	☐	
Congestive Heart Failure	☐	☐		Schizophrenia	☐	☐	
COPD	☐	☐		Self-Harm or harm to others	☐	☐	
Cystic Fibrosis	☐	☐		Skin abnormalities	☐	☐	
Depression	☐	☐		Smoking	☐	☐	
Diabetes	☐	☐		Stroke	☐	☐	
Dizzy or fainting spells	☐	☐		Suicidal Attempt/ Ideation *(if yes please explain)*	☐	☐	
Eating Disorder	☐	☐		Surgery	☐	☐	
Eczema	☐	☐		Thyroid Problems	☐	☐	
Epilepsy or Seizure Disorder	☐	☐		Upper Gastrointestinal Disease (ulcer, hernia, reflux)	☐	☐	
Fracture	☐	☐		Visual impairments	☐	☐	

Has student ever been hospitalized for any reason? ☐ YES ☐ NO
If YES, please explain: _____

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____
2. Frequency of seizures: _____ Date of last seizure: _____
3. What might trigger a seizure in your child? _____
4. Are there any warnings and/or behavior changes before the seizure occurs? ☐ YES ☐ NO
   If YES, please explain: _____
5. Does your child ever stop breathing or require oxygen during seizures? ☐ YES ☐ NO
   If YES, please explain: _____
   How does your child react after a seizure is over? _____
6. Has child ever been hospitalized for continuous seizures? ☐ YES ☐ NO
   If YES, please explain: _____

Student Name: _____

STUDENT AND FAMILY MEDICAL HEALTH AND HISTORY *(continued)*

Seizure Type	Frequency	Description

Primary Care Provider Information *REQUIRED*

Primary Physician/Doctor:

_____

Primary Pharmacy and location (city/state):

_____

Primary Clinic (city/state/phone):

_____

Please request a copy of a recent History & Physical and medication list from student's primary physician/doctor and include in the application packet if able.

Student Allergies (REQUIRED- if none put "none"):

_____

_____

Please list all current prescription and over the counter medications your child is taking:

Medication Name	Dose	Frequency	Purpose

STUDENT NAME: _____ DOB: _____

At Flandreau Indian School we offer the following **Over the Counter (OTC)** medications as needed. Please sign at the bottom if you consent to your child receiving the following as needed. These are distributed and documented by nursing and authorized staff only.

- **Midol** – two tabs by mouth every 8 hours as needed for menstrual cramps (biological females only)
- **Acetaminophen/Tylenol** – 1000 mg by mouth every 8 hours as needed for pain/fever
- **Ibuprofen/Motrin** – 400mg by mouth every 8 hours as needed for pain/fever
- **Bisacodyl/Dulcolax** – 5mg by mouth daily as needed for constipation
- **Pepto-Bismol/generic brand** – 524mg by mouth per hour as needed for upset stomach/diarrhea, up to 4200mg in 24-hour period
- **Mylanta One** – 1 tablet as needed for heartburn, sour stomach, bloating, gas
- **Refresh Plus/generic brand** – 1-2 drops in affected eye as needed up to 4x daily for dry eyes
- **Robitussin DM/generic brand** – 1 tablet every 4 hours as needed for cough or congestion
- **Benadryl/generic** – 25mg by mouth every 4-6 hours as needed for cough or congestion
- **Cetirizine/Zyrtec** – 10mg daily as needed for allergies, runny nose, cold symptoms, rash, or hives (if patient does not have as scheduled med)
- **Cough drops** – 1 drop every 2 hours as needed for cough or sore throat

☐ **YES**, I do give consent for _____ to receive **Over the Counter (OTC)** medications as needed.
(Name of Student)

☐ **NO**, I do not give permission for _____ to receive **Over the Counter (OTC)** medications as needed.
(Name of Student)

The above medical health and history is completed to the best of my knowledge. I understand that if there are health and safety concerns that exceed what Flandreau Indian School can provide, my child may be sent home for health and safety reasons.

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

Student Name: _____

MEDICAL CONSENTS & INSURANCE INFORMATION

IN LOCO PARENTIS PERMISSION

I, _____, give consent, for reasonable cause and assurance for the health and safety of all students, all Flandreau Indian School staff may act *In Loco Parentis,* in the best interest of my student, _____, in authorizing medical care or mental health care for him/her. Care to be rendered to the above-named minor under supervision and upon the advice of a qualified health care provider, emergency and acute health care for accidents or illnesses, mental or psychological/ behavioral care, dental and optical care. The FIS Staff have the authority to sign all paperwork required for emergencies, medical or hospital care at any medical facility.

Definition - *In Loco Parentis*

In loco parentis is a term used in situations where another individual or agency is acting in place of a parent on behalf of a minor. The term is used in legal settings to assign the rights, duties and responsibilities of a parent to another person or agency. Alternatively, the term has been used in less formal references to describe the role played by an educational institution, such as a boarding school, college, or university in supervising minors and young adults.

_____

Address *City* *State* *Zip*

_____

Home Phone Number *Cell Phone Number* *Work Phone Number*

Parent/Guardian (Signature)_____ **Date**_____/_____/_____

**This permission shall remain in effect throughout the student's enrollment at FIS.*

HEALTH INSURANCE INFORMATION

Medical / Pharmacy Private Insurance: YES☐ NO☐ Medicaid: YES☐ NO☐ IHS: YES☐ NO☐

Name of Insurance Company: _____

Insurance Company Address: _____

Name of Policy Holder: _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Group Number: _____ ID Number: _____

Dental Private Insurance: YES☐ NO☐ Medicaid: YES☐ NO☐ IHS: YES☐ NO☐

Name of Insurance Company: _____

Insurance Company Address: _____

Name of Policy Holder: _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Group Number: _____ ID Number: _____

Vision Private Insurance: YES☐ NO☐ Medicaid: YES☐ NO☐ IHS: YES☐ NO☐

Name of Insurance Company: _____

Insurance Company Address: _____

Name of Policy Holder: _____ Date of Birth: ____/____/_____ SSN: _____-_____-_____

Group Number: _____ ID Number: _____

Student Name: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

- I authorize the use or disclosure of the above-named individual's health information including History and Physical Exam Information, student and family medical history, medication history and current usage pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored events and FIS sponsored events. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
- The information identified above may be used by or disclosed to the FIS school nurse, Athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
- This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand the revocation will not apply to information that has already been released I response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- This authorization will expire when a student graduates or withdraws.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need NOT sign this form to ensure healthcare treatment.

Expectations or Special Instructions:

_____

_____

Parent/Guardian

(Signature)_____ **Date**_____/_____/_____

Student (*if over 18*)

(Signature)_____ **Date**_____/_____/_____

This form must be completed annually and must be available for inspection at the school.

Flandreau Santee Sioux Tribal Health Center

Consent for Treatment of Minor - FIS

The treatment of a minor requires coordination between the healthcare provider and child's parent or guardian. The provider's role is to ensure that the parent or guardian is aware of and agrees with the care plan.

PATIENT INFORMATION			
Patient's Last Name:	First Name:	Middle:	Date of Birth:

AUTHORIZATION & CONSENT FOR THE TREATMENT OF A MINOR

The parent or legal guardian authorizes consent for Flandreau Santee Sioux Tribal Health Center to arrange for or provide the following services:

1. **Healthcare** including medical examinations, routine laboratory studies, x-ray procedures and skin tests
2. **Dental** care including dental examinations, preventative use of fluorides, and necessary emergency care
3. **Mental Health** and Substance Use Disorder (S.U.D.) services including evaluation and treatment as necessary
4. **Transportation** of the child to and from another Health Facility for these services

Exceptions or special instructions:

_____

_____

_____

PROXY AUTHORIZATION FOR OTHERS TO CONSENT OR BE INVOLED IN CARE

As the parent/legal guardian of the above minor patient authorize Flandreau Indian School (FIS) staff as a proxy who will be able to bring my child to his/her visit(s) and to give consent in person for the health care of my minor child. This person may also sign any necessary consents or acknowledgments on my behalf, including responsibility for payment. I further state that there are no Court Orders now in effect in any jurisdiction that would prohibit me from exercising the power I now seek to authorize. I understand that protected health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making. In the event FSST HC or FIS is unable to reach me for non-routine care as described below that FIS staff can invoke "In Loco Parentis" for the immediate healthcare needs as recommended by a medical provider.

ACKNOWLEDGMENT & AGREEMENT

I hereby give consent for all of the above services. This authorization shall remain effective for one year from the date signed, unless revoked sooner in writing by parent or legal guardian and delivered to Flandreau Santee Sioux Tribal Health Center. This authorization is given pursuant the provisions of South Dakota Codified Law 20-9-4.2.

To revoke this authorization, please send written notice to Flandreau Santee Sioux Tribal Health Center 403 West Board, PO Box 329 Flandreau, SD 57028.

Valid: Throughout School Enrollment Year 2025-2026

_____	_____	_____	
Name of Parent/Legal Representative *(print)*	Signature	Date	MRN #

FLANDREAU SANTEE SIOUX TRIBAL HEALTH CENTER
BEHAVIORAL HEALTH DEPARTMENT

CLIENT RIGHTS AND RESPONSIBILITIES

As a client of the Flandreau Santee Sioux Tribal Health Center – Behavioral Health, your rights include, but are not limited to the following:

- The right to confidentiality and privacy of all medical/counseling records and information given in treatment.
- The right to confidentiality of all records, correspondence and information relating to assessment, diagnosis and treatment in accordance with 42U.S. C. 290 dd-3 and ee-3 and 42 Code of Federal Regulations, part 2 and Indian health Service Notice of Privacy Practices, HIPAA-Health Insurance Portability and Accountability Act. Exceptions to this include:

  a.) The client consents in writing; OR
  b.) The disclosure is mandated by court order; or
  c.) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
  d.) The client commits or threatens to commit a crime either at the program or against any person who works for the program; or
  e.) Program personnel have reason to believe that the client is a threat OT harm to self or other people
  f.) We may disclose limited protected health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness or missing person;
  g.) If you are believed to be a victim of a crime, a law enforcement official requests information about you and we are unable to obtain your agreement because of in capacity or other emergency circumstances, we may disclose the

requested information if we determine that such a disclosure would be in your best interests;
h.) We may use or disclose protected health information as we believe is necessary to prevent or lessen a serious and imminent threat to the health OT safety of a person;
i) We may use or disclose protected health information in the course of judiciary and administrative proceedings if required or authorized by law;
j.) We may use or disclose protected health information to report a crime committed on IHS health facility premises or when IHS is providing emergency health care; and
k.) We may make any other disclosures that are required by law.

- The right to be treated with respect and dignity.
- The right to be free of any exploitation or abuse; including, for example, any financial or sexual relationship with any agency personnel or any member of the governing board.
- The right to receive treatment that is sensitive to you as an individual in a non-discriminatory manner.
- The right to actively participate in your treatment plans as well as any modification of that plan to insure your understanding and agreement with this plan.
- The right to know the reasons why a particular treatment is considered appropriate.
- The right to refuse any proposed treatment or medication unless in an emergency.
- The right to receive an explanation of diagnosis and prescribed medications and any side effects.
- The right to locate alternative sources of assistance.
- The right to be informed of the volunteer or student status of a therapist, or therapist process in gaining licensure.
- The right to review your case records unless conditions arise as specified by South Dakota Codified Law.
- The right to assert grievances if your rights are violated.
- The right to have access to advocacy services at any time.
- The right to receive explanation if you are terminated for services or suspended from services for a specified period of time.

To maximize beneficial client outcome, clients should be aware of their responsibilities. The client is responsible for:

- Following recommended and agreed upon treatment plan. Punctuality of appointments and notification to FSST HC – Behavioral Health if unable to attend a session prior to appointment.
- Consideration of the rights of the staff and other clients
- Being respectful of the property of others
- Maintaining cleanliness and order
- Providing accurate medical and personal information.

Clients Rights and Responsibilities

- No use of obscene language or disruptive behaviors.
- Parents will take responsibility for their child's appointments and transportation needs.
- Advising FSST HC – Behavioral Health on changes in residence or work hours that may interfere with appointments.
- Adults take full responsibility for their transportation to treatment.
- Upon receipt of court order for a substance evaluation, immediately set appointment due to the lengthy process of the completion of this document. Evaluations are completed in 2-3 weeks. The FSST HC – Behavioral Health will not write letters notifying the court that you have an appointment scheduled because you failed to get your evaluation done in a timely manner.
- If you are referred to inpatient treatment and discontinue or are discharged, you are responsible for your actions and the consequences. The FSST HC – Behavioral Health will not write letters to the Court on your behalf.
- If you do not attend an inpatient treatment program because you choose not to, the FSST Health Center – Behavioral Health will not prioritize you ahead of other clients we are assisting.
- If you are eligible and are paid for by the FSST for Keystone Treatment, you will be responsible for the financial agreement if you do not complete Aftercare with the FSST HC – Behavioral Health.

_____ _____

Client Signature Date

_____ _____

Counselor Signature Date

FLANDREAU SANTEE SIOUX TRIBE

Flandreau Santee Sioux Tribal
Health Center

403 W. Broad Ave. / P.O. Box 329 Flandreau, SD 57028
Phone: (605)997-2642 Clinic Phone: (605)997-3844
Fax: (605)997-9940 Medical Records Fax: (605)997-3694

INFORMED CONSENT FOR THERAPY

INTRODUCTION

The Flandreau Santee Sioux Tribal Health Center (FSST HC) would like to welcome you to our mental health and substance abuse services. For you to make an informed decision about the type of care and services you desire, it's important to be familiar with the specific therapeutic and case management services that we offer. PLEASE read this information carefully and ask any questions that you may have about the services or about how you will be provided with the care/treatment that you want or need.

COUNSELING RISKS AND BENEFITS

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

PATIENT RIGHTS

During your involvement with our facility, you have the following right(s) to:

- Be informed about the treatment planned, including benefits expected, risks involved, and participation in the development of your treatment plan.
- Refuse treatment.
- Reserve confidentiality.
- Be treated with full recognition of your personal dignity, individuality, and need for privacy.
- Receive services in adequate facilities.
- Know the qualifications of the counselor providing you service
- Receive a written explanation, stating your right for appeal (if any), if you are found ineligible for services.

CONFIDENTIALITY

- The Health Information Portability Act (HIPPA) requires that your information and records are kept protected and confidential unless you sign a Release of Information (ROI) asking for your records, information, or updates to an outside agency. This request may be revoked at any time.
- All interactions with the Flandreau Santee Sioux Behavioral Health Clinic, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. The behavioral health team works as an interdisciplinary team that may include Case Management, Social Services, and Medical Providers employed by the FSST. If you have questions or concerns your therapist can provide answers for each individual case. The information shared with the team is based on a 'Need To Know' basis.

_____ _____

Patient Name Chart Number

_____

Provider Name

06/30/2025

Flandreau Santee Sioux Tribal
Health Center

403 W. Broad Ave. / P.O. Box 329 Flandreau, SD 57028
Phone: (605)997-2642 Clinic Phone: (605)997-3844
Fax: (605)997-9940 Medical Records Fax: (605)997-3694

EXCEPTIONS TO CONFIDENTIALITY

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities and/or a Qualified Mental Health Professional responsible for ensuring safety. Therapists have a legal duty to warn any individual who may be in imminent danger.
- The law requires that any Flandreau Santee Sioux Behavioral Health staff who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age to report this information to child protection services.
- The law requires that any Flandreau Santee Sioux Behavioral Health staff who have knowledge or reasonable suspicion of abuse, neglect or exploitation of elders and adults with disabilities to adult protective services.
- Insurance companies may review information solely for the purpose of payment for services. Please refer to your insurance carrier for detailed information.

GRIEVEANCE PROCESS

The Flandreau Santee Sioux Tribal Health Center (FSST HC) strives to provide quality services which are monitored on-going through weekly staff meetings, case management reviews, and quarterly reports. If you have a complaint about our service or providers, you can address it by visiting the FSST HC Behavioral Health Director who may ask you to submit it in writing. The FSST HC will consult with the Flandreau Sioux Tribe Health Administrator for investigation and resolution.

STATEMENT OF AGREEMENT

In signing below, I acknowledge that I fully understand what I have read and have discussed this document with my counselor or psychiatrist. I have had an opportunity to ask questions, and I consent to (or on behalf of my minor child or guardian) participate in counseling with the Flandreau Santee Sioux Tribal Health Center.

_____ _____

Client/Minor's Signature Date

_____ _____

Parent/Guardian's Signature Date
(If client is a minor child)

_____ _____

Counselor/Psychiatrist's Signature Date

DEFINITIONS

1. HEALTH CARE:

Health care is the provision of health services of preventive, diagnostic, therapeutic and/or rehabilitative nature that do not involve major surgical procedures.

The purpose of medical examination is to appraise the child's health and physical condition. The medical examination consists of two parts: in the first part, questions are asked relative to the health, present and past, of the child and his/her parents; in the second part, a thorough examination is made of the child's body, including weight, height, blood pressure, vision, and hearing.

Laboratory studies include tests of urine and blood.

X-rays are taken when necessary to see if there is any abnormality within the body.

A skin test consists of the injection into the skin of about a drop of a substance such as "tuberculin" or "coccidioidin." By means of these tests and x-rays of the chest, the physician determines whether the patient has or has had tuberculosis or valley fever.

2. DENTAL CARE:

Dental care begins with the dental examination, which consists of (a) examining tooth, gums, tongue and other parts of mouth with dental mirror and explorer (probe) and (b) taking dental x-rays as needed.

Routine dental care includes those services necessary to prevent the loss of teeth, such as cleaning the teeth, applying fluoride to the teeth, filling decayed teeth, and pulling teeth in order to prevent infection or clear up existing infection.

Necessary emergency dental care consists of those services that cannot be deferred without endangering the child's health or life, such as the relief pain, the cleaning up of infection, and the control of bleeding.

3. MENTAL HEALTH SERVICES:

Mental health services include psychological and psycho-educational testing, psychiatric evaluation and consultation or assessment by mental health professionals. The information obtained is used to determine if it is appropriate or necessary to develop a treatment program for the child.

4. EMERGENCY HEALTH CARE:

Emergency health care includes surgical and/or non-surgical procedures that cannot be deferred without endangering the child's health or life, surgical procedures that can be deferred are not authorized by the consent in this form. In such cases, the specific authorization for surgery from the parent or legal guardian is required.

Flandreau Santee Sioux Tribal Health Center

This form serves as a record of consent for the Flandreau Indian School (FIS) student listed below to receive the following vaccinations from the Flandreau Santee Sioux Tribal Health Center (FSST HC) during the 2025-2026 school year, based on the latest national guidelines and eligibility.

- I acknowledge that Flandreau Santee Sioux Tribal Health Center (FSST HC) provided me and I have been afforded the opportunity to read the CDC Vaccine Information Statement for the vaccine(s) linked with the QR code found here → or found at https://www.cdc.gov/vaccines/hcp/current-vis/index.html.
- I understand that the student will be screened for eligibility prior to receiving any vaccine dose based on the recommended vaccine schedule by the National Advisory Committee for Immunization Practices (ACIP).
- I understand that vaccinations may take place on FIS grounds during vaccine clinics administered by FSST HC staff or at FSST HC during a scheduled appointment time.
- I understand that after giving consent, if I change my mind and do not want to have my student complete the vaccination or vaccination series, that I may call FIS nursing staff or FSST HC Public Health.
- I understand I am able to contact FIS nursing staff @ 1-605-997-3773 or FSST HC Public Health @ 1-605-997-2642 with any questions or concerns regarding the vaccines listed below or the vaccination process.

Vaccine	Consent (Circle Yes or No)
Seasonal Influenza (Flu)	☐ Yes ☐ No
Meningococcal (MenACWY)	Yes No
Meningococcal B Series	☐ Yes ☐ No
HPV Series (Human Papillomavirus)	☐ Yes ☐ No

- I consent to the vaccine(s) selected above as indicated by circling "Yes" option to be given to the student listed .

Student's Full Name (Print) _____ Student's Birthdate _____

Printed Name of Legal Guardian _____

Signature of Legal Guardian _____ Date &Time _____

Flandreau Indian School - School Health Services

Student Medical Action Plan

STUDENT INFORMATION

Name: _____ DOB: ____/____/____

Allergies: _____

Guardian Name: _____ Relation: _____

Cell: _____ Home: _____ Work: _____ Other: _____

Emergency Contact: _____ Relation: _____

Cell: _____ Home: _____ Work: _____ Other: _____

MEDICATIONS

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

HEALTH DIAGNOSES

1. _____
2. _____
3. _____

ACTIONS TO BE TAKEN

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

SIGNATURES

This action plan will remain in effect for the currently enrolled school year or until terminated by medical physician or with written notification from the parent/guardian on file.

Parent/Guardian: _____ Date: _____

Physician: _____ Date: _____

FIS Nurse: _____ Date: _____

ATTACHMENT A

BUREAU OF INDIAN EDUCATION

AUTHORIZATION TO ADMINISTER PRESCRIBED/OVER-THE-COUNTER MEDICATION

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby request and authorize designated and properly instructed school personnel to administer prescribed medication as directed by the prescribing physician or other duly licensed provider (PART II below). I certify that I have legal authority to consent to the administration of prescribed medication following the provider's order. I understand additional prescriber/parent authorizations will be necessary for each medication to be administered, and if the dosage of the medication is changed. If necessary, I authorize **the designated school health care official to communicate with the prescriber or the student's health care provider as allowed by HIPAA.**

STUDENT INFORMATION

Student Name _____ **Date of Birth** _____ **Gender M** ___ **F** ___
Last First MI

School _____ **Grade**_____ **School Year**_____ **Height (inches)** _____ **Weight (lbs)** _____

List all medication(s) student is taking, including over-the-counter medication(s):

_____

_____

List any known drug allergies/reactions: _____

Parent/Guardian Signature _____ **Date** _____

Contact Number(s): _____ **(Day)** _____ **(Evening)**

PART II—TO BE COMPLETED BY THE PRESCRIBER

PLEASE USE A SEPARATE FORM FOR EACH MEDICATION

Name of Medication: _____ **Diagnosis:** _____

Dosage: _____ **Time(s)/Frequency to be given:** _____

Route of Administration: _____ **PRN (as needed)** ___**Yes** ___**No** **If PRN, (signs/symptoms):** _____

_____

Side Effects: _____

Begin Medication: _____ **Stop Medication:** _____
Date Date

Guardian Consent Obtained: _____ YES _____ **NO** **Date** ____/____/_____ **TIME:** _____ **AM/PM**

Special Instructions:
Refrigeration required? ____Yes ___No
Is medicine a controlled substance? ____Yes ___No
Is this an emergency self carry/self administration medication? ___Yes ___No
Has student been instructed in the proper self administration of medicine? ___Yes ___No

Prescriber's authorization for self carry/self-administration of emergency medication: _____
Signature Date

Prescriber's Name/Title: _____ **Phone**_____
(Type or Print)

Address:_____ **Fax**_____

Prescriber's signature: _____ **Date**_____

PART III—TO BE COMPLETED BY School Nurse/Other Duly Licensed Health Care Provider

- ☐ Parts I and II above are completed, including signatures.
- ☐ Prescription medication is properly labeled by a pharmacist and within the expiration date.
- ☐ Medication label and prescriber order are consistent.
- ☐ Over-the-counter medication is in an original container with manufacturer's dosage label intact.

Principal/Authorized School Personnel Signature _____**Date**_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: December 31, 2026
See OMB Statement on Reverse.

Complete all sections, date, and sign

I. AUTHORIZATION

I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Flandreau Indian School
ADDRESS	ADDRESS 1132 N Crescent St
CITY/STATE	CITY/STATE Flandreau, South Dakota 57028

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☒ School ☐ Other *(Specify)* _____
☐ Personal Use ☐ Disability ☐ Research ☒ Health Information Exchange *(IHS/Other)* _____

V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date (mm/dd/yyyy) or expiration event)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

	NAME *(Last, First, MI)*	
	ADDRESS	
	CITY/STATE	
	DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: December 31, 2026
See OMB Statement on Reverse.

Complete all sections, date, and sign

I. AUTHORIZATION

I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. THE INFORMATION IS TO BE DISCLOSED BY:	III. AND IS TO BE PROVIDED TO:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Flandreau Santee Sioux Tribal Health Center
ADDRESS	ADDRESS 403 W Broad Ave
CITY/STATE	CITY/STATE Flandreau, South Dakota 57028

IV. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment or Other Healthcare Operations ☐ Attorney ☐ School ☐ Other *(Specify)* _____
☐ Personal Use ☐ Disability ☐ Research ☐ Health Information Exchange *(IHS/Other)* _____

V. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Use Disorder Treatment/Referral ☐ HIV/AIDS-related Treatment ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Sexually Transmitted Diseases ☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

VI. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date (mm/dd/yyyy) or expiration event)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Insurance Exchange.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

	NAME *(Last, First, MI)*	
	ADDRESS	
	CITY/STATE	
	DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

Instructions for Completing IHS Form 810
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Section III, provide the name of the person, facility, and address that will receive the information.

    a. If the information is being disclosed to prevent multiple enrollments in a withdrawal management or maintenance treatment program, please provide the name of each central registry, withdrawal management, and maintenance treatment program to which disclosure may be made OR state "any withdrawal management or maintenance treatment program within 200 miles of [IHS Facility permitted to make the disclosure]".

4. Section IV, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE, as well as the name or general designation of the HIE participants who may access your records (e.g., a specific provider(s) or "my current and future treating providers").
5. Section V, check the appropriate box as applicable.

    a. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.

    b. **Only the period of events from** – specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.

    c. **Other (specify)** – e.g., Purchased Referred Care (PRC), Billing, Employee Health.

    d. **Entire Record** – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

    e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES *MUST* BE CHECKED BY THE PATIENT.**

    f. **Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES (which are separate from progress notes and contain the therapist's impressions and the content of psychotherapy conversations), ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

    IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

6. Section VI, if a different expiration date or event is desired, please specify. When you opt-in to share information through the HIE, an expiration date must be entered; it is recommended that a date five (5) years into the future be entered to provide for continuity of care.

    a. If authorizing the release of records for court-ordered substance use disorder treatment, the expiration date/event must be no later than the final disposition of the criminal proceeding.

7. Section VI, Please sign (or mark) and date.
8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0917-0030. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, OMS/DRPC, 5600 Fishers Lane, Rockville, MD 20857, Attention: Information Collections Clearance Officer.

SDHSAA HEALTH HISTORY FORM - To be completed (with parent/guardian if student is under 18) in years when a physical exam is given, prior to the exam.

Name: _____ **Date of Birth:** _____

Date of Exam: _____ **Sports:** _____

List all past and current medical conditions:	
Have you ever had surgery? If Yes, list all procedures:	
List all prescriptions, over-the-counter meds or supplements you currently take:	
Do you have any allergies? If Yes, Please list them here:	

Over the last two weeks, how often have you been bothered by the following problems? (Circle Response)

	Not At All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest in pleasure or doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes				

ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR"
& EXPLAIN ANY YES ANSWERS ON THE BACK OF THIS SHEET:

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns you'd like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illnesses?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? (Example: electrocardiography or echocardiography)		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before 35 years of age (including drowning or unexplained car crash)		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS) short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CVPT)?		
13. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or a game?		

BONE AND JOINT QUESTIONS, CONTINUED:	Yes	No
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
21. Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had, or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to, or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet, or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
29. Have you ever had COVID-19?		
FEMALES ONLY	**Yes**	**No**
30. Have you ever had a menstrual period?		
31. How old were you when you had your first period?		
32. When was your most recent period?		
33. How many periods have you had in the past 12 months?		

CERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct:

Signature of Athlete: _____

Signature of parent/guardian (if under 18): _____

Date: _____

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SDHSAA PREPARTICIPATION PHYSICAL EXAM FORM

Athlete Name: _____ **Date of Birth:** _____

Date of Exam: _____ **Annual/Biennial/Triennial:** _____

Physician Reminders:

1. **Consider additional questions on more sensitive issues:**
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, vaping, chewing tobacco, snuff or dip?
   - Over the past 30 days, have you used chewing tobacco, snuff or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seatbelt or helmet?
2. **Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)**

EXAMINATION		
Height:	Weight:	BP:
Pulse:	Vision: R 20/ L 20/	Corrected?:

MEDICAL	**Normal**	**Abnormal Findings**
Appearance		
Head/Mouth		
Eyes, ears, nose and throat - Pupils equal & Hearing		
Lymph Nodes		
Heart* -Heart sounds, murmurs, pulse, rhythm, auscultation		
Lungs		
Abdomen - Liver/Spleen, masses		
Skin - HSV, Lesions, Staph, MRSA, etc.		
Neurological		
MUSCULOSKELETAL	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, Hand and Fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional • Double-leg squat test, single-leg squat test, box drop or step drop test		

***** *Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination*

Sports Participation Recommended for (Mark One):

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendation for further evaluation or treatment of: _____

☐ Medically eligible for certain sports (list here): _____

☐ Not medically eligible pending further evaluation: _____

☐ Not medically eligible for any sports: _____

Name of Examiner: _____

Signature of Examiner: _____

Date of Exam: _____

Note: SDCL allows Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Licensed Physician Assistant and Licensed Nurse Practitioners as those that can provide this recommendation.