



YUKON FLATS SCHOOL DISTRICT  
P.O. Box 350  
Fort Yukon, Alaska 99740  
Phone: (907) 662-2515 / Fax: (907) 662-3094  
Bill Walz, Superintendent

**STUDENT ENROLLMENT FORM**

SCHOOL: \_\_\_\_\_

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

Last School Attended \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

CHILD'S BIRTH DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

CHILD'S SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CHILD'S PHONE#: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_

FATHER'S ADDRESS: \_\_\_\_\_

FATHER'S PHONE#: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

MOTHER'S ADDRESS: \_\_\_\_\_ (If Different)

**MOTHER'S PHONE #:** \_\_\_\_\_ **(If Different)**

GUARDIAN'S NAME:  
(If Different From Parents) \_\_\_\_\_

GUARDIAN'S ADDRESS: \_\_\_\_\_

GUARDIAN'S PHONE #: \_\_\_\_\_

If your child becomes ill and you are not at home, please list the name and phone number of the person you would like us to contact, or describe where the person lives if they have no phone.

_____	_____	_____
Name	Phone#	Directions/Descriptions





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### **MIGRANT EDUCATION QUESTIONNAIRE**

**Migrant Education is a Federal Program that provides educational funding for students who accompany their parents or guardians in agricultural, or fishing activities that provide a primary means of support and requires them to be away from their home. If the information you provide on this form determines that your child qualifies you will then be contacted by a recruiter to fill out the federal form.**

**SCHOOL:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PARENT NAME:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**CHILD'S NAME:** \_\_\_\_\_ **CHILD'S BIRTH DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- 1) **HAS YOUR CHILD GONE SUBSISTENCE FISHING WITH YOU, A RELATIVE, OR GUARDIAN WITHIN THE LAST 3 YEARS?**  
\_\_\_\_ YES \_\_\_\_ NO
- 2) **HAS YOUR CHILD GONE COMMERCIAL FISHING WITH YOU, A RELATIVE, OR GUARDIAN WITHIN THE LAST 3 YEARS?**  
\_\_\_\_ YES \_\_\_\_ NO
- 3) **IF YES (FOR QUESTION 1 OR 2), WAS IT 20 MILES (RIVER OR ROAD) OR MORE FROM YOUR HOME?**  
\_\_\_\_ YES \_\_\_\_ NO
- 4) **WHAT WAS THE NAME OF THE RIVER, TRIBUTARY, OR LAKE WHERE HE/SHE FISHED?**  
\_\_\_\_\_
- 5) **DID YOUR CHILD STAY OUT FISHING FOR A TOTAL OF 7 OR MORE NIGHTS (AT LEAST 3 NIGHTS AT A TIME) DURING THE YEAR?**  
\_\_\_\_ YES \_\_\_\_ NO
- 6) **WERE THE FISH CAUGHT USED AS AN IMPORTANT PART OF PROVIDING FOR YOUR FAMILY?**  
\_\_\_\_ YES \_\_\_\_ NO

7) **WHAT KIND OF FISH WERE CAUGHT?**  
\_\_\_ **WHITEFISH** \_\_\_ **SALMON** \_\_\_ **PIKE** \_\_\_ **GRAYLING**

8) **HOW WERE THEY CAUGHT?**  
\_\_\_ **NET** \_\_\_ **FISH WHEEL** \_\_\_ **JIGGING** \_\_\_ **SPEARING**

# PARENT LANGUAGE QUESTIONNAIRE (Home Language Survey)

**Yukon Flats School District** This form is required by State and Federal law.

Identification of students who may have limited proficiency in the English language enables the school to provide appropriate learning programs for the student. Please complete this form and return it to the school office as soon as possible. If you have questions or need help with the form, please contact your local school principal teacher.

**Student Name:** \_\_\_\_\_ **Alaska Student ID #:** \_\_\_\_\_  
(Last Name, First Name)

**Place of Birth:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**School:** \_\_\_\_\_ **Grade:** \_\_\_\_ **Sex:**  Female  Male

### PART I: STUDENT LANGUAGE BACKGROUND

1. What is the first language learned by the student?       English       Other \_\_\_\_\_  
*Specify*
2. What language(s) does the student currently use in the home?       English       Other \_\_\_\_\_  
*Specify*
3. Is this student participating in a student exchange program?       Yes       No
4. How long has the student attended school in the U.S.A.?       3 or more full school years       Less than 3 full school years

### PART II: FAMILY LANGUAGE BACKGROUND (Please complete all columns)

	Mother/Guardian	Father/Guardian	Other Significant Adult* Relationship:
1. Home community and State			
2. First language learned			
3. Language(s) spoken <b>to the student</b>			
4. Language(s) spoken <b>in the adult's home</b>			

\*Other significant adult could be a grandparent, aunt, uncle, daycare provider, etc. who has contributed to the student's language development.

### PART III: PARENT VERIFICATION OF LANGUAGE USE (Please check appropriate box)

	Only the other language, no English	Mostly the other language, some English	The other language & English equally	Mostly English, some of the other language	Only English
A. When the student speaks with <b>family</b> , he/she speaks:					
B. When the student speaks with <b>friends</b> , he/she speaks:					

Parent/Guardian Signature:	Telephone Number:
Printed Name:	Date:

THIS ONLY NEEDS TO BE FILLED OUT IF YOUR CHILD DID NOT ATTEND THIS  
SCHOOL LAST YEAR

ED FORM 506

No. 1810/0031

DEPARTMENT OF EDUCATION  
OFFICE OF INDIAN EDUCATION  
WASHINGTON, DC 20202

**TITLE VII STUDENT ELIGIBILITY CERTIFICATION**  
Elementary and Secondary Education Act, Title VII, Part A, Subpart 1

Parents: **Please return this completed form to your child's school.** In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition from the Act may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form which contains at least the child's name, the name of the tribe, band or group, and your signature, your child cannot be counted by the school for funding under the Act. **This form will become part of your child's school record and will not need to be completed every year.** The information on this form will not be released without your written approval.

*Definition: Indian means any individual, who is (1) a member (as defined by the Indian tribe, or band), of an Indian tribe, or band including those Indian tribes, bands, or groups terminated since 1940, and those recognized by the State in which they reside; or (2) a descendant in the first or second degree (parent or grandparent) as described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an Eskimo or Aleut or other Alaska Native; or (5) a member of an organized Indian group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.*

NAME OF CHILD \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(As shown on school enrollment records)

School Name \_\_\_\_\_ Grade \_\_\_\_\_

NAME OF TRIBE, BAND OR GROUP \_\_\_\_\_

Tribe, Band or Group is: (check one)

\_\_\_\_\_ Federally Recognized, \_\_\_\_\_ State \_\_\_\_\_ Organized Indian  
\_\_\_\_\_ including Alaska Native \_\_\_\_\_ Recognized \_\_\_\_\_ Terminated \_\_\_\_\_ #4 of the definition above  
Group meeting

Name of individual with tribal membership: \_\_\_\_\_

Individual named is (check one): \_\_\_\_\_ Child \_\_\_\_\_ Child's parent \_\_\_\_\_ Child's grandparent

Proof of membership, as defined by tribe, band, or group:

A. Membership or enrollment number. (if readily available) \_\_\_\_\_ (OR)

B. Other (explain) \_\_\_\_\_

Name and address of organization maintaining membership data for the tribe, band or group:

I verify that the information provided above is accurate:

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Mailing Address \_\_\_\_\_ Telephone \_\_\_\_\_



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**STUDENT HEALTH SURVEY AND PERMISSION FORM**

STUDENT NAME: \_\_\_\_\_ STUDENT BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

I give permission for my child to have a T.B skin test provided yearly by the school nurse, community health aide, or public health nurse.  **Yes**  **No** **Signature** \_\_\_\_\_

If No, please state why: \_\_\_\_\_

*(It is required by state law for all children to have annual T.B. skin testing done unless there is a documented medical exemption.)*

I give permission for school personnel to administer acetaminophen (Tylenol) to my child during school or at school-sponsored events for complaints of headaches or minor aches and pains.  **Yes**  **No**

Does your child have any behavior or attention problems?  **Yes**  **No**

Medical History (Check those health problems your child has or has had in the past)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>Asthma</b>                | <input type="checkbox"/> <b>Frequent Nose Bleeds</b>          | <input type="checkbox"/> <b>Vision Problems</b>     |
| <input type="checkbox"/> <b>Diabetes</b>              | <input type="checkbox"/> <b>Chronic Ear Infections</b>        | <input type="checkbox"/> <b>Speech Difficulties</b> |
| <input type="checkbox"/> <b>Heart Disease/Murmurs</b> | <input type="checkbox"/> <b>Skin Problems</b>                 | <input type="checkbox"/> <b>Hearing</b>             |
| <input type="checkbox"/> <b>Problems</b>              |   |   |
| <input type="checkbox"/> <b>Seizures or Epilepsy</b>  | <input type="checkbox"/> <b>Bowel and/or Bladder Problems</b> |   |

**Does your child have any other health problems or handicaps that are not mentioned above?**

**Yes**  **No** **If Yes, what are they?** \_\_\_\_\_

**If your child currently under a doctor's care for any of these problems?**  **Yes**  
 **No**

**If yes, Doctor's name:** \_\_\_\_\_

**Is your child on any medications for any of the above conditions?**  **Yes**  **No**

**If yes, what medication:** \_\_\_\_\_

**Will your child need to take these medications at school?**  **Yes**  **No**

*(If your child needs to take medication at school, please see the principal for instructions about how medication is monitored in the school setting.)*

**List any operations or injuries that would have required hospitalization, and the dates these occurred.**

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

**Does your child have any allergies?**  **Yes**  **No** **If yes, what are they?**

\_\_\_\_\_

**Do you have any other concerns you would like us to know about that would help us work with your child here in school?**

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



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**IMMUNIZATION VERIFICATION**

**SCHOOL:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

PARENT NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ CHILD'S BIRTH DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD TO THIS FORM.

IF YOU DO NOT HAVE THE ORIGINAL VERIFICATION YOU MAY OBTAIN ONE AT THE HEALTH CARE CENTER WHERE YOUR CHILD WAS IMMUNIZED.

**AUTHORIZATION FOR RELEASE OF IMMUNIZATION / TB RECORDS TO COMPLY WITH ALAKSA'S "NO SHOTS, NO SCHOOL" LAW**

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

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

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

Name of Parent/Guardian: \_\_\_\_\_

Health Care Provider / Organization releasing information: \_\_\_\_\_

School / Organization requesting information: \_\_\_\_\_

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

- Immunization Records
- Tuberculosis screening results

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

Please check only one:

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

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

Printed Name of parent or guardian: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**School Year 2005-2006 Application for Free and Reduced Price School Meals**  
**Please fill this form out fully, even if you child does not**  
**eat lunch in the school. This allows the district to apply for important**  
**funding sources that benefit our local school.**

<b>Part 1 Children in School</b> (Please print or type) Use a separate application for each foster child.				<b>Food Stamp or Alaska Temporary Assistance Case #.</b> Skip to part 5 if you list a Food Stamp or TANF case number. <b>Do not use Medicaid or Denali Kid Care #</b>	
Name, Last	First, M.I.	Grade	Name of School		
<b>Part 2</b> If the child you are applying for is homeless, migrant or a runaway, check the appropriate box and call [your school homeless liaison, migrant coordinator at phone # _____] <input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Runaway					
<b>Part 3 Foster child</b> If this application is for a child who is the legal responsibility of a welfare agency or court, check this box <input type="checkbox"/> and provide the child's monthly personal use income. _____ Write "0" if child has no personal use income. Skip Part 4, complete part 5, and optional Part 6. (Only the signature of a foster parent or other official representing the child is required to complete application.)					
<b>Part 4 Total household gross income – You must tell us how much and how often.</b> *Military households see page 2. ➤ For any child you gave a Food Stamp or ATAP/NFAP case number for, complete only box G. Then complete Part 5.					
A- Name	B- Check if NO income	C- Earnings from work before deductions and how often. <i>Example: \$200/ weekly</i>	D- Monthly Assistance; Child Support, Alimony	E- Monthly payments; Pensions, Retirement, Social Security	F- Any other monthly income
	<input type="checkbox"/>	\$ /	\$	\$	\$
	<input type="checkbox"/>	\$ /	\$	\$	\$
	<input type="checkbox"/>	\$ /	\$	\$	\$
	<input type="checkbox"/>	\$ /	\$	\$	\$
	<input type="checkbox"/>	\$ /	\$	\$	\$
	<input type="checkbox"/>	\$ /	\$	\$	\$
	<input type="checkbox"/>	\$ /	\$	\$	\$
	<input type="checkbox"/>	\$ /	\$	\$	\$
<b>Subtotal:</b>		\$	\$	\$	\$
<b>G-Alaska Permanent Fund Dividend:</b> How many of the adults and children listed were approved for Permanent Fund Dividends in 2004 _____ in 2005 _____? Include everyone who was approved for a PFD, even if part or the entire dividend was garnished.			<ul style="list-style-type: none"> <li>• For office use only</li> <li>• Total household size _____</li> <li>• Year _____ PFD \$ _____</li> <li>Total Monthly Income \$ _____</li> </ul>		
<ul style="list-style-type: none"> <li>• Write "0" if no one was approved for a PFD.</li> <li>• Your application cannot be approved if this information is missing.</li> </ul>					
<b>Part 5 Signature and Social Security Number</b>					
<ul style="list-style-type: none"> <li>• I certify (promise) that all information on this application is true and that all income is reported.</li> <li>• I understand that the school will get Federal funds based on the information I give.</li> <li>• I understand that school officials may verify (check) the information on the application.</li> <li>• I also understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.</li> </ul>					
X _____ Sign here	_____ - _____ - _____ Social Security Number	_____ - _____ Home phone number	_____ - _____ Work phone number		
<input type="checkbox"/> I do not have a Social Security Number (See Privacy Act Information on the back of this page.)					
_____	_____	_____	_____	_____	_____
Printed name of adult	Date signed	Mailing address	city	state	zip code

Comment [ljc1]:

Comment [ljc2]: