Hózhó Academy

P.O. Box 1772 ♦ Gallup, NM 87305
505-862-9887 (*phone*) ♦ 505-722-2629 (*fax*)
Website: www.hozhoacademy.org

New Student Registration 2018/2019

Legal Student Name *(As it appears on birth certificate)*	**Date of Birth:**	**Grade: (18/19)**	**Age:**
First Name *Middle Initial* *Last Name*			

Registration Checklist

Forms	Documentation	Other Materials
☐ Registration Checklist ☐ Transcript/Records Request ☐ General Student Information ☐ Release Form ☐ Medical Authorization, Consent & History Form ☐ Student Housing Questionnaire	☐ Birth certificate (Note – if not available, other documents may be accepted for verification of legal name and DOB) ☐ Up-to-date immunization record or Department of Health approved waiver ☐ Two (2) proof of physical address to prove NM state residency	☐ Language Usage Survey Required for all first to US school registrant starting at Kindergarten (only required upon initial enrollment)

Registration Disclosure Statements & Program Considerations

Yes/ No

☐ / ☐ My child currently has an **IEP**, qualifying disability: _____

☐ / ☐ My child currently has a **504 Plan**, qualifying medical condition: _____

☐ / ☐ My child currently has a **SAT Plan**, area(s) of concern: _____

☐ / ☐ My child is a **Teen Parent**.

☐ / ☐ My child is a living in a **Foster Home**.

☐ / ☐ My child is a **Migrant Student**. *A migratory child is a child who is, or whose parent, spouse, or guardian is, a migratory agricultural worker or migratory fisher, and who, in the preceding 36 months, has moved from one school district to another, to obtain or accompany such parent, spouse, or guardian, in order to obtain temporary or seasonal employment in agricultural or fishing work as a principal means of livelihood.*

☐ / ☐ My child is **Displaced or Homeless** by definition**.** *The McKinney-Vento Act defines displaced / homeless children as "individuals who lack a fixed, regular, and adequate nighttime residence." This may include: Children and youth sharing housing due to loss of housing, economic hardship or a similar reason; Children and youth living in motels, hotels, trailer parks, or camp grounds due to lack of alternative accommodations; Children and youth living in emergency or transitional shelters; Children and youth abandoned in hospitals; Children and youth awaiting foster care placement; Children and youth whose primary nighttime residence is not ordinarily used as a regular sleeping accommodation (e.g. park benches, etc); Children and youth living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations; and Migratory children and youth living in any of the above situations.*

[MUST FILLOUT DISPLACE/ HOMELESS QUESTIONAIRE] **NOTE: STUDENT INFORMATION TO BE FORWARDED TO OUR COUNSELOR FOR SUPPORT IF ELIGIBLE.**

☐ / ☐ My Child has been **EXPELLED** from another school in the last 12 months. *A student who has been expelled during the last twelve (12) months by any school district or private school in the United States or who is not in compliance with a condition of disciplinary action based on behavior detrimental to the welfare or safety of other students or school employees imposed by any other school or school district in the United States within the last twelve (12) months shall not be admitted. Acceptance for enrollment may be revoked upon finding the existence of any of these conditions.*

Parent/Guardian Signature _____ Date: _____

TRANSCRIPT/RECORDS REQUEST

The following student has enrolled at Hózhó Academy:

Legal Student Name *(As it appears on birth certificate)*	**Date of Birth:**	**Grade:**	**Age:**
First Name Middle Initial Last Name			

Last School Attended	Address:	Phone:	Dates Attended:
		Fax:	Grade(s) Attended:

Please send the following records:

- **OFFICIAL TRANSCRIPTS**
- **WITHDRAWN GRADES (CREDITS EARNED TO DATE)**
- **IMMUNIZATION RECORDS/HEALTH RECORDS**
- **SPECIAL EDUCATION RECORDS (if applicable)**
- **TEST RECORDS**
- **ATTENDANCE RECORDS**
- **LANGUAGE USE SURVEY**

Please send information to:

Hózhó Academy

Address: ***P.O. Box 1772***
Gallup, NM 87305

Fax: ***505-722-2629***

NOTE: FEDERAL LAW (20 U.S.C 1232) CONSENT IS NOT REQUIRED IN ORDER FOR YOU TO TRANSFER EDUCATION RECORDS. CR.F 99.31A – SUCH RECORDS ARE SUBJECT TO DISCLOSURE TO OFFICIALS OF ANOTHER SCHOOL OR SCHOOL SYSTEM IN WHICH THE STUDENTS SEEK OR INTENDS TO ENROLL WITHOUT WRITTEN CONSENT OF THE PARENTS.

*****To be filed with school administrative assistant*****

GENERAL STUDENT INFORMATION

Legal First Name	Legal Middle Name	Legal Last Name

State ID / Perm ID	**Enrollment Date:**	Gender ☐ Male ☐ Female	Grade	Home Language Preference: ☐ English ☐ Spanish ☐ Other: ____

Birth Date	Birth Place	Birth Certificate Number	Birth State	Birth Country

Student Phone Number: Type: ☐ Cell ☐ Home Phone	Student Email:

Ethnicity: Please check one ☐ Hispanic / ☐ Non-Hispanic	Race: ☐ Caucasian ☐ Asian ☐ African American ☐ American Indian/Alaskan Native , is so specify tribe: _____

Home Address (Physical Address)	Mailing Address (If different from Home Physical Address)

Language Class Preference (please choose 1)

☐ I would like for my child to participate in Spanish Language Class.	☐ I would like for my child to participate in Navajo Language Class.

Student Transportation (please choose 1)

☐ I would like for my student to ride the bus to school.	Pick up/drop off address (if different from Home Physical Address):

Parent/Guardian Custodial Information

Relation: Father	Name/nombre:	Address	Employer

Check all that apply:	☐ Contact Allowed	☐ Education Rights	☐ Has Custody	☐ Mailing Allowed	☐ Enrolling Parent	☐ Release To	☐ Financially Responsible	☐ Deceased

Cell Phone: ( )	Home Phone: ( )	Work Phone: ( )	Email:

Relation: Mother	Name/nombre:	Address	Employer

Check all that apply:	☐ Contact Allowed	☐ Education Rights	☐ Has Custody	☐ Mailing Allowed	☐ Enrolling Parent	☐ Release To	☐ Financially Responsible	☐ Deceased

Cell Phone: ( )	Home Phone: ( )	Work Phone: ( )	Email:

In Case of Emergency: *Names of persons who can assume temporary responsibility and are authorized to pick up.*

Name	Relationship	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone

Siblings: List all siblings attending school at Hózhó Academy.

Name	Gender	Grade
Name	Gender	Grade
Name	Gender	Grade
Name	Gender	Grade
Name	Gender	Grade
Name	Gender	Grade

RELEASE FORM

Legal Student Name *(As it appears on birth certificate)*			**Date of Birth:**	**Grade:**	**Age:**
First Name	*Middle Initial*	*Last Name*			

In order to comply with FERPA (Family Educational Rights and Privacy Act) and the No Child Left Behind Act of 2001, it will be necessary to obtain parental permission in order to publish or release your child's name and/or address.

Media / Photo Release (Check One)

☐ YES/ ☐ NO I give my permission for my child to be interviewed by media representatives.

☐ YES/ ☐ NO I give my permission for my child to be photographed, or videotaped by media representatives.

Student Art Work Permission Slip

☐ YES/ ☐ NO I give my permission for my child's artwork to be displayed and/or published in Hózhó Academy publications.

School Web Sites

☐ YES/ ☐ NO I give my permission to allow my child's photo to be published on the Hózhó Academy website.

Directory Information

☐ YES/ ☐ NO I give my permission to allow my child's directory information (name, local and permanent address, electronic mail address, telephone listing; date and place of birth; photograph, video or electronic images; participation in officially recognized activities and sports; weight and height of members in athletic teams; dates of attendance; degrees conferred, awards received, and their dates; and other educational institutions attended) to be disclosed. (Note: the primary purpose of directory information is for school publications including, for example, a yearbook or honor roll list.)

Parent/Guardian Signature _____ Date: _____

MEDICAL HISTORY & INFORMATION (p. 1 of 2)

Legal Student Name *(As it appears on birth certificate)* **Date of Birth:** **Grade:** **Age:**

_____ _____ ____ ____

First Name *Middle Initial* *Last Name*

Insurance and Doctor Information

Insurance Company	Subscribers Name	ID Number

Please Check Type:

☐ Private/Personal Insurance ☐ Medicaid ☐ Uninsured

Doctor _____ Phone _____

Dentist _____ Phone _____

Hospital _____ Phone _____

Health Conditions

1. Specify health conditions/allergies: _____
2. Is your child on daily medication? ☐ NO / ☐ Yes, specify _____
3. Recent surgery, accident or illness (past year) _____

Please indicate if student has had or is currently under treatment for any of the following conditions. Give year or age when problem occurred. Please indicate if student has had or is currently under treatment for any of the following conditions:

☐ YES / ☐ NO Asthma. Current Inhaler? ☐ YES / ☐ NO

☐ YES / ☐ NO Diabetes. On Insulin? ☐ YES / ☐ NO

☐ YES / ☐ NO Ear/Hearing Problem. Type: _____

☐ YES / ☐ NO Emotional Problem. Type: _____

☐ YES / ☐ NO Seizures Type: _____

☐ YES / ☐ NO High Blood Pressure

☐ YES / ☐ NO Heart Problems. Type: _____

☐ YES / ☐ NO Hepatitis. Type: _____

☐ YES / ☐ NO Seasonal Allergies.

☐ YES / ☐ NO Food Allergies. Type: _____ Epi-Pen? ☐ YES / ☐ NO

☐ YES / ☐ NO Medication Allergies. Type: _____ Epi-Pen? ☐ YES / ☐ NO

☐ YES / ☐ NO Reactions to medicine/injections Type: _____

☐ YES / ☐ NO Meningitis

☐ YES / ☐ NO Migraine Headaches

☐ YES / ☐ NO Muscular Weakness or Paralysis

☐ YES / ☐ NO Bleeding Disorders. Type: _____

☐ YES / ☐ NO Infectious Disease. Type: _____

☐ YES / ☐ NO Hospitalized or serious illness, surgery or accidents? When/For what? _____

☐ YES / ☐ NO Vision? ☐ Corrected ☐ Wears glasses ☐ Wears contact lenses

☐ YES / ☐ NO Long Term Medications? Name: _____

What/dose/time? _____

☐ YES / ☐ NO Immunizations Current?

Name/Number of Doctor's Office/Clinic where last immunizations were received?

_____

*****To Be Filed in Student Health Record with School Nurse or Administrative Assistant*****

MEDICAL HISTORY & INFORMATION (p. 2 of 2)

Have you ever been informed of the need to be on antibiotic therapy prior to dental treatment? Yes ☐ No ☐

If yes, identify therapy: _____

Please list any additional problems/concerns/conditions not listed above.

_____

_____

Administration of Medication

I give permission for my child to take the following over-the-counter medication at school, (students may not carry medication at school), with the supervision of the nurse. Dosages will be administered in accordance with Age/weight per the dosing directions.

- Acetaminophen (Tylenol) Regular Strength (325 mg) ☐ Yes ☐ No
- Acetaminophen (Tylenol) Extra Strength (500 mg) ☐ Yes ☐ No
- Ibuprofen (Motrin/Advil) Regular Strength ☐ Yes ☐ No
- Pepto-Bismol/Tums ☐ Yes ☐ No
- Midol/Pamprin ☐ Yes ☐ No
- Allergy Medication (Claritin, Zyrtec, Generic Brand) ☐ Yes ☐ No
- Cough Syrup/Cough Drops/Throat Spray ☐ Yes ☐ No
- Saline Eye Drops ☐ Yes ☐ No
- Triple Antibiotic Cream ☐ Yes ☐ No
- Hydrocortisone Cream ☐ Yes ☐ No

Consent for Emergency Treatment

I, the undersigned parent/guardian, give my consent for the above named child to be released to me or my spouse or to the friend/relative I have so designated and/or to be taken by ambulance to the nearest hospital in case of emergency.

I understand that Hózhó Academy does not provide accident medical/dental coverage for students for injuries/illnesses occurring at school. I understand that I may voluntarily purchase a student accident insurance plan.

I further acknowledge that I am financially responsible for medical, dental, ambulance, or other health care expenses or transportation of my child home, which might occur as a result of such illness or injury.

Parent/Guardian Signature _____ Date: _____

Medical Emergency Contact information: *Names of persons who can assume temporary responsibility and are authorized to pick up.*

Name	Relationship Parent / Guardian 1	Home Phone	Work Phone	Other Phone
Name	Relationship Parent / Guardian 2	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone
Name	Relationship	Home Phone	Work Phone	Other Phone

*****To Be Filed in Student Health Record with School Nurse or Administrative Assistant*****

Student Housing Questionnaire

Legal Student Name *(As it appears on birth certificate)*			**Date of Birth:**	**Grade:**	**Age:**
First Name	*Middle Initial*	*Last Name*			

Hózhó Academy Students may be eligible for additional educational services depending on your housing situation. Additional services and rights include the right to stay at the same school even if you move and include access to free meals at school. Eligibility can be determined by completing this questionnaire.

This form is to learn more about you and/ or your family's current housing situation. Please begin by completing your contact information and signing the form, your signature indicates that you have completed this form to the best of your knowledge. Then proceed to answer question 1 and follow directions to STOP or PROCEED with questions 2 and 3.

Father/Guardian Name*:*			Mother/Guardian Name*:*		
Cell Phone/*Celular*:	Home Phone/*Casa*:	Work/Msg / *Trabajo*:	Cell Phone/*Celular*:	Home Phone/*Casa*:	Work/Msg / *Trabajo*:
Mailing Address/*Dirección Postal*:			Mailing Address/*Dirección Postal*:		

Parent/Guardian Signature_____ Date _____

1. Where do you and / or your family currently live?

Section A

☐ Live in my own home (rent or own) with immediate family (spouse/partner, children, parents).

Section B

☐ Temporarily with another family
☐ With an adult that is not a parent or legal guardian
☐ Rent in a temporary space (for example: motel, hotel, trailer park or campground)
☐ In a place that lacks running water or electricity
☐ In a temporary shelter or other temporary housing

☐ Other (please note):_____

Continue **If you checked a box in Section B, complete the remainder of this form.**

2. You may be contacted by a member of your school's educational support staff to discuss possible support eligibility. Please check the box below indicating if you would like to be contacted.

☐ YES, please contact me. ☐ NO, please do not contact me.

3. If you checked a box in Section B, your child(ren) may be eligible for additional support. Please list their information below.

Name	M/F	Birth Date	Grade	School