



Yakama Nation Tribal School

P. O. Box 151 – 601 Linden Street - Toppenish WA 98948
(509) 865-4778 or (509) 865-5121 Ext. 4525/4528 – Fax (509) 865-6092



2018 Summer School

Returning Student Application

Mission Statement:

The Yakama Nation Tribal School is committed to guiding students to become life-long learners, while strengthening cultural values and building character through authentic and meaningful exploration.

Dear Parents:

Thank you for selecting Yakama Nation as your choice to educate your student. This is a responsibility that YNTS Faculty and Staff take seriously. The check-off list on the next page (over) can be used as a guide for completing this application. The Admissions Committee will review and notify each applicant by mail or phone as to the status of his or her application.

Falsification or withholding any information in the application will be grounds for non-acceptance or revocation of your student's admission. Make sure **ALL** necessary copies of documents are attached. Incomplete application packages will not be reviewed.

Sincerely,

Frank Mesplie
Y.N.T.S. Superintendent

B. Adam Strom
Y.N.T.S. Principal



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Application for Enrollment

PLEASE PRINT CLEARLY AND USE BLACK OR BLUE INK

Legal papers must be in student records, the school will not be responsible if these documents are not a part of the student's record.

Legal Name: _____ Other Names Used: _____
First Middle Last

DOB: _____ Age: _____ Sex: _____ Place of Birth: _____

Phone #1: _____ Phone #2: _____ Message Phone #: _____

Mailing Address: _____

PO / Street Number City State Zip Code

Physical Address (if different than above): _____

Street Number City State Zip Code

If only one parent has custody or there is a legal guardian we will need a copy of the legal papers on file.

FATHER: _____ Mailing Address: _____

Phone #1: _____ Phone #2: _____ Message Phone #: _____

MOTHER: _____ Mailing Address: _____

Phone #1: _____ Phone #2: _____ Message Phone #: _____

LEGAL GUARDIAN: _____ Mailing Address: _____

Home Phone #: _____ Cell Phone #: _____ Message Phone #: _____

Emergency Contact for Illness or Accident:

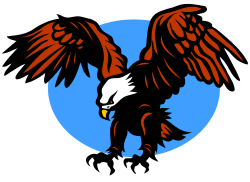
Two contacts other than the parent(s)/guardian should be listed in the event a parent/guardian cannot be contacted.

1) _____ Relationship: _____

Phone #1: _____ Phone #2: _____ Message Phone #: _____

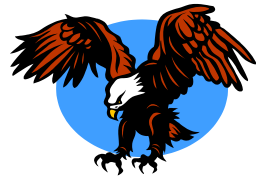
2) _____ Relationship: _____

Phone #1: _____ Phone #2: _____ Message Phone #: _____



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TRANSPORTATION REQUEST

Student Name: _____ Phone #1: _____

Mailing Address: _____ Message Phone #: _____

Physical Address: _____

Style and Color of the house: _____

Directions to Home (describe how to get to your home from the school): _____

Draw A Map (include cross roads or landmarks):

Schedule Requested:

Pick Up and Take Home Morning Pick Up only Afternoon Take Home only No Transportation Requested

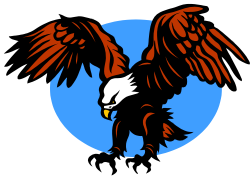
Check days of week transportation is needed:

Monday Tuesday Wednesday Thursday Friday

FOR OFFICE USE ONLY:

Assigned Bus Route: _____ Driver: _____

Person making assignment: _____ Date: _____



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Medical History

Does your student have or had any of the following conditions:

Condition	YES	NO	Explain:	Condition	YES	NO	Explain:
Epilepsy / Seizures				Ear Aches			
Concussion/Head Injury				Vertigo			
Traumatic Brain Injury				Tinnitus (ringing in ears)			
Stroke/Brain Hemorrhage				Diabetes			
Frequent Headaches				Anemia			
Fainting / Dizziness				Bruises Easily			
Migraines				Frequent Nose Bleeds			
Vision Problems				Broken Bones/Dislocations			
High Blood Pressure				Frequent Sprains			
Heart Murmur				Arthritis / Rheumatism			
Heart Disease				Back Problems			
Pace Maker/ Valve				Kidney / Liver Problems			
Asthma (uses inhaler)				Stomach Problems			
TB / Lung Disease				Jaundice / Hepatitis (Type)			
Sinus Problems				Rheumatic/Scarlet Fever			
Seasonal Allergies				Depression / Anxiety			
Hives / Skin Rash				Mental / Nervous Conditions			
ALLERGIES:				ADHD / ADD (on medication)			
Latex				WEARS:			
Food (peanuts, fish...)				Glasses / Contacts			
Insects (bees, wasps...)				Hearing Aid			
Medicines (penicillin...)				Prosthetic Limb			
Uses EPI-PEN for reaction?							
Uses Benadryl for reaction?							

Immunizations up-to-date? Y N

Has your student had any major or minor operations within the last two years? Y N Explain: _____

Is your student under doctor care? Y N Explain: _____

Is your student on any medication? Y N List: _____

List any special instructions or information you wish the school to know: _____

In the event of an emergency and the school is unable to contact me, I give the Yakama Nation Tribal School and its employees permission to seek medical treatment for my student at a hospital or to a licensed healthcare provider:

_____ No _____ Yes Preferred Medical Facility: _____

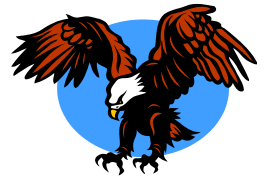
PARENT/GUARDIAN SIGNATURE: _____

DATE: _____



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Parent Compact

- I will ensure my student attends school daily and limit absences.
- I will make sure my student has the necessary supplies for school.
- I will encourage my student to try hard and do the best that they can.
- I will encourage my student to recognize, feel good about and build on their strengths.
- I will make sure my student completes their work and turns it in to the teacher.
- I will teach my student to value their education.
- I will teach my student to respect their teachers, school staff, classmates and themselves with respect by their words and their actions.
- I will ensure my student follows school rules, policies and classroom expectations.
- I will talk to my student every day, listen to them, and value what they say and offer praise and encouragement.
- I will encourage my student to ask questions when they don't understand something.
- I will get involved in my child's education by attending 20 hours Parent-Student-Teacher Conferences and special events such as JOM, PBL nights etc. as I am able to.
- I will serve as a good role model and teach them by example as well as by word.

I understand that the key to my student's future is education and I will follow the points of this compact to the best of my ability.

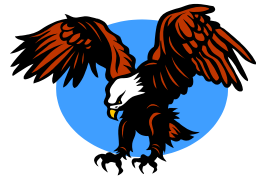
Parent Signature: _____

Date: _____



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Student Compact

- I will take responsibility for attending school every day.
- I will come to school ready to learn.
- I will come to class prepared.
- I will do my best and try hard to succeed.
- I will take responsibility to complete all unfinished work and assigned homework.
- I will treat my teachers, school staff, other students and myself with respect by my words and my actions.
- I will follow the school rules, policies and classroom expectations.
- I will talk to my parent(s), guardian(s) or other interested adult about what is happening in school.
- I will ask questions when I don't understand something.
- I will encourage my peers to succeed, by word and by example.

I understand that the key to my future is education and I will follow the points of this compact to the best of my ability.

Student Signature: _____

Date: _____

Parent Signature: _____

Date: _____



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Student Contract

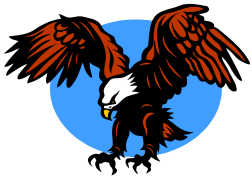
I, _____, agree to the following set of conditions of admissions to the Yakama Nation Tribal School:

- I will sign a release to previously attended schools in order for YNTS to obtain information regarding staff concerns there, including suspicion of drug use.
- I will request a release of information regarding any chemical dependency assessments completed while enrolled at YNTS.
- I will satisfy all previous staff/agency recommendations for disciplinary or treatment purposes prior to being admitted to, or in order to continue as a student of, the Yakama Nation Tribal School.
- I will follow all rules and policies of YNTS regarding attendance, behavior, drug use, dress code, gang involvement and violence as outlined in the Student Handbook.
- I understand that the rules and policies of YNTS may involve contacting the Yakama Nation Tribal Police for some infractions.
- I understand that the rules and policies of YNTS may require me to submit to a UA (urine analysis) and/or complete a chemical dependency assessment.
- I agree to follow the recommendations of a chemical dependency assessment if the result of the UA is positive for any substance prohibited within the rules and policies outlined in the Student Handbook.
- I understand that as a result of a positive UA, I will be expelled until I have completed the recommended treatment. Students will be subject to random UAs.

If I fail to follow this contract, I understand that I will be disciplined as per school policy. This discipline will entail suspension or expulsion. You may be refused any future admission to Yakama Nation Tribal School until you have completed a program (drugs/alcohol) or if dropped for behavior, attendance, or other. You will have to attend another school for one full school year before being considered for enrollment at YNTS for a third time substance use violation.

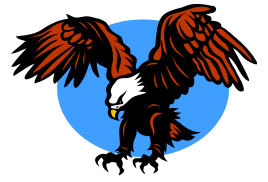
Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____



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Dental Health Screening Consent

YNTS Students are invited to take part in an annual Dental Screening that is coordinated with the Indian Health Service of Toppenish. This screening is free and strictly voluntary and is not intended to replace your student’s regular check-up with their dentist. The results may be used for statistical purposes and your student’s individual records will be kept confidential. Parents/guardians may receive a notice with any recommendations for follow-up dental care.

We also encourage parents/guardians to give the school authorization to seek emergency dental care if your student has a sudden dental emergency while at school. This authorization will be in effect for the entire school year.

Student Name: _____
First Name Last Name

DOB: _____ **Chart Number (if known):** _____

_____ **YES** _____ **NO** I give permission for my student to be transported by a school vehicle to the IHS Dental Clinic of Toppenish if needed to receive a free dental screening that may include:

- Oral Assessment
- Oral Hygiene Instruction
- Dental Radiographs (X-rays)
- Teeth Cleaning
- Topical Fluoride Treatment
- Enamel Sealants on premolar and molar teeth

_____ **YES** _____ **NO** I give permission for my student to receive EMERGENCY DENTAL TREATMENT by a qualified, licensed dentist, in needed.

Parent/Guardian Signature

Date

Contact Number



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Dental Screening Medical History



What is the reason for your visit to the dental clinic today? _____

What is the name of your medical doctor? _____

Has there been any change in your general health in the past year? _____

List any medications (pills or drugs) you are currently taking. _____

Do you have any disease, condition or problem not listed below? _____

Are you currently ill? YES NO What is your illness? _____

Please check all that apply:	YES	NO
Do you have a toothache now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you received medical care in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to medication?	<input type="checkbox"/>	<input type="checkbox"/>
What are your allergies: _____		
Are you allergic to latex?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a bleeding problem that needed medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have chest pains?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you recovering from an addiction?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, do you want to quit?	<input type="checkbox"/>	<input type="checkbox"/>
How long does it take to smoke a pack or chew a can? _____		
Do you have a reason to believe you have been exposed to AIDS or HIV?	<input type="checkbox"/>	<input type="checkbox"/>
Anyone in your family have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking hormone medicines? (birth control, pills, patches, injection)	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had the following? (Check all that apply)	YES	NO
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve/Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
TB/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Do you use an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
STD	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or Metal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking steroids?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any concerns about receiving dental treatment? _____

Children must be accompanied by legal guardian/parent at dental clinic, otherwise cannot be seen due to safety regulations

Patient/Guardian Consent for Treatment: _____ **Date:** _____

Dentist: _____

Date: _____

FOR STAFF ONLY:

Blood Sugar: _____ BP: _____ Initials/Date: _____ Updates: _____

Notes: _____