ATTENTION:
OGLALA LAKOTA COUNTY SCHOOL DISTRICT
PARENTS AND THOSE WHO WILL BE REGISTERING FOR THE UPCOMING 2022-2023 SCHOOL YEAR

In accordance with all required school aged vaccinations we will require students ages 5 and older to submit proof of the COVID Vaccination (Vaccination Card or Medical Record showing Vaccination dates), in order to attend in person schooling.

If you have an exemption from taking the COVID Vaccination please submit that upon registering your student.

For those students who have <u>not</u> taken the COVID Vaccination or do <u>not</u> have a exemption, you many still register and enroll with Oglala Lakota County Schools as an online student only.

Questions please contact the building the Principal and/or Laticia Decory Wellness Director

OGLALA LAKOTA COUNTY SCHOOL DISTRICT 65-1

P.O. Box 109, Batesland, South Dakota 57716

SCHOOL REGISTRATION FORM

Date Entered:_____

CHILD'S NAME:_____ DOB:_____
Last Name First Name M.I.

SOCIAL SECURITY #:_____ MAILING ADDRESS:_____
P.O. Box # City State Zip Code

TEACHER:_____ GRADE:_____ BUS#:_____ DRIVER:_____

NAME OF LAST SCHOOL ATTENDED:_____
School School's Address City State Zip Code

NAME(S) & GRADE(S) OF BROTHER(S)/SISTER(S) ATTENDING THIS SCHOOL:

_____

_____

_____

LEGAL GUARDIANSHIP OF STUDENT INFORMATION
(Please circle one of the following)

PARENTS SINGLE PARENT: Mother Father Other

GUARDIAN'S NAME:_____

RELATIONSHIP TO STUDENT:_____

PLACE OF EMPLOYMENT:_____

HOME PHONE#:_____ WORK PHONE#:_____

IN CASE OF EMERGENCY, WHERE CAN THE PARENT OR GUARDIAN BE REACHED DURING SCHOOL HOURS?:_____

_____

_____

_____

874 FUNDING INFORMATION

☐ INDIAN ☐ NON-INDIAN

☐ MALE ☐ FEMALE

DIRECTIONS TO HOME:

_____

_____

RANGE, TOWNSHIP, SECTION:

_____

_____

DO YOU PAY PROPERTY TAXES?

☐ YES ☐ NO

ETHNICITY AND RACE INFORMATION

ETHNICITY (CHECK ONE): ☐ NO, NOT HISPANIC/LATINO ☐ YES, HISPANIC/LATINO

RACE (CHECK ONE OR MORE): ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ WHITE

☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

THE FOLLOWING INFORMATION IS NECESSARY FOR EDUCATIONAL AND HEALTH FUNDING PURPOSES

STUDENT'S PHS HOSPITAL #:_____ TITLE 19 or ADC#:_____

STUDENT'S TRIBAL ENROLLMENT #:_____ DEGREE OF INDIAN BLOOD:_____

TRIBAL AFFILIATION:_____ AGENCY:_____

PLEASE FILL OUT THE INFORMATION BELOW IF THE STUDENT IS NOT YET ENROLLED

FATHER'S NAME:_____ MOTHER'S NAME:_____

FATHER'S TRIBAL ENROLLMENT #:_____ MOTHER'S TRIBAL ENROLLMENT#:_____

TRIBAL AFFILIATION:_____ TRIBAL AFFILIATION:_____

THIS CHILD MAY BE CHECKED OUT OF SCHOOL BY THE FOLLOWING PEOPLE ONLY (List Name(s) and Relationship to child):

_____

_____

_____

PARENT OR GUARDIAN SIGNATURE:

OGLALA LAKOTA COUNTY SCHOOL
DISTRICT 65-1
P.O. BOX 109, BATESLAND, SD 57716

2022-2023 School Year Survey Form

Dear Parents / Guardians:
The Oglala Lakota County School District 65-1 is eligible to receive Impact Aid funding (Federal funds, which are paid in lieu of taxes on trust lands). In order for the school your child is attending to receive i mpact aid funds we must have the following information.

1. Name of Child: _____
   First Middle Last
2. Child's Date of Birth: _____ Female or Male
3. School _____ Teacher _____ Grade _____
4. Town of Residence of Child on Survey Date _____
   City State
5. Child's Enrollment # _____ with the _____ Tribe.
6. Exact Physical Location of child's residence - housing name, house number, how many miles and direction from
   mailing address. (Please be as specific as you can with your directions)

   _____

   _____
7. The following land description is **absolutely necessary** regarding where you live. Call BIA Reality office at 867-1001

   Range Unit # _____ Township # _____ Section # _____ Tract# _____
8. Do you pay property taxes to the county for the land you live on? Yes____ No____
9. Name and mailing address of Parents or Guardians on date of survey.

   Name and mailing address of Parents or Guardians' Employer on date of survey.
10. Parent's occupation on survey date: _____

Student Social Security Number:

_____
Signature of Parent/Guardian

_____
Date

OMB Control No. 1810-0021 (Exp. 04/30/2023)

ED 506 Form
Indian Student Eligibility Certification Form for Title VI Indian Education Formula Grant Program

Parent/Guardian: This form serves as the official record of the eligibility determination for each individual child included in the student count for the Title VI Indian Education Formula Grant Program. If you choose to submit a form, your child could be counted for funding under the program. The grantee receives the grant funds based on the number of eligible forms counted during the established count period. You are not required to complete or submit this form unless you wish for your child(ren) to be included in the Indian student count. This form should be kept on file with the grant applicant and will not need to be completed every year. Where applicable, the information contained in this form may be released with your prior written consent or the prior written consent of an eligible student (aged 18 or over), or if otherwise authorized by law, if doing so would be permissible under the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any applicable state or local confidentiality requirements.

Student Information

Name of the Child _____ Date of Birth _____ Grade level _____

Name of School _____ School District _____

Tribal Membership

The individual with Tribal membership is the (select only one): ○ child ○ child's parent ○ child's grandparent

If the individual with Tribal membership is **not** the child listed above, name the individual (parent/grandparent) with tribal membership: _____

Name and address of Tribe or Band that maintains updated and accurate membership data for the individual listed above:

Name _____ Address _____

City _____ State _____ Zip Code _____

The Tribe or Band is (select only one):

- ○ Federally Recognized Tribe
- ○ State Recognized Tribe
- ○ Terminated Tribe
- ○ Alaska Native
- ○ 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.

Proof of membership in Tribe or Band listed above, as defined by Tribe or Band is:

- ○ Membership or enrollment number establishing membership (if readily available) or
- ○ Other evidence establishing membership in the Tribe listed above (describe and attach)

Membership or enrollment number establishing membership (if readily available) or other evidence establishing membership in the Tribe listed above (describe and attach). _____

Attestation Statement

I verify that the information provided above is true and correct to the best of my knowledge and belief.

Printed Name of Parent/Guardian _____ Signature _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Email _____ Date _____

For Parent/Guardians:

Definitions:
Indian means an individual who is (1) A member of an Indian Tribe or Band, as membership is defined by the Indian Tribe or Band, including any Tribe or Band terminated since 1940, and any Tribe or Band recognized by the State in which the Tribe or Band resides; (2) A descendant of a parent or grandparent who meets the requirements described in paragraph (1) of this definition; (3) Considered by the Secretary of the Interior to be an Indian for any purpose; (4) An Eskimo, 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 on October 19, 1994.

Student Information: Write the name of the child, date of birth, grade level, name of school and school district. Only name one child per form.

Tribal Membership: Write the name of the individual with the tribal membership, if it is not the child listed. Only one name is needed for this section, even though multiple persons may have tribal membership. Select only one identifier: the child, child's parent or grandparent, for whom you can provide membership information.

Write the name and address of the organization that maintains updated and accurate membership data for such Tribe or Band of Indians. The name does not need to be the official name as it appears exactly on the Department of Interior's list of federally recognized Tribes, but the name must be recognizable and be of sufficient detail to permit verification of the eligibility of the Tribe. Check only one box indicated whether it is a Federally Recognized, State Recognized, Terminated Tribe or Organized Indian Group. Write the enrollment number establishing the membership for the child, parent or grandparent, if readily available, or other evidence of membership.

Attestation Statement: Provide the printed name of parent/guardian and signature, address, phone number and email of the parent or guardian of the child. The signature of the parent or guardian of the child verifies the accuracy of the information supplied.

Paperwork Burden Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1810-0021. The time required to complete this portion of the information collection per type of respondent is estimated to average: 15 minutes per Indian student certification (ED 506) form; including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-4651. If you have comments or concerns regarding the status of your individual submission of this form, write directly to: Office of Indian Education, U.S. Department of Education, 400 Maryland Avenue, S.W., LBJ/Room 3W238, Washington, D.C. 20202-6335

Johnson O'Malley Program
OGLALA SIOUX TRIBE
P.O. Box 1986
Pine Ridge, South Dakota 57770
Fax: 1-605-867-1968 • Telephone 1-605-867-5977

In order for your child/student to receive Johnson O'Malley (JOM) Supplemental Education Assistance, he/she must first be certified as an eligible recipient. Eligibility requirements are simple:

1) Member of a federally-recognized Tribe; or 2) ¼ or more degree Indian Blood.
*Please provide a copy of your child's degree of Indian Blood.

Your cooperation in providing the information will assist JOM staff in completing the certification process. If you do not provide a copy of your child's degree of Indian Blood, his/her certification will be incomplete.

This document will be forwarded to respective Tribal or Bureau agencies who will verify the information you have provided. Additionally, you are asked to read and sign the release at bottom of page.

*Please make sure that all information below is completely filled out, so that we can better serve your child through the OST Johnson O'Malley program.

Student Name: _____ D.O.B.:___/___/___

School Attending: _____ Grade: _____

Tribe or Agency: _____ Blood Degree: _____
*Please attach a copy of your child's degree of Indian Blood.

Mother's Name: _____ D.O.B.:___/___/___

Tribe/Agency where Mother's enrolled: _____

Enrollment Number: _____ Blood Degree: _____

Father's Name: _____ D.O.B.:___/___/___

Tribe/Agency where Father's enrolled: _____

Enrollment Number: _____ Blood Degree: _____

over ->

AUTHORIZATION FOR RELEASE OF INFORMATION

The client parent or guardian authorizes the Oglala Sioux Tribe Johnson O'Malley Program making referral, and the agency or public school to whom this referral is addressed, to release all such information as necessary to insure maximum coordination and proper delivery of service(s) and follow-up with regard to this referral. All information exchanged in such manner will be held in confidence and will not be disseminated further without a signed release from the client as parent or guardian.

_____ ____/____/____
Parent/Guardian

Address of parent or legal guardian:

_____

_____ Current telephone (___) ____ - _____

- If you are not the parent, please attach legal guardianship documents.

FOR BUREAU OF INDIAN AFFAIRS/TRIBAL ENROLLMENT USE ONLY:

The Oglala Sioux Tribe Johnson O'Malley Program requests your assistance in verifying the preceding information as provided. This document will be used to determine listed student's eligibility for assistance according to federal regulation(s). Please sign and return this document to:

Johnson O'Malley Program
Oglala Sioux Tribe
P.O. Box 1986
Pine Ridge, South Dakota 57770

I hereby certify that I have reviewed appropriate records and do further certify that the degree of Indian Blood or Enrollment status of individual(s) listed is true and correct to the best of my knowledge.

_____ ____/____/____
*Signature and Title

Oglala Lakota County School District
Photo, Video & Social Media Release Form

Throughout the school year your child will reach goals and accomplishments that we like to recognize them for, publicly, but we can't do so without your permission. There may be times when Oglala Lakota County School District (OLCSD) staff, with the approval of the school principal, may take photographs of students, audio/videotape students, or interview students for school related stories in a way that would individually identify a specific student. Those photographs and/or videotaped images or interviews may appear in District/School publications, in District/School video productions, on the District/School website, on District authorized social networking sites such as Facebook or Twitter or in the news media. To authorize your child's photographs and/or videotaped image or interview to be used for these purposes, please complete this form and return it to your child's school.

_____ (Please initial) **I hereby grant unto the Oglala Lakota County School District permission and unlimited license to use my child's photograph and/or videotaped image or interview for the purposes mentioned above. I understand and agree that OLCSD may use the license and these photos and/or videotaped images or interview in subsequent school years unless I revoke this authorization and license in writing to the school principal or superintendent. I further grant unto the Oglala Lakota County School District permission to merit my child to be photographed, audio, recorded/videotaped, or interviewed for school related stories or articles, and I waive any subsequent claims or lawsuits arising from the recording of my child and any product containing my child's image.**

_____ (Please initial) **I do not grant permission to Oglala Lakota County District to use my child's photos and video.**

Student's Name: _____

School: _____

Parent/Guardian Name: _____

Address: _____

City/State: _____ Zip Code: _____

Telephone Number: _____

Parent/Guardian Signature: _____ Date: _____

*Students 18 years of age or older may sign this release for themselves.

*Please complete one form per child.

Oglala Lakota County School District

Batesland ▼ Wolf Creek ▼ Rockyford ▼ Red Shirt

Student Network/Internet User Agreement

Introduction

We are pleased to offer students of the Oglala Lakota County School District access to the district computer network resources, and the Internet. To use these resources, parents of all students must sign and return this form. Parents, please read and complete this document carefully, review its contents with your son/daughter, and sign and initial where appropriate. Any questions or concerns about this permission form or any aspect of the computer network should be referred to your school's Site Technology Coordinator.

General Network Use

The network is provided for students to conduct research and complete assignments. Access to network services is given to students who agree to act in a considerate and responsible manner. Students are responsible for good behavior on school computer networks just as they are in a classroom or a school hallway. To ensure the use of electronic communication systems in the District are compliant with this agreement, network administrators may monitor usage of District purchased equipment from time to time. Access is a privilege - not a right. As such, general school rules for behavior and communications apply and users must comply with district standards and honor the agreements they have signed (see over).

Network storage areas may be treated like school lockers. Network administrators may review files and communications (i.e. computers, email, cell phones, pagers, chat, and instant messaging) in order to appropriately to maintain system integrity and ensure that users are using the system responsibly. Users should not expect that files stored on district servers are ever private, as electronic systems are not personal property, including school internet, staff/students maintain no right or expectation of privacy related to their use of District Electronic Communication Systems.

Internet / World Wide Web

Access to the Internet will enable students to use thousands of libraries and databases. Within reason, freedom of speech and access to information will be honored. Families should be warned that some material accessible via the Internet might contain items that are illegal, defamatory, inaccurate or potentially offensive to some people. While our intent is to make Internet access available to further educational goals and objectives, students may find ways to access other materials as well. Filtering software is in use, but no filtering system is capable of blocking 100% of the inappropriate material available on the Internet. We believe that the benefit to students to access the Internet, in the form of information resources and opportunities for collaboration, exceed any disadvantages. Ultimately, parents and guardians of minors are responsible for setting and conveying the standards that their children should follow when using media and information sources. The Oglala Lakota County School District does not provide off campus or home-based Internet access. Parents are urged to explore the resource with their children, as there are many areas not suitable for access by children.

Publishing to the World Wide Web

Parents, your daughter or son's work may be considered for publication on the World Wide Web, specifically on the student's school's web site. Such publishing requires parent/guardian permission (see over). The work will appear with a copyright notice prohibiting the copying of such work without express written permission. In the event anyone requests such permission, those requests will be forwarded to the student's parent/guardian.

It is the policy of the Oglala Lakota County School District that no students name and photo will be published together on the school web site. It is our policy that publication means either the students photo or name and not both.

It is the policy of the Oglala Lakota County School District to follow the guidelines set forth in the Child Internet Protection Act located on the American Library Association website at: http://www.ala.org

Directions

Read carefully! Then complete the green highlighted areas on the back page and return to the school. This information will be kept on record with the technology coordinator. Only Office Staff, Technology Staff, and the Classroom Teacher will have access to this information. We must have this document on record for your child to able to use school computers or access the Internet.

Print Name: _____ Grade: _____

Oglala Lakota County Schools
Student Network/Internet User Agreement and Parent Permission Form

To use networked resources, all students must sign and return this form, and those under age 18 must obtain parental permission. The activities listed below are not permitted:

- ☐ Sending or displaying offensive messages or pictures
- ☐ Using obscene language, defamatory, offensive or harassing via any Electronic Communication (email, chat, text messaging, or websites)
- ☐ Giving personal information, such as complete name, phone number, address or identifiable photo, without permission from teacher and parent or guardian
- ☐ Harassing, insulting or attacking others
- ☐ Intentional or negligence causing damage or modifying computers, computer systems or computer networks will result in monetary charges related to repair, replacement or re-configuration
- ☐ Installing or attempting to install any program, game or application not approved by the District
- ☐ Violating copyright laws
- ☐ Using others' passwords
- ☐ Trespassing in others' folders, work or files
- ☐ All Chat Rooms, Multimedia Downloads, Outside Email (Google, Yahoo, Hotmail, etc.)
- ☐ Social Networking Websites are Blocked and not allowed access on the school networks
- ☐ Employing the network for commercial purposes, financial gain, or fraud.
- ☐ Accessing and playing games not approved by the teacher or administration
- ☐ Hacking Sites, Games or Gambling Sites and Proxy Avoidance Sites are Blocked

Violations may result in a loss of access as well as other disciplinary or legal action

Student User Agreement:

As a user of the Oglala Lakota County Public Schools computer network, I hereby agree to comply with the statements and expectations outlined in this document and to honor all relevant laws and restrictions. In addition, I hereby waive any right or expectation of privacy I might have in any communication including emails, instant messaging, and documents that may be accessed by the District through the network.

(Initial appropriate items)

_____I agree to use the network responsibly

_____I grant permission to have my work or un-named group pictures published to the World Wide Web

Student Signature _____ Date _____

Parent/Guardian Permission:

Parent/Guardian Permission:

All students are provided with access to district computer resources. In addition to accessing our district computer network, as the parent or legal guardian, I grant permission for the above named student to:(Initial appropriateitems)

_____Access the Internet

_____Have his/her materials published to the World Wide Web

_____Have his/her name or photo published on the World Wide Web, according to Guidelines stated on the previous page of this document.

These permissions are granted for an indefinite period of time, unless otherwise requested. I understand that individuals and families may be held liable for violations. I understand that some materials on the Internet may be objectionable, but I accept responsibility for guidance of Internet use - setting and conveying standards for my daughter, son, or guardian to follow when selecting, sharing or exploring information and media.

I understand that the District takes reasonable steps to limit offensive material from the network accessible to my child. I further understand that no such system is fool proof. In consideration of allowing my child access to the network and Internet I hereby waive any claim my child or I might make relating to the content of information or images my child may encounter on the network. In addition, I hereby waive any state or federal right or expectation of privacy my child or I might have with respect to communication to, from or about my child that may be accessed through the network, including without limitation emails, instant messaging, documents and the like and the District's access to such material.

Parent Signature_____Date _____

Oglala Lakota County School District 65-1

Dr. Anthony Fairbanks
Superintendent

Business Manager

Ann Eagle Bull
Human Resource Director

OLCSD Mission
To Strengthen the Lakota Identity and Values of Students and to Assure Their Overall Well-Being and Academic Success.

Debbie Blue Bird
Board President
Todd O'Bryan
Board Vice-President

Laticia 'Doni' DeCory
Tom Conroy
Robert Two Crow
Board Members

Ph.# (605) 288-1921 Fx.# (605) 288-1814

PO Box 109, Batesland, South Dakota 57716
www.olcsd.com

Oglala Lakota County School District *Device Check Out & User Agreement*

Welcome back to the 2021-2022 School Year! Oglala Lakota County School District Technology Department is working hard to provide educational devices to each student to utilize during these times of unsurety. We are looking forward to this partnership between the school district, your student's teacher(s), and the parents/guardians in our attempt to provide an educational environment that provides the technology needs of our students whether they're face-to-face or doing online learning.

- The device that your child is being issued is an educational tool and to be utilized for educational purposes only.
- Students are responsible for any damages, losses and costs incurred due to misuse, negligence, loss or theft of OLCSD devices.
- OLCSD Administrators have the right and responsibility to review files and communications on our devices to maintain system integrity and to ensure students are using devices properly and responsibly.
- Devices may be locked down without notice.
- All devices: Chromebooks, iPads, Hot Spots, chargers, power cords and cases are the sole property of OLCSD.
- OLCSD reserves the right to request the return of the equipment at any time.
- Should your student transfer to another school throughout the school year or be dropped it is your responsibility to ***immediately*** return all devices, cases and chargers/power cords to your respective school prior to release of student records.

Damage/Repair Cost:

Broken Screen	$50.00
Damaged Keyboard	$60.00
Damaged Case	$15.00
iPad Charger/Chromebook Power cord	$25.00/$60.00
Total Loss: New Device	$300.00

***Please return device to OLCSD Schools/Staff ONLY. DO NOT have any other (3rd Party) companies/people try to fix our device (screens, etc) having a 3rd party work on our devices will void any warranty we have and the parent/guardian may be charged for damages or cost of device.

***Please do not eat or drink while using your device as this is when most damage occurs.

Thank you for your cooperation in this manner and we look forward to maintaining an educational program for your child. Please notify your students teacher if you have technology or device issues.

I agree to the guidelines and procedures outlined on this form and agree to take responsibility (including financial) for my student's device.

Student Name: _____ Grade: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

To be filled out by staff when actual device is checked out:

Device Name: _____ Asset Tag: _____

Staff Name: _____ Date: _____

Oglala Lakota County School District #65-1

Parental Permission

For School Health Care Program 2022-2023

Child's Name_____**Grade** _____**Date of Birth**_____

The following is for routine health care services, provided in school facilities by school health personnel with standing orders from Public Health Service physicians. Staff must ensure that immunizations records are current.

Please Initial or check **ONLY** the services listed that you want for your child.

____ Permission to test your child for covid.

____Transport children to the PHS hospital or other medical facilities for emergency treatment (i.e., Bleeding wound) or contact appropriate authorities for transportation accordingly (i.e., Fracture). Parent are contacted to meet at the hospital.

____Do routine hearing and vision screening as indicated.

____Transport, **if parental transportation is not available,** identified children in need of further vison and hearing screening. And the child's permission slip must be signed.

____Transport, **if parental transportation is not available,** identified children for routine dental exams and sealants, if further care is indicated, a follow-up letter is to be sent to parents/guardians who are responsible for further care and transportation.

____Send all medications, that the child is to take, to the Nurse's Office for dispensing, identification of the medication, instructions for dispensing physician are to accompany the medication.

____Administer medications approved through standing orders for: headaches, fever, conjunctivitis, earache, and cold symptoms.

____Do treatments for respiratory conditions as ordered by a physician.

____Take, as needed vital signs: blood pressure, pulse, height, weight, temperature, etc.

____Apply, when indicated by possible fracture or sprain, splint or elastic bandages.

____Shower and change clothes in case of need.

____Soak body parts that have sores on them.

____Apply dressing or topical medications as needed for lacerations, abrasions, or other injures, such as burns.

____Clean heads that are infested and/or infected.

Please list any **allergies or medical conditions** your child has: _____

_____

Please list any **medications** being taken by your child: _____

_____

Please list all **emergency phone numbers** where you can be reached in case of a medical emergency:

_____

Parent or Guardian _____ Date:

OGLALA LAKOTA COUNTY SCHOOLS STUDENT INFORMATION

Student Print Name: Student Date of Birth:

Student School: Red Shirt School Child/Student Address:

Parent/Guardian Print Name: Parent/Guardian Tel./Mobile #:

Parent/Guardian Email address: Best way to contact you:

My Student WILL____/ WILL NOT _____ Need transportation to and from School.

In consideration of _____ (NAME OF STUDENT) (hereinafter "Student") being allowed to attend and participate in-person activities at the _____ School (hereinafter "School") school related activities (hereinafter "Activities"), to include but not limited to educational, co-curricular, and extracurricular programs, the undersigned acknowledges (initial) and agrees that:

(initials)

_____ 1. There is still a risk of contracting COVID 19 in the school setting but I understand that the School Staff are making every effort to mitigate these risks.

_____ 2. Upon returning back to in-person learning, my student will adhere to all safety precautions and measures set up by the School.

_____ 3. Wearing a mask is NOT Optional. All Students and Staff Shall wear their masks at all times when within 6ft of another person except when eating or drinking.

_____ 4. Exemptions will only be granted in certain limited cases:
   a. For students who need a medical exemption, due to a health condition that would make it unsafe to undergo testing (e.g., facial trauma, nasal surgery), use the **Student Medical Exemption Form**.
   b. This form must be signed by a physician and you must submit medical documentation from a health care provider.

_____ 5. All School safety procedures must be followed while in school or participating in school-sponsored activities; this includes the bus. Students will be **REQUIRED** to wear their masks on the bus as well.

_____ 6. If my student does not feel well and/or has any of the following symptoms, he/she will be kept home:
   a. Cough;
   b. Shortness of Breath or Difficulty Breathing;
   c. Fever Of 100.4 Degrees Fahrenheit Or Above;
   d. Chills;
   e. Muscle Pain;
   f. Sore Throat;
   g. New Loss of Taste or Smell.

_____ 7. The Student or the parent or guardian will notify School officials if the student currently has symptoms or has been in contact with anyone with a confirmed COVID-19 diagnosis in the last 14 days. The Student will not attend School Activities or Athletics.

_____ 8. The School reserves the right to conduct screening measures, including but not limited to, taking Student's temperature, random/selective testing and inquiring about current symptoms, before Student may attend school, practice or an event. A separate permission form is

Oglala Lakota County School District COVID19 Test Permission Form

The permission granted with this form is for the school to test your child for COVID19 in the event they have symptoms at the school. Students would only be tested if exhibiting symptoms at school. The parent/guardian would be called prior to the testing.

If you consent, your child will receive a free diagnostic test for the COVID-19 virus. Collecting a specimen for testing involves inserting a small swab, similar to a Q-Tip, into the front of the nose and/or collecting saliva (spit).

If your child has a specimen collected for testing at school, we will send information home with the student. We will also make every effort to contact the parent/guardian. COVID- 19 test results will generally be provided within 15-30 minutes.

Parent/Guardian Information

Parent/Guardian Print Name: _____

Parent/Guardian Address: _____

Parent/Guardian Phone #: _____

Parent/Guardian Email Address: _____

Child/Student Information

Child/Student Print Name: _____

Child/Student Address: _____

Child/Student Date of Birth: _____

Child/Student School: _____

- o I consent for my child to be tested

By signing below, I attest that:

- I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named.
- I consent for my child to be tested for COVID-19 infection.
- I understand that my child would only be tested if they were showing symptoms.
- I understand that this consent form will be valid through the 2020-2021 regular school year, unless I notify the designated contact person from my child's school in writing that I revoke my consent.
- I understand that my child's test results and other information may be disclosed as permitted by law to the Oglala Sioux Tribal Health Authority and the South Dakota Department of Health.
- I understand that if I am a student age 18 or older, or may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my own behalf.

Signature of Parent/Guardian (Child under 18): _____

Date: _____

Signature of Student (if older than 18): _____ Date: _____

STUDENT HEALTH HISTORY FORM AND RELEASE OF INFORMATION ~ SCHOOL YEAR 20___

Student ID _____ *(official use only)*

Student Name (*print first*) _____ (*print last*) _____ DOB _____ Grade ___ F☐ M☐

Your student's health history is important to provide the best care at school. It is the responsibility of the parent /guardian to notify the school of new or existing health concerns. If your student is prescribed medication or requires a treatment at school, it is the responsibility of the parent or guardian to notify the school and provide the medication or necessary equipment for use at school.

Last physical exam _____ Healthcare Provider _____

Last dental exam _____ Dental Provider _____

Last vision exam _____ Vision Specialist _____

My student has the following (NEW or EXISTING) medical condition(s). (Check all that apply)

HEAD
- ☐ Concussion (loss of consciousness)
- ☐ Concussion (no loss of consciousness)
- ☐ Migraines (diagnosed)
- ☐ Frequent headaches
- ☐ Seizures
- ☐ Other _____

EYES
- ☐ Vision concerns
- ☐ Glasses/Contacts
- ☐ Vision Loss/both eyes
- ☐ Vision Loss/one eye
- ☐ Other _____

EAR/NOSE/THROAT/ MOUTH
- ☐ Frequent earaches/infections
- ☐ Tubes in place
- ☐ Hearing loss/condition
- ☐ Hearing aid
- ☐ Speech problems
- ☐ Swallowing problem
- ☐ Dental pain or concerns
- ☐ Other _____

HEART/LUNGS
- ☐ Asthma
- ☐ Heart condition
- ☐ Other _____

ABDOMEN/INTESTINAL/ URINARY
- ☐ Frequent stomachaches
- ☐ Urinary or bowel concerns
- ☐ Other _____

BONE/MUSCLE/JOINT
- ☐ Muscular concerns
- ☐ Knee, back, bone or joint concerns
- ☐ Scoliosis
- ☐ Other _____

CHROMOSOME/GENETIC
- ☐ Down Syndrome
- ☐ Other _____

SKIN
- ☐ Skin concerns
- ☐ Other _____

ALLERGIES
- ☐ Anaphylactic shock
- ☐ Anaphylactic/foods
- ☐ Anaphylactic/nuts
- ☐ Anaphylactic/peanuts
- ☐ Anaphylactic/stings
- ☐ Allergy, Airborne
- ☐ Allergy, Animals
- ☐ Allergy, Medication
- ☐ Allergy, Food
- ☐ Allergy, Latex
- ☐ Lactose Intolerance

List specific allergy(ies): _____

ENDOCRINE/BLOOD
- ☐ Diabetes/Type I
- ☐ Diabetes/Type II
- ☐ Blood disorder
- ☐ Other _____

EMOTIONAL/BEHAVIORAL /PSYCHOLOGICAL
- ☐ Mental/emotional concerns
- ☐ Other _____

OTHER
- ☐ _____
- ☐ _____

☐ **My Child has NO (new or existing) health concerns.**
(If you check this box, you agree to communicate with the school regarding new health concerns during the school year.)

My child will require the following medication types given during the school day (check all that apply):

☐ **Long-Term Prescribed Medication**
The Long-Term form must be completed by the parent/guardian AND healthcare provider: MD/DO/ANP/PA & medication delivered in a properly labeled pharmacy container.

☐ **Short-Term Prescribed Medication**
The Short-Term form must be completed by parent/guardian & medication delivered in a properly labeled pharmacy container.

☐ **OTC/Over the Counter Medication**
To have an Over-The-Counter medication at school,

My child will require the following emergency medication(s) at school, check all that apply (*parent/guardian must provide*):
- ☐ Epinephrine (EpiPen or Auvi-Q)
- ☐ Antihistamine (Benadryl)
- ☐ Rescue Inhaler
- ☐ Glucagon
- ☐ Diazepam rectal gel

My child will require the following plan or other treatment at school (check all that apply):
- ☐ Student Allergy/Anaphylaxis Action Plan
- ☐ Asthma Action Plan
- ☐ Individualized Healthcare Plan -Diabetes with injection
- ☐ Individualized Healthcare Plan –Diabetes with pump
- ☐ Seizure Action Plan
- ☐ Other treatment in school

***Release of Information:** The disclosure of health information within the school is limited to information necessary to serve the student's health and education interests. Your *voluntary* agreement gives permission for school staff to be informed of precautions and procedures necessary to protect your child at school and foster academic success.

☐ I Agree _____ ☐ I Disagree _____ Parent/Guardian Signature _____ Date _____

Form adapted from Anchorage School District Nursing & Health Services

Revised 01/2021

INITIAL STUDENT HEALTH HISTORY

(Parent/Guardian: The purpose of this form is to identify problems that may affect learning for the student. You may choose not to answer any question. The school nurse is available to help you at #_____ ☐M ☐T ☐W ☐Th ☐F)

Student Name:_____ DOB:_____ Student #:_____

Person Providing History:_____ Relationship to Student:_____

Is this person the biological parent? Y ☐ N ☐

Home Phone:_____ Work Phone:_____ Cell Phone: _____

DEVELOPMENTAL HISTORY

1. Has the student received physical, occupational, speech, or language therapy? Y ☐ N ☐
   If Y, explain:_____
2. Are you or has anyone ever been concerned about the student's development? Y ☐ N ☐
   If Y, explain:_____

HEALTH HISTORY

Check any of the following which the student currently has or has had diagnosed in the past.

☐Asthma	☐Cancer	☐Convulsion or seizures
☐Allergies	☐Depression	☐Excessive thirst
☐Anaphylaxis	☐Diabetes	☐Head injury
☐Anemia	☐Kidney disease	☐Heart problems or murmur
☐ADD/ADHD	☐Frequent Urination	☐Hepatitis (yellow jaundice)
☐Thyroid disease	☐Nerve or muscle disease	☐Ingestion of poisons/medication
☐Shingles	☐Frequent/severe headaches	☐Vaccine Preventable Diseases
☐Life changing events/accidents		☐Other health concerns

Explain any check mark and give age of problem onset or diagnosis:_____

1. List any other diagnosis, syndrome or disability the student has or has had in past. (List condition, treatment, who diagnosed, etc.) _____
2. Has the student had more than 3 colds, sinus infections, or ear infections in any one year? Y ☐ N ☐
   If Y, explain:_____
3. Has the student ever had any vision or hearing problems? Y ☐ N ☐
   If Y, explain:_____

4. **Medication** - Is the student taking medication now? Y☐ N☐
If Y, list the medications (include prescribed, over-the-counter, herbal and other remedies) and the condition for which the student takes this remedy): _____

_____

Has the student ever taken any medication for longer than two weeks? Y☐ N☐
If Y, list medication and when it was taken? _____

_____

5. **Sleep** – Number of hours of sleep the student gets most nights: _____ Normal bedtime: _____

Student falls asleep easily. Y☐ N☐ Student wakes up easily. Y☐ N☐
Student wakes up rested. Y☐ N☐ Student's sleep is: ☐sound ☐restless.

Student: ☐snores ☐ wets his/her pants or wets the bed ☐ has other sleep issues.
Explain: _____

Student has a usual bedtime routine. Y☐ N☐ Student sleeps in his/her own bed. Y☐ N☐.

6. **Nutrition** – Student eats at least 3 meals each day. Y☐ N☐
Student: ☐has healthy appetite ☐is picky eater ☐is sometimes picky ☐ is sometimes not picky.

Do you have any concerns about student's eating? Y☐ N☐
If Y, explain: _____

Do you have any concerns about student's physical activity? Y☐ N☐
If Y, explain: _____

Does student have any food allergies? Y☐ N☐
If Y, explain: _____

7. **Behavior** – Student has friendships that seem normal for his/her age. Y☐ N☐
If N, explain: _____
Do you have any concerns about student's behavior? Y☐ N☐
If Y, explain: _____

Oglala Sioux Tribe

Oyate Bli Helya Diabetes Program

"Empowering the Lakota Oyate through Diabetes Prevention, Education, & Wellness."

P.O. Box 5046
101 Oglala St
Pine Ridge, SD 57770
Fax: (605) 867-2344
Phone: (605) 867-1706

Tribute! Oglala-ISC Super ...

************************Consent Form**************************

Greetings! Your Child is invited and encouraged to participate in the OST Oyate Bli Helya Diabetes Program. This program was developed to help the Oyate learn about diabetes and prevention to combat the diabetes epidemic within the Native American population. The data compiled through screenings will assist the staff in strategic planning to maintain the best and results in the prevention of diabetes.

Your Child will be screened once in the Fall semester and once in the Spring semester. This screening will take place in the school, on scheduled days, where their height and weight will be taken. This will determine your child's body mass index (*BMI*) for their gender and age from the Center for Disease control website (*CDC.gov*).

From here this will determine if your child is referred to our CNA, who will do a finger stick, which will determine your child's glucose level for the past 3 months (*A1C test*). This program will screen all participating students in grades Kindergarten through 8th grade in the participating schools on the *Pine Ridge* Indian Reservation.

If you wish to seek further testing on your child, we recommend seeking the assistance of a physician who can perform a fasting plasma insulin or fasting plasma glucose test to confirm a valid measurement for each of these tests done to your child.

CONFIDENTIALITY is maintained and enforced by the Oglala Sioux Tribe, the State of South Dakota and The *Federal Privacy* Act of 1974.

I hereby give my permission to the OST Oyate Bli Helya Diabetes Program to screen my child and provide services and referrals for my child regarding their screening results. I understand that my child and/or other family members who are volunteering to utilize our services will not hold the OST Oyate Bli Helya Diabetes Program responsible for any accidents that may occur during the screening process.

I understand [illegible] signature & date signed will be valid for up to five (5) years & [illegible]

Refusal letters can be obtained at the Oyate Bli Helya Diabetes Program offices by calling (605) 867-1706.

PLEASE PRINT

Today's date: ____/____/____

Child's Legal First Name: _____

Child's Middle Name: _____

Child's Legal Last Name: _____ (Jr., II, or III)

Child's Birthdate: _____ Gender: Male / Female

Address: _____ City /State / Zip: _____

Contact Phone: _____ Email: _____

Does your child have any Medical Conditions / Disabilities (Mental/Physical)?
(This information is confidential and will help us better serve your child)

_____

Print Name of Parent / Legal Guardian: _____

Signature of Parent / Legal Guardian: _____

School: _____ Grade / Homeroom: _____

STAFF USE ONLY / PLEASE DO NOT WRITE IN BOXES

School Year:	School Year:	School Year:	School Year:	School Year:
Date Screened:	Date Screened:	Date Screened:	Date Screened:	Date Screened:
Height:	Height:	Height:	Height:	Height:
Weight:	Weight:	Weight:	Weight:	Weight:
Staff Initials:	Staff Initials:	Staff Initials:	Staff Initials:	Staff Initials:
BMI:	BMI:	BMI:	BMI:	BMI:
BMI %:	BMI %:	BMI %:	BMI %:	BMI %:
Classification:	Classification:	Classification:	Classification:	Classification:
Staff Initials:	Staff Initials:	Staff Initials:	Staff Initials:	Staff Initials:
HbA1c Level:	HbA1c Level:	HbA1c Level:	HbA1c Level:	HbA1c Level:
Classification:	Classification:	Classification:	Classification:	Classification:
Staff Initials:	Staff Initials:	Staff Initials:	Staff Initials:	Staff Initials:

Pine Ridge Dental Service Unit School Sealant Program Consent Form

Dear Families,

A free dental program will be in your child's school. Your child will receive preventative dental services that include a dental screening, tooth cleaning, sealants, fluoride varnish, silver diamine fluoride and tips on how to care for their teeth.

Name:_____

School:_____ Date of Birth:_____ Sex: M/F

Address:_____ Grade:_____ Teacher:_____

Parent/Guardian:_____ City/State/Zip:_____

Email:_____ Cell Phone:_____

Emergency Contact:_____ Home:_____ Work:_____

Relationship:_____ Phone:_____

Health History	Yes	No	
Allergies			Reaction Type
Medications			
Past Surgeries			
Pregnant			
Heart Conditions			

Condition	Yes	No	Explanation
Asthma			
HIV			
Hepatitis			Type:
Gastrointestinal			
Diabetes/Type			
Seizures			
Joint Replacement			
Hospitalizations			

CoVID 19 Screening	Yes	No
Tested positive for COVID 19		
Loss of taste or smell		
Cough		
Shortness of Breath		
Muscle Pain/Body Aches		
Nausea/Vomiting/Diarrhea		
Headache		
Fever/feverish		

	Yes	No
Are you experiencing any tooth pain?		
Is this your first dental visit?		
Does anyone smoke in the home?		
Do you brush your teeth daily?		

Dental Insurance	
Medicaid ID	
Private	
IHS	

Consent

Yes	No	Procedures
		Dental screening, teeth cleaning, sealants, fluoride varnish
		Silver diamine fluoride (will turn area of tooth with cavity black, see attachment, baby teeth only)
		Dental exam, x-rays, nitrous oxide, fillings and extractions

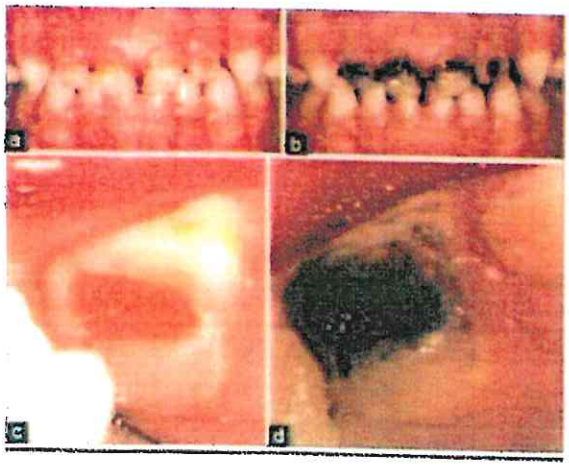
Signature Provider _____ Date _____

Date _____

Pine Ridge Dental Service Unit Silver Diamine Fluoride (SDF) Consent

Facts for consideration:

- Silver Diamine Fluoride (SDF) is an antibiotic liquid used on cavities to help stop the cavity process within the enamel (white part of tooth) and treat tooth sensitivity.
- Additional SDF application may be recommended.
- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.
- **The affected area will stain black permanently, this is an indication SDF is working.** Healthy tooth structure will not stain.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Color changes on the surface can normally be polished off. The edge between a tooth and filling may keep the color.
- If SDF gets on skin or gums, a harmless brown or white stain may appear and will disappear in 1-3 weeks.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied.
- **If allergic to SILVER SDF isn't a therapeutic option.**



PINE RIDGE IHS MOBILE CLINIC
P O BOX 1201
PINE RIDGE, SD 57770

OFFICE PHONE NUMBER: 605-687-3316
MSA PHONE NUMBER: 605-441-0869

CONSENT TO TREAT

I hereby give consent to the Pine Ridge IHS mobile clinic to treat my child for well child physicals as well as any illness related issues and to give immunizations and the seasonal flu vaccine.

Child's Name: _____

Birth Date: _____

Residence: _____

List allergies to any food or medication, history of patient/family heart disease. If yes, who, what problem, age of onset and/or any other medical condition your child has or if your child is on any medications:

_____

_____

_____

_____ I do not want my child to be given the seasonal flu vaccine

For males needing a physical, I consent for hernia check:

_____Yes _____No

Signature of Parent/Guardian or Responsible Party: _____

Date: _____

Oglala Lakota County School District 65-1

To strengthen the Lakota identity and values of students and to assure their overall well-being and academic success.

Date:

Please release ALL student records related to the following items:		
___ Health Records ___ Birth Certificate ___ Immunization Records ___ Standardized Testing	___ Transcripts ___ Individual Education Plan (IEP) ___ Psychological Records	___ Cumulative Records (Including attendance) ___ Enrollment History ___ Discipline Records ___ Tribal Enrollment
Oglala Lakota County Schools		
___ Batesland School (K-8) P.O. Box 49, 206 School St. Batesland, SD 57716 Phone: 605-455-6678 Fax: 605-288-1986 Email: Torey.Yankton@k12.sd.us SPED: Rena.Conroy@k12.sd.us	___ Red Shirt School (K-8) 38 Tatanka Nunpa Road Hermosa, SD 57744 Phone: 605-255-4224 Fax: 605-255-5396 Email: Mary.Belt@k12.sd.us SPED: Rena.Conroy@k12.sd.us	___ Rockyford School (K-8) 14 Bia 33 Porcupine, SD 57772 Phone: 605-455-2438 Fax: 605-455-2091 Email: Carolyn.OBryan@k12.sd.us SPED: Rena.Conroy@k12.sd.us
___ Wolf Creek School (K-8) P.O. Box 469, 41 Wolf Creek Road Pine Ridge, SD 57770 Phone: 605-867-5174 Fax: 605-867-5067 Email: Monica.Vocu@k12.sd.us or Deanna.Bigcrow@k12.sd.us SPED: Rena.Conroy@k12.sd.us	___ Virtual High School (9-12) P.O. Box 109 Batesland, SD 57716 Phone: 605-455-6693 Fax: 605-288-1813 Email: Michelle.Parmenter@k12.sd.us SPED: Rena.Conroy@k12.sd.us	___ Lakota Tech High School (9-12) P.O. Box 109 Batesland, SD 57716 Phone: 605-455-6940 Fax: 605-867-1285 Email: Olcsd.LTTranscripts@k12.sd.us SPED: Rena.Conroy@k12.sd.us

FOR TRANSFER STUDENTS

Oglala Lakota County School District 65-1

Dr. Anthony Fairbanks
Superintendent

Coy Sasse
Business Manager

OLCSD Mission
To Strengthen the Lakota Identity and Values of Students and to Assure Their Overall Well-Being and Academic Success.

Ph.# (605) 288-1921
PO Box 109, Batesland, South Dakota 57716
Fax. # (605) 288-
www.olcsd.com

Dear Parents/Guardians,

The McKinney-Vento Homeless Act defines "homeless children and youth" as individuals who lack a fixed, regular, or adequate night time residence. The rights and services under the McKinney-Vento Act are included in the Oglala Lakota County School District Homeless policy.

The attached form is designed to assist in applying the definition to individual students to determine eligibility for rights and services under the McKinney-Vento Act.

Please complete this form if you believe that your children meet the definition under the McKinney-Vento Act.

HOMELESS POLICY

THE OGLALA LAKOTA COUNTY SCHOOL DISTRICT 65-1 POLICY IS TO:

- Ensure the immediate enrollment of children or youth experiencing homelessness until all enrollment records may be secure; i.e. academic records, medical records, proof of residency, or other documentation
- Keep a student experiencing homelessness in the school of origin, except when parent or guardian waives that right.
- Ensure the elimination of stigmatization or segregated services and elimination of other identified barriers for homeless children and youth
- Provide children or youth experiencing homelessness with the same services offered to other students in the school, including the following:
  a) Transportation services
  b) Educational services for which the child or youth meets the eligibility criteria, such as services provided under Title I of the Elementary and Secondary Education Act of 1965, or similar state or local programs, educational programs for children with disabilities, and educational programs for students with limited English proficiency.
  c) Programs in vocational and technical education.
  d) Programs for gifted and talented students.
  e) School nutrition programs.

Oglala Lakota County School District 65-1
VERIFICATION OF MCKINNEY-VENTO ELIGIBILITY

Completion of this form is not mandatory and it will be confidential. This may give you access to more resources. This form is intended to address the requirements of the McKinney-Vento Act (Title IV, Part A, of Every Student Succeeds Act, or ESSA). Answers and information given below will assist in determining if the student "meets the eligibility criteria for services provided under the McKinney-Vento Act.

Where does the student stay at night?

_____ In a shelter _____
Name of Shelter

_____ In a Motel/Hotel _____
Name of Business

_____ At a campsite or campground _____
Name of Business

_____ Temporarily living with more than one family in a house, mobile home, or apartment due to loss of home, economic hardship, etc.... _____
Address

_____ Student is an unaccompanied youth (Living on their own) _____
Address

_____ Is in an arrangement that is not fixed, regular, and adequate and is not described by the above choices. Please describe the arrangement:

_____

_____

Student Name: _____ Date of Birth: _____ School: _____

Student Name: _____ Date of Birth: _____ School: _____

Student Name: _____ Date of Birth: _____ School: _____

I, (printed name) _____ declare as follows:

_____ I am the parent/legal guardian of the student(s) named above
_____ I am an unaccompanied youth.

Since, (date) _____, our family has not had a permanent residence.

Under penalty of perjury under the laws of this state, I declare that the information provided here is true and correct and of my own personal knowledge and that, if called upon to testify, I would be competent to do so.

Name of person completing the form: _____

Signature: _____ Date: _____

Would you like the Coordinator to contact you?

Yes ____ Current phone number_____
No ____

Oglala Lakota County School District 65-1

Dr. Anthony Fairbanks
Superintendent

Sophia Conroy
Business Manager

OLCSD Mission
To Strengthen the Lakota Identity and Values of Students and to Assure Their Overall Well-Being and Academic Success.

Laticia DeCory
Board President

Debbie Blue Bird
Board Vice-President

Chuck Conroy
Tom Conroy
Todd O'Bryan
Board Members

Ph.# (605) 288-1921
Fx.# (605) 288-1814
PO Box 109, Batesland, South Dakota 57716
www.olcsd.com

Dear Parent/Guardian,

The Home Language questions below are used as a tool to determine if your child is eligible for English Language support services. If a language other than English is used by you or child most of the time in the home, the school may need to give your child an English Language Proficiency assessment. If that is the case, results of the assessment will be shared with you and a plan for English Language services.

Student Information	
Student First Name	Student Last Name
Date of Birth:	School Name:

Language Questions	Responses
What language is most frequently spoken at home?	
What language did you child learn when they began to talk?	
Which language does your child speak at home?	
Which language do you most frequently speak to your child?	

Parent/Guardian Signature _____ Date _____

OGLALA LAKOTA COUNTY SCHOOL
DISTRICT 65-1 K-8 STUDENT HANDBOOK
SY 2022-2023

PLEASE SIGN BELOW AND RETURN TO SCHOOL OFFICE

I (We),_____,
(Print parent/guardian name)

Parent(s)/Guardian(s) of _____
(Print Student Name)

I have received the contents of the Oglala Lakota County 65-1 K-8 Student Handbook.

_____
Signature of Parent/Guardian

_____
Date

_____
Signature of Parent/Guardian (2)

_____
Date

Date received at school office: _____