Lower Brule Day School

P.O. Box 245, 229 BIA Route 10
Lower Brule, SD 57548
Phone: 605-815-5370 Fax: 833-734-1159

Lance Witte, Superintendent
605/815-5370

Logan Moeller, MS-HS Principal
605/815-5375

Wendy Kroupa, ES Principal
605/815-5376

2023-2024 School Year

Lower Brule Elementary School Student Application

Print Student Name: _____ Birthdate: _____ M ___ F___

Current Grade: BK/K (must be 5 yrs. old before Sept. 1st) 1st 2nd 3rd 4th 5th (Circle one)

Degree of Indian Blood_____ Tribe _____ Enrollment # _____

Mothers Name: _____ ( ) Living ( ) Deceased

Degree of Indian Blood_____ Tribe _____ Enrollment # _____

Living with child? Yes: ____ No: ____

Fathers Name: _____ ( ) Living ( ) Deceased

Degree of Indian Blood_____ Tribe _____ Enrollment # _____

Living with child? Yes: ____ No: ____

If no, who does the child reside with? _____

Legal Parent/Guardian Name: _____ Relationship to Child: _____

Work Number: _____ Home/Cell Number: _____

Email address: _____

Emergency contact: _____ Phone Number: _____

_____

Home Address City Zip Code

_____

Mailing Address *if different from home* City Zip Code

Medical Information

Allergies: _____ Medication: _____
(Only fill out if student has to take during school hours)

Any other medical information you would like to provide.

Previous School Information

School Last Attended

School Address City Zip Code

Who can check your student out? (Must be 21 years old)

_____ _____

_____ _____

_____ _____

Student Documents Needed Check List

____ Birth Certificate

____ Tribal Enrollment

____ Legal Guardianship

____ Immunization Records

I am legally responsible for this student and hereby apply for his/her admission to this school. I understand that additional information may be requested by the school before the student is enrolled.

X_____ Date: _____
(Signature of Parent/Legal Guardian)

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BIE Home Language Survey
2022-2023 School Year

First Name: _____ **Last Name:** _____

Federal Code: 25: CFR 32.3
"It's the responsibility of the federal government to provide comprehensive education programs and services for Indians and Alaska Natives."
Federal requirements direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. BIE has contracted with WIDA (World Class Instructional Design and Assessment) to provide English Learner Assessments and Supports identified in this Home Language Survey.

BIE Mission Statement:
"Provide quality education opportunities from early childhood through life in accordance with the Tribes' needs for cultural and economic well-being..."

School Mission Statement:
The Lower Brule Schools, guided by the Wolakota values fulfilled by the Kul Wicasa Oyate, provides a safe and inclusive environment where students learn and succeed by engaging students through the best educational practices.

Purpose: The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order for the school to provide adequate instructional programs and services. As parents or guardians, your cooperation is requested in complying with these requirements.

Please respond to each of the questions listed as accurately as possible.

For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any questions unanswered. If you have any questions, you have the right to share them before your student's English proficiency is assessed.

1. **Which language did your child learn when they first began to talk?**

2. **Which language does your child most frequently speak at home?**

3. **Which language do you (the parents/guardians) use more often when speaking with your child?**

4. Which language is spoken more often by other adults in the home?

5. Do you believe your child might need additional support learning the academic language for math, science, reading, or writing?

Additional Information (Optional)

Please sign and date this form in the spaces provided below, then return this form to your child's school. Thank you for your cooperation.

Signature of Parent or Guardian _____

Date _____ School Official Verification _____

Criteria for Screening

If a language other than English is identified for any of the primary language questions above, your child will be recommended for screening.

*** Please Note: SOME items in this template can be modified to represent the specific needs of LEAs in efforts to gain knowledge of student EL status better. Questions 1-3 are not negotiable and must remain as stated per federal requirements. Additionally, the Federal Code, BIE Mission Statement, and Purpose sections remain as stated. Thank you.

BIE Sample Form HLS, Revised July 2021

Lower Brule Day School
P.O. Box 245, 229 BIA Route 10
Lower Brule, SD 57548
Phone: 605-473-0215 Fax: 605-473-0217

Lance Witte, Superintendent/MS-HS Principal
605/473-0216

Mr. Wildmike Pata, ES Principal
605/473-5382

Technology/Picture Permission Slip

Dear Parents/Guiardians;

We are required to have an Internet Permission slip before your child can access the internet. We will keep them on file. We also have a School Facebook page, so we will be taking pictures of them and their activities and putting on our School Facebook page with your permission.

I (we) hereby give the school consent to use my students picture for internet use.

Childs Name:_____

Parent/Guardian Name:_____

Sincerely,

Lance L. Witte - Superintendent of Schools
605-461-8586

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Lance Witte, Superintendent/MS-HS Principal
605/473-0216

Ms. Wendy Kroupa, ES Principal
605/473-5382

Lower Brule Schools Medical Form

Name of Student_____ Date of Birth_____

I (we),_____give consent for the Lower Brule School to arrange for or to provide the following health services for this child:

1. Health including medical examinations, routine laboratory studies, x-ray procedures, and skin tests.
2. Dental care including dental examinations, preventive use of fluorides, and necessary emergency dental care.
3. Mental health services including evaluation and treatment as necessary.
4. Emergency health care for accidents or illness.
5. Transportation of the child to and/or from another health facility for these services.
6. Eye Examinations
7. Scoliosis Screenings Girls, grade 5 & 7 and boys grade 8 at the request of the school
8. Immunizations for KG -12th grade, Covid Test, Flu Vaccination, SDHSAA Sports Physicals, and Covid Vaccinations.

☐ I hereby give consent for all the above services.

☐ Exceptions or Special Instructions:

_____

_____

Signed_____
Address_____
Relationship_____
Date_____

This form is good for one year from the date it was signed.

DELTA DENTAL®

MOBILE PROGRAM

Patient Information and Permission Form

General information

Patient information

_____
Legal name (please print)

_____ _____/_____/_____
Age Birth date (mm/dd/yyyy)

Sex ☐ Male ☐ Female

_____ _____
School attending Grade

Race
☐ White ☐ Asian ☐ Other
☐ Black or African American
☐ American Indian or Alaska Native
☐ Hawaiian or Other Pacific Islander
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Parent/guardian information

_____
Name (please print)

_____
Relation to patient

_____
Home (mailing) address

_____ _____
City Zip

Home phone (_____)_____-_____

Work phone (_____)_____-_____

Cell phone (_____)_____-_____
☐ Check here if you do not want to receive text messages.

Emergency contact information

_____
Name (please print)

_____
Relation to patient

Phone ( ) -

Dental history

Dental visits should start at first tooth.

☐ Yes ☐ No Is this the patient's first dental visit?
If no, how long has it been?
☐ Less than 2 years ☐ More than 2 years

_____
Past or current dentist's name

☐ Yes ☐ No Is the patient experiencing toothache/ mouth pain/face swelling?

☐ Yes ☐ No Has the patient visited the ER/hospital for dental pain in the last year?

☐ Yes ☐ No Has dental pain caused you or your child to miss school and/or work in the last year?
☐ School ☐ Work ☐ Both

Medical history

_____
Patient's current physician

Date of last medical exam (mm/yy) _____/_____

☐ Yes ☐ No Is the patient taking any medications?
If yes, please list _____

_____

☐ Yes ☐ No Does the patient have any allergies?
If yes, please list _____

_____

☐ Yes ☐ No Does the patient have any special needs that would require special arrangements for dental care? e.g. autism
If yes, please explain _____

☐ Yes ☐ No Is the patient pregnant?

Does the patient have, or have they had, a history of the following:

☐ ADHD
☐ AIDS / HIV
☐ Anemia
☐ Anxiety
☐ Asthma
☐ Birth defects
☐ Cancer
☐ Cerebral Palsy
☐ Diabetes
☐ Epilepsy/seizures
☐ Excessive bleeding
☐ Fainting
☐ Heart problems
☐ Hepatitis
☐ Kidney disease
☐ Liver disease
☐ Mono
☐ Rheumatic fever
☐ Tuberculosis
☐ Other _____

Please explain your answers:

Continue on back.