

First Mesa Elementary  
 School  
 Student Enrollment  
 Application



**2024 -  
 2025**

New Student \_\_\_\_\_

Returning Student \_\_\_\_\_

Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Cover Page/Check List

- |  |  |
|--|--|
| <input type="checkbox"/> Student Application (2 pages)                       | <input type="checkbox"/> One Call Form (1 page)                        |
| <input type="checkbox"/> Student Checkout Form (1 page)                      | <input type="checkbox"/> FERPA Form (1 page)                           |
| <input type="checkbox"/> Student Transportation (1 page)                     | <input type="checkbox"/> Student Residency Verification Form (1 page)  |
| <input type="checkbox"/> Student Health History (1 page)                     | <input type="checkbox"/> Release of Records Form (1 page)              |
| <input type="checkbox"/> Medical Attention Form (1 page)                     | <input type="checkbox"/> Primary Home Language Survey (1 page)         |
| <input type="checkbox"/> OTC Medication Consent Form (1 page)                | <input type="checkbox"/> 2024-2025 Influenza Vaccination Form (1 page) |
| <input type="checkbox"/> Sports/Local Field Trip/Photo Consent Form (1 page) | <input type="checkbox"/> Annual Sport Physical Form (2 pages)          |
| <input type="checkbox"/> 2024-2025 Dental Prevention Consent Form (1 page)   |  |

**\*Required documentation at time of registration:**

- \*Birth Certificate     \*Tribal Enrollment/C.I.B.     \*Updated Immunization Record
- \*Affidavit of Temporary Guardianship (if applicable)

**NOTE: INCOMPLETE APPLICATION WILL DELAY ENROLLMENT. PLEASE ENSURE TO HAVE ALL PROPER DOCUMENTATION AT TIME OF ENROLLMENT.**

FOR OFFICIAL USE ONLY			
Received Date: _____	Received by: _____		
Status: COMPLETE: _____	PENDING: _____		
Comments: _____			
Enrollment:    APPROVED _____	DISAPPROVED _____		
CSA's Signature: _____			
NASIS Entry Date: ____/____/____	Enrollment Code: _____	NASIS ID#: _____	
Teacher Placement: _____	Grade: _____	Room #: _____	



**First Mesa Elementary School**  
**P.O. Box 750**  
**Polacca, AZ 86042**  
**Phone: 928 737 2581 Fax 928 737 2323**

**IDENTIFICATION:**

Student Name: (Last, First, MI)	Grade:
Gender: Male ( <input type="checkbox"/> ) Female ( <input type="checkbox"/> )	Date of Birth:
Place of Birth:	Age:

**ADDRESS:**

Mailing Address: (PO Box #, City, Zip Code)	Physical Address: (Directions/Description of home, City, Zip Code)
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**ETHNICITY (Please choose one of the following Federally Mandated Categories):**

( <input type="checkbox"/> ) American Indian or Alaskan Native	( <input type="checkbox"/> ) Native Hawaiian or Other Pacific Islander
Tribal Affiliation:	( <input type="checkbox"/> ) Asian
Village Affiliations:	( <input type="checkbox"/> ) Caucasian/White
Enrollment/CIB #:	( <input type="checkbox"/> ) African American/Black

**FAMILY DATA INFORMATION:**

	Last/First Name, Address	(x) lives with student	(x) has legal custody	Home Phone/Cell Phone	Employer/ Work Phone	Email Address
Father						
Mother						
Step-father						
Step-mother						
Other (specify)						

*Note: In cases where custody/visitation affects the school, the school shall follow the most recent court order on file with the school. It is the responsibility of the custodial parent/guardian to provide the school with the most current court order.*





**FAMILY DATA (CONT.) please list brothers/sisters of student now living in home:**

Name:	Age:	School Attending:
1.		
2.		
3.		

**PREVIOUS SCHOOL INFORMATION:**

Last School Attended:	School Address:	Grade:	Date Withdrawn:
Has student ever attended First Mesa Elementary? ( ) Yes ( ) No	Has student ever been retained: ( ) Yes ( ) No	If "Yes", what grade:	Other Schools Attended:

**SPECIAL SERVICES (Please check all that apply) Note: If "X" please provide most recent information, i.e. IEP, etc.**

Special Education		Speech Therapy	
Physical Therapy		Gifted & Talented	
Occupational Therapy		Completed Head Start	
Counseling		Section 504 Plan	

**EMERGENCY CONTACT INFO (please list individuals other than yourself to be contacted):**

*Note: Parents/Guardians will be the 1<sup>st</sup> point of contact. If parent/guardian is unavailable, listed individuals will be contacted.*

Name:	Relationship to student:	Home Phone #	Cell Phone #	Work Phone #

I/We (Parent/Guardian) am/are legally responsible for this student and hereby apply for his/her admission to First Mesa Elementary School. I/we understand that additional information may be requested by the school before the student is enrolled.

Parent/Guardian Name (PRINT): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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



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Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

**Student Checkout Form**

Parents or legal guardians of students must designate authorized individuals to checkout his/her student. Phone calls will not be accepted for checkout authorization.

Note: A person checking out a student must be prepared to show proper identification. Individuals must be 18 years or older to checkout a student.

Please list each individual below (including yourself)

Individual Name:	Relationship:	Contact Phone Number:

Parent/Guardian Name: (PRINT): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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





Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

**Student Transportation Form**

**PARENT/GUARDIAN CONTACT INFORMATION**

Parent/Guardian Name	Relationship	Home Phone	Cell Phone

**Village/Community:** \_\_\_\_\_

<u>Primary AM Pick Up Location</u>	<u>Primary PM Drop Off Location</u>	<u>Alternative PU/DO Location</u>
<u>MAP</u>	<u>MAP</u>	<u>MAP</u>

Special Needs Accommodations required? YES ( ) NO ( )

Please list accommodations needed: \_\_\_\_\_

- Pick -Up and Drop -Off destinations are scheduled as close as possible to student’s residence. If roads become impassable (i.e. muddy roads, etc.) due to inclement weather or other reasons, buses will not transport on dirt roads. Parents are encouraged to use alternative stops.
- Students are encouraged to utilize primary arrangements. This eliminates overcrowding on buses.
- Alternate Pick up and Drop Off arrangements are encouraged to be communicated in advance. **Only a Parent/Guardian written note will be accepted. NO Phone Call Arrangements.**
  - On Full Days, bus notes will be accepted until 12:00 PM.
  - On Half Days, bus notes will be accepted until 10:00 AM.
  - Emergencies and urgent changes after the listed times or arrangements without a written note must be approved by the Registrar.
- Kindergarten students must be received at their PM Drop Off.

**Parent/Guardian Name (PRINT):** \_\_\_\_\_

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

<b>For Official Use Only:</b>	
Bus Driver Assignment: _____	Bus # _____



Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

### Student Health History

Gender: Male( <input type="checkbox"/> ) Female ( <input type="checkbox"/> )	Date of Birth:	Age:
Parent(s)/Guardian(s) Name:	Address:	Physical Address:
Home Phone:	Cell Phone:	Work Phone:

**HEALTH HISTORY:**

Please check "YES" OR "NO" for the following health conditions. If "YES", please indicate the age of diagnosis.

Condition	YES	NO	AGE	Condition	YES	NO	AGE
Anemia				Hepatitis			
Arthritis				Tuberculosis			
Asthma				Kidney Problems			
Allergies (i.e. food, seasonal, medication, etc.)				Migraine Headaches			
Back Problems				Seizures/Epilepsy			
Behavioral Health: (anxiety, depression, anger issues, etc.)				Spinal Injuries			
Diabetes				Sore Throats			
Wears Glasses/Contacts				Surgeries or Operations			
Hyperactive				Sprains or Fractures			

If "YES" to any of the above, please explain briefly: \_\_\_\_\_

Is your child currently taking prescribed medications or over the counter medication? YES (  ) NO (  )

If "YES", when does medication to be administered? (  ) During School Hours (  ) At Home

If "YES", please complete the following sections:

Type of Medication:	Diagnosis/Reason for Medication:
Time(s) Medication is Administered:	Dates Medication is Administer: From: _____ To: _____
Hospital Name & Address:	Physician's Name & Phone Number:

Parent/Guardian Name (PRINT): \_\_\_\_\_

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





Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

### Medical Attention Form

First Mesa Elementary School provides a health care program for all students. Clinical care will be provided during the present clinic hours by qualified and authorized medical personnel in the nurse's office. Parents/Guardians must take student to the hospital/clinic for care during times when the nurse's office is closed.

The Nurse's Office at First Mesa Elementary School agrees to provide the following services:

- Emergency Medical Care: for accidents or serious illness occurring during school hours. When necessary, the student will be transported to the Hopi Health Care Center.
- Routine Health Care includes: preventative health screening and health counseling. Available services may include: immunizations, care for adolescent physical concerns, drug and alcohol assessment, counseling, and dental care including sealants and preventative use of fluorides.
- Care for Non-Emergency Illnesses includes: topical antibiotics and indicated medical prescriptions.
- Immunizations: State Law requires that ALL school age children MUST have current immunization records on file in order to be enrolled and attend school. Please bring your child's most recent immunization record with you during enrollment process. (Please refer to the Arizona School Immunization Law for more information.)
- Vision, Hearing, and Scoliosis Screening: of select students in accordance with state regulations, and any student requesting examinations.
- Behavioral Health Services: including evaluation and treatment as necessary. In the event of a behavior issues where a child may cause harm to self to others, the following steps may be taken:
  - Parent/Guardian will be notified.
  - The Hopi Emergency Medical Services (EMS) will be contacted.
  - The Hopi Law Enforcement Services (HLES) will be contacted.
  - School Personnel may exercise reasonable care to ensure the safety of the student and others.

All medical records are kept confidential. No medical information will be shared between staff and school personnel unless important to student care. No elective procedures will be performed without parental permission. Student will be guaranteed confidential care in accordance with Arizona State Law.

( ) I (We) hereby consent for all the services listed above.

( ) Exceptional or Special Instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I (we) fully understand all statements/guidelines of provided medical services available to my child while attending First Mesa Elementary School.

Parent/Guardian Name (PRINT): \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

**Permission to Administer OTC Medications at School**

First Mesa Elementary School has common "over the counter" (OTC), medications in our Nurse's Office. We use brand names and generic name medicines. If you would like FMES to offer your child these medicines, please **CIRCLE "Yes"** or **"No"** for the following OTC medications listed below.

- Yes No Aloe Vera Gel – (Burns)
- Yes No Advil / Ibuprofen – (Injury, pain, and swelling)
- Yes No Bacitracin Zinc Ointment / Neosporin – (Anti-infection ointment)
- Yes No Benadryl / Diphenhydramine – (Oral medication given for suspected allergic reactions and seasonal allergy symptoms, may cause drowsiness. Medication will ONLY be administered to students after consulting with parents. Cream/Ointment is used for itchy insect bites or rash.)
- Yes No Tylenol / Acetaminophen – (Fever, Pain).
- Yes No Claritin / Loratidine – (Oral medication given for suspected allergic reactions and seasonal allergy symptoms, does not induce sleep. Medication will ONLY be administered to students after consulting with parents.
- Yes No Chloraseptic Spray – (Sore throat, numbing sensation).
- Yes No Cortisone Cream / Anti-itch cream – (Insect bites, itching and inflammation of skin).
- Yes No Menthol Cough Drops – (Cough)
- Yes No Pepto Bismal / Bismuth Subsalicylate – (Diarrhea, nausea, and upset stomach).
- Yes No Tums / Calcium Carbonate – (Stomach ache, heartburn).

*NOTE: Please notify the nurse what other medications your child takes at home.*

I have circled "Yes" for medicines my student may be given at school and have circled "No" for medicines that should NOT be given to my child.

Parent/Guardian Name (PRINT): \_\_\_\_\_

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

**For Official Use ONLY**

Received by Nurse/Staff On: \_\_\_\_\_ Signature: \_\_\_\_\_





Student Name: \_\_\_\_\_

Grade: \_\_\_\_\_

**Sports Participation/Local Field Trip/Photo Consent**

First Mesa Elementary School (FMES) offers participation in sports offered by the Hopi Elementary Athletic League (HEAL). Students who will participate in any sports activity must have a completed Annual Participation Physical Examination on file prior to participation. Physicals are good for one (1) school year.

FMES provides extracurricular activities and involvement in school clubs. During the school year, local trips sponsored by a school organization (i.e. Student Council, 6<sup>th</sup> Grade transition, Gifted and Talented, etc.) may be planned. Parents/Guardians will be given prior notification of any trips off campus.

FMES may at times take photographs of school sponsored events. Such photos may depict students' name, class or group involvement and may only be used for publicity, illustration, advertising and web content. Only with parental consent will photographs be utilized for such use.

Please initial those that apply:

\_\_\_\_\_ I (we) hereby grant permission for my/our child to participate in the HEAL Sports program which includes but is not limited to, cross country, basketball and cheerleading. I (we) understand that my/our child will need a current Annual Participation Physical Examination on file prior to participation.

\_\_\_\_\_ I (we) hereby grant permission for my/our child to participate in the organized school sponsored activity trip as approved. I (we) understand that students will be properly chaperoned and all precautions will be taken to ensure his/her safety.

\_\_\_\_\_ I (we) grant to First Mesa Elementary School (FMES), its representative and employees the right to take photographs of my child in connection with school wide activities for the current school year. I authorize FMES, its assignees and transferees to copyright, use and publish the same in print and/or electronically. I (we) agree that FMES may use such photographs of my child with or without his/her name and for any lawful purpose, including publicity, illustration, advertising and web content.

Parent/Guardian Name (PRINT): \_\_\_\_\_

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



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## ONE CALL SYSTEM

One Form per Household

First Mesa Elementary School uses the "One Call" System to better our communication with Parents/Guardians. Messages are sent via phone, email and/or text. These messages will include weekly activities, emergencies, delays, etc. Please indicate your information below if you would like to be part of this communication system.

Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:
Student Name:	Grade:

Please check all that will apply:

	CELL PHONE	#:	Name:
	CELL PHONE	#:	Name:
	HOME PHONE	#:	Name:
	HOME PHONE	#:	Name:
	EMAIL		Name:
	EMAIL		Name:

Parent/Guardian Name (PRINT): \_\_\_\_\_

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

Official Use ONLY

Data Entry Date: \_\_\_\_\_ Signature One Call Administrator: \_\_\_\_\_





Family Educational Rights and Privacy Act (FERPA)

School Year 2024—2025

I have received information about my rights under FERPA and understand my right to request that any of the items listed below not be disclosed as Directory Information to any outside group, other than those having a legal right to the information, without my written permission. Those having a legal right might include federal auditors, those having oversight responsibilities, circumstances regarding health and safety, emergencies or other similar entities.

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

I **ALLOW** the following directory information regarding my student to be disclosed:

**CHECK ALL THAT APPLY:**

1.  Student's Name
2.  Participation in officially recognized activities and sports
3.  Telephone Listing
4.  Age of members of athletic teams
5.  Photograph
6.  Honors and awards received
7.  Dates of attendance
8.  Grade Level

I **DO NOT** want any directory information regarding my student disclosed., (No information will be disclosed without prior written permission).

Parent/Guardian Name (PRINT NAME): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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



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## Primary Home Language Survey

Complete survey and return to Registrar's Office upon student registration. Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

*Survey questions are in compliance with Arizona Administrative Code, R7-2-306(B)(1), (2)(a-c).*

1. What is the primary language used in the home regardless of the language spoken by the student? \_\_\_\_\_
2. What is the language most often spoken by the student: \_\_\_\_\_
3. What is the language that the student first acquired: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name (PRINT): \_\_\_\_\_

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

*Primary Home Language Survey*

*In NASIS, please indicate the student's home primary language*

*Original: Student File*

*SX: Site EL Coordinator*





### Student Residency Verification Document

Student Name	Grade	Date of Birth

The purpose of this form is to address the requirements of the McKinney – Vento Act. This document will be used by school personnel and partnering agencies to ensure all providers have the necessary information to support the child and his/her family.

1. Presently, where is the student living? Check one box

SECTION A	SECTION B
<input type="checkbox"/> in a shelter <input type="checkbox"/> with more than one family in a house or apartment <input type="checkbox"/> in a motel, car or campsite <input type="checkbox"/> with friends or family members (other than parent/guardians)  <b>CONTINUE:</b> If you have checked a box in Section A, complete # 2 and the remainder of this form.	<input type="checkbox"/> Choices in Section A do not apply    <b>STOP:</b> If you have checked this Section, you do NOT need to complete the remainder of this form. Please submit to school personnel.

2. Does the student live with:

- |   |  |
|---|--|
| <input type="checkbox"/> One (1) Parent                   | <input type="checkbox"/> A Relative, Friend(s), or other adult             |
| <input type="checkbox"/> Two (2) Parents                  | <input type="checkbox"/> Alone with no Adults                              |
| <input type="checkbox"/> One (1) Parent and another adult | <input type="checkbox"/> An adult that is not the parent or legal guardian |

Name of Parent(s)/Legal Guardian: PLEASE PRINT	
Mailing Address, State, Zip Code	
Phone Number:	
Signature of Parent/Legal Guardian:	

**For Official Use Only:**

If the parent has checked Section B above, completion of this form is not required.

For any choices in Section A, this form must be completed and provided to School Registrar immediately after completion. Form will be kept separately from the Student Cumulative Record for audit purposes during the school year.

School Administrator's determination of Section A circumstances:	
School Contact Person who may know of the family's situation & Phone #:	
Date Faxed to the Office of Coordinator:	



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## Release of Records

Office of Registrar

Student Name	Date of Birth	Grade

The above named student has recently enrolled at First Mesa Elementary School. To ensure proper placement and services, please forward this student's academic and health records, including but not limited to, the following:

Academic & Attendance Records	Special Education Records (IEP & 504 Plans)
Health & Immunization Records	Related Services Records i.e. Speech, OT/PT, etc.
Official Transcripts/Report Cards	Psychological Evaluation Records
Achievement Test Scores (AZ Merit/Stanford/etc.)	Gifted and Talented Records
Discipline Records	Birth Certificate
Official Withdrawal Forms	Tribal Enrollment/CIB

Record Released From (Previous School Name):	
Title/Department:	
Address:	
City/State/Zip:	
Phone Number:	
Fax Number:	

It is understood that the confidentiality of such records continue to be maintained. Thank you for your assistance and prompt attention to this request.

Parent/Guardian Signature: \_\_\_\_\_

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

Name/Title of School Official: \_\_\_\_\_

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

Signature of School Official: \_\_\_\_\_

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

*NOTE: According to the Education Amendments of 1974, "Protection of the Rights and Privacy of Parents and Students," Section 438, Subsection (B) (1), Parts A & B, Page 97; School Officials, including teachers with the educational institution and office of other school in school systems in which the student may intend to enroll, may receive a student's record without a written consent for such release. Also pursuant to State Law 15-828, Paragraph F; no school shall withhold records due to financial debts.*

### For Official Use Only

1 <sup>st</sup> Request	2 <sup>nd</sup> Request	3 <sup>rd</sup> Request



DEPARTMENT OF HEALTH & HUMAN SERVICES



Public Health Service  
Indian Health Service

Hopi Health Care Center  
P.O. Box 4000  
Highway 264, MM 388  
Polacca, Arizona 86042

Influenza and COVID Vaccination Clinic  
2024-2025 PARENT CONSENT FORM

**Section 1: Information about Student to Receive Vaccine(s) - (please print)**

STUDENT INFORMATION		
<u>Last Name</u>	<u>First Name</u>	<u>Middle Initial</u>
<u>Student's Date of Birth</u>	<u>HHCC Chart #</u>	<u>Student's Gender</u> Male or Female
PARENT / LEGAL GUARDIAN		
<u>Last Name</u>	<u>First Name</u>	<u>Middle Initial</u>

**Section 2: Student Health History**

	YES	NO
1. Does the student have a serious allergy to eggs or previous dose of Flu?		
2. Is the student sick today?		
3. Does the student have allergies to medications, food or other: (if yes, please list below)		
4. Has the student had a serious reaction to any vaccine in the past?		
5. Last dose of the COVID-19 vaccination? _____		
6. Does the student have a health condition or undergoing treatment (i.e. cancer, leukemia, or AIDS), that makes them moderately or severely immunocompromised?		
7. Has the student had a allergic reaction to any component or previous dose of the COVID-19 vaccine?		
8. Does the student take Cortisone, Prednisone, other steroids, anti-cancer drugs or x-ray treatments?		
9. Has the student received a transfusion of blood plasma or a medicine called Gamma Globulin?		
10. Is the student pregnant or at risk of becoming pregnant within the next month? ** First day of Last Menstrual Period (Date): _____ **		

**Section 3: Consent for Immunization(s)**

<input checked="" type="checkbox"/> <b>I GIVE CONSENT FOR:</b> (I have read and understand the VIS form(s) attached) ___ Flu      ___ COVID Monovalent  _____ <b>Signature of Parent / Legal Guardian</b>	_____ <b>Date</b>
<input checked="" type="checkbox"/> <b>** Parent/Legal Guardian Contact Phone #:</b> _____	

Please return consent to the student's school as soon as possible.

For more information about the immunizations, please call the Hopi Health Care Center PHN office at (928) 737-6257.