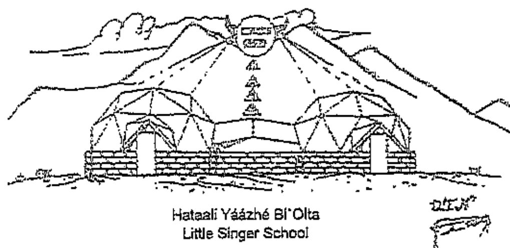


WELCOME TO:

LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * Phone: (928) 686-6108 * Fax: (928) 686-6207

Listed below is important information you must provide to enroll your child (ren):

1. Kindergarten: a child is eligible for admission if he/she is five (5) years of age prior to September 30, of the current school year.
2. You **must have a current updated** documentary proof of the required immunization
3. Social Security Card
4. Census Number and/or Certificate of Indian Blood
5. Copy of Birth Certificate
6. Current transcript/report card from last previous school attended

Please note:

- All above documents must be on file before we can accept your child (ren) for enrollment.
- Absences: a student absent for ten consecutive days of unexcused absences will be withdrawn from enrollment.

School Board Members: President: Mr. Leslie Williams * Vice-President: Harry Wagoner * Secretary/Treasurer: Ms. Verna Yazzie * Member: Mrs. RoseBell Walker

OMB Control No. 1076-0122 (Expires: 08/31/2018)

Hataali Yáázhé Bi'Olta
Little Singer School

LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * Phone: (928) 686-6108 * Fax: (928) 686-6207

STUDENT ENROLLMENT APPLICATION

Type of School:	Funding:	School Year:
(X) Day	( ) Pub.Law 100-297	( ) 15/16
( ) Boarding	(X) Pub. Law 93-638 Contract	( ) 16/17
( ) Dormitory	( ) BIA Operated	(X) 17/18

Student's Name: ______________________ (LAST / FIRST / MIDDLE) Grade Applying for: ________

Date of Birth: ________ Gender: ( ) M ( ) F Place of Birth: ________

Census Number: ________ Tribal Affiliation: ________ Degree Indian: ________

Agency Name: ________ Home Phone Number: ________

Mother's Name: ________ Work Phone Number: ________

Email Address: ________ Cell Phone Number: ________

Census Number: ________ Tribe: ________ Agency: ________

Father's Name: ________ Work Phone Number: ________

Email Address: ________ Cell Phone Number: ________

Census Number: ________ Tribe: ________ Agency: ________

Guardian's Name: ________ Work Phone Number: ________

Email Address: ________ Cell Phone Number: ________

Census Number: ________ Tribe: ________ Agency: ________

Mailing Address: ________

Physical Address: ________

Name/Phone Number of person to contact if parent cannot be reached: ________

Student Participated in Special Education: ( )Yes ( )No

Name of Previous School Attended: ________ Grade Completed: ________

Address: ________ Phone Number: ________

Reason for Leaving: ________

Dominant language spoken in the home: (1) ________ (2) ________

I AM LEGALLY RESPONSIBLE FOR MY CHILD AND HEREBY APPLY FOR HIS/HER ADMISSION TO THIS SCHOOL. I UNDERSTAND THAT ADDITIONAL INFORMATION MAY BE REQUESTED BEFORE THE STUDENT IS ENROLLED.

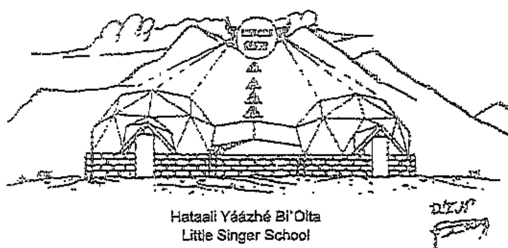
Signature of Parent/Guardian: ________ **Date:** ________

* *

School Application: ( )Approved ( )Not Approved Principal Signatuare: ________

Signature of Agency Official: ________ **Date:** ________

School Board Members: President: Mr. Leslie Williams * Vice-President: Harry Wagoner * Secretary/Treasurer: Ms. Verna Yazzie * Member: Mrs. RoseBell Walker



LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * Phone: (928) 686-6108 * Fax: (928) 686-6207

STUDENT'S TRAVEL AUTHORIZATION

I, (We) hereby grant permission for my, (Our) child:

______________________________ ____________
Child's Name Grade

participates in field trips. I understand that my child will be properly chaperoned and all precautions will be taken to insure his/her safety. The purpose field trips may include the following: Recreational, School Clubs, Town Trips, On-Reservation, Off-Reservation, Overnight, Out-Of-State, Extracurricular and others.

Out-of-State Trips must have School Board approval with separate signed parental permission slip.

Instructional Goals: To develop a continual Bilingual and Bicultural program incorporating a curriculum with Navajo and English components for Navajo Students in grades Kindergarten through sixth inclusively.

PERMISSION IS GRANTED FOR MEDICAL ATTENTION, IF ANY ACCIDENT OCCURS AND SUCH MEDICAL HELP IS NEEDED, I ALSO RELIEVE THE SCHOOL FROM ANY LIABILITY FOR INJURY DURING THIS FIELD TRIP TO MY CHILD.

______________________ ______________________________
Date Parent/Guardian Signature

School Board Members: President: Mr. Leslie Williams * Vice-President: Harry Wagoner * Secretary/Treasurer: Ms. Verna Yazzie * Member: Mrs. RoseBell Walker

State of Arizona
Department of Education
Office of English Language Acquisition Services

Primary Home Language Other Than English (PHLOTE)
Home Language Survey

(Effective April 4, 2011)

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

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

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 ______________________________ Student ID ______________

Date of Birth ______________________________ SAIS ID ______________

Parent/Guardian Signature __________________________ Date ____________

District or Charter ____

School ____

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

In SAIS, please indicate the student's home or primary language.

1535 West Jefferson Street, Phoenix, Arizona 85007 • 602-542-0753 • www.azed.gov/oelas

OMB Number 1810-0021

U.S. DEPARTMENT OF EDUCATION
OFFICE OF INDIAN EDUCATION
WASHINGTON, DC 20202

TITLE VII STUDENT ELIGIBILITY CERTIFICATION

Elementary and Secondary Education Act, Title VII, Part A, Subpart 1

Parents: Please return this completed form to your child's school. In order to apply for a formula grant under the Indian Education Program, your child's school must determine the number of Indian children enrolled. Any child who meets the following definition may be counted for this purpose. You are not required to complete or submit this form to the school. However, if you choose not to submit a form, the school cannot count your child for funding under the program. **This form will become part of your child's school and will not need to be completed every year. This form will be maintained at the school** and information on the form will not be released without your written approval.

Definition: Indian means any individual who is (1) a member (as defined by the Indian tribe or band) of an Indian tribe or band, including those Indian tribe or bands terminated since 1940, and those recognized by the State in which the tribe or band reside; or (2) a descendent in the first or second degree (parent or grandparent) as described in (1); or (3) considered by the Secretary of the Interior to be an Indian for any purpose; or (4) an Eskimo or Aleut or other Alaska Native; or (5) a member of an organized group that received a grant under the Indian Education Act of 1988 as it was in effect October 19, 1994.

NAME OF CHILD ______________________ Date of Birth ______________

School Name LITTLE SINGER COMMUNITY SCHOOL Grade ______________

NAME OF TRIBE, BAND OR GROUP ______________________

Tribe, Band or Group is: (check one)

☐ Federally Recognized, Including Alaska Native ☐ State Recognized ☐ Terminated ☐ Organized Indian Group Meeting #5 of the Definition Above

Name of individual with tribal membership: ______________________

Individual named is (check one): ☐ Child ☐ Child's Parent ☐ Child's Grandparent

Proof of membership, as defined by tribe, band, or group is: ______________________

A. Membership or enrollment number (if readily available) ______________ (OR)

B. Other (explain) ______________________

Name and address of organization maintaining membership data for the tribe, band or group:

____

I verify that the information provided above is accurate: ______________________

PARENT'S SIGNATURE ______________________ DATE ______________

Mailing Address ______________________ Telephone ______________

PAPERWORK BURDEN STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collectoin 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 imporving 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., FOB-6/Room 3W111, Washington, D.C. 20202-6335.

Hataali Yáázhé Bi'Olta
Little Singer School

LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * Phone: (928) 686-6108 * Fax: (928) 686-6207

SCHOOL PERMISSION CHECK-OUT FORM

Student's Name: ______________________ Grade: __________

Student's Name: ______________________ Grade: __________

Student's Name: ______________________ Grade: __________

Student's Name: ______________________ Grade: __________

My child(ren) listed above can be checked out only by the following person(s) listed below:

NAME OF PERSON (Must be 18 years old to check out the child)	RELATIONSHIP

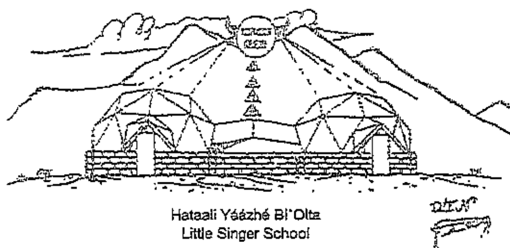
The following people may **not** check out my child: **(must have legal court document on file)**

NAME OF PERSON	RELATIONSHIP	REASON FOR DENIAL

______________________ Parent/Guardian Signature

__________ Date

School Board Members: President: Mr. Leslie Williams * Vice-President: Harry Wagoner * Secretary/Treasurer: Ms. Verna Yazzie * Member: Mrs. RoseBell Walker



LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * Phone: (928) 686-6108 * Fax: (928) 686-6207

REQUEST FOR STUDENT RECORDS

STUDENT'S NAME______________________________ **DOB**____________ **GRADE**__________

Name of School Last Attended____

Address________________________________City______________State__________Zip________

Phone Number____________________________Fax Number______________________________

PLEASE SEND THE FOLLOWING INFORMATION:

- Transcript/Report Cards or Withdrawal grades
- AIMS/Achievement Test Scores
- Immunization/Health records
- Discipline & Attendance
- Birth Certificate
- Certificate Indian Blood
- **IF AVAILABLE** send Met or Psychological or Psychiatric Records, Special Ed, IEP records. Please forward to ATTN: SPED Teacher. **Send ASAP!!**

While I understand that educational records may be sent without written consent, I also request that psychological, speech education and other pertinent information be sent. **Thank you in advance for your help and cooperation.**

______________________________________ ____________________

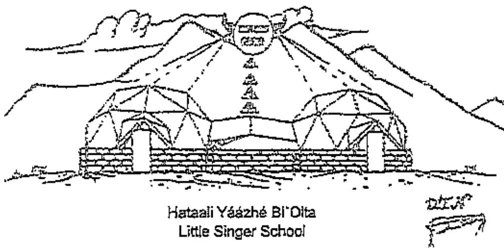
Parent/Requester's Signature Date

1st Request:_______________

2nd Request:_______________

3rd Request:_______________

School Board Members: President: Mr. Leslie Williams * Vice-President: Harry Wagoner * Secretary/Treasurer: Ms. Verna Yazzie * Member: Mrs. RoseBell Walker



LITTLE SINGER COMMUNITY SCHOOL

P.O. Box AQ * Winslow, Arizona 86047 * Phone: (928) 686-6108 * Fax: (928) 686-6207

Photo/Videotape Release Form

Throughout the school year, there may be times when Little Singer Community School staff, the media, or other organizations, with the approval of the school principal, may take photographs of students, audiotape/videotape students, or interview students for school-related stories in a way that would individually identify a specific student. Those photographs and/or audio/videotaped images or interviews may appear in school publications; on the Web; in the news media; or in other nonprofit, education-related organizations' publications. Please complete this form, and return it to your child's school.

❑ **I hereby grant unto my child's school and to the Little Singer Community School permission to use my child's photograph and/or videotaped image for the purposes mentioned above. I understand and agree that Little Singer Community School may use these photos and/or videotaped images in subsequent school years unless I revoke this authorization by notifying the school principal in writing. I further grant unto Little Singer Community School permission to allow my child to be photographed, audio/videotaped, or interviewed by the news media or other organizations for school-related stories or articles.**

❑ **Decline**

Student's Name: ____

Parents/Guardian Signature: ______________________________ Date: __________

School Board Members: President: Mr. Leslie Williams * Vice-President: Harry Wagoner * Secretary/Treasurer: Ms. Verna Yazzie * Member: Mrs. RoseBell Walker

LITTLE SINGER COMMUNITY SCHOOL
SCHOOL BUS AGREEMENT

Student's Name (PRINT):________________________ **Grade:**________ **Route:**____________________

Transportation of students is a privilege extended to students in this School Area. It is the responsibility of both the driver and the students to do everything possible to make it a safe ride. The privilege of a student to ride a school bus is contingent upon the continuous observation of the safety rules and acceptable behavior.

SAFETY REGULATIONS

1. Follow the Bus Driver's directions.
2. Arrive at your established bus stop TEN (10) minutes PRIOR to the bus's scheduled arrival time.
3. Bus driver shall assign seats; students shall keep the same seat all year unless driver makes the change.
4. Be courteous, profane language is NOT allowed on the bus.
5. Stay in your seat until the bus comes to a complete stop, face forward, avoids destructive or dangerous behavior.
6. Do not eat or drink on the bus.
7. Keep your body-that includes your head, hands and feet-inside your seat area, not outside the windows or in the aisle.
8. Do not smoke on the bus. No drugs or tobacco products of any kind are allowed on the bus.
9. Glass containers are NOT allowed on the bus.
10. Flammable materials, lasers, or weapons are NOT allowed on the bus.
11. Talk in a normal tone of voice.
12. Your bus conduct should be the same as what is expected in the classroom.
13. Students are responsible for the area in which they sit.
14. When you exit the bus and cross the street: walk 10 feet in front of the bus, look and listen for oncoming traffic.

I have read the bus safety regulations and understand them. I know that if I choose not to follow these rules and receive a SCHOOL INCIDENT REPORT, the following will happen:

1st Incident Report: My parents will be notified and I will be warned about the consequences of choosing not to follow the rules.
2nd Incident Report: My parents will be notified and I will have chosen to lose all bus riding privileges for a period of three (3) to five (5) days depending on the severity of the offense. I MUST arrange my own transportation to and from school.
3rd Incident Report: My parents will be notified and I will have chosen to lose all bus riding privileges for a period of up to two (2) weeks depending on the severity of the offense. I MUST arrange my own transportation to and from school.
4th Incident Report: My parents will be notified and I will have chosen to lose all bus riding privileges for the remainder of the school year. I MUST arrange my own transportation to and from school.

Certain very serious misbehavior may result in immediate removal of a student by administration.
I understand that school administrators and transportation personnel support each other in appropriate disciplinary action for the violation of these rules to include loss of bus privileges.

My signature below indicates my understanding of the school bus rules and the consequences if I choose not to follow them. I understand and agree to follow the rules. I have reviewed this agreement with my child. He/She understands the rules and we both understand the consequences of misbehavior on the bus.

________________	________________	________________
Print Mother's Name	**Print Father's Name**	**Family's Physical Address**
Mother's Daytime Phone #	**Father's Daytime Phone #**	**Other Contact Phone #**
Student's Signature	**Parent/Guardian Signature**	**Date**

Winslow Indian Health Care Center (WIHCC)
500 North Indiana Avenue
Winslow, Arizona 86047

PARENTAL/GUARDIAN CONSENT FOR SCHOOL HEALTH SERVICES

Full Name of Student____DOB__________________

Social Security#___________________________School___________________________________

I (We), ____

Authorize WIHCC to arrange for/ or to provide the following health services for my child while he/she is attending school and/or the dormitory:

1. Health care including medical examination, routine laboratory studies, x-ray procedures, and skin tests.
2. Dental care including dental examinations, preventive use of fluorides and sealants necessary routine & emergency dental care.
3. Mental health services including evaluation and treatment as necessary.
4. Emergency health care for accidents or illnesses.
5. Transportation of the child to and/or from another health care facility for these services.

I hereby give consent for all of the above services.

Exceptions or Special Instructions: ____
____
____

Print Name ____

Signature ____

Address ____

Relationship ____

For School Year_________________

PLEASE RETURN THIS FORM TO THE SCHOOL

White Copy--Medical Records　　Yellow Copy--School　　Pink Copy--Parent/Guardian

DATABASE

Winslow Indian Health Care Center
500 North Indiana Avenue
Winslow, Arizona 86047

IAME (LAST, FIRST, MIDDLE)	OTHER NAMES USED(MAIDEN NAME)	WIHCC NO.	SEX M F

IRTH DATE	PLACE OF BIRTH (CITY, STATE)	SOCIAL-SECURITY NO.	MARITAL STATUS	INTERNET Y N

URRENT COMMUNITY	DATE MOVED	LOCATION OF HOME (DIRECTIONS TO YOUR HOME, ETC. PLEASE BE SPECIFIC.)

IAILING ADDRESS	CITY/STATE	ZIP CODE

IOME PHONE NUMBER	MESSAGE PHONE NUMBER	WORK PHONE NUMBER

INDIAN BLOOD QUANTUM	TRIBE	DEGREE	CENSUS NUMBER	CIB Y N
	OTHER TRIBE	DEGREE	RELIGION	

ATHER'S NAME	CITY OF BIRTH	STATE OF BIRTH
IOTHER'S MAIDEN NAME	CITY OF BIRTH	STATE OF BIRTH

MPLOYER(IF APPLICABLE)	SPOUSE'S EMPLOYER(IF APPLICABLE)
MPLOYER'S ADDRESS	SPOUSE'S EMPLOYER'S ADDRESS
MPLOYER PHONE NUMBER	SPOUSE'S EMPLOYER PHONE NUMBER

F YOU ARE UNEMPLOYED, PLEASE GIVE SOURCE OF INCOME

___UNEMPLOYMENT ___RETIREMENT ___SSI ___SSB WELFARE___ OTHER___

AME OF EMPLOYER (FATHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER
AME OF EMPLOYER (MOTHER)18 & UNDER	EMPLOYER ADDRESS	EMPLOYER TELEPHONE NUMBER

MERGENCY CONTACT PERSON		NEXT OF KIN CONTACT PERSON	
ELATIONSHIP	PHONE NUMBER	RELATIONSHIP	PHONE NUMBER
DDRESS		ADDRESS	

HEALTH INSURANCE INFORMATION

DO YOU HAVE MEDICARE COVERAGE?	YES	NO	DO YOU HAVE RAILROAD RETIREMENT COVERAGE?	YES	NO
DO YOU HAVE AHCCCS (MEDICAID)?	YES	NO	DO YOU HAVE PRIVATE INSURANCE COVERAGE?	YES	NO

ILITARY SERVICE?	YES	NO	BRANCH	CLAIM NUMBER	ENTRY DATE	SEPARATION DATE

IETNAM VETERAN?	YES	NO	SERVICE CONNECTED?	YES	NO

OUSEHOLD INFORMATION: How many family members in your household – including children?

PLEASE READ AND SIGN CAREFULLY

authorize Winslow Indian Health Care Center to release any medical information or records necessary to process my Medicare, Medicaid or other insurance aims. I authorize my insurance company to pay medical benefits directly to Winslow Indian Health Care Center. If I am a non-beneficiary, I understand co-yments and deductibles will be requested at the time of service. I understand that I will be responsible for all costs if my account should be turned over to llections.

GNATURE OF PATIENT, PARENT OR GUARDIAN	DATE

Patient Medical History- Mobile Dental Clinic

WIHCC - Dental Department - 500 North Indiana Avenue, Winslow, Arizona 86047

Name: (Last,First,Middle) Please Print*	WIHCC Chart Number:	School Name:
Have you been a patient in the hospital within the last two years? If YES, please write specifics of visit / admittance.		
Please list any medications and/or substances / drugs that you are now taking, or have taken in the last year. Please be specific.		

PLEASE ANSWER EACH QUESTION WITH SPECIFIC STATEMENT

YES	NO	Are you allergic to any medications? Please list items:	
YES	NO	Chest pain or heart attack	Date of Attack:
YES	NO	Heart Murmur	Date of Diagnosis:
YES	NO	Heart Valve Replacement Surgery or Heart Surgery	Date of Surgery:
YES	NO	Rheumatic Fever	
YES	NO	Pacemaker	
YES	NO	High Blood Pressure	Have you taken your medication(s) today?
YES	NO	Stroke	
YES	NO	Epilepsy or Seizures	
YES	NO	Do you, or a relative have Diabetes?	Have you taken your medication(s) today?
YES	NO	Arthritis or Rheumatism	
YES	NO	Artificial Joint / Dentures	Which joint / Denture?
YES	NO	Asthma	
YES	NO	Tuberculosis	
YES	NO	Sinus Trouble	
YES	NO	Ulcers	
YES	NO	Kidney Disease or Dialysis	
YES	NO	Cancer or Tumors	
YES	NO	Hepatitis or Liver Disease	
YES	NO	Blood Transfusions	
YES	NO	Sexually Transmitted Disease	
YES	NO	Have you ever had any severe or uncontrolled bleeding?	
YES	NO	Have you been exposed to the AIDS Virus?	
YES	NO	Are you HIV positive?	
YES	NO	Do you use Alcohol?	
YES	NO	Do you use tobacco?	
YES	NO	Do you have any concerns about receiving Dental treatment?	
Please list any other medical conditions that you may have:			

FEMALES ONLY

YES	NO	Are you Pregnant?
YES	NO	Are you on Birth Control?
Date of last Menstrual Period:		

Comments:

PARENTAL CONSENT

I understand that behavior management of children is an important part of quality dental care for my child. I consent to the following techniques:

A. Parent may be asked to leave treatment area.
B. Only the Dentist or Dental Assistant speaks to the child.
C. Voice Control – We may use a firm voice.
D. Physical Restraint can include holding child to use of papoose board.

Also, the following instrument may be used: a. Rubber dam b. Mouth Prop

WIHCC DENTAL CONSENT FORM

Preventative Restoration is hard plastic coatings which protect the grooved surfaces of permanent teeth. They seal the deep pits and fissures and prevent decay. Minor risks include gagging, swallowing/aspiration of required dental materials, and small temporary change in bite.
Standard Restorations are amalgam or tooth colored fillings that are placed after all decay (caries) is removed.
Fluoride Varnish Program can help reduce cavities.
Periodontal Programs teach your child about gum disease and its prevention. Additionally, we may be able to provide a cleaning for certain grades as time and resources permit. Minor after effects may include bleeding or sore gums.
Emergency dental services are available as needed. If emergency treatment is necessary informal consent will also be obtained from the child's legal guardian (parent, school, representative, etc.)

Anesthetic Risks Include: discomfort, rapid pulse, swelling, bruising, infection, anxious feelings, allergic reactions, and lip chewing in children. Anesthetics occasionally are not effective in some patients.

We participate in School Externship/Residencies; Dental Students & Hygiene Students may see you.

The above answers are true to the best of my knowledge. I give my consent for myself or my child under the age of 18 to receive routine care such as examinations, x-rays, cleaning or fillings and for any other type of dental care as explained by the dentist	
Signature or Thumbprint, Parent or Legal Guardian:	Date:
Signature of Dentist:	Date:

HEALTH HISTORY FORM
(To be filled out and signed by the parent)

Student's Name:______________________________ Grade:_______ DOB:_______________ Sex: ( ) Male ( ) Female

( ) Known eye condition or defect in vision ( ) Glasses worn ( ) Known hearing problems ( ) Uses hearing aid

( ) Chronic ear infection ( ) Myringotomy – tubes in ears ( ) Subject to any condition which may result in a classroom emergency?

If any checked, please explain____

____

Does student have any health or physical problem which might affect school attendance or participation in P.E.?______________

____

Please list any medication(s) student is now taking (Consent needed for medication given at school)__________________

____

Has your child had any surgery?__________If so, what kind?_______________________________

Does your child have any handicaps or deformities that might affect his/her school work?____________________

____

Operations:____________Nature_________Year____________ Fractures:_____________ Nature________Year__________

Tuberculin skin test: Positive reaction____________ Negative reaction_____________ Year________________

If student has had prolonged absences from school, state why and the doctor:_____________________________

____

Has student ever had contact with a T.B. patient: ( ) Yes ( ) No

Dates of last: Tetanus Booster________________ Chest X-ray________________

Does your child require or has he/she ever received special help for: ( ) Speech Therapy ( ) Learning Disabilities ( ) EMH

( ) Physical handicap ( ) Emotional handicap ( ) Gifted

Other:____

Do you have any children or do you know of any children under age 21 who are handicapped and not in any educational program?

____

If emergency service involving medical action or treatment is required and neither the parents nor guardians can be contacted, I hereby consent for the student named above to be given medical care by the doctor selected by the school.

Name of Family Physician:____

Yes	No	Check each item	Yes	No	Check each item	Yes	No	Check each item
		Allergy to insect stings			Heart murmur			Orthopedic shoes, braces, etc.
		Allergies/Hay Fever			Hepatitis			Pneumonia
		Anemia			Hernia			Polio
		Arthritis			Hives			Rheumatic fever
		Asthma			Hyperactivity			Scoliosis
		Chicken Pox			Kidney trouble			Sinus trouble (severe)
		Concussion			Measles			Sore throats (chronic)
		Diabetes			Mental health concerns			Strep infection
		Eczema			Menstrual cramps (severe)			Tuberculosis
		Emotional problems			Migraine headaches			Whooping cough
		Epilepsy			Mononucleosis			**Others:**
		Fainting (frequent)			Mumps			**Others:**

Parent or Guardian Signature:______________________________ Date:____________________