San Sim:on School

HC01 Box 8292 Sells, AZ 85634

Phone: (520) 839-4546 Fax: (520)362-2405

https://sss.bie.edu/

2026-2027 Enrollment Packet

This packet contains the document information necessary for your child to be enrolled at San Simo:n Elementary School.

ALL DOCUMENTS AND INFORMATION REQUESTED MUST BE COMPLETED AND RETURNED INTO THE SCHOOL OFFICE BEFORE YOUR CHILD CAN ATTEND SCHOOL.

The school staff are available to assist you in completing the packet or providing translation if requested. A complete enrollment application is required by LAW to protect the student, family, school, and for the purpose of generating funds for operating the school.

SAN SIMON SCHOOL
HC01 Box 8292 Sells, AZ 85634
Phone: (520) 362-2231 Fax: (520)362-2405
https://www.sansimonindians.org/

Enrollment Application Checklist

This packet contains the following items which are necessary for admission at San Simon School:

- ☐ Student Enrollment Information
- ☐ Emergency & Release Information Form
- ☐ Physical Location of Home and Map
- ☐ Medical Consent/Allergy Information Form
- ☐ Permission to Publish Pictures Form
- ☐ Home Language Survey Form
- ☐ McKinney Vento Questionnaire
- ☐ Request for Transcripts Form (if applicable)

Documents required for enrollment, please attach copies of the following documents:

- ☐ Certificate of Indian Blood (CIB) or letter of enrollment
- ☐ Birth Certificate
- ☐ Current Year Immunization Record

If applicable, the following documents are needed to complete the enrollment packet:

- ☐ Guardianship Documentation
- ☐ Official Grades from the last school attended and an Official Withdrawal Slip

Complete all parts of the application. If there are any questions or you need assistance in completing the application packet, please contact the school at 520-839-4546

A Parent/Guardian Signature is required on several of the pages.

Pages that request a signature:

- ☐ Page 4 Student Enrollment Application
- ☐ Page 6 Student Emergency Information and Check out Permission Form
- ☐ Page 7 Permission to Publish Picture
- ☐ Page 8 Permission to Give "Occasional" over the counter medication.
- ☐ Page 9 Tohono O'odham Dental Clinic Form
- ☐ Page 10 Indian Health Services Consent Form
- ☐ Page 11 Tohono O'odham Nation Health Care Consent Form
- ☐ Page 12 Healthy O'odham Promotion Program Parent Consent For
- ☐ Page 13 McKinney-Vento Education for Homeless Children & Youth Program Student Housing Questionnaire
- ☐ Page 14 Eye Exams & Glasses Consent Form
- ☐ Page 15 School Records Release Form

Student Enrollment Application for Students Enrolled in Bureau-Funded Schools

Name of School:

Type:	Funding:
Day School ( )	Pub. Law 100-297 Grant ( )
Boarding School ( )	Pub. Law 93-638 Contract ( )
Peripheral Dormitory ( )	BIA Operated ( )

1. Student Name:

Last: First: Middle Initial:

Address: Street:

City: State: Zip Code

Miles from home to school:

Date of Birth: Place of Birth:

Month Day Year

Sex: Male( ) Female( ) Verified by:

Tribal Affiliation: Degree Indian:

Enrollment Number: Home Agency:

Dominant Language spoken in the home: (1.) (2.)

2. Family Information	
Father:	**Mother:**
Address:	**Address:**
Tribal Affiliation:	**Tribal Affiliation:**
Home Agency:	**Home Agency:**
Enrollment Number:	**Enrollment Number:**
Living: ( ) Dead: ( )	**Living: ( ) Dead: ( )**
Occupation (Optional)	**Occupation (Optional)**
Employer:	**Employer:**
Home Telephone:	**Home Telephone:**
Work:	**Work:**
Emergency:	**Emergency:**
Other (specify)	**other (specify)**

Legal Guardian: Address: Tribal Affiliation: Home Agency: Enrollment Number: Occupation (Optional): Employer:	Other (group home, etc.): Address: Telephone: Student Lives With: Telephone Home: Work: Emergency: Other (specify)

3. School(s) Previously Attended:

School Name: Address: City/State:	Dates: Attended: Reasons for Leaving:	Grades: Completed:
School Name: Address: City/State:	Dates: Attended: Reasons for Leaving:	Grades: Completed:
School Name: Address: City/State:	Dates: Attended: Reasons for Leaving:	Grades: Completed:

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.

Signature of Parent/Legal Guardian Date:

Date Enrollment: Approved:	Not Approved:	Principal	Date

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Village and Physical Location of Home: (Use Specific Description)

_____

_____

_____

Please draw a map of the location of your home.

N

S

Student Check Out School Year 2026-2027

Student Name: _____
First **Middle** **Last**

Male( ) **Female( )** **Date of Birth:**_____ **Grade:**_____

Village_____ **District**_____

Parent(s)/Guardian Name_____

Mailing Address: _____

Email: _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____

Who can we contact in case of emergency if we cannot find the parent/guardian?

Name: _____ **Phone Number:** _____

List any allergies or medical conditions the school should be aware of:

_____

_____

_____

The Following people have my permission to check my child out of school.

Name:	**Relationship to Student**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Parent/Guardian: _____ **Date:** _____

Principal: _____ **Date:** _____

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Permission to Publish Pictures

I,_____hereby,

Parent Name

_____give permission

_____do NOT give permission

.....to San Simo:n to publish pictures of my child

_____in appropriate media sources for purpose relating to school functions.

Parent Signature_____ Date_____

Arizona Department of Education

Office of English Language Acquisition Services

Home Language Survey

The responses to this Home Language Survey (HLS) are used by the school to provide the most appropriate instructional programs and services for the student. **The answers below will determine if a student will take the Arizona English Language Learner Assessment (AZELLA).** Please respond to each of the three questions as accurately as possible. If you need to correct any of your responses, this must be done **before** the student takes the AZELLA Placement Test.

1. **What language do people speak in the home *most* of the time?**

   _____

2. **What language does the student speak *most* of the time?**

   _____

3. **What language did the student *first* speak or understand?**

   _____

Student Name_____ District Student ID_____

Date of Birth_____ SSID_____

Parent/Guardian Signature_____ Date_____

District or Charter_____

School_____

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

In AzEDS, please enter all three HLS responses.

These HLS questions are in compliance with Arizona Administrative Code (R7-2-306(B)(1),(2)(a-c). (Revised 05-2023)

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Sells, Arizona 85634
Telephone (520) 362-2231 Fax: (520) 362-2405

PARENT PERMISSION TO GIVE "OCCASIONAL" OVER-THE-COUNTER MEDICATION

Student Name_____ Teacher_____ Grade_____

Over-the-counter (OTC) medication are drugs that do not require a prescription and are purchased "over-the-counter." This form is required before over-the-counter medication can be administered at school.

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

_____ I approve all medication listed below.
_____ I do not want any OTC meds given to my child.
_____ I only approve the medication listed with my initials.

ORAL:

_____ Acetaminophen (i.e., Tylenol)
_____ Antihistamine (i.e., Benadryl)
_____ Ibuprofen (i.e., Advil, Motrin)
_____ Cough Drops
_____ Pepto Bismal
_____ Midol (Menstrual Period Relief)

TOPICAL:

_____ Antibiotic Cream (i.e., Neosporin)
_____ Benadryl Spray (i.e., Caladryl, Diphenhydramine)

Medication for elementary students will be given by staff.

I further agree to hold the designated person(s) harmless to any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

THE MEDICATIONS INDICATED ABOVE WITH MY INITIALS MAY BE ADMINISTERED TO MY STUDENT

_____ _____
(Signature of Parent or Guardian) (Date)

TOHONO O'ODHAM NATION SELLS HOSPITAL
DENTAL CLINIC
P.O. BOX 548
SELLS, AZ 85634
(520)383-7341

CHILD'S NAME: _____ **D.O.B.** _____
(Please print)

MEDICAL HISTORY: Please check all that apply, if **yes**, please briefly explain.

	YES	NO		YES	NO
Allergies			Liver disease/ Hepatitis		
Heart Murmur			Bleeding tendencies		
Diabetes Mellitus			Heart Vascular disease		
Medication Usage			Latex Allergy		
Convulsion/Seizure			Under Doctors Care		
Rheumatic Fever			Other		
Asthma					

Dear Parents:

We need your permission to provide Dental Screenings, Fluoride treatments, Silver Diamine Fluoride applications, Brushing, Flossing and Sealants for your child at school, you do not need to be present. A dental screening is a brief look at teeth and gums checking for cavities and the health of the gums. Fluoride treatment is Fluoride varnish brushed on the teeth, Fluoride strengthens teeth. Silver Diamine Fluoride application (SDF) is a liquid antimicrobial agent placed on teeth to prevent or slow the growth of cavities. Dental sealants are thin coatings painted on the chewing surfaces of the back teeth that may prevent cavities for many years. **WE CANNOT DO A SCREENING EXAM AND TREATMENT FOR YOUR CHILD UNLESS YOU FILL OUT THE FOLLOWING INFORMATION AND SIGN BELOW GIVING US PERMISSION. PLEASE RETURN THIS FORM TO THE SCHOOL. THANK YOU!**

If you have any questions please contact the **TON Sells Dental Clinic (520)383-7341 or (520)383-7200 ext.5336**

Please circle one of the answers.

1. **YES-** I want my child to have Dental Screenings, Fluoride treatments, Brushing and Flossing, Sealants and Silver Diamine Fluoride (SDF) if necessary by the Tohono O'odham Sells dental staff.

2. **NO-** I do not want my child to have Dental Screenings, Fluoride treatments, Brushing and Flossing, Sealants and Silver Diamine Fluoride (SDF) by the Tohono O'odham Sells dental staff.

3. **I ONLY-** want my child to have:_____

_____

_____ _____
Signature of Parent/Guardian **Date**

Email (please print) _____ **Phone** _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

CONSENT OF PARENT OR LEGAL GUARDIAN OR OTHER PERSON* WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE CHILD

(Before completing this form, please read information on reverse side.)

Name of Student _____ Birth Date _____

I (We), _____
have read the Consent Form for the Indian Health to arrange for or to provide the following health services for this child:

1. Health care 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.

☐ I hereby give consent for all of the above services.

☐ Exceptions or Special Instructions: _____

_____

_____

Signed _____

Address _____

Relationship _____

Date _____ Valid Until: _____

PLEASE RETURN THIS FORM TO THE SCHOOL

(The third page of this form is for you to keep)

*Parent is defined as one who in the absence of the parent or legal guardian provides a home for the child such as next of kin.

HS-7
(rev)

COPY 1_(IHS RECORD)

TOHONO O'ODHAM NATION HEALTH CARE

School Health Program

Adolescent and School Based Health Clinic

CONSENT FOR ROUTINE IMMUNIZATIONS

Section 1: Student's Personal Information (Parent/ guardian must complete)

First Name,	Last Name	Birthdate (mo./day/yr.)	School	Teacher
Phone # (home, cell, work)				
Parent/Guardian Name		Your Relationship to this Student		

Section 2: Student's Health Checklist (Parent/ guardian must complete)

1) Has this student ever had a serious or life-threatening or allergic reaction to a vaccine or vaccine component? No ☐ Yes ☐
   If yes, describe: _____
2) Does this student have any medical conditions or severe allergies? No ☐ Yes ☐
   If yes, describe: _____
3) Has this student received a blood transfusion or a blood product in the past year (e.g. after surgery)? No ☐ Yes ☐
   If yes, describe product and date: _____
4) Does this student take medication (e.g. prednisone) or have a disease which lowers immunity (e.g. cancer)? No ☐ Yes ☐
   If yes, describe: _____
5) Has this student had chickenpox disease (varicella)? No ☐ Yes ☐
   If Yes, how old was child: _____
6) Has this student received any vaccines in the past 30 days? No ☐ Yes ☐
   If yes, specify vaccine(s): _____
7) Has this student ever received a vaccine outside of Arizona that is not on record with IHS? No ☐ Yes ☐
   If yes, specify vaccine(s), date(s) and location if known: _____

Insurance for VFC: Check all that apply for this student: ☐ AHCCCS, Medicaid, or CMPD ☐ Uninsured ☐ Kids Care
☐ Native American/Alaska Native ☐ Private Insurance ☐ Underinsured: health insurance, but coverage does not include vaccines

I understand the information in the immunization fact sheets provided to me. My questions have been answered to my complete satisfaction. I understand the benefits and possible reactions for these vaccines, and the possible risks to this student if they are not immunized. If this student has an adverse reaction to these vaccines, medical attention will be sought and public health informed. Unless cancelled in writing, I give Indian Health Service permission to give my child any of the below listed immunization due now and during the next twelve months.
Immunizations required by Arizona State Law: Diphtheria/Tetanus/Pertussis (DTaP), Tetanus/Diphtheria (Td), Meningococcal, Tetanus/Diphtheria/Pertussis (Tdap), Polio, Measles/Mumps/Rubella (MMR), Hepatitis B, and Varicella (Chicken Pox).
Immunizations recommended by American Academy of Pediatrics: Human Papilloma Virus (HPV4 series), Hepatitis A series, Influenza (Flu shot or nasal spray)

I consent for Student/patient to receive all above vaccinations: No ☐ Yes ☐
I consent for Student/Patient to receive the seasonal influenza vaccine No ☐ Yes ☐

Signature _____ Date _____

ANY QUESTIONS? Please call the HS School Health Program at (520)383-7328 or the Nurse Practitioner at your child's school
Enclosed: Vaccine Information Sheets for all above listed vaccines

Healthy O'odham Promotion Program
Screening Consent Form

Date: _____ **District/Community:** _____

				☐M ☐F
Child's First Name	**Child's Last Name**	**DOB**	**Age**	**Gender**

Doctor's Name: _____ **Doctor's Phone Number:** _____

I am being asked to read the following material to ensure that I am informed to the nature of the screening service. Signing this form will indicate that I have been informed of the procedure and risks and that I give my consent to have my child's pulse and random blood sugar checked, during the HOPP Pre & Post screening assessments for the 2023 – 2024 school year.

Risks

If I agree to have my child participate, I am aware that there are **NO** common serious risks when pulses to obtain heart rate are conducted; nor risks in obtaining blood from my child's finger; there may be temporary tenderness at the puncture site. There is a **rare** chance the puncture may lead to an **infection** at the sample site on the finger.

Confidentiality

By signing this consent form, I allow the Healthy O'odham Promotion Program to use my child's screening and patient care data for analysis and reporting. Data will be analyzed and reported only by groups of clients/patients who participate in various activities of this program. My child(s) name and other information will not be revealed.

Body Mass Index (BMI); I consent to the measurement of my child's height/weight to assess BMI	**Diabetes (high blood sugar); I** consent to the measurement of my child's blood sugar using a blood glucose meter (glucometer).	**Pulse;** I consent to the measurement of my child's pulse.
☐**Yes, I do** want my child's BMI taken	☐**Yes,** I do want my child's blood sugar taken.	☐**Yes, I Do** want my child's pulse taken.
☐**No, I do not** want my child's BMI taken	☐**No, I Do Not** want my child's blood sugar taken.	☐**No, I Do Not** want my child's pulse taken

_____ _____

Signature of Parent or Legal Guardian Date

If you have any questions about this testing, please call Healthy O'odham Promotion Program at 520-383-6240.

McKinney-Vento Education for Homeless Children & Youth Program
STUDENT HOUSING QUESTIONNAIRE

Information contained on this form is confidential and used to determine whether a child or youth meets the definition of homeless under the McKinney-Vento Act. The Education for Homeless Children and Youth (EHCY) program as authorized under Title VII-B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.). Please note, false claims about living situations may affect enrollment.

Section A

Today's date: _____

Name of individual completing this form: _____

Your telephone number: _____ Your email address: _____

Student name: _____

Last school attended: _____ Current grade: _____ Birth date: _____

Do you have additional children attending school in our district? Yes ☐ No ☐

Do you have children of the preschool age? Yes ☐ No ☐

Please provide information about additional children attending school in our district or of preschool age.

Last Name	First Name	Grade	School	District

Address of where the student slept last night: _____

Is this address based on a temporary living arrangement due to the loss of housing? Yes ☐ No ☐
(Examples: sharing the housing with others due to economic hardship or similar reason; hotel/motel; shelter; transitional housing; car; park; campsite; and inadequate housing, including no running water, electricity, or adequate space)

NOTE: If you checked "No" to the temporary living arrangement, you may STOP here. If you checked "Yes", please continue to the next section.

McKinney-Vento Education for Homeless Children & Youth Program
STUDENT HOUSING QUESTIONNAIRE

Section B

Name of the parent/guardian/adult caring for the student: _____

Relationship to the student: _____

If the address you provided in section A is based on a temporary living arrangement, is it due to loss of housing or economic hardship? Yes ☐ No ☐

Please place an "X" in each box that best describes where the student sleeps at night.

☐ In a place that does not have windows, doors, running water, heat, electricity, or overcrowded

☐ Staying with a friend or relative because of loss of housing, economic hardship, or similar reason
(Example: eviction, foreclosure, fire, flood, lost job, divorce, domestic violence, kicked out by parents, ran away from home)

What date did you begin staying here? _____

☐ In a shelter/transitional housing program (name of agency): _____

What date did you begin staying here? _____

☐ In an unsheltered location (e.g. tent, vehicle, abandoned building, streets, campground, park, bus/train station, or similar place)
Provide the main cross streets of this unsheltered location: _____

☐ In a hotel/motel (name of hotel/motel & address) _____

What date did you begin staying here? _____

☐ With an adult that is not a parent or court appointed legal guardian

☐ Alone, not in the care of a parent or court appointed legal guardian

☐ None of the above (Please explain): _____

_____

The following signature certifies that the information provided above is accurate. False claims about living situations may affect enrollment.

_____ _____
Signature of Person Providing Information Parent/Legal guardian/Caregiver/Student — Date

For School Use Only

Please note, the student's cumulative file should not include a copy of this form. **Do not make copies of this form.** If Section B is filled out, please notify the LEA Homeless Education Liaison, and provide the original form to them.

Name of school site personnel who enrolled the student: _____

Please check the housing types that apply:

Sheltered ☐ Doubled-up ☐ Unsheltered/FEMA/Substandard ☐ Hotel/Motel ☐

Unaccompanied youth: Yes ☐ No ☐ Transportation to school of origin needed: Yes ☐ No ☐

Date received by Homeless Liaison _____

San Simon - San Simon School District

www.CompleteVision.org
480-371-8167
info@CompleteVision.org

Complete Vision Care and your school have partnered together to bring mobile eye care to the school.

It is recommended that once children reach school-age they have their eyes tested at least every 1-2 years. Up to 80% of a child's learning in school is through their vision. Research shows that 1 in 10 children have a vision problem significant enough to impact their learning. With a thorough eye exam, we will assess your child's visual system to reassure you that their vision will not be a limiting factor in reaching their full potential.

At the initial visit, the doctor and technicians will thoroughly **assess the vision** at distance and near, **eye focusing**, **eye teaming**, and **eye movement** abilities. We will measure the presence of any refractive errors (**nearsighted**, **farsighted**, or **astigmatism**). We will perform a **comprehensive** eye exam to properly evaluate eye **health**. After completing the examination, the doctor will send a written report back to you via the school nurse. If referrals for further evaluation are needed, we will coordinate directly with the parents.

USE QR code to schedule your student
(or return this paper consent form)

Dr. Joshua Leonard & Dr. Jolie LeGate
Complete Vision Care, PLLC
PH: 480-371-8167
www.completevision.org
info@completevision.org

www.CompleteVision.org
480-371-8167
info@CompleteVision.org

San Simon - San Simon School District

EYE EXAMS AND GLASSES **COVERED** WITH AHCCCS INSURANCE
CONSENT TO TREAT MINOR

Use QR Code to give consent online (or return this form)

Complete Vision Care will be partnering with your school to provide eye exams to your child at school during school hours. A report will be filled out and sent home for each examination.

Patients full name:_____**DOB:**_____
AHCCCS Insurance plan: _____
Policy number for Child (A Number) _____
Other Insurance name: _____
Insured's name and DOB: _____
Parent / Legal Guardians Name:_____
Cell Number: _____
List any medical eye issues or major health concerns:_____

-To allow for treatment for patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. In the event that a minor child presents for a non urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

-If your child needs glasses, we will assist them in choosing a frame from our frame selection and we will communicate with the school nurse for delivery.

I hereby consent to:

A routine Comprehensive Eye Exam, which may include, assessing the visual and ocular health and fitting for and prescribing prescription glasses and billing insurance when indicated. I acknowledge that I have received and reviewed the practice's Notice of Privacy Practices, which explains how my health information may be used and disclosed for treatment, payment, and healthcare operations. I consent to the use and disclosure of my health information as necessary for my care, including communications regarding appointments, test results, and billing. I also give permission for Complete Vision Care to release my vision screening results to the school nurse for the purposes of the state-required vision screening. I understand that I have the right to request restrictions on the use of my information, but the practice is not required to agree to such restrictions. If further examination or testing is recommended, I/we agree to be contacted for further scheduling.

While dilation is not necessary for every student, by signing this form, I give Complete Vision Care permission to dilate my child if the doctor deems necessary to complete the comprehensive eye exam. I understand that dilation will cause temporary light sensitivity and blurry vision. (If dilation if a concern, please contact our office prior to the exam)

I/We authorize Complete Vision Care, PLLC to provide treatment and bill our insurance for an eye exam and glasses when indicated.

Signature of parent or legal guardian **Relationship to Patient** **Date**

SAN SIMON SCHOOL
HC01 Box 8292 Sells, AZ 85634
Phone: (520) 362-2231 Fax: (520)362-2405
https://www.sansimonindians.org/

School Records Release Form

Student Name: _____ Date of Birth: _____

I am requesting educational records from: (last school of attendance)

Name of School: _____ Phone Number: _____

City: _____ State: _____ Fax Number: _____

Documents: Bitrh Certificate and or guardianship documents, current immunization record, discipline records.

Progress Records: Include transcript of grades, test results related to achievement and measurement, records of attendance (including NWEA/MAP testing and state assessment.

Special Education Records: To include speech and language evaluations, educational assessment, student study team reports, most recent IEP, signed psychological reports, other eligibility data/determinations and behavior plans.

504 Plans All 504 Plans

To be sent to: **San Simon School**
Attn: Registrar
HC01 Box 8292 Sells AZ, 85634
Fax: (520)362-2495 Email: jessica.juan@bie.edu

I hereby authorize the release of all records for the above-named child.

Parent's Name: (Please Print): _____

Parent's Signature: _____ Date: _____