CROW CREEK TRIBAL SCHOOLS

DORMITORY APPLICATION

SCHOOL YEAR 2023-24

CCTS Residential Program

State of Purpose

The purpose of the CCTS Dormitory is to provide a traditional home-living environment to student attending Crow Creek Tribal Schools. WE are not a Therapeutic dormitory, so we may not be able to meet the needs of all students. All student applicants will be reviewed by the dormitory committee to determine if the CCTS residential program can meet each student´ residential need. Waiting list is in place if needed.

The Residential Program provides a home living environment, activities, and assists with academic requirements seven (7) days a week for students in 7th - 12th grade. The bedrooms are furnished for 1 - 4 students depending on the size of the room. The rooms are assigned by grade. Snacks are provided in the evenings.

- **Dormitory houses students in Grade 7th-12th. ALL NEW freshman students MUST have PHYSICALS for sports and/or DORMITORY. Please get physicals appointments for dormitory and sports BEFORE school begins.**
- **ALL DORMITORY students need Physicals & Notifications of ANY MEDS they are on OR have been on in the past, forms are attached.**
- **IMMUNIZATIONS [Mandatory] need to be updated w/ covid 19 Vaccine.**
- **A permission slip must be signed for FLU SHOTS.**
- **ANY HEALTH ISSUES OR ALLERGIES must be reported by calling the School Nurse or the Dormitory Supervisor at 605-852-2258 Ext. 265**

HEALTH CARE SERVICES are readily available through the school nurse and I.H.S. care. The off reservation students are screened by the School Nurse before they are taken to the I.H.S for their appointments.
The local parents are responsible for their students health needs as per I.H.S. requirement.
The Residential staff are certified in Cardiac Pulmonary Resuscitation, Automated External Defibrillator and Emergency First Aid.

Equine (Horse) Wellness Program

SUN'WAKAN WACINKICIYA
[Student/family/staff]

Mission Statement

Sun'wakan Wacinkiciya is an equine wellness program for students/family/staff. It exists to provide medicine with the horse in being one with each other and to connect with one another. WE learn to bring, create and pray to have medicine in hopes to mount our people, back on the horse. This equine wellness will help our students/families/staff to be strong and healthy with assisted activities for personal growth, equine education and connection for the community.

Imawakan'-the sound of my voice, has the ability to create or destroy.

APPLICATION CHECK OFF LIST

√ Check off List	Student FORMS/Documents	COMPLETE	COMMENTS
	Application Packet-Living Situation History, Behavior Issues, Social History-Counseling Guardianship Documentation is Mandatory Temporary Custody form attached if needed		
	Immunization Record w/ covid 19 **Physical**-MANDATORY **Medicaid/Health Insurance card (**copy)		
	Check Out Form-MANDATORY NOTARIZED		
	Student Health forms- Over the Counter Medication, Health History, and Medical Power of Attorney. Mandatory Notarized		
	Sun'wakan Wacinkiciya /Equine (Horse) Wellness student/family FORM		
	Indian Health Service •Patient Registration Forms •Authorization to Furnish Information• Notice to Patient • Acknowledgement Receipt of Privacy Practices, Authorization to Furnish Information •Notice to Patients-Consent Form		

PLEASE UPDATE ADDRESS

IF YOUR MAILING ADDRESS, PHONE NUMBER OR YOU MOVE (EVEN TEMPORARILY) YOU NEED TO NOTIFY THE SCHOOL and DORMITORY WITH THIS INFORMATION

Address for mailing to student

CROW CREEK TRIBAL SCHOOL
C/O DORMITORY
[STUDENT NAME]
103 Chieftain Road
Stephan SD 57346

Dormitory Contact Information

Phone: 605-852-2747 605.852.2737
ext. 274 (boys dorm) ext. 275 (girls dorm)
Fax: 605.852.2747
Email: Deanna.Eare@k12.sd.us

TRANSPORTATION –IF STUDENT is accepted, the dormitory will provide transportation. Our policy states if a student comes to the dormitory at beginning of year with the schools transportation the student will be eligible to be transported home during vacations and end of school year that way. If the student comes to dormitory with parent/guardian, student will be ineligible for transportation during vacations and end of school year.

The Dorm Council helps plan the monthly activities including, Monthly Incentive trips with staff.

•RECREATION
The **recreation** center has X-Box, PS3, and Wii. Intermural and canteen available.

•DORM-Student of the Month/Year incentives

•Counseling Services

•HONOR Dorm-students in academic standing in school and dormitory.

•STUDY HALL
Available from 3:30 - 4:30 PM Sunday - Thursday.
Teachers are available for students to help with homework.
•Computers on site

•LAUNDRY SERVICES
Available in each dorm for student use.
Detergent is provided or students may bring their own.

•SECURITY
Provided after school hours and overnights. Security is available at 605-852.2258 ext. 254 or 253

•TRANSPORTATION-off reservation students is provided (to and from home) for Thanksgiving, Christmas, and OTHER CIRCUMSTANCES.

Crow Creek Tribal Schools-Student Dormitory Application

[The Home Living Specialist will call each parent/guardian to review, prior to approval.]
Failure to provide an accurate response to all questions can result in denial of application.

Section I: Educational History (Please Print)

Student Name: _____Last Name _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Relationship to student: _____email: _____

Phone #s: Home _____ Cell _____ Work _____
Other phone #s for emergencies: _____; _____.

Mailing Address: _____ City _____ State _____ Zip _____

Mother Name: _____ **Father Name:** _____

Address: _____ **Address** _____

City: _____**State:** _____**Zip:** _____ **City:** _____**State:** _____**Zip:** _____
Contact #: _____Email: _____ Contact #: _____Email:___ _____
Employer: _____ Employer: _____
Address: _____ Address: _____
Phone #: _____Job Title:_____ Phone #: _____Job Title:_____

Check boxes below to indicate previous and current educational placements, if known.

Kind of Placement (check all that apply)	Previous	Most recent
Regular Classroom	❑	❑
Regular Classroom with in-class support and/or accommodations	❑	❑
Special Education Classroom/Resource Room	❑	❑
Alternative School	❑	❑
Treatment Program	❑	❑
Residential School and Dorm	❑	❑
Home and/or Hospital-based Instruction	❑	❑
Not in school – suspended	❑	❑
Not in school – expelled	❑	❑
Please describe educational placement(s) checked above:		

Section II: Living Situation History

Check boxes to indicate previous and current living situations, if known.

Type (check all that apply)	**Previous (Before)**	**Current (Now)**
One Parent (indicate Mother or Father):	❑	❑
Relatives	❑	❑
Foster Care	❑	❑
Group Home	❑	❑
Emergency Shelter	❑	❑
Residential Treatment (non-drug/alcohol)	❑	❑
Drug/Alcohol Residential Treatment Program	❑	❑
Medical Hospital	❑	❑

Psychiatric Hospital	☐	☐
Juvenile Center (JDC)	☐	☐
Correctional Facility (i.e. Custer)	☐	☐
Has a child	☐	☐
Has fathered a child or been pregnant	☐	☐

Section III: Behavioral Issues

Student's FULL Name: _____ **Date:** _____

Note to Parents/Guardians:

Your providing accurate information will help us provide your child with the best possible services to help her/him have a successful year in our dorm.

Has the child or youth ever exhibited any of the behaviors listed below? If yes, check those that apply.		
☐ Shows strong emotions	☐ Impulsive	☐ Stealing
☐ Extreme sadness	☐ Anxiety	☐ Depression
☐ Runs away	☐ Mood changes	☐ Hard time sleeping
☐ Eating disorder	☐ Hyperactivity	☐ Bladder/bowel problems
☐ Not accepting authority	☐ Refusal to accept limits	☐ Argues with others
☐ Verbal aggression	☐ Self-injurious behavior	☐ Persistent school refusal
☐ Anger towards self	☐ Anger towards others	☐ Cutting
☐ Expressed aggression towards people	☐ Expressed aggression towards property	☐ Tends to avoid social contact with others
☐ Expressed thoughts of suicide	☐ Shown suicidal behavior	☐ Suicidal attempts
☐ A family member or very close friend has committed suicide		
☐ Has a social services case worker	☐ Extreme withdrawal from family	☐ Serious sleep disturbance
☐ Fire setting/fire play	☐ Animal cruelty	☐ Problems with the law
☐ Missed more than 10 days of school last year	☐ Suspension (out of school) during past year	☐ Expelled from school during the past two years
☐ Huffing inhalants (paint, hairspray, glue, nail polish)	☐ Huffing "dusters" (aerosol air cleaners - to clean key-boards, etc.)	☐ Huffing alcohol-based products or other aerosol-type products
☐ Substance abuse	☐ Experienced trauma	☐ Inappropriate behavior
☐ Has been arrested	☐ Has a probation officer	☐ Bullying
☐ Special concerns or counseling help you would like to see for your child: (please list)		

Section IV: Social History – Counseling Information

Student's FULL Name: _____ Date: _____

[Failure to provide an accurate response to questions can result in denial of application or your child's immediate release from the CCTS Dorms.]

Has your child received any out-patient counseling or therapy for substance abuse, mental health or behavioral issues?
_____Yes _____No
If yes, please identify and describe what kind and have the Counselor or therapist send a report and recommendations to the Dorm Counselor, Crow Creek Tribal Schools Dorms.

Why did they seek counseling? _____
Name & Title of Counselor or
Therapist:_____

Address: _____
Phone Number: _____ Date(s) of Counseling: _____

Has your child ever received in-patient services treatment program for substance abuse, mental health or behavioral issues? _____ Yes _____ No
If yes, please have the treatment program send a report and aftercare recommendations to the Dorm Counselor, Crow Creek Tribal Schools Dorms.

Did they complete this? ____ Yes ____ No was this helpful? ____ Yes ____ No
Name of Treatment Program:

_____
Address: _____
Phone Number: _____ Date of Treatment: _____

Has your child ever been arrested? _____ Yes _____ No
Has your child ever received services from a correctional program? ____ Yes ____ No
If yes, explain. _____
Please have the facility send a report & recommendations to the CCTS Dorm Counselor.
Name of Correctional Facility:

_____
Address: _____
Phone Number: _____ Date of admittance: _____

Does your child have a Social Worker or Probation officer? If so, please provide name and contact information.

_____
Has your child ever been arrested or charged with a sexual offense? ____Yes ____No

As your child ever been a victim of sexual abuse? _____Yes _____No
If yes for either, please describe: _____
If yes, has your child/youth been in counseling? ____ Yes ____ No

Has your child displayed any anger against others or themselves? ____ Yes ____ No
If yes, please explain. _____

Does your child use "cutting" as a way to solve problems? _____ Yes _____ No
If yes, please explain.

_____

What is the cutting behavior? (i.e. possibly using a razor to cut their arms.)

Has your child missed more than ten days of school during the past school year? _____ Yes _____ No If yes, please explain:_____

Has your child been expelled during the past school year? _____ Yes _____ No
If yes, please explain:

_____

Has your child received an out-of-school suspension during the last school year?
If yes, please explain:

_____

Do you have any special concerns for which you would like the counselor to be aware?

_____

List any medications your child has been prescribed during the past year:

Name of medication(s)	Dosage	How often taken?

_____ _____ _____

Parent/Guardian (print) **Signature of Parent/Guardian** **Date**

☑ PHYSICAL INFORMATION

MANDATORY FOR DORMITORY STUDENTS

IF YOU ARE INTERESTED IN ANY KIND OF SPORTS AT CROW CREEK TRIBAL SCHOOLS PLEASE GO TO THE FOLLOWING SDHSAA WEB SITE FOR PHYSICAL FORMS

http://www.sdhsaa.com/

DORMITORY WILL accept THIS Physical.

CROW CREEK TRIBAL SCHOOLS

SCHOOL/I.H.S. COUNSELING CONSENT FORM

Student's Name: _____Grade: _____ Age:_____

CONSENT FOR COUNSELING SERVICES

Confidentiality and Limits to Confidentiality

Trust and honesty are crucial to the development of all therapeutic relationships. Therefore, we place high value on the confidentiality of information you share within you sessions. You should, however, be aware that legal, ethical and licensure requirements specify certain conditions in which it may be necessary for you provider to discuss information about you care with other professionals. If you have any questions about these limitations, please ask for provider before counseling begins.

Circumstances may occur:

- Danger that you may harm yourself or others, or are incapable for caring for yourself.
- Suspicion of abuse of children, elderly or disabled persons
- A Court Order to release you records.
- Your provider may sometime find it necessary to obtain professional consultation, in regards to the course of your care.
- Consultation regarding your case may be sought periodically with his/her supervisor and other colleagues only when needed.
- Your providers will inform you when he/she determines consultation is necessary. Your identity may or may not be disclose when this occurs.

I give permission for my child to receive counseling services from Crow Creek Tribal School or through Indian Health Services in Fort Thompson, SD. I understand that this service will be given if and when my child's behavior indicates the need. I understand that if I do not give consent for counseling services from the school or Indian Health Service, I must provide an outside source for counseling if deemed necessary.

I give consent for the school dormitory team to act as a Loco Parentis/Surrogate parent for my child in case my child may require emergency medical assistance or other complications that may arise during the school year.

I acknowledge that I fully understand what I have read. I understand that I will have an opportunity to ask questions as needed, and that I consent for my Son/daughter to participate in counseling with the CCTS School/Dorm and Ft. Thompson I.H.S. Behavioral Health Program if needed.

_

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

Crow Creek Tribal Schools

CHECK OUT FORM-[Dormitory Student]

CCTS Staff are NOT allowed to check out dormitory students at any time, unless under special circumstances approved by the Principal, Dormitory Supervisor or Superintendent.

Policy: Only immediate family members can check-out dorm students. Immediate family is defined (as Mother, Father, Legal Guardian, Sister, brother, Grandparent, aunt or uncle.) This person must be at least 25 years of age [BIE guidelines].

It is very important the Parent/Legal Guardian have this form complete and notarized for the safety of our students. Students will not be allowed to check out of the dormitory or school unless they are released to a person whose name appears on this permission form.

Student Name	Home Reservation

_____ _____

Print Parent/Legal Guardian Name **Phone # you can be reached at immediately**

_____

PO Box/Address **City** **State** **Zip**

- I hereby give the following adults permission to check out my son/daughter for week-ends or holidays.
- I understand that these adults must personally pick up the student and sign him/her out from the school (if during school hours) and from the dormitory.
- I understand that off reservation students may not check out to Ft. Thompson and surrounding communities for overnight unless with parents or legal guardian.
  (Handwriting must correspond to notarized signatures at bottom of the page)
- I also give the school permission to seek out adequate housing and transportation for my son/daughter during emergencies.

[List names of adults for consent to check out student from the dormitory]

_____ _____

_____ _____

_____ _____

_____

Print Parent/Gurardian Name

_____ _____

Signature of Parent/Legal Guardian Verified by Notary of the Public

_____ _____

Date My Commission Expires

CROW CREEK TRIBAL SCHOOLS

103 CHIEFTAIN ROAD – STEPHAN, SOUTH DAKOTA 57346

NURSING DEPARTMENT

School year 2023-24

ADMINISTRATION OF OTC (OVER THE COUNTER) MEDICATIONS
PARENT / GUARDIAN AUTHORIZATION FORM

I AFFIRM THAT I AM THE PARENT/GUARDIAN, _____

PRINT FULL NAME OF PARENT / GUARDIAN

OF MINOR CHILD (REN) LISTED BELOW:

CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE

Over-the-Counter medication are drugs that do not require a prescription and are purchased as "over-the-counter".

This form is a consent to allow school nurse(s) to administer OTC medications, including homeopathic/herbal medications and aspirin the following are over the counter medication:

Anti-biotic Cream (i.e. Bacitracin, Triple Anti-biotic Ointment)
Oral Products (i.e. Oragel, Chloroseptic)
Pseudoephedrin, Cough Drops)
Antipyretic (i.e. Tylenol)
Anti-septic Spray /topical (i.e. Bactine)
Antihistamine (i.e. Benedryl, Loratadine)
Antacids (i.e. Mylanta, Maalox, Tums)
Hydrocortisone Cream (i.e. Anti-Itch Relief)
Cold/Cough Medicine (Guaifenesin, Phenlephrine,
NSAIDS (i.e. Motrin, Advil, Ibuprofen)
Burn Relief Gel Eye Drops (i.e. Sodium Chloride)

PARENT / GUARDIAN SIGNATURE REQUIRED

_____ _____

Parent/Guardian Name [Please Print] **Date**

_____

Parent Guardian Signature

CROW CREEK TRIBAL SCHOOLS

103 CHIEFTAIN ROAD – STEPHAN, SOUTH DAKOTA 57346

School year 2023-24

CCTS STUDENT HEALTH HISTORY FORM
(NEW FORM NEEDED ANNUALLY)

1 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

2 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

3 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

4 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

5 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

6 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

7 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

8 Student Name:_____ Age: DOB: Gender: Male Female Grade:_____

****When Answering for different children, use their number in the "YES" or "NO"****

This is part of Paperwork Reduction Act (PRA), if you would like to answer a student health history for each child, request separate forms from the CCTS Nursing Department

STUDENT HEALTH HISTORY

	YES	NO	DOES YOUR CHILD HAVE OR HAD OR IS THERE A HISTORY OF:	YES	NO
Taking prescription medication or OTC Medication daily?			ASTHMA		
Does your child have a chronic illness? Please List:			RECURRENT COUGH		
Has your child ever been hospitalized? When? For?			BRONCHITIS		
Is your child allergic to any medications? Please List:			PNEUMONIA		
Does your child have any food allergies? Please List:			CORONA VIRUS / COVID-19		
Are your child's immunizations up to date?			ECZEMA		
Immunizations must be complete and current,			EAR INFECTION (S) CHRONIC? SEASONAL?		
Students will be dropped if not complete and current			TOOTH ACHE		
Is your child hearing impaired?			FREQUENT HEADACHES		
Do you want hearing devices/aids kept at school?			ABDOMINAL PAIN		
Is your child vision impaired?			CONSTIPATION		
Do you want your child's glasses stored at school?			BLADDER/KIDNEY / BEDWETTING		
Does your child have Diabetes?			HEART MURMUR/HEART CONDITION/DISEASE		
TYPE 1 OR TYPE 2 ? PLEASE PROVIDE INSULIN THERAPY			ANEMIA/BLEEDING/CLOTTING DISORDER		
TREATMENTS AND/OR MEDICATIONS			THYROID DISORDER		
Has your child been diagnosed with COVID19?			**PLEASE LIST HERE:**		
Is your child infected with COVID19 NOW?			ADD/ADHD		
When was your child infected? DATE:			MENTAL HEALTH ISSUES		
Has your child received COVID19 Vaccine?			USE OF DRUGS OR ALCOHOL		
If so, WHEN? DATE:					
WHEN IS 2ND VACCINATION DUE? DATE:			ANY MEDICAL CONDITIONS YOU ARE CONCERNED ABOUT &		
			THAT YOU WANT NURSING DEPT TO LOOK INTO?		

Any Medical Diagnosis CCTS should be aware of?_____

CROW CREEK TRIBAL SCHOOLS

103 CHIEFTAIN ROAD – STEPHAN, SOUTH DAKOTA 57346

NURSING DEPARTMENT

School year 2023-24

Medical Power of Attorney

(For the Care of a Minor Child)

I affirm that I am the parent and/or legal guardian of the minor child (ren) named below.

_____ _____

PRINT Parent / Guardian Full Name **Today's Date**

CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE
CHILD'S NAME	AGE/GRADE	CHILD'S NAME	AGE/GRADE

I, further, give consent to the **CROW CREEK TRIBAL SCHOOL NURSING STAFF, DORMITORY/RESIDENTIAL STAFF AND CROW CREEK TRIBAL SCHOOL STAFF** to provide the following health services for my child (ren):

1. Health care including medical examinations, routine laboratory studies, x ray procedures, and skin tests
2. Dental care including dental examination, preventative 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 (ren) to and/or from another health facility for these services.

I have read and UNDERSTAND this is a legal document and affirm my consent by signing my signature herein:

_____ _____

SIGNATURE OF PARENT/LEGAL GUARDIAN **DATE**

ADDRESS:_____

ADDRESS **CITY** **STATE** **ZIP**

RELATIONSHIP TO CHILD (REN):_____

Home Phone **Cell Phone**

_____	_____	_____
Print Name Parent/Guardian	Signature of Parent/Legal Guardian	DATE
_____	_____	_____
Verified by Notary of Public	My Commission Expires	Date