U.S. Department of the Interior
Bureau of Indian Education
Bureau-Operated Schools

San Simo:n Elementary School

HC01 Box 8292 Sells, 85634

Phone: 520-362-2231 Fax: 520-362-2405

2022-2023 ENROLLMENT APPLICATION

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 in order to protect the student, family, and school and for the purpose of generating funds of operating the school.

U.S. Department of the Interior
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Parent(s)/Guardian(s) a 2022-2023 school application has been sent to you. Please complete all forms and return for your child/children enrollment package to file the Official Student Cumulative Folder.

NEW STUDENTS NEED THE FOLLOWING

-Birth Certificate or Baptism Certificate

-Certificate of Indian Blood (CIB) from Enrollment Office

-Social Security Card or Number

- Update Immunization **(No Baby Record)**

Thank You
Frank Rogers
Principal
San Simo:n School

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:

Mailing Address:

Directions to Home:

Date of Birth:

Month Day Year

Place of Birth:

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 Name:	**Mother Name:**
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:**

Legal Guardian Name & Address:

Case Worker Name and Address:

Tribal Affiliation:

Telephone:

Home Agency:

Student Lives With:
Telephone Home:

Enrollment Number:

Work:

Employer (Optional):

Emergency:

:

3. School(s) Previously Attended:

School Name:

Dates:
Attended:
Reasons for Leaving:

Grades:
Completed:

Address:
City/State:

School Name:

Dates:
Attended:
Reasons for Leaving:

Grades:
Completed:

Address:
City/State:

School Name:

Dates:
Attended:
Reasons for Leaving:

Grades:
Completed:

Address:
City/State:

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.

Parent/Guardian
Sign:

Date:

APPROVED

NOT APPROVED

Date of Enrollment:

Principal:

Date:

Student Emergency Information and Check out Permission Form

School Year 2022-2023

Student Name_____ **Birthdate**_____

Last Name, First Name Middle Name

Student Lives With_____ _____

Name Relationship

Village_____ **District**_____

Parent/Guardian Name_____

Full Address_____

Home Phone_____ **Work Phone**_____

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

Name_____ **Relationship**_____

Phone _____

The Following people have my permission to check my child out of school or sign notes and permission slips for them.

Name	**Relationship**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

_____

Parent/Guardian Signature **Date**

Principal: _____ **Date:** _____

The Smiles Movement

PO Box 767
Camp Verde, AZ 86322

thesmilesmovement@gmail.com

Ph: 928-567-1832
Fax: 928-567-6500

Please return this form to the school!

DEAR CONCERNED PARENT:

Dental disease is the #1 reason children miss school. The Smiles Movement has been providing care for your children for over 30 years at no charge to you. You have a choice; you can choose to go through the process at IHS, or enjoy the convenience of having our experienced doctors care for your child at their school. We thank you for once again choosing our practice that over the years has served thousands of children. To participate, your child must be enrolled in an appropriate AHCCCS program which is easily done at most IHS facilities.

IF YOU CHOOSE TO HAVE YOUR CHILD CONSIDERED FOR TREATMENT YOU MUST COMPLETE THE FOLLOWING:

Child's Name_____Male_____Female_____

Child's Social Security Number_____Date of Birth____/____/____

Emergency Contact_____Phone #_____

School Name_____Teacher's Name_____Grade____

HEALTH HISTORY

PLEASE TELL US ABOUT YOUR CHILD'S HEALTH HISTORY. CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR CHILD:

Has your child had?	NO	YES
Allergy to medication	___	___
Rheumatic Fever	___	___
Psychiatric Treatment	___	___
Seizure Disorder	___	___
Diabetes	___	___
AIDS/HIV Positive	___	___
Hospitalizations	___	___
Vision or speech problems	___	___
Could your child be pregnant?	___	___

	NO	YES
Heart Murmur	___	___
Bleeding Disorders	___	___
High Blood Pressure	___	___
Asthma	___	___
Hepatitis/Jaundice	___	___
Anemia	___	___
Latex Allergy	___	___
Other Serious Illness	___	___

Is your child under a Physician's care? NO____YES____
Is your child taking any medication? ____ ____
Any problems with local anesthetic? ____ ____

PLEASE EXPLAIN ANY "YES" ANSWERS:_____

What is your primary concern for your child's oral health?_____

PLEASE TURN OVER AND COMPLETE

CONSENT FOR TREATMENT AND PATIENT MANAGEMENT

Following your child's examination, that consists of radiographs (x-rays) and in some cases, a panoramic scan, and cleaning, the doctor may determine that your child requires additional dental treatment, including silver fillings, routine baby tooth extractions, stainless steel crowns, and pulp treatments for deciduous (baby) teeth. These pulp treatments are routine procedures for baby teeth. More involved pulp treatments for permanent teeth (root canals) are referred.

The Smiles Movement dentists make all decisions very carefully, including referring your children who may benefit from sedation, protecting your child from injury with a gentle hand, or in the event of a critical situation, briefly using a papoose board similar to those used by physicians and hospitals. It is always our priority to give your child excellent dental care, protect them, and create a pleasant visit. These efforts will help insure positive dental experiences for a lifetime of smiles. If our dentists make the decision to refer your child, they take all factors into consideration, including the very limited number of general anesthesia appointments available at the IHS. We coordinate our schedules with the school nurse, and we welcome and encourage you to participate, however, we do understand that in some circumstances you cannot attend.

We have had great success with our program and we are looking forward to providing your child with excellent dental care. Participation in this program could affect future benefits your child may receive under private insurance or from another private dentist.

- **HELP US COMBAT DENTAL DISEASE, THE #1 CAUSE OF MISSED SCHOOL TIME**
- **WE WANT TO GIVE YOUR CHILD A SMILE THAT LASTS A LIFETIME**

CONSENT FOR TREATMENT AND AKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing below I acknowledge that: (Please check one below)

1._____ YES. I give permission for my child to receive necessary treatment!
I am aware that I have rights outlined in the Notice of Privacy Practices and that a copy of this notice is available for my review.
I consent to the sharing of this information with the IHS Dental program.

2._____ No. I do not want my child to receive necessary dental treatment provided at their school. I will assume responsibility for obtaining their treatment elsewhere.

I understand that I may refuse to sign this Consent and Acknowledgement.

X_____Date_____
Parent or Guardian

Please print your name_____

If you have any questions, please call our office at 928-567-1832

PLEASE TURN OVER AND COMPLETE

TOHONO O'ODHAM NATION HEALTH CARE (TONHC)
POLICY AND PROCEDURE

Tohono O'odham Nation Health Care Consists of Facilities:
Sells, San Xavier, Santa Rosa, San Simon

AUTHORIZATION TO CONSENT FOR TREATMENT ON BEHALF OF A PATIENT

I am the parent or legal guardian of _____
Name and Date of Birth

The following people have my permission to seek medical attention and treatment on behalf this patient:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that the individuals designated above have been authorized to perform a significant function, and I have not given authorization to any individual without due consideration. Further, I will not hold TONHC liable for failing to contact me before providing medical treatment to my minor child based upon the authorization of one of the individuals I have herein designated.

If, in the future, I have determined that one or more of these designated individuals shall no longer have the right to authorize medical care for my minor child, I agree to notify TONHC by appearing in person with picture ID and filling out a new form. If I am unable to appear in person, I may give notice in writing, including my signature, by mail to the Patient Registration Office.

_____	_____
Parent/Legal Guardian Signature	T.O.N Health Care Employee Signature
_____	_____
Parent/Legal Guardian Printed Name	T.O.N Health Care Employee Printed Name
_____	_____
Date	Date

Appendix A

TOHONO O'ODHAM NATION HEALTH CARE
POLICY AND PROCEDURE

Note: Consists of all T.O.N Health Care Sites (Sells, San Xavier, Santa Rosa, San Simon)

AUTHORIZATION TO CONSENT FOR TREATMENT ON BEHALF OF A MINOR

A. In general, all patients less than 18 years of age must be accompanied by a parent or legal guardian in order to receive evaluation and/or treatment.

B. Exception is made when there is an emergency condition requiring medical attention, and waiting for the arrival and/or consent of the parent or legal guardian would dangerously delay emergency care. However, every effort is made to contact the parent or legal guardian as quickly as possible.

C. In order to designate others who have permission to bring a child or adolescent in and consent for their healthcare, a parent or legal guardian may complete the appropriate form at patient registration. (See attachment – **Authorization to Consent for Treatment on Behalf of a Minor**).

D. Minors in various situations have various consent requirements (and confidentiality rights). The attached chart – Tohono O'odham Nation Health Care Legal Consent Requirements and Confidentiality Rights for Medical Treatment of Minors in various circumstances – details the appropriate management of these issues.

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 IHS 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

VACCINE INFORMATION STATEMENT

DTaP (Diphtheria, Tetanus, Pertussis) Vaccine: *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

DTaP vaccine can prevent **diphtheria, tetanus,** and **pertussis.**

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- DIPHTHERIA (D) can lead to difficulty breathing, heart failure, paralysis, or death.
- TETANUS (T) causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- PERTUSSIS (aP), also known as "whooping cough," can cause uncontrollable, violent coughing that makes it hard to breathe, eat, or drink. Pertussis can be extremely serious especially in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

2. DTaP vaccine

DTaP is only for children younger than 7 years old. Different vaccines against tetanus, diphtheria, and pertussis (Tdap and Td) are available for older children, adolescents, and adults.

It is recommended that children receive 5 doses of DTaP, usually at the following ages:

- 2 months
- 4 months
- 6 months
- 15–18 months
- 4–6 years

DTaP may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

DTaP may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis**, or has any **severe, life-threatening allergies**
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP or DTaP)**
- Has **seizures or another nervous system problem**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria**

In some cases, your child's health care provider may decide to postpone DTaP vaccination until a future visit.

Children with minor illnesses, such as a cold, may be vaccinated. Children who are moderately or severely ill should usually wait until they recover before getting DTaP vaccine.

Your child's health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness or swelling where the shot was given, fever, fussiness, feeling tired, loss of appetite, and vomiting sometimes happen after DTaP vaccination.
- More serious reactions, such as seizures, non-stop crying for 3 hours or more, or high fever (over 105°F) after DTaP vaccination happen much less often. Rarely, vaccination is followed by swelling of the entire arm or leg, especially in older children when they receive their fourth or fifth dose.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

Tdap (Tetanus, Diphtheria, Pertussis) Vaccine: *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Tdap vaccine can prevent **tetanus, diphtheria,** and **pertussis.**

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- TETANUS (T) causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- DIPHTHERIA (D) can lead to difficulty breathing, heart failure, paralysis, or death.
- PERTUSSIS (aP), also known as "whooping cough," can cause uncontrollable, violent coughing that makes it hard to breathe, eat, or drink. Pertussis can be extremely serious especially in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

2. Tdap vaccine

Tdap is only for children 7 years and older, adolescents, and adults.

Adolescents should receive a single dose of Tdap, preferably at age 11 or 12 years.

Pregnant people should get a dose of Tdap during every pregnancy, preferably during the early part of the third trimester, to help protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Adults who have never received Tdap should get a dose of Tdap.

Also, **adults should receive a booster dose of either Tdap or Td** (a different vaccine that protects against tetanus and diphtheria but not pertussis) **every 10 years,** or after 5 years in the case of a severe or dirty wound or burn.

Tdap may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis,** or has any **severe, life-threatening allergies**
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap)**
- Has **seizures or another nervous system problem**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria**

In some cases, your health care provider may decide to postpone Tdap vaccination until a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting Tdap vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Pain, redness, or swelling where the shot was given, mild fever, headache, feeling tired, and nausea, vomiting, diarrhea, or stomachache sometimes happen after Tdap vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

Varicella (Chickenpox) Vaccine:
What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Varicella vaccine can prevent **varicella**.

Varicella, also called "chickenpox," causes an itchy rash that usually lasts about a week. It can also cause fever, tiredness, loss of appetite, and headache. It can lead to skin infections, pneumonia, inflammation of the blood vessels, swelling of the brain and/or spinal cord covering, and infections of the bloodstream, bone, or joints. Some people who get chickenpox get a painful rash called "shingles" (also known as herpes zoster) years later.

Chickenpox is usually mild, but it can be serious in infants under 12 months of age, adolescents, adults, pregnant people, and people with a weakened immune system. Some people get so sick that they need to be hospitalized. It doesn't happen often, but people can die from chickenpox.

Most people who are vaccinated with 2 doses of varicella vaccine will be protected for life.

2. Varicella vaccine

Children need 2 doses of varicella vaccine, usually:
- First dose: age 12 through 15 months
- Second dose: age 4 through 6 years

Older children, adolescents, and **adults** also need 2 doses of varicella vaccine if they are not already immune to chickenpox.

Varicella vaccine may be given at the same time as other vaccines. Also, a child between 12 months and 12 years of age might receive varicella vaccine together with MMR (measles, mumps, and rubella) vaccine in a single shot, known as MMRV. Your health care provider can give you more information.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:
- Has had an **allergic reaction after a previous dose of varicella vaccine**, or has any **severe, life-threatening allergies**
- Is **pregnant** or thinks they might be pregnant—pregnant people should not get varicella vaccine
- Has a **weakened immune system**, or has a **parent, brother, or sister with a history of hereditary or congenital immune system problems**
- **Is taking salicylates** (such as aspirin)
- Has recently **had a blood transfusion or received other blood products**
- Has **tuberculosis**
- Has **gotten any other vaccines in the past 4 weeks**

In some cases, your health care provider may decide to postpone varicella vaccination until a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting varicella vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Sore arm from the injection, redness or rash where the shot is given, or fever can happen after varicella vaccination.
- More serious reactions happen very rarely. These can include pneumonia, infection of the brain and/or spinal cord covering, or seizures that are often associated with fever.
- In people with serious immune system problems, this vaccine may cause an infection that may be life-threatening. People with serious immune system problems should not get varicella vaccine.

It is possible for a vaccinated person to develop a rash. If this happens, the varicella vaccine virus could be spread to an unprotected person. Anyone who gets a rash should stay away from infants and people with a weakened immune system until the rash goes away. Talk with your health care provider to learn more.

Some people who are vaccinated against chickenpox get shingles (herpes zoster) years later. This is much less common after vaccination than after chickenpox disease.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

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The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

MMR Vaccine (Measles, Mumps, and Rubella): *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

MMR vaccine can prevent **measles, mumps,** and **rubella.**

- MEASLES (M) causes fever, cough, runny nose, and red, watery eyes, commonly followed by a rash that covers the whole body. It can lead to seizures (often associated with fever), ear infections, diarrhea, and pneumonia. Rarely, measles can cause brain damage or death.
- MUMPS (M) causes fever, headache, muscle aches, tiredness, loss of appetite, and swollen and tender salivary glands under the ears. It can lead to deafness, swelling of the brain and/or spinal cord covering, painful swelling of the testicles or ovaries, and, very rarely, death.
- RUBELLA (R) causes fever, sore throat, rash, headache, and eye irritation. It can cause arthritis in up to half of teenage and adult women. If a person gets rubella while they are pregnant, they could have a miscarriage or the baby could be born with serious birth defects.

Most people who are vaccinated with MMR will be protected for life. Vaccines and high rates of vaccination have made these diseases much less common in the United States.

2. MMR vaccine

Children need 2 doses of MMR vaccine, usually:

- First dose at age 12 through 15 months
- Second dose at age 4 through 6 years

Infants who will be traveling outside the United States when they are between 6 and 11 months of age should get a dose of MMR vaccine before travel. These children should still get 2 additional doses at the recommended ages for long-lasting protection.

Older children, adolescents, and **adults** also need 1 or 2 doses of MMR vaccine if they are not already immune to measles, mumps, and rubella. Your health care provider can help you determine how many doses you need.

A third dose of MMR might be recommended for certain people in mumps outbreak situations.

MMR vaccine may be given at the same time as other vaccines. Children 12 months through 12 years of age might receive MMR vaccine together with varicella vaccine in a single shot, known as MMRV. Your health care provider can give you more information.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of MMR or MMRV vaccine,** or has any **severe, life-threatening allergies**
- Is **pregnant** or thinks they might be pregnant—pregnant people should not get MMR vaccine
- Has a **weakened immune system,** or has a **parent, brother, or sister with a history of hereditary or congenital immune system problems**
- Has ever had a **condition that makes him or her bruise or bleed easily**
- Has recently **had a blood transfusion or received other blood products**
- Has **tuberculosis**
- Has **gotten any other vaccines in the past 4 weeks**

In some cases, your health care provider may decide to postpone MMR vaccination until a future visit.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting MMR vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Sore arm from the injection or redness where the shot is given, fever, and a mild rash can happen after MMR vaccination.
- Swelling of the glands in the cheeks or neck or temporary pain and stiffness in the joints (mostly in teenage or adult women) sometimes occur after MMR vaccination.
- More serious reactions happen rarely. These can include seizures (often associated with fever) or temporary low platelet count that can cause unusual bleeding or bruising.
- In people with serious immune system problems, this vaccine may cause an infection that may be life-threatening. People with serious immune system problems should not get MMR vaccine.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

Polio Vaccine:
What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Polio vaccine can prevent **polio.**

Polio (or poliomyelitis) is a disabling and life-threatening disease caused by poliovirus, which can infect a person's spinal cord, leading to paralysis.

Most people infected with poliovirus have no symptoms, and many recover without complications. Some people will experience sore throat, fever, tiredness, nausea, headache, or stomach pain.

A smaller group of people will develop more serious symptoms that affect the brain and spinal cord:
- Paresthesia (feeling of pins and needles in the legs),
- Meningitis (infection of the covering of the spinal cord and/or brain), or
- Paralysis (can't move parts of the body) or weakness in the arms, legs, or both.

Paralysis is the most severe symptom associated with polio because it can lead to permanent disability and death.

Improvements in limb paralysis can occur, but in some people new muscle pain and weakness may develop 15 to 40 years later. This is called "post-polio syndrome."

Polio has been eliminated from the United States, but it still occurs in other parts of the world. The best way to protect yourself and keep the United States polio-free is to maintain high immunity (protection) in the population against polio through vaccination.

2. Polio vaccine

Children should usually get 4 doses of polio vaccine at ages 2 months, 4 months, 6–18 months, and 4–6 years.

Most **adults** do not need polio vaccine because they were already vaccinated against polio as children. Some adults are at higher risk and should consider polio vaccination, including:
- People traveling to certain parts of the world
- Laboratory workers who might handle poliovirus
- Health care workers treating patients who could have polio
- Unvaccinated people whose children will be receiving oral poliovirus vaccine (for example, international adoptees or refugees)

Polio vaccine may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

Polio vaccine may be given at the same time as other vaccines.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of polio vaccine**, or has any **severe, life-threatening allergies**

In some cases, your health care provider may decide to postpone polio vaccination until a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting polio vaccine.

Not much is known about the risks of this vaccine for pregnant or breastfeeding people. However, polio vaccine can be given if a pregnant person is at increased risk for infection and requires immediate protection.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- A sore spot with redness, swelling, or pain where the shot is given can happen after polio vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

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- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at www.cdc.gov/vaccines.

HPV (Human Papillomavirus) Vaccine: *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

HPV (human papillomavirus) vaccine can prevent infection with some types of human papillomavirus.

HPV infections can cause certain types of cancers, including:

- cervical, vaginal, and vulvar cancers in women
- penile cancer in men
- anal cancers in both men and women
- cancers of tonsils, base of tongue, and back of throat (oropharyngeal cancer) in both men and women

HPV infections can also cause anogenital warts.

HPV vaccine can prevent over 90% of cancers caused by HPV.

HPV is spread through intimate skin-to-skin or sexual contact. HPV infections are so common that nearly all people will get at least one type of HPV at some time in their lives. Most HPV infections go away on their own within 2 years. But sometimes HPV infections will last longer and can cause cancers later in life.

2. HPV vaccine

HPV vaccine is routinely recommended for adolescents at 11 or 12 years of age to ensure they are protected before they are exposed to the virus. HPV vaccine may be given beginning at age 9 years and vaccination is recommended for everyone through 26 years of age.

HPV vaccine may be given to adults 27 through 45 years of age, based on discussions between the patient and health care provider.

Most children who get the first dose before 15 years of age need 2 doses of HPV vaccine. People who get the first dose at or after 15 years of age and younger people with certain immunocompromising conditions need 3 doses. Your health care provider can give you more information.

HPV vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of HPV vaccine**, or has any **severe, life-threatening allergies**
- Is **pregnant**—HPV vaccine is not recommended until after pregnancy

In some cases, your health care provider may decide to postpone HPV vaccination until a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting HPV vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, or swelling where the shot is given can happen after HPV vaccination.
- Fever or headache can happen after HPV vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

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  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

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

CHILD'S NAME: _____ **D.O.B.** _____

MEDICAL HISTORY

		Yes	NO
Allergies	_____		
Heart Murmur			
Diabetes Mellitus			
Medication Usage	_____		
Convulsion/ Seizures			
Rheumatic Fever			
Asthma			

		Yes	No
Liver disease/ Hepatitis			
Bleeding Tendencies			
Heart/Vascular disease			
Under Doctors Care			
Latex Allergy			
Other	_____ _____		

Tohono O'odham Sells Dental Clinic

Dear Parents:

We need your permission to provide dental screenings, sealants, fluoride treatment, and brushing and flossing instruction for your child at school. A dental screening is a quick look at the teeth to check for cavities on the tops of the teeth. Sealants are used to seal the tops of the teeth to help prevent cavities. The fluoride treatment is fluoride varnish brushed on the teeth and allowed to stay for a day. Fluoride helps to strengthen the teeth.

If you have any question please feel free to contact the **TON Sells Dental clinic** at **(520)383-7341**

Please circle one of the answers.

1. **Yes** - I want my child to have dental screening, sealants, fluoride treatment, and brushing and flossing instruction by the Tohono O'odham Sells dental staff.
2. **NO** - I do not want my child to have dental screening, sealants, fluoride treatment, and brushing and flossing instruction by the Tohono O'odham Sells dental staff.
3. I **only** want my child to have screening and fluoride.
4. **Other** _____

Signature: Parent or guardian _____ Date: _____

Please return this form to the school

Thank you.

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 01-2020)

U.S. Department of the Interior
Bureau of Indian Education
Bureau-Operated Schools

HC 01 Box 8292
Sells, Arizona 85634
Telephone (520) 362-2231 Fax (520) 362-2405
Principal- Frank Rogers

Permission to Publish Pictures

_____I give permission to San Simon School to publish pictures of my child in appropriate media sources for purpose relating to school functions.

_____I do not give consent to San Simon School to publish pictures of my child.

Student Name:_____

Parent Signature: _____ Date:

U.S. Department of the Interior
Bureau of Indian Education
Bureau-Operated Schools

HC 01 Box 8292
Sells, Arizona 85634
Telephone (520) 362-2231 Fax (520) 362-2405
Principal- Frank Rogers

Release of Records

As the Parent/Guardian of _____

_____**, I hereby authorize**

Prior School Name: _____

Prior School Address: _____

_____

To transfer my child's records. Certificate of Indian Blood (CIB), Birth Certificate, Health records, Speech records, Special Education records. I also consent to the release of any Psychological Evaluation which may be available.

Parent/Guardian: _____
Date:

Principal: _____
Date: