



SEMINOLE TRIBE OF FLORIDA
AHFACHKEE SCHOOL
SCHOOL YEAR 2023-2024

STUDENT INFORMATION

(Office Use **ONLY**) START DATE _____

Last Name First Name Middle Name Shirt Size ☐ Male ☐ Female

Other Name answers to Date of Birth Age

STUDENT DEMOGRAPHICS

Physical Address

Mailing Address Home Phone Cell Phone
E-mail Address

STUDENT RESIDES WITH ☐ Both Parents ☐ Father ☐ Mother ☐ Foster Family ☐ Other
(explain) _

Legal Guardian (Print Name) ☐ Mother ☐ Father ☐ Other (explain) Daytime Emergency Phone #

Legal Guardian (Print Name) ☐ Mother ☐ Father ☐ Other (explain) Daytime Emergency Phone #

Member of federally recognized tribe ☐ Yes ☐ No Name of Student's tribe: _

Tribal enrollment/census # _____

Tribal Letter of Descendancy _____

Names and grades of siblings attending this school: _

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Authorization for (student name): _____ for the following: In case of an accident or illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to contact the nearest medical facility for treatment if necessary. I give permission for the school to dispense to my child any medicine in the original prescription container bearing the student's name ordered by a licensed physician sent by the parent or guardian if the need arises.

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

NOTICE OF SCREENING

Screening (vision, hearing, speech, and dental) will be done in selected grades and for all new students. If you **DO NOT** wish for your child to participate, please notify the school in writing.

PHOTOGRAPHY/MEDIA AUTHORIZATION

Ahfachkee School may photograph and/or video for publication purposes (such as, the yearbook, school website). If you **DO NOT** wish for your child to be photographed, please notify the school in writing.



SEMINOLE TRIBE OF FLORIDA AHFACHKEE SCHOOL

SCHOOL YEAR 2023-2024

STUDENT INFORMATION

(Continuation)

(Office Use ONLY) START DATE _____

Home Language Survey (If the answer is "Yes" to any of these questions, the student must be tested for English proficiency.)			
☐ Yes ☐ No	Is a language other than English used in the home?	If "yes", which language?	
☐ Yes ☐ No	Does the student have a first language other than English?	If "yes", which language?	
☐ Yes ☐ No	Does the student most frequently speak a language other than English?	If "yes", which language?	

Has the student previously been:				
☐ Yes ☐ No	Enrolled in Public School?	☐ Yes ☐ No	Retained (repeated the same grade)?	
☐ Yes ☐ No	Enrolled in a Charter School ?	☐ Yes ☐ No	In Exceptional Student Education (ESE)?	
☐ Yes ☐ No	Enrolled in a Home Education	☐ Yes ☐ No	On a 504 plan?	
☐ Yes ☐ No	Expelled from school?	☐ Yes ☐ No	In an ESOL program?	
☐ Yes ☐ No	Convicted of a felony?	☐ Yes ☐ No	In a Magnet program?	
☐ Yes ☐ No	Involved in the Juvenile Justice System?	☐ Yes ☐ No	In Foster Care?	
☐ Yes ☐ No	Referred for mental health services?	☐ Yes ☐ No	In a Gifted program?	
Previous School Name(s)	City/State/Country	Year(s) Attended	Last Grade Attended	Type
				☐ Public ☐ Private ☐ Charter ☐ Home Ed
				☐ Public ☐ Private ☐ Charter ☐ Home Ed



AHFACHKEE SCHOOL
School Year 2023-2024

EMERGENCY CONTACT / CHECK OUT LIST

Student Name: _____ Date of Birth: _____ Current Grade: _____

Parent/Guardian: _____ **Physical** Address: _____

Home Phone: _____ Work: _____ Cell: _____

The following have my permission to be contacted in case of emergency and to check out my child.

* Two contacts minimum (required)

Name of Contact	Relationship	Phone Number	Emergency Contact	Check Out
			☐	☐
			☐	☐
			☐	☐
			☐	☐

I REALIZE THAT THE SCHOOL WILL NOT RELEASE THE ABOVE NAMED CHILD TO ANYONE UNLESS THEIR NAME IS WRITTEN ABOVE ON THIS FORM. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO LET THE SCHOOL KNOW IN WRITING WHEN THERE IS TO BE A CHANGE IN THE PERSON(S) WHO HAVE MY PERMISSION TO CHECK OUT THE ABOVE NAMED CHILD. FOR THE SAFETY OF MY CHILD, I WILL KEEP MY INFORMATION UPDATED AND CURRENT.

Please provide a copy of the paperwork if your child has No Contact Orders, Restraining Orders, Power of Attorney, Guardianship, Custody.

STUDENT TRANSPORTATION

Please indicate the dismissal for your child with the days of the week. M = Monday T = Tuesday W = Wednesday R = Thursday F = Friday	BC Bus	Immokalee Bus	Parent Pickup	Walk, ride ATV, etc.	Drive (must have a copy of valid driver license, proof of insurance on file at school)
ARRIVAL					
DEPARTURE					
EARLY RELEASE					

Dismissal Changes: If there is a need to change your child's dismissal plan, please provide a written note with the changes (date/sign) to the front office **by 10:00 AM**. Students should be checked out prior to 1:45PM on a full day and 11:15AM on an early release day.

In the event that a bus driver is unable to locate a parent/adult/older sibling in the home when dropping a child (K - 4th Grades) off at home, the child will be returned to the school. Attempts will then be made to contact the parent/guardian.

Parent/Guardian Signature _____ Date _____



AHFACHKEE SCHOOL
School Year 2023-2024

HEALTH HISTORY

Student's Name: _____ Date of Birth: _____ Sex: _____

Parent/Guardian: _____ Phone: (h) _____ (w) _____

Cell Phone: (1) _____ (2) _____ (3) _____

Please check if your child has any known food allergies:

☐ Seafood ☐ Shellfish ☐ Peanuts ☐ Dairy Products

Other (Please list) _____

Is your child allergic to insect bites/stings? ☐ No ☐ Yes

Please list _____

Is your child allergic to any medication(s)? ☐ No ☐ Yes

Please list _____

List any other allergies: _____

MEDICAL INFORMATION

Does your child or has your child ever had any of the following, **please check all that apply:**

- | | | |
|--|---|---|
| ☐ AIDS/HIV | ☐ Epilepsy | ☐ Pregnancy |
| ☐ Allergies | ☐ Heart Murmur | ☐ Rheumatic Fever |
| ☐ Anemia/Blood Disorder | ☐ Heart Problems | ☐ Sexually Transmitted Disease |
| ☐ Asthma | ☐ High Blood Pressure | ☐ Stroke |
| ☐ Cancer/Tumors | ☐ Kidney Problems | ☐ Thyroid Problems |
| ☐ Diabetes | ☐ Liver Problems/Hepatitis | ☐ Tuberculosis/Lung Disease |
| ☐ Emotional Problems | ☐ Neurological Problems | ☐ Other _____ |

Is your child currently under the care of a physician?

☐ Yes ☐ No

Name of Physician: _____ Phone Number: _____

Reason for treatment: _____

Is your child currently taking medications, including "over the counter"? ☐ Yes ☐ No

If yes, describe: _____

The above medical information is true to the best of my knowledge:

Signature: _____ **Relationship:** _____ **Date:** _____



AHFACHKEE SCHOOL
School Year 2023-2024

TITLE I A COMPACT

STUDENT

LEGAL GUARDIAN

AHFACHKEE SCHOOL

AS A STUDENT I PROMISE TO:	AS A CARING SUPPORTIVE ADULT I PROMISE TO:	AS A SCHOOL WE PROMISE TO:
Attend School regularly and be on time	Foster a positive attitude toward school	Respect and enhance the unique culture of each child
Be responsible for my own actions	Be actively involved in my child's education	Provide quality instruction in a safe and drug free school
Read at Home	Communicate regularly with my child's teacher	Provide an intellectually stimulating curriculum that reflects and preserves the cultural integrity of the people and holds high expectations of all children
Do my part to make my school a safe place	Actively promote literacy in our home	Communicate with and include families in the education process
Take pride in the grounds and property of my school	See that my child attends school every day rested and ready to learn	Model behavior and attitude of positive character traits
Arrive rested and ready to learn	Encourage my child to complete school work and homework	Support positive behavior in the classroom
Complete all school assignments including homework.	Obtain and have my child complete assignments after absences	Encourage your child to reach his/her potential
	Provide telephone and address changes to school offices	
Student signature	Legal guardian signature	Administrator signature
Add Comments as desired	Add Comments as desired	

NATIVE LANGUAGE INSTRUCTION

"I give permission for my child to receive Native Language instruction for the purpose of maintenance or restoration and enhancement."

☐

YES, I CONSENT

☐

NO, I DO NOT CONSENT (attach letter if declining participation)

Parent/Legal Guardian Signature

Date



HOUSING INFORMATION FORM

Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

Student _____ Parent/Guardian _____

School _____ Phone _____

Age _____ Grade _____ D.O.B. _____

Address _____ City _____

Zip Code _____ Is this address Temporary or Permanent? (circle one)

Please choose which of the following situations the student currently resides in (you can choose more than one):

_____ House or apartment with parent or guardian

_____ Motel, car, or campsite

_____ Shelter or other temporary housing

_____ With friends or family members (other than or in addition to parent/guardian)

If you are living in shared housing, please check all of the following reasons that apply:

_____ Loss of housing

_____ Economic situation

_____ Temporarily waiting for house or apartment

_____ Provide care for a family member

_____ Living with boyfriend/girlfriend

_____ Loss of employment

_____ Parent/Guardian is deployed

_____ Other (Please explain)

Are you a student under the age of 18 and living apart from your parents or guardians? Yes _____ No _____

Housing and Educational Rights

Students without fixed, regular, and adequate nighttime residences have the following rights:

- 1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations;
- 2) Transportation to the school of origin for the regular school day;
- 3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that it is offered to other students.

Any questions about these rights can be directed to the local McKinney-Vento liaison, Valerie Whiteside, at 863-227-3389 or the State Coordinator, Marie SilverHatBand, at 202-860-4188.

By signing below, I acknowledge that I have received and understand the above rights.

Signature of Parent/Guardian OR Unattached Youth

Date

Signature of Local McKinney-Vento Liaison

Date

.....

SEMINOLE TRIBE OF FLORIDA AHFACHKEE SCHOOL

Chairman
Marcellus W. Osceola Jr.
Vice Chairman - President

Treasurer
PETE HAHN
Secretary
LAVONNE ROSE



Principal
Philip Baer
Assistant Principal
Nuria Suarez

30290 Josie Billie Hwy.
PMB 1005
Clewiston, FL 33440
Telephone: 863-983-6348
FAX: 863-983-6535
<http://www.seminolewarriors.com>

Authorization to Release or Receive Information

Date: _____

Name and address of school/facility student previously attended or will be attending:

STUDENT NAME: _____ DATE OF BIRTH: _____

By signing, I authorize Ahfachkee School to release ☐ or receive ☐ the following:

1. ☐ Official School Transcript
2. ☐ Health/Immunization Record
3. ☐ Birth Certificate
4. ☐ Standardized Test Scores
5. ☐ Exceptional Student Educational record/Special Education
6. ☐ Other (Specify) _____

*I understand that any and all personally identifiable information is protected under FERPA. I further understand that I may waive that protection and give access to my student's records for individuals of my choice. I agree to **wave my rights** under FERPA and request that the about date be released to the listed school/office/individual(s).*

For the following purpose:

1. ☐ Exchange of Information
2. ☐ Personal Records
3. ☐ Student Transfer

The Federal Family and Privacy Act do not require parent permission for sending records to a school to which the student is transferring. In such case no parent authorization may appear here.

Signature of Parent/Guardian

Relationship to Student

Date



SEMINOLE TRIBE OF FLORIDA

Education Department

Authorization for the Release of Information

Student: _____
First Middle Last

Date of Birth

Tribal Member #

The signature below authorizes the release of records and information as indicated for the purpose of:

- Monitor Education Progress
- Assessments and Referrals
- Family Services
- Coordinate education services
- Other (Please specify): _____

I hereby request and authorize STOF Education Department: ☐ Disclose to ☐ Obtain From

Person/Agency: _____ Phone: _____

TO BE RELEASED TO/REQUESTED FROM: Seminole Tribe of Florida's Education Department

• **BIG CYPRESS**

31000 Josie Billie Hwy
Clewiston, FL 33440
(863)902-3200

• **BRIGHTON**

650 Harney Pond Rd Ste 112
Okeechobee, FL 34974
(863)763-3572

• **HOLLYWOOD/TRAIL/FT. PIERCE**

3100 N. 63rd Avenue
Hollywood, FL 33024
(954)989-6840 ext 10500

• **IMMOKALEE/NAPLES**

295 Stockade Road
Immokalee, FL 34142
(239)867-5303

• **TAMPA**

6401 Harney Road
Tampa, FL 33610
(813)246-3100

Information to be released:

- Attendance Information
- Discipline Records/Actions
- Assessments and Evaluations
- Psychological Evaluations
- Contact Information
- Report Cards/Progress Reports
- Standardized Test Information/Results
- Transcripts
- Dates and Reasons for Special Program Enrollment/Withdrawals
- ESE Reports
- Current IEP/504 Plan
- Contact Information

I hereby authorize the above indicated information/records to be disclosed from the Person/Agency and to be released to the STOF Education Department. I understand the information is strictly confidential and will be used for the purposes stated above. I understand that this authorization will remain in effect from the date of signature to be valid throughout the immediately following full school year up to and including August 1 of that year or until it is revoked by my written consent.

I have been informed and understand my rights regarding the release of these records.

Parent/Guardian Signature

Date

Advisor Signature

Date

Revocation

Parent/Guardian Signature

Date