



**the**  
**Chickasaw Nation**  
**Chickasaw Children's Village**

1185 Village Road / Kingston, OK 73439 / Office (580) 564-3060 / Fax (580) 564-3605

**Bill Anoatubby**  
Governor

## APPLICATION

## FOR

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*Student's Name*

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Grade Entering

***The mission of the Children's Village of the Chickasaw Nation is to provide Indian children with the opportunity for social, spiritual and personal development through professional guidance in a safe, nurturing environment, with an emphasis on their educational needs.***



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**Bill Anoatubby  
Governor**

Dear Parent or Legal Guardian:

Enclosed is an application for enrollment at the *Chickasaw Children's Village*. Please complete and sign each page and return it to us as soon as possible. Each of the items listed must be received to complete this application. Students cannot be admitted without these items:

Copy of your child's:

1. Certificate of Degree of Indian Blood Card or tribal letter
2. Up to date immunization record
3. Birth certificate
4. Social Security card
5. School transcript or most current grades
6. Private insurance, Medicaid or SoonerCare insurance card
7. Current contact list

**All applications must be in by cut-off date:** \_\_\_\_\_

**PLEASE NOTIFY US IMMEDIATELY OF ALL ADDRESS AND PHONE NUMBER CHANGES**

Sincerely,

Sallie Wallace  
Director

Enclosure: Application

**All forms must be completely filled out and notarized before your application is considered for enrollment.**



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**Bill Anoatubby  
Governor**

**APPLICATION FOR ENROLLMENT**

**Returning (if returning student)**

**New**

Do you wish to be in the same cottage as last year?  Yes  No

Name of student: \_\_\_\_\_ Grade: \_\_\_\_\_

Gender:  Male  Female Birth date: \_\_\_\_\_ Social Security no.: \_\_\_\_\_

Affiliated Indian tribe(s): \_\_\_\_\_ Degree: \_\_\_\_\_

Church preference: \_\_\_\_\_ Can student attend another church?  Yes  No

Name and address of parent or legal guardian:

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Directions to your home:

Name and phone number of neighbor, friend or relative:

Has student attended boarding school before?  Yes  No If so, where? \_\_\_\_\_

Does the student want to come?  Yes  No If no, please explain:

Reason for referral:

*(Please put any additional information on back of page.)*

Names of brothers and sisters:

1. \_\_\_\_\_  Male  Female Age: \_\_\_\_\_
2. \_\_\_\_\_  Male  Female Age: \_\_\_\_\_
3. \_\_\_\_\_  Male  Female Age: \_\_\_\_\_



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Please initial one or more of the items below if you wish to give your child permission to leave the *Chickasaw Children's Village* campus without the sponsorship of the *Chickasaw Children's Village* and/or Kingston Public Schools.

1. \_\_\_\_ Student is to leave *only* with written permission each time from parent/legal guardian.
2. \_\_\_\_ Student is to leave campus *only* with parent or legal guardian.
3. \_\_\_\_ Student is to leave campus with authorized persons listed below: MUST be over 21 years of age.
4. \_\_\_\_ To add other names to the check-out list, a parent/legal guardian must submit a signed permission statement through fax, letter or in person to the director 48 hours prior to student check-out.

(1) \_\_\_\_\_ (3) \_\_\_\_\_

(2) \_\_\_\_\_ (4) \_\_\_\_\_

I, \_\_\_\_\_, am legally responsible for \_\_\_\_\_ and understand that the *Chickasaw Children's Village* (CCV) is released of responsibility whenever the student is checked out by authorized persons.

CCV may request additional information before the child is enrolled.

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date



**FAMILY AND INSURANCE INFORMATION**

Person filling out form:  Parent  Legal guardian

Father: \_\_\_\_\_

Age: \_\_\_\_  Living  Deceased

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Phone: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Emergency: \_\_\_\_\_

Tribal affiliation: \_\_\_\_\_

Dominant language spoken in the home:

\_\_\_\_\_

Home agency: \_\_\_\_\_

Do you have Medicaid (SoonerCare)?  
 Yes  No If yes, what is the Medicaid number/person code? \_\_\_\_\_

Do you have private/group health insurance?  
 Yes  No If yes, please provide the insurance company's name and address:

Name of insured: \_\_\_\_\_

Relationship to student: (please check one)  
 Parent  Legal guardian

What is the policy ID or Social Security no.?  
\_\_\_\_\_

Group name/group number: \_\_\_\_\_

Father's known allergies: \_\_\_\_\_

\_\_\_\_\_

Mother: \_\_\_\_\_

Maiden name: \_\_\_\_\_

Age: \_\_\_\_  Living  Deceased

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Phone: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Emergency: \_\_\_\_\_

Tribal affiliation: \_\_\_\_\_

Dominant language spoken in the home:

\_\_\_\_\_

Home agency: \_\_\_\_\_

Do you have Medicaid (SoonerCare)?  
 Yes  No If yes, what is the Medicaid number/person code? \_\_\_\_\_

Do you have private/group health insurance?  
 Yes  No If yes, please provide the insurance company's name and address:

Name of insured: \_\_\_\_\_

Relationship to student: (please check one)  
 Parent  Legal guardian

What is the policy ID or Social Security no.?  
\_\_\_\_\_

Group name/group number: \_\_\_\_\_

Mother's known allergies: \_\_\_\_\_

\_\_\_\_\_





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**For office use only:**  
Chickasaw Nation Medical Record  
no: \_\_\_\_\_  
Other: \_\_\_\_\_

Chickasaw Children's Village student:

Name: \_\_\_\_\_  
Last First Middle

Birth date Gender Parent/legal guardian name Home phone

PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY AND ACCURATELY. ASK ABOUT ANY QUESTION YOU DO NOT UNDERSTAND. IF MORE SPACE IS NEEDED, SHOW NUMBER AND EXPLAIN ON BACK OF SHEET.

- Are you being treated by a doctor now?  YES  NO  
If yes, explain: \_\_\_\_\_
- Have you ever had any serious illness or been hospitalized? Have you had any medical treatments, tests or surgeries?  YES  NO  
If yes, explain: \_\_\_\_\_
- Are you taking any medications (including over-the-counter, herbal, birth control, etc.) now?  YES  NO  
In the past year?  YES  NO  
If yes, explain: \_\_\_\_\_

4. Have you ever had any of the following conditions? Explain below and give date or age.

	YES	NO	Dt/Age		YES	NO	Dt/Age		YES	NO	Dt/Age
1. Respiratory disease				8. Anemia				15. Arthritis			
2. Heart problems or disease				9. Asthma				16. Epilepsy			
3. Heart murmur				10. Allergies/sinus				17. STDs			
4. High blood pressure				11. Tuberculosis				18. Kidney disorders			
5. Stroke				12. Hepatitis				19. Circulation problems			
6. Rheumatic fever				13. Jaundice				20. Skin disorders			
7. Diabetes				14. Liver disease				21. Stomach disorders			

- Are you allergic to any drug or medicine of any kind – such as penicillin, codeine, Novocain, lidocaine, etc.?  YES  NO  
If yes, explain: \_\_\_\_\_
- Are you allergic to anything (including food, insect stings, pollen, etc.) resulting in swelling, hives, asthma, etc.?  YES  NO  
If yes, explain: \_\_\_\_\_
- Have you ever had excessive bleeding that required treatment?  YES  NO  
If yes, explain: \_\_\_\_\_
- Have you ever had a blood transfusion or blood products?  YES  NO  
If yes, explain: \_\_\_\_\_
- Do you have any wounds or injuries that heal slowly or have other complications?  YES  NO  
If yes, explain: \_\_\_\_\_
- Have you had any joint replacements?  YES  NO Do you have any artificial limbs or lens implants?  YES  NO
- Have you ever fainted or been knocked unconscious?  YES  NO  
If yes, explain: \_\_\_\_\_
- Are you on any special diet at this time?  YES  NO  
If yes, explain: \_\_\_\_\_
- Have you had x-ray treatment (besides for fractures and routine chest x-rays)?  YES  NO  
If yes, explain: \_\_\_\_\_
- Do you have any disease, condition or problem that you think the doctor or dentist should know about?  YES  NO  
If yes, explain: \_\_\_\_\_
- Are you pregnant?  YES  NO  N/A

16. Have you had any trouble associated with dental treatment?

YES  NO

If yes, explain: \_\_\_\_\_

17. Is the student up to date on immunizations?

YES  NO

18. Does the parent suspect that the child is using drugs or alcohol?

YES  NO

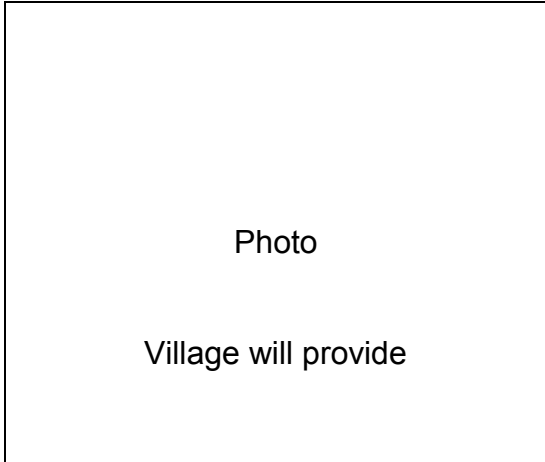
Parent/legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Name: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_  
 Tattoos: \_\_\_\_\_ Hair Length: \_\_\_\_\_ Scars: \_\_\_\_\_  
 Remarks/details: \_\_\_\_\_

I, \_\_\_\_\_ being the parent/legal guardian of \_\_\_\_\_  
 hereby give *Chickasaw Children's Village* staff authorization/responsibility to initiate proceedings for detention  
 orders, missing persons reports, runaway juvenile reports and/or any documents/procedures needed in the  
 event my child leaves the *Chickasaw Children's Village* or Kingston Public Schools or any CCV activities or  
 Kingston school activities without expressed permission from *Chickasaw Children's Village* staff. The  
 permission is given so that my child may be located and returned to a safe environment as soon as possible.

\_\_\_\_\_  
 Signature of parent or legal guardian Date

\_\_\_\_\_  
 Signature of witness Date



**AUTHORIZATION FOR TREATMENT AND DISCLOSURE OF CLINICAL INFORMATION**

I am legally responsible for \_\_\_\_\_ and hereby give consent for any medical, dental, counseling, substance abuse screening and drug/alcohol treatment that become necessary while the child is in school. I also approve such inoculations and treatments in the field of preventive medicine as may be deemed necessary by medical personnel.

I further understand that I will be notified when emergency situations arise in any medical, dental, counseling, substance abuse screening and drug/alcohol treatment situations.

I authorize this release knowing and understanding the records may contain information relating to a reportable communicable disease, which is confidential according to Oklahoma state law.

Consent is also given for the disclosure and exchange of pertinent information essential for medical treatment, drug/alcohol treatment and substance abuse screening or counseling services. This information may be interchanged between the health services and the *Chickasaw Children's Village* beginning \_\_\_\_\_ and ending \_\_\_\_\_.

Consent is given for a drug screening to be done upon acceptance of application.

\_\_\_\_\_  
 Signature of parent/legal guardian

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 City State Zip code

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Phone number

State of \_\_\_\_\_

County of: \_\_\_\_\_

Signed before me on \_\_\_\_\_ 20\_\_\_\_

By \_\_\_\_\_

Identification \_\_\_\_\_

My commission expires \_\_\_\_\_

\_\_\_\_\_  
 Notary Public



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**PLEASE PRINT**

DATE OF EXAM: \_\_\_\_\_

**MEDICAL HISTORY**

Date of last doctor visit: \_\_\_\_\_

Name of facility: \_\_\_\_\_

Allergies:  Yes  No If yes, specify: \_\_\_\_\_

Medical problems:  Yes  No If yes, specify: \_\_\_\_\_

Current medications:  Yes  No If yes, specify: \_\_\_\_\_

**PREPARTICIPATION PHYSICAL EVALUATION**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Body fat (optional): \_\_\_\_\_% Pulse: \_\_\_\_\_

BP: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Initial BP Post exercise 5 min. post ex.

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected:  Yes  No Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

MEDICAL

NORMAL

ABNORMAL FINDINGS:

Appearance		
Eyes/ears/throat		
Lymph nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia (male only)		
Skin		

**MUSCULOSKELETAL**

Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

**CLEARANCE**

- Cleared
- Cleared after completing evaluation/rehabilitation for:

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations:

Name and title of examiner (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of examiner: \_\_\_\_\_

# OSSAA PHYSICAL EXAMINATION AND PARENTAL CONSENT FORM

**PLEASE PRINT**

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Grade: \_\_\_\_\_ School: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Personal physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 In case of emergency, contact: Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_

Explain "Yes" answers below. Circle questions you don't know the answers to.

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
1. Have you had a medical illness or injury since your last check-up or sports physical?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an ongoing or chronic illness?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized overnight?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses, contact or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had a sprain, strain or swelling after injury?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	Have you broken or fractured any bones or dislocated any joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, check appropriate box and explain below:		
Have you ever had a rash or hives develop during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip
5. Have you ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh
Have you ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee
Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Skin/calf
Do you get tired more quickly than your friends do during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle
Have you ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper arm		<input type="checkbox"/> Foot
Have you had high blood pressure or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you want to weigh more or less than you do now?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been told you have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Do you lose weight regularly to meet weight requirements for your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you feel stressed out?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	15. Record the dates of your most recent immunizations (shots) for:	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever denied or restricted your participation in sports for any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus: _____ Measles: _____		
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: _____ Chickenpox: _____		
7. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here:		
Have you ever been knocked out, become unconscious or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have frequent or severe headaches?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Have you ever had numbness or tingling in your arms, hands, legs or feet?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
8. Have you ever become ill from exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
9. Do you cough, wheeze or have trouble breathing during or after activity?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Do you have seasonal allergies that require medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
List allergies: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		

The above information is correct the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk to injury in athletic participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, trainers or other personnel properly trained.

Signature of parent/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of athlete: \_\_\_\_\_



**RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, hereby give my consent to \_\_\_\_\_  
 (Parent/legal guardian) (Doctor, hospital, clinic, agency or school)

Its directors, designee or records department, to release information contained in \_\_\_\_\_  
 (Child's name)

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Record number: \_\_\_\_\_, record's

to the individual or organization listed below:

1. Name or title of person(s) or organization to whom disclosure is to be made:

ATTN: Chickasaw Children's Village  
 1185 Village Road  
 Kingston, Oklahoma 73439

Method(s) of Release:  
 Verbal telephone  Written  
 Electronic mail  Fax

2. Specific type of information to be disclosed:

Medical  Psychological  Vocational  
 Other: \_\_\_\_\_

3. The purpose and need for such disclosure:

Establish eligibility for services  Case staffing  
 Determine need for and/or type of treatment  Other: \_\_\_\_\_

4. The confidential information I authorize for release may include information about communicable or venereal disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

5. I understand this release may be revoked at any time and shall be valid no longer than is reasonably necessary to accomplish the purpose for which it is given.

6. This release expires up the student's exit from the Chickasaw Children's Village, unless otherwise indicated.

\_\_\_\_\_  
 Parent/legal guardian signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 Witnessed by

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date



**PRIVACY ACT UNDERSTANDING AND LEGAL SIGNATURE FORM**

I have read the Privacy Act Notice (Public Law 93-579) and have been informed that my child's records in the health and medical records system at:

The Chickasaw Nation Division of Health

I understand that the information given by me or collected is necessary for the Chickasaw Nation Division of Health to provide services for my child's health and well being. Furthermore, I have been informed that my child's records or any portion of the records shall not be disclosed to another agency or person unless specified as routine use without my signed consent.

I give permission for Chickasaw Children's Village staff to accompany my child to the health facility and to be in the examination room during appointments (with the exception of mental health appointments).

\_\_\_\_\_  
Student name

\_\_\_\_\_  
Signature of parent/legal guardian, if listed above is a minor.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



**CONSENT FOR URINE DRUG SCREEN**

**Student name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The Chickasaw Children's Village has a zero tolerance substance abuse policy.**

In keeping with this policy it may be necessary to do random drug testing as needed while my child is here on the CCV campus. I understand that this screening will be a urine drug screening. My signature below indicates that I give my consent for my child to receive urine drug screens at the *Chickasaw Children's Village*. I further understand that staff of the same gender may observe collection of urine. Results from these screenings will be confidential and known only to necessary staff and that I will receive results if requested.

This consent is in effect from \_\_\_\_\_ to \_\_\_\_\_.  
Date Date

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



**EDUCATION INFORMATION**

Previous school attended: \_\_\_\_\_

Address: \_\_\_\_\_

Date and grades completed: \_\_\_\_\_

Please provide most current copy of your report card.

Reason for leaving:

Has your child: (check appropriate boxes)

Been retained in same grade?  Yes  No

Been tested for Special Education,  
 Attention Deficit Disorder and/or Learning  
 Disabilities Disorder?

Yes  No Please explain:

\_\_\_\_\_

Received speech therapy?  Yes  No

Been in special education classes or have  
 classroom modifications?  Yes  No

**Consent for Release of Education Records**

I authorize \_\_\_\_\_ School District and all education departments thereof to release all portions of my child's educational record, which may be confidential or otherwise, including special education records, to:

Chickasaw Children's Village  
 1185 Village Road  
 Kingston, Oklahoma 73439  
 (580) 564-3060  
 Fax: (580) 564-3605

Student name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Signature of parent/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Attention:** According to the Family Educational Rights and Privacy Act of 1974 (Public Law 93-380) the parents, legal guardians or 18-year-old students have the right to make a written request to view any records released.





**CELL PHONE POLICY**

The following cell phone policy was presented by the Chickasaw Children's Village Students Action Committee and adopted by the student body of the Chickasaw Children's Village. Students and parents/legal guardians will be asked to sign this policy stating that they understand and agree to this policy.

The use of cell phones is considered a privilege. Any inappropriate use of the phones will result in consequences for the students.

1. Signed form from parents/legal guardians and students releasing CCV from all responsibility of phone (stolen, lost, damaged or wrongful use).
2. Students will only be allowed to use phones from 5:00 p.m. (or after study hall) to 10:00 p.m. (or their lights out time in their cottage) on weekdays. On the weekends the time will be 9:00 a.m. to bedtime in their cottage. Phones will be turned in to the house parents each night.
3. Students in extracurricular activities will only be allowed to take them if the house parent is in attendance for the activity (if school allows).
4. When phones are checked in with the house parent, they will be checked for sim cards.

**CONSEQUENCES FOR IMPROPER PHONE USE**

1. 1<sup>st</sup> Offense – Loss of phone for a certain amount of time.
2. 2<sup>nd</sup> Offense – Loss of phone for a longer period of time.
3. 3<sup>rd</sup> Offense – Phone returned to parent (if phone returns to CCV it will be kept in the main office until the end of school semester or year depending on the offense).
4. The amount of time and consequence will be relative to the offense.

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

CCV staff signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **CHICKASAW CHILDREN'S VILLAGE HANDBOOK**

The Chickasaw Children's Village Handbook is presented to each student and parent/guardian during orientation or when the student enrolls at the CCV. The staff has read or explained the expectations and rules of the CCV to the students and parents/guardians.

I, \_\_\_\_\_ (student), have been provided with the Chickasaw Children's Village Handbook and understand that I must follow the guidelines outlined in this handbook.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_, parent of \_\_\_\_\_, have been provided with the Chickasaw Children's Village Handbook and understand and will help my child abide by the rules outlined within this handbook.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of director: \_\_\_\_\_ Date: \_\_\_\_\_



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Governor**

Dear parents/legal guardians:

The Chickasaw Children's Village requests permission to use photographs, audio tapes, video tapes/films and DVDs of your child taken during the school year. This project is to showcase our Native American students enrolled at the Chickasaw Children's Village. The photos, videos and DVDs will be used for PowerPoint presentations, newsletters, tribal web pages and television media. If you have any questions, please contact us at (580) 564-3060.

Thank you!

Name of student: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Grade: \_\_\_\_\_

Name of parent/legal guardian: \_\_\_\_\_

Yes! You have my permission to use photos, DVDs or audio/video of my child.

No! You do not have my permission to use photos, DVDs or audio/video of my child.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/legal guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Received by Chickasaw Children's Village on:

Date: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_



## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **What is medical information?**

The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by the Chickasaw Children's Village or CCV, health plan or others and 2) relates to your past, present or future physical or mental health or condition; the provision of health care (e.g., mental health) to you; or the past, present or future payment for the provision of health care to you.

***The CCV employs licensed mental health professionals and support staff who are required to comply with the Oklahoma Mental Health Law (43A O.S. 1-101) and the various statutes governing professions and occupations in Oklahoma (59 O.S. 15.1 et seq.), more specifically those statutes governing mental health professionals. The CCV creates and maintains treatment records that contain individually identifiable health information about you. These records are generally referred to as medical records or mental health records, and this notice, among other things, concerns the privacy and confidentiality of those records and the information contained therein.***

### ***Uses and disclosures without your authorization - for treatment, payment or health care operations***

Federal privacy rules and regulations allow health care providers (CCV) who have had a direct treatment relationship with you to use or disclose your personal health information, without your written authorization, to carry out the health care provider's own treatment, payment or health care operations. The CCV may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

***An example of a use or disclosure for treatment purposes:*** if CCV decides to consult with another licensed health care provider about your condition, CCV is permitted to use and disclose your personal health information, which is otherwise confidential, to help in the diagnosis or treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard because physicians and other health care providers need access to the full record and/or full and complete information to provide quality care. The word treatment includes, among other things, the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

***An example of a use or disclosure for payment purposes:*** if your health plan requests a copy of your health records or a portion thereof to determine whether or not payment is warranted under the terms of your policy or contract, CCV is permitted to use and disclose your personal health information.

***An example of a use or disclosure for health care operations purposes:*** if your health plan decides to audit CCV to review competence and performance or to detect possible fraud or abuse, your mental health records may be used or disclosed for those purposes.

*PLEASE NOTE: The CCV may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.*

### **Other Uses and Disclosures Without Your Authorization**

CCV may be required or permitted to disclose your personal health information (e.g., your mental health records) without your written authorization. The following circumstances are examples of when such disclosures may or will be made:

- 1) if disclosure is compelled by a court pursuant to an order of a court with jurisdiction;
- 2) if disclosure is compelled by a board, commission or administrative agency for purposes of adjudication pursuant to its lawful authority; or
- 3) if disclosure is compelled by a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum (e.g., a subpoena for mental health records), notice to appear or any provision authorizing discovery in a proceeding before a court or administrative agency.
- 4) if disclosure is compelled by a board, commission or administrative agency pursuant to an investigative subpoena issued pursuant to its lawful authority.
- 5) if disclosure is compelled by an arbitrator or arbitration panel, when arbitration is lawfully requested by either party, pursuant to a subpoena duces tecum or any other provision authorizing discovery in a proceeding before an arbitrator or arbitration panel.
- 6) if disclosure is compelled by a search warrant lawfully issued to a governmental law enforcement agency.
- 7) if disclosure is compelled by the patient or the patient's representative pursuant to federal statutes or regulations (e.g., the federal Privacy Rule, which requires this notice).
- 8) if disclosure is compelled by the applicable tribal, federal or state child abuse laws which require reporting if there is a reasonable suspicion of child abuse or neglect.
- 9) if disclosure is compelled by the applicable federal, tribal or state abuse laws which require reporting if there is a reasonable suspicion of elder abuse or dependent adult abuse.
- 10) if disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or to the person or property of others, and it is determined that disclosure is necessary to prevent the threatened danger.
- 11) if disclosure is compelled or permitted by the fact that you tell us of a serious threat (imminent) of physical violence to be committed by you against a reasonably identifiable victim or victims.
- 12) if disclosure is compelled or permitted, in the event of your death, to the coroner to determine the cause of your death.
- 13) CCV is permitted to contact you without your prior authorization to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you.
- 14) if disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, including but not limited to, audits, criminal or civil investigations, or licensure or disciplinary actions.
- 15) if disclosure is compelled by the secretary of the U.S. Department of Health and Human Services to investigate or determine CCV compliance with privacy requirements under the federal regulations.
- 16) if disclosure is otherwise specifically required by law.

**PLEASE NOTE:** The above list is not an exhaustive list, but informs you of most circumstances when disclosures without your written authorization may be made. Other uses and disclosures will generally be made, but not always, only with your written authorization, even though federal privacy regulations or applicable law may allow additional uses or disclosures without your written authorization. Uses or disclosures made with your written authorization will be limited in scope to the information specified in the authorization form, which must identify the information in a specific and meaningful fashion. You may revoke your written authorization at any time, provided that the revocation is in writing and except to the extent that CCV has taken action in reliance on your written authorization. Your right to revoke an authorization is also limited if the authorization was obtained as a condition of obtaining insurance coverage for you. In general, uses or disclosures by CCV of your personal health information without your authorization will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure. Similarly, when CCV

requests your personal health information from another health care provider, health plan or health care clearinghouse, CCV will make an effort to limit the information requested to the minimum necessary to accomplish the intended purpose of the request. As mentioned above, the minimum necessary standard does not apply to disclosures to or requests by a health care provider for treatment purposes because health care providers need complete access to information in order to provide quality care.

### **Your rights regarding protected health information**

- 1) You have the right to request restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment or health care operations. CCV is not required to agree to your requested restriction. If CCV does agree, CCV will maintain a written record of the agreed upon restriction.
- 2) You have the right to receive confidential communications of protected health information from CCV by alternative means or at alternative locations.
- 3) You have the right to inspect and copy protected health information about you by making a specific request to do so in writing. This right to inspect and copy is not absolute. In other words, CCV is permitted to deny access for specified reasons. For instance, you do not have the right of access with respect to CCV psychotherapy notes. The term psychotherapy notes means notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's mental health record. The term excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
- 4) You have the right to amend protected health information in CCV records by making a request to do so in writing that provides a reason to support the requested amendment. This right to amend is not absolute. CCV is permitted to deny the requested amendment for specified reasons. **You also have the right, subject to limitations, to provide CCV with a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.**
- 5) You have the right to receive an accounting from CCV of the disclosures of protected health information made by CCV in the six years prior to the date on which the accounting is requested. As with other rights, this right is not absolute. CCV is permitted to deny the request for specified reasons. For instance, CCV does not have to account for disclosures made to carry out CCV treatment, payment or health care operations. CCV also does not have to account for disclosures of protected health information that are made with your written authorization, since you have a right to receive a copy of any such authorization you sign.
- 6) You have the right to obtain a paper copy of this notice from CCV upon request.

***PLEASE NOTE: to avoid confusion or misunderstanding, CCV asks that if you wish to exercise any of the rights enumerated above, you put your request in writing and deliver or send the writing to CCV. If you wish to learn more detailed information about any of the above rights, or their limitations, please contact the CCV privacy officer. CCV is willing to discuss any of these matters with you.***

### **Chickasaw Children's Village responsibilities**

CCV is required by law to maintain the privacy and confidentiality of your personal health information. This notice is intended to let you know of CCV's legal duties, your rights and CCV privacy practices with respect to such information. CCV is required to abide by the terms of the notice currently in effect. CCV reserves the right to change the terms of this notice and/or CCV privacy practices and to make the changes effective for all protected health information that CCV maintains, even if it was created or received prior to the effective date of the notice revision. If CCV makes a revision to this notice, CCV will make the notice available at CCV offices upon request on or after the effective date of the revision and CCV will post the revised notice in a clear and prominent location.

The privacy officer of the CCV will develop, implement and adopt clear privacy policies and procedures. The privacy officer will be responsible for assuring that these privacy policies and procedures are followed by CCV mental health professionals and any employees who work for or who may work for the CCV in the future. The privacy officer will have trained or will train any employees who may work for the CCV so that they understand its privacy policies and procedures. In general, patient records and information about patients are treated as confidential within the CCV and are released to no one without the written authorization of the patient, except as indicated in this notice or except as may be otherwise permitted by law. Patient records are kept secured so that they are not readily available to those who do not need them.

If you believe your privacy rights may have been violated, you can submit a complaint to the CCV's privacy officer or to the secretary of the U.S. Department of Health and Human Services. You may file a complaint with the CCV by simply providing the privacy officer with a writing that specifies the manner in which you believe the violation occurred, the approximate date of such occurrence and any details that you believe will be helpful. The OSDC privacy officer's telephone number is (580) 436-1222. The privacy officer will not retaliate against you in any way for filing a complaint with CCV or with the secretary of the U.S. Department of Health and Human Services. Complaints to the secretary must be filed in writing. A complaint to the secretary can be sent to:

**U.S. Department of Health and Human Services  
Office for Civil Rights  
1301 Young Street, Suite 1169  
Dallas, Texas 75202**

**For more information please visit <http://www.hhs.gov/ocr/privacy/hipaa/complaints>.**

If you need or desire further information related to this notice or its contents, or if you have any questions about this notice or its contents, please contact the CCV privacy officer. As the contact person for the CCV, the privacy officer will do his or her best to answer your questions and to provide you with additional information.

This notice first became effective on April 14, 2003.



**Child Intake Form**

**I. Demographics**

Last name: \_\_\_\_\_ First: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Tribal affiliation: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (office): \_\_\_\_\_ (cell): \_\_\_\_\_

Name of person completing form: \_\_\_\_\_

Are you the parent of the child?  Yes  No  
If no, are you the legal guardian?  Yes  No

In case of an emergency, contact: Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**II. Present life situation**

**List all household members**

Name	Age	Relationship	History of drug or alcohol abuse?

Do you live in:  house  apartment  duplex  other: \_\_\_\_\_

Do you have:  running water  electricity  gas  propane  other: \_\_\_\_\_

How are your basic needs met? (sources of income): \_\_\_\_\_

Are you involved in social activities?  Yes  No

If yes, describe:

Á

Have there been any significant changes to these activities in the past six months?  Yes  No

If yes, describe:

Á

Is the child's parent/guardian willing to participate in therapeutic services?  Yes  No

If yes, describe:

Á

**Parents' information:**

Father's name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Education level: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Mother's name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Education level: \_\_\_\_\_ Birth date: \_\_\_\_\_

**Stepparents' information** (if applicable):

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Education level: \_\_\_\_\_  
Describe the relationship with child: \_\_\_\_\_  
Schedule of visitation with non-custodial parent: \_\_\_\_\_  
What was the age of the child when stepparent entered the family? \_\_\_\_\_

**III. Medical/emotional history**

Please list all inpatient and outpatient treatment for major medical/mental health issues.

Reason	Where	When	How long?	Doctor/counselor

Please list your primary care physician: \_\_\_\_\_

Is your child on any medications?  Yes  No  
If yes, please list (include over the counter medication):

Are there any significant allergies (including medication)?  Yes  No  
If yes, please list:

Has there been any testing for possible special education and/or school placement?  Yes  No  
If so, please list:

---

**IV. Development**

**Pregnancy and labor**

Was there any complication related to the pregnancy of this child?  Yes  No  
If yes, please list:

Please list all medications taken during pregnancy.

During the pregnancy:

How many cigarettes were smoked a day? \_\_\_\_\_

How often was alcohol used? \_\_\_\_\_ Quantity? \_\_\_\_\_

How often were street drugs used? \_\_\_\_\_ Quantity? \_\_\_\_\_

Did the child require oxygen at birth? \_\_\_\_\_

Was the child cuddly as a baby? \_\_\_\_\_

Was the child irritable as a baby? \_\_\_\_\_

**Developmental Milestones**

At what age did the child:

Sit independently: \_\_\_\_\_ Crawl: \_\_\_\_\_ Walk independently: \_\_\_\_\_

Does the child have difficulty with age appropriate activities? (e.g., riding a bike, catching a ball, dressing, etc.)

Does/did the child coo, babble and generally respond to attempted communication?

---

**V. Education**

What is the child's current grade level? \_\_\_\_\_

Please list any problems the child has experienced at school:

What adjustments have been made to address these problems?

Please indicate if the child has a problem with:

.... alertness to the world around them? \_\_\_\_\_

.... attention span? \_\_\_\_\_

.... ability to problem solve? \_\_\_\_\_

.... ability to do math in his/her head? \_\_\_\_\_

.... appears to be on grade level with other children their age? \_\_\_\_\_

Are there any speech, language, hearing, visual or other learning disabilities? If so, please describe:

Does the child have an immunization record that has been verified by school? \_\_\_\_\_

---

## VI. Family history/relations

Please list if the biological parents' families:

- .... had a history of depression or anxiety? \_\_\_\_\_
- .... had a history of emotional abuse? \_\_\_\_\_
- .... attempted or committed suicide? \_\_\_\_\_
- .... used street drugs? \_\_\_\_\_
- .... was a heavy drinker? \_\_\_\_\_
- .... had problems with the law? \_\_\_\_\_
- .... had other serious problems? \_\_\_\_\_

Describe the child's parents' relationship to each other?

Describe the child's relationship with his/her brothers/sisters:

- |  |  |
|--|--|
| <input type="checkbox"/> Good                    | <input type="checkbox"/> Will not relate to them |
| <input type="checkbox"/> Fair                    | <input type="checkbox"/> Poor                    |
| <input type="checkbox"/> Loving and affectionate | <input type="checkbox"/> Will not share          |
| <input type="checkbox"/> Hits or aggravates      | <input type="checkbox"/> Other: _____            |

Describe the child's relationship with his/her peers:

- |  |  |
|--|--|
| <input type="checkbox"/> Good                    | <input type="checkbox"/> Will not relate to them |
| <input type="checkbox"/> Fair                    | <input type="checkbox"/> Poor                    |
| <input type="checkbox"/> Loving and affectionate | <input type="checkbox"/> Will not share          |
| <input type="checkbox"/> Hits or aggravates      | <input type="checkbox"/> Other: _____            |

What responsibilities does the child have at home?

What kinds of discipline are used in the child's family? (Please check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Try to talk or reason with the child | <input type="checkbox"/> Spank           |
| <input type="checkbox"/> Firm language                        | <input type="checkbox"/> Deny privileges |
| <input type="checkbox"/> Stand in corner                      | <input type="checkbox"/> Nothing works   |
| <input type="checkbox"/> Other: _____                         |  |

Which of the above discipline methods seem to work the best?

Have there been any family disruptions, (e.g. death of family member, friend or pet, divorce, violence in the home, alcohol/drug use in the home, birth of sibling, remarriage, etc.) which might have affected the child?

---

## VII. Abuse and trauma history

Has your child ever been a victim of abuse or neglect?  Yes  No

If yes, please describe:

How has this affected your child? \_\_\_\_\_

Has your child ever been sexually molested?  Yes  No

If yes, when? \_\_\_\_\_

How has this affected your child? \_\_\_\_\_

Has the child ever been convicted of a crime?  Yes  No

If yes, please describe:

Is your child sexually active?  Yes  No

**Has your child had struggles with:**

Sexual identity

Sexual conflict/guilt

Sexual performance

### VIII. Addiction history

Has your child been involved in risk taking behaviors (e.g. gangs, stealing, risky driving, DUI/DWI, etc.)?

Yes  No

If yes, please describe:

How have these behaviors affected his/her personal life (e.g. home, school, work):

Has the child been exposed to addictive behaviors (e.g. tobacco, alcohol, drugs, porn)?  Yes  No

If yes, please describe? \_\_\_\_\_

**Please indicate your use of the following:**

	Daily	2-3 x week	Once week	2-3 x month	Once a month	4-6 x year	Once a year	Age at 1 <sup>st</sup> use	Date of last use
Beer									
Wine									
Liquor									
Marijuana									
Cocaine									
Heroin									
Methamphetamine									
Prescription drugs									
Other (name):									
Smokeless tobacco:									
Smoking tobacco:									

## IX. Presenting problem

Behavior problems	Age	Mild	Moderate	Severe
1. Excessive crying	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Excessive nail biting	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Excessive vomiting	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Thumb sucking	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Frequent chewing on substances	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Stuttering	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Bed wetting after age 3	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Soiling after age 3	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Chronic constipation	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Chronic diarrhea	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Temper tantrums	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Masturbation	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Extreme shyness	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Extreme goodness	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Fighting and quarrelling	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Lying	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Stealing	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Frequent nightmares	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Sleep walking	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Tics (muscle spasms or jerks)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Fears	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Fire setting	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Anxious states	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Sexual problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Problems with authorities	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Withdrawal from friends	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the child have any other specific fears, emotional reactions, behavioral problems, etc., that are a concern?

Please list any other specific question or concerns you would like the evaluation to address.

Is there any additional information that may be helpful to the evaluation of the child?

Would you like information on advance directives?  Yes  No

## Consent for Treatment

**Please read the following paragraphs carefully. This consent will remain in effect until it is revoked in writing or termination of treatment.**

Counseling is as much an art as it is a science. While many people have been shown to benefit from it, the results cannot be guaranteed. The benefit a person receives from counseling depends on many variables, e.g., how long he/she has had the problems(s), severity of problem(s) and the support he/she receives from family, friends, church and community. The client's level of commitment to therapy is critical to success. Due to each person's uniqueness, treatment may vary greatly.

It is important to be aware of the possible risks of being involved in counseling. Although counseling is unlikely to be harmful, it may not produce any significant improvements. Also, self-examination and the exploration of one's feeling may result in periods of emotional pain. Finally, progress in therapy is typically not steady. Your full involvement and cooperation in setting treatment goals and in the counseling process itself are necessary to realize maximum gains.

### Confidentiality

By law and professional ethics, your sessions are strictly confidential. No information will be shared with anyone without your written permission. If you are seeing another therapist or health professional, it may be necessary for the Chickasaw Children's Village (CCV) to contact that person so that our efforts can be coordinated. If this is necessary, the CCV counselor will ask for and obtain your written permission. Exceptions to this confidentiality policy are as follows:

- If CCV is ordered by the court to testify or release records.
- If you are a victim or perpetrator of child abuse, CCV is required by law to report this to the authorities responsible for investigating child abuse.
- If you are a victim or perpetrator of elder or dependent adult abuse, the CCV counselor is required by law to report this to adult protective services or other appropriate authorities.
- If you threaten harm to yourself, someone else or the property of others, the CCV counselor may be required to call the police and warn the potential victim or take other reasonable steps to prevent the threatened harm.

By signing below, I acknowledge that I have read the above statements and that I am aware that counseling carries no precise guarantees of success. Understanding this, I still choose to participate in the counseling process. I also understand that no information will be shared with anyone without written permission, except for those circumstances described above.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

CCV counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# KINGSTON INDEPENDENT SCHOOL DISTRICT

Dear Parent:

The Kingston Independent School District requests permission to use photographs, audio-tapes and video tapes/films and DVDs of your child taken during the \_\_\_\_\_ school year. This project is part of our efforts to showcase our outstanding students who are enrolled in the Kingston I.S.D. The photos, videos and DVDs will be used for educational and promotional purposes including PowerPoint presentations, newsletters, print media, school web page, yearbook, school fund raisers, television media, national board certification and broadcast media.

Please sign the attached form and return it to the school. If you have any questions, please call (580) 564-2384.

.....

Name of student: \_\_\_\_\_ Home phone: \_\_\_\_\_

School (check one):  KES  KMS  KHS Cell phone: \_\_\_\_\_

Grade: \_\_\_\_\_

Name of parent/guardian: \_\_\_\_\_ Day phone: \_\_\_\_\_

**YES! You have my permission to use photos, DVDs, audio/videos or the work of**

\_\_\_\_\_  
STUDENT NAME

To promote the school district or inform the public about Kingston Public Schools through brochures, power point presentations, DVDs, videos, newspapers, yearbook or other publications.

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN