Pierre Indian Learning Center
3001 E. Sully Avenue
Pierre, South Dakota 57501-4419
Phone: (605) 224-8661 Fax: (605) 224-8465

nne River Sioux Tribe
Creek Sioux Tribe
eau-Santee Sioux Tribe
Brule Sioux Tribe
Lakota Nation
a Nation
ud Sioux Tribe
e Sioux Tribe of Nebraska
on-Wahpeton Oyate
Lake Nation
ng Rock Sioux Tribe
n, Hidatsa & Arikara Nation
Mountain Band
ppewa Indians
bago Tribe of Nebraska
n Sioux Tribe

Dear Parent/Guardian:

Health care is a very important part of the program we provide to children while they are in attendance at Pierre Indian Learning Center. Our services include an on-site health clinic for injuries, illnesses, medications and health education, working closely with family physicians and specialists in the Pierre area.

If you don't have personal health insurance for your child, please seek coverage by Medicaid or through CHIP (a federally funded health insurance for children). **This coverage must be in place before you send your child to Pierre Indian Learning Center. Please contact a social worker in your area for medical coverage.**

The following must be completed and on file at Pierre Indian Learning Center **before** child arrives at our school:

1) **Proof of current health insurance and/or Medicaid coverage; we require a copy of the open and active card that includes name, policy/ID number.**
2) **A complete physical exam**
3) **A complete dental exam**
4) **A complete vision exam. If glasses are recommended, they must accompany the student to school.**
5) **Immunization Records**

Due to the high cost of medical care, it is important that these items are covered through your Indian Health Service Unit or through the clinic of your choice, **BEFORE** your child comes to school.

We look forward to working with your child.

Sincerely,

Mitchell Kleinsasser, RN
PILC School Nurse

HEALTH CARE INFORMATION

The following must be completed prior to admission to PILC

Student Name _____

P.O. Box _____ Physical Address _____

City _____ County _____ State _____ Zip Code _____

The student resides with _____

Relationship to the student _____

Home Phone _____ Work Phone _____

Social Security Number (student) _____ Sex (student) ___ Birth Date (student) _____

Does your family have a state or tribal social worker who assists you? ( ) Yes ( ) No

If yes, name: _____ Phone _____

Mailing Address _____ City _____ State _____ Zip _____

Previous School _____ Last grade completed _____

Mailing Address _____ City _____ State _____ Zip _____

Medicaid Number _____ **or**

Insurance Company Name _____ Policy Number _____

Indian Health Service Unit address where current information can be requested

_____

_____

Current Immunizations must accompany this application (see enclosed physical form)

Does the student have **allergies** to medications? ( ) Yes ( ) No

If yes, which medication(s) _____

Reaction(s)? _____

Does the student have **allergies** to foods? ( ) Yes ( ) No

If yes, which food(s) _____

Reaction(s)? _____

Is the student disabled physically or mentally? ( ) Yes ( ) No

If yes, in what way? _____

When/where was the disability identified _____

_____

Parent/Guardian Signature _____ **Date** _____

RELEASE OF INFORMATION CONSENT

This is to certify that I, _____, do hereby agree to the release of
(PRINT: Parent/Legal Guardian)

medical and psychological/psychiatric report, evaluation or hospitalization records for:

_____ / _____ / _____
(PRINT: Student's Name) (Student's Date of Birth) (Student's Social Security Number)

This release should include immunization records, medical records, hospital stays, and psychiatric or other treatment records. All this information will be filed in the student's health records with other confidential information.

REQUESTOR **Pierre Indian Learning Center**
3001 E Sully Avenue
Pierre, SD 57501-4419

FACILITY WHERE STUDENT'S MEDICAL RECORDS ARE:
(Please Print)

NAME: _____

ATTN: _____

FAX NUMBER: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Parent/Guardian Signature _____ **Date** _____

CONSENT OF PARENT OR LEGAL GUARDIAN WHO HAS PRIMARY RESPONSIBILITY

FOR THE CARE OF THE CHILD

Student Name (please print) _____ DOB _____

I/We, _____
being the parent(s) or legal guardian(s)of the above-named student have read and understand the consent and give my (our) consent for the Pierre Indian Learning Center (PILC) to provide the following health services for this student **during the time he/she is enrolled at PILC:**

1. Health care including, but not limited to, medical and nursing examinations and treatments, laboratory studies, x-ray procedures, immunizations and blood draws ordered by the physician. The treatment may include medication.

2. Health education and instruction including, but not limited to, AIDS education, self-examination, routine health maintenance, age and gender appropriate sexuality education, and sexually transmitted infection (STI) education, and access to SD Family Planning Clinic.

3. Emergency Optometry care.

4. Emergency care.

5. Emergency health care for accidents and/or illness, which may include surgery if indicated.

6. Transportation of the child to and from health facilities for these services.

7. Emergency mental health care.

8. Dental exams, follow up and emergency dental care.

Parent/Guardian Signature _____ **Date** _____

I. **CHILD'S HEALTH HISTORY** – IMPORTANT, the listed below item needs to be completed.

If YES, an explanation needs to be included.

Has your child had:			**Describe**
Suicidal Ideation	( ) Yes	( ) No	Currently _____
Previous diagnosis of ADHD/ADD	( ) Yes	( ) No	Currently _____
Chickenpox	( ) Yes	( ) No	Currently _____
Ear infections	( ) Yes	( ) No	Currently _____
Pneumonia	( ) Yes	( ) No	Currently _____
Bronchitis	( ) Yes	( ) No	Currently _____
Asthma	( ) Yes	( ) No	Currently _____
Urinary infection	( ) Yes	( ) No	Currently _____
Diabetes	( ) Yes	( ) No	Currently _____
Hepatitis	( ) Yes	( ) No	Currently _____
Seizures	( ) Yes	( ) No	Currently _____
Bedwetting problems	( ) Yes	( ) No	Currently _____
Sleeping problems	( ) Yes	( ) No	Currently _____
Eating problems	( ) Yes	( ) No	Currently _____
Hyperactivity	( ) Yes	( ) No	Currently _____
Stammering/lisping	( ) Yes	( ) No	Currently _____
Accident prone	( ) Yes	( ) No	Currently _____
Depressed/withdrawn	( ) Yes	( ) No	Currently _____
Nervousness	( ) Yes	( ) No	Currently _____
Constipation and/or bowel accidents	( ) Yes	( ) No	Currently _____
Injuries (burns, broken bones, knocked unconscious, etc.)	( ) Yes	( ) No	Currently _____
Cardiac Defect/History of Cardiac Problems	( ) Yes	( ) No	Currently _____
MRSA (Methicillin-resistant Staphlococcus Aureaus	( ) Yes	( ) No	Currently _____
Fainting with exertion or activity	( ) Yes	( ) No	Currently _____

Explanation _____

_____

Any serious sickness, hospitalization or surgeries? ( ) Yes ( ) No

If yes, please state date, type of sickness/surgery, hospital, and physician's name who treated the child.

_____

_____

Does your child wear glasses for vision problems? ( ) Yes ( ) No

Has your child ever seen a doctor for hearing problems ( ) Yes ( ) No

When did your child last see a medical doctor or a physician's assistant? _____

For what? _____

_____

Parent/Guardian Signature _____ **Date** _____

NOTE: If the student is or has taken **medication** for psychological problems, (example: hyperactivity and/or depression), **the doctor's records must accompany this application.**

ADDITIONALLY: in the case of psychiatric hospitalization, **a discharge summary must accompany this application!**

PRESENT MEDICATIONS

If the applicant is receiving any medications at the present time, please list name of drug, dosage, date started, purpose and any adverse reactions to the drug. (Please include oral and topical medications.)

1. Drug:_____ Dosage:_____ Date Started:_____
   Purpose:_____
2. Drug:_____ Dosage:_____ Date Started:_____
   Purpose:_____

PAST MEDICATIONS

If the applicant has received any other medication in the past, please list name of drug, dosage, date started, purpose, date discontinued and reason(s) for discontinuing.

1. Drug:_____ Dosage:_____ Date Discontinued:_____
   Purpose:_____
2. Drug:_____ Dosage:_____ Date Discontinued:_____
   Purpose:_____

Has this child been in treatment for Emotional, Alcohol/Drug or Behavior issues?

Explain, Date(s)

_____

_____

_____

Other problems or additional information helpful to the care of your child.

_____

_____

Parent/Guardian Signature _____ **Date** _____

II. FAMILY HEALTH HISTORY

Please check any of the following diseases or health problems that have affected your family. (Example: mother, father, grandparents, etc.)

DISEASE OR PROBLEM	STUDENT	RELATIVE (adult's only)	EXPLAIN
Diabetes			
Epilepsy			
Cancer			
High Blood Pressure			
Heart Attacks			
Urinary/Kidney problems			
Pneumonia			
Tuberculosis			
Hearing problems			
Smoking/Alcohol			
Drug addiction			
Nervous/Mental disorders			
Hepatitis			
Family history of sudden unexplained death under age 50.			

Parent/Guardian Signature _____ Date _____

BEHAVIORAL

Is there a behavioral plan in place for your child at school? (IEP or academic file)? Yes_____ No_____

Behavioral Concerns (if applicable)

____Hitting	____Kicking
____Spitting	____Swearing
____Hair Pulling	____Running Away
____Fire Starting	____Inappropriate Sexual Behavior
____Cruelty to animals	____Criminal Activity

____Inappropriate touching (describe) _____

_____

_____

____Self Abusive (describe) _____

____Other(s) _____

1. What does your child do when angry or frustrated?

_____

_____

2. What typically will calm or stop your child from being angry or frustrated?

_____

_____

3. Does your child display physically aggressive behaviors to him/herself or other(s)?

If so, how often and what is the duration of the behavior? _____

_____

_____

4. Please list any other behavior concerns that you have for your child:

_____

_____

5. Is your child presently, or in the past, on Probation? Yes_____ No_____

If YES, please explain_____

_____

_____

Name of Court Services/Probation Officer: _____

Parent/Guardian Signature _____ Date _____

Avera

Avera 2020-2021

COVID-19 Screening and Vaccine Administration Record

PLEASE PRINT:

Last Name: _____ **First Name:** _____ **Date of Birth:** _____ **Age:** _____

Employer: _____ **Email Address:** _____ **Phone Number:** _____

Address: _____

PLEASE ANSWER THESE QUESTIONS	**YES**	**NO**
1. Have you received a previous dose of the COVID-19 vaccine?		
a. If yes, Date and manufacturer of previous dose_____		
b. If yes, did you experience an allergic reaction after the vaccine (hives, angioedema, respiratory distress (e.g., wheezing, stridor), facial/lip swelling)?		
2. Are you under the age of 18? (*If you are under 18 you must have a parental consent to receive vaccine. Pfizer can be given to those 12 and older; Moderna and Janssen can be given to those 18 and older.)*		
3. Are you currently on quarantine due to an exposure to COVID-19?		
4. Are you currently on isolation due to being diagnosed with COVID-19 in the last 10 days?		
5. Have you received monoclonal antibodies or convalescent plasma in the last 90 days for the treatment of COVID-19?		
6. Have you had a serious allergic reaction or anaphylaxis due to ANY cause (food, medications, bees, etc.)		
7. Do you have an allergy to polyethylene glycol (PEG), polysorbate or a component of the vaccine? (Refer to the EUA Fact Sheet of the Pfizer, Moderna, or Janssen COVID-19 vaccines.)		
8. Have you had an allergic reaction or anaphylaxis to a prior vaccine or other injectable medicine (intravenous, subcutaneous, or intramuscular)?		
9. Are you pregnant or breastfeeding?		
a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your Physician?		
10. Do you have HIV, other immunocompromising conditions or take immunosuppressive medication or therapies?		
a. If yes, have you discussed and received counseling regarding COVID-19 vaccination from your Physician		

I received and read the Emergency Use Authorization fact sheet information regarding the possible side effects, risks and contraindications of the COVID-19 vaccine. Avera will disclose this immunization to the appropriate State Immunization Registry Database.

If the named individual is under the age of 18, as parent or guardian I acknowledge receipt of the Emergency Use Authorization and consent to have the Pfizer vaccine administered to him/her. Parent/Guardian: _____

ADMINISTRATIVE USE ONLY:

Vaccine: COVID-19	Emergency Use Authorization (Circle One): Pfizer – BioNTech COVID-19 Vaccine Moderna COVID-19 Vaccine Janssen COVID-19 Vaccine		
Date & Time Vaccine Administered:	Vaccine Manufacturer/Lot Number/Expiration Date:	Site	Signature & Title of Vaccine Administrator:
		IM Deltoid: Location (circle one) Left Right	

Observation Time (circle one): 15 minutes 30 minutes

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

PHYSICAL HEALTH EXAM

Date of Exam _____

STUDENTS NAME_____ Date of Birth _____

HISTORY or PRESENT

Allergies _____

Medications _____

Medical Conditions _____

Emotional/Psychiatric Conditions_____

SCREENINGS/ASSESSMENTS (Please enter dates if done previously)

Measurements _____ Height _____ Weight _____

Blood Pressure _____ Results _____/_____

Tuberculosis: Assess the individual's personal & environmental risk factors & perform tests as needed.

_____ Low Risk: No testing recommended at this time

_____ At Risk: Test performed

Date _____ Type _____ Results _____

Recommendations _____

IMMUNIZATIONS (Please review record & provide update as appropriate for age).

WE REQUIRE A COPY OF ALL IMMUNIZATIONS.

Immunizations reviewed and up to date for age ( ) Yes ( ) No

Immunizations given today _____

OTHER TESTS (Need determined by provider)

Urinalysis Date _____ Results _____

_____ Results _____

Other (specify): Date

NAME _____

PHYSICAL EXAM/ASSESSMENTS

	Normal	Abnormal	Referred	Not Evaluated	Comments/Treatment Plan
General Appearance					
Speech					
Head					
Skin					
Eyes External Aspects					
Optic Fundoscopic					
Cover Test					
Ears External Canal					
Nose, Mouth, Pharynx					
Teeth					
Heart					
Lungs					
Abdomen					
Genitalia					
Bones, Joints, Muscles					
Neurological/Social					
Fine Motor					
Communication Skills					
Cognitive					
Self-Help Skills					
Social Skills					
Glands (lymph/thyroid)					
Muscular Coordination					
Other					

COMMENTS/RECOMMENDATIONS _____

_____

_____

Provider Signature _____ Date _____

Print Name _____

Clinic/Agency (Please Print) _____