ONEIDA NATION SCHOOL SYSTEM
2024-2025 RETURNING STUDENT APPLICATION

Student Name	Grade	Date of Birth	Tribe	Roll Number

My child(ren) live(s) with: ☐ **Mother** Only ☐ **Father** Only ☐ **Both** ☐ ***Other Legal Guardian**: **submit copy of court documents.**

***Other Legal Guardian's** First Name: _____ M.I.: _____ Last Name: _____

PO Box: _____ City: _____ State: _____ Zip: _____ Relationship to student: _____

Street address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____ Work Phone: _____ dept._____

MOTHER'S INFORMATION
This is a Step-Mother ☐

Complete Name: _____

PO Box: _____ City: _____ State: _____ Zip: _____

Street Address: _____ Apt ____

City: _____ State: _____ Zip: _____

Email address: _____

Cell #: _____ Home #: _____

Work #: _____ dept. _____ x._____

FATHER'S INFORMATION
This is a Step-Father ☐

Complete Name: _____

PO Box: _____ City: _____ State: _____ Zip: _____

Street Address: _____ Apt ____

City: _____ State: _____ Zip: _____

Email address: _____

Cell #: _____ Home #: _____

Work #: _____ dept._____ x._____

◯ I would like the Johnson O'Malley **(JOM)** parent group to contact me via email to inform me of meetings.

If the child/dependent under my custody needs emergency medical treatment and I am not reachable, please contact the following persons. I understand that these contacts must be reliable contacts. *Please keep all contact information up-to-date throughout the entire school year.*

First Name	**M.I.**	Last Name	Relationship to Student	(____)_____ Cell Phone Number
First Name	**M.I.**	Last Name	Relationship to Student	(____)_____ Cell Phone Number
First Name	**M.I.**	Last Name	Relationship to Student	(____)_____ Cell Phone Number

I authorize the Principal or his/her Designee to take appropriate action to ensure that the necessary emergency medical treatment be administered to my child at the Oneida Health Center or any medical facility. I understand that the Principal or Designee will do what is in the best interest of the child.

_____ _____

Parent / Guardian Signature **Date**

Oneida Nation School System

Bus Transportation Form

Student(s) will require bus transportation: Yes ☐ No ☐ Date needing transportation to start _____

- Bus / End of Day Announcements must be called into the office **by or before 2:30 p.m.**
- Parents are responsible to coordinate transportation for students needing multiple drop-offs and or pick-ups.
- For kindergarten students: an adult must be visible at drop-off site or student will be returned to school.
- Allow at least three (3) business days for Lamer's Bus to schedule on bus route.
- Students must abide bus safety policies and procedures.

Child's Name:	Grade:	Office only to complete	Student is New/Active
_____	_____	#_____	New Active
_____	_____	#_____	New Active
_____	_____	#_____	New Active
_____	_____	#_____	New Active

Is this a new address: Yes ☐ No ☐ New address is for: ☐ Mother ☐ Father ☐ Both ☐ Other Legal Guardian

If student(s) moved to new address other than the bus pick up and or drop off, please provide the complete new address, including apartment number:

_____

Street Address Apt # City Zip Code

Student(s) live with: ☐ Mother ☐ Father ☐ Both ☐ Other Legal Guardian, name: _____

Mother / Guardian's Name: _____
Cell #: _____ (W) _____

Father / Guardian's Name: _____
Cell #: _____ (W) _____

TO SCHOOL:
Pick Up Address: _____
Street Apt # City Zip Code
This is Day Care/Childcare Address? ☐ No Yes ☐, Name: _____

FROM SCHOOL:
Drop Off Address: _____
Street Apt # City Zip Code
This is Day Care/Childcare Address? ☐ No Yes ☐, Name: _____

☐ Infinite Campus updated: _____ ☐ Bus Coordinator: _____ ☐ Lamer's: _____

BIE Home Language Survey
School Year 2024-2025

Student First Name: _____ **Student Last Name:** _____

Federal Code: 25: CFR 32.3 & Revised CFR 30.109

"It's the responsibility of the federal government to provide comprehensive education programs and services for Indians and Alaska Natives."

Federal requirements direct schools to assess the English language proficiency of students. The process begins with determining the language(s) spoken in the home of each student. BIE has contracted with WIDA (World Class Instructional Design and Assessment) to provide English Learner Assessments and Supports identified in this Home Language Survey.

BIE Mission Statement:
"Provide quality education opportunities from early childhood through life in accordance with the Tribes' needs for cultural and economic well-being..."

Purpose: The responses to the home language survey will assist in determining if a student's proficiency in English should be tested. This information is essential in order that the school to provide adequate instructional programs and services. As parents or guardians your cooperation is requested in complying with these requirements.

Please respond to each of the questions listed as accurately as possible.

For each question, write the name(s) of the language(s) that apply in the space provided. Please do not leave any question unanswered. If you have any questions, you have the right to share them before your student's English proficiency is assessed.

1. **Which language did your child learn when they first began to talk?**

   _____

   _____

2. **Which language does your child most frequently speak at home?**

   _____

   _____

3. **Which language do you (the parents/guardians) use more often when speaking with your child?**

   _____

   _____

4. **Which language is spoken more often by other adults in the home?**

_____

_____

5. **Do you believe your child might need additional support learning the academic language for math, science, reading, or writing? (if first language or other language besides English is spoken in home)**

_____

_____

Additional Information (Optional)

_____

_____

Please sign and date this form in the spaces provided below, then return this form to your child's school.

Thank you for your cooperation.

Signature of Parent or Guardian _____

Date _____ **School Official Verification** _____

Criteria for Screening

If a language other than English is identified for any of the primary language questions above, your child will be recommended for screening.

ONEIDA NATION SCHOOL SYSTEM

HEALTH FORM

In an effort to ensure that every child receives the best care while at school, we are asking every parent to answer health-related questions about their child. By being aware of the health conditions or medications your child has, we can be better prepared to help make your child's school time successful, safe and healthy. **Please complete one form per child.**

Name:	**Birthdate:**	**Grade:**

ALLERGY INFORMATION

Does your child have ALLERGIES? (type: Seasonal, Food, Medication, Insects)	**Yes** ☐	**No** ☐

Allergies

☐ Food	Specify:	**Does your child require emergency epinephrine: ☐ Yes ☐ No**
☐ Insect	Specify:	Does your child require oral antihistamine? ☐ Yes ☐ No
☐ Seasonal	Specify:	

MEDICAL and HEALTH CONDITIONS

Does your child have a chronic medical or health condition?	**Yes** ☐	**No** ☐

Has your child been diagnosed with any of the following conditions by a Healthcare Provider (check all that apply)? ***Is this a change from last school year?*** ***☐ Yes*** ***☐ No***

☐ ADD/ADHD	☐ Emotional/Behavioral/Psych	☐ Heart Condition: _____
☐ Asthma	☐ Headaches/Migraines	☐ Epilepsy/Seizures
☐ Diabetes	☐ Orthopedic	☐ Other _____

Details/Specifics regarding condition:

MEDICATIONS

MEDICATION: Is your child currently taking any medication? ☐ Yes ☐ No

Type of medication:	Reason for medication:	When is it given?

If your child uses an **inhaler**, do they **carry it with them**? *For elementary and middle school students, please discuss self-carry with school nurse*	**Yes** ☐	**No** ☐
If your child is on **nebulizer treatments**, do they need to have a **supply at school**?	**Yes** ☐	**No** ☐

ADDITIONAL INFORMATION

Has your child had hearing testing or been recommended to have one completed?	**Yes** ☐	**No** ☐
Does your child wear corrective lenses (Glasses or Contacts)?	**Yes** ☐	**No** ☐
Has the student received vaccines outside of WI? *If yes, please provide records*	**Yes** ☐	**No** ☐

_____ **Please INITIAL to verify understanding:** *The School Nurse, employed by the Oneida Comprehensive Health Division, does have access to your child's health records at the Oneida Community Health Center.*

Parent/ Guardian Signature: _____ **DATE:** _____

For office use: Initials _____ Date Received _____ F/U: Yes No Start Date _____

Oneida Comprehensive Health Division
Oneida Community Health Center
Behavioral Health Services
Anna John Resident Centered Care Community
Employee Health Nursing

ONEIDA

Oneida Community Health Center
Dental Clinic at School

Dear Parents,

The goal of the Oneida Dental Clinic is to provide a school based dental program that would allow your child to receive preventive dental care without you needing to bring her/him to the Dental Clinic. In order to accomplish this goal, the Dental Clinic, is offering to perform examinations, x-rays, cleanings, fluoride, and sealants for your child enrolled in the Oneida School system.

We realize appointments are hard to get, especially cleaning appointments. So, we hope that with this program your child will receive preventive dental care quicker and more consistently.

Please read the attached form. If you would like your child to be a part of the program, please fill out the form and return it to the school.

Please note: The procedures are strictly preventive in nature. **No other dental care, will be performed on your child in the school based program. If your child is in need of further dental treatment, you will be informed and contacted by the Oneida Dental Clinic.

Your child must be registered at the Oneida Community Health Center in order to be seen in the schools.

Thank You,

The Oneida Dental Staff

CDHC Parent Letter 3.21.18

Mailing Address: P.O. Box 365, Oneida, WI 54155
https://oneida-nsn.gov/resources/health/

Oneida Community Health Center	525 Airport Rd., Oneida, WI 54155	Phone: (920) 869-2711 or 1-866-869-2711	Fax: (920) 869-1780
Behavioral Health Services	2640 West Point Rd., Green Bay, WI 54304	Phone: (920) 490-3790 or 1-888-490-2457	Fax: (920) 490-3883
Anna John Resident Centered Care Community	2901 S. Overland Rd., Oneida, WI 54155	Phone: (920) 869-2797	Fax: (920) 869-3238
Employee Health Nursing	701 Packerland Dr., Green Bay, WI 54303	Phone: (920) 405-4492	Fax: (920) 405-4494

Oneida Comprehensive Health Division
Oneida Community Health Center
Behavioral Health Services
Anna John Resident Centered Care Community
Employee Health Nursing

ONEIDA

2024-2025 SCHOOL DENTAL CARE CONSENT FORM

Last Name:_____ First Name:_____ M.I.___

Birth Date:_____ ( ) Male / ( ) Female Tribal Affiliation:_____

Home Phone:_____ Cell Phone:_____

Address:_____ City/Zip Code:_____

Emergency Contact Person/Phone #: _____

Medical History: Check all that apply ( ) Anemia ( ) Asthma ( ) Bleeding problems ( ) Diabetes ( ) HIV+
( ) Heart condition ( ) Hepatitis ( ) Latex Allergy ( ) Rheumatic Fever ( ) Seizures ( ) Tuberculosis
Other:_____

List current medications:_____

Does your child have any allergies?_____

Has your child had any serious illnesses, injuries or operations?_____

Is there any other information we should know about your child's health or special needs? ( )No ( ) Yes
_____

Dental Insurance: ( ) No ( ) Yes Name:_____ ( ) No Insurance
( ) Medical Assistance / BadgerCare / Forward Health

Please read carefully:

_____ **No, I do not want my child to participate in the Dental Prevention Program at Oneida Nation Schools.**
_____ Yes, I give consent for my child to participate in the Dental Prevention Program to be conducted by the OCHC Dental Clinic.
_____ Yes, I have answered the medical history questions on this form correctly and completely, to the best of my knowledge.
_____ Yes, I give permission for my child to receive any preventive and diagnostic treatment, including an Examination, x-rays films, dental cleaning, fluoride treatment and sealants as deemed necessary by the OCHC dental Staff.
_____ Yes, I agree to seek any follow-up care my child may need from the OCHC Dental Clinic or dentist of my choice.
_____ Yes, I understand that I will not receive a bill for any dental services proved by the dental prevention Program at Oneida Nation School, however, the OCHC will bill my insurance, if applicable.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Name (Print) Phone #

Mailing Address: P.O. Box 365, Oneida, WI 54155
https://oneida-nsn.gov/resources/health/

Oneida Community Health Center	525 Airport Rd., Oneida, WI 54155	Phone: (920) 869-2711 or 1-866-869-2711	Fax: (920) 869-1780
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ONEIDA NATION SCHOOL SYSTEM

Oneida Nation Elementary
P.O. Box 365
N7125 Seminary Road
Oneida, WI 54155
(920) 869-1676
FAX (920) 869-1684

Oneida Nation High School
P.O. Box 365
N7210 Seminary Road
Oneida, WI 54155
(920) 869-4308
FAX (920) 869-4045

To: ONSS Families
Date: June 13, 2024
Subject: School Supplies

Per School Board and JOM Parent Committee action, the school is purchasing school supplies for all K-12 students of the Oneida Nation School System for the 2024-2025 school year.

Families will be responsible for gym shoes, a change of clothing, and backpacks.

If you can, we recommend purchasing extra supplies (pencils, glue sticks, markers, etc.) while they are on sale, to replenish their supplies for 2nd semester.

Thank you,

JOM Parent Committee

Oneida Nation School System
2024-2025 Calendar

August	20 - 23	Staff In-Service
	22	Open House
	26	**First Day of School**
September	2	Labor Day – No School
	25	Professional Development Day – No School
	26	Mid-quarter 1
October	3	Parent / Teacher Conference, 12:30 p.m. dismissal
	24	Family Feast, 12:30 p.m. dismissal
	25	Staff In-Service, No School
	29	End of Quarter 1
	(TBD)	Harvest Ceremonies (School in Session)
November	11	Veterans Day, No School
	27	No School
	28	Thanksgiving Day, No School
	29	Indian Day, No School
December	5	Mid-quarter 2
	11	Professional Development Day, No School
	20	Half Day, 12:30 p.m. dismissal
	23-31	Winter Break, No School
	25	Christmas Day
January	1	New Year's Day, No School
	2	Classes Resume
	6-7	Mid-Winter Ceremonies, No School
	20	End of Quarter 2 and 1st Semester
February	6	Parent / Teacher Conference, 12:30 p.m. dismissal
	12	Professional Development Day, No School
	12	Mid-Quarter 3
March	12	Professional Development Day, No School
	24-28	Spring Break, No School
	31	End of Quarter 3
April	9	Professional Development Day, No School
	18	Good Friday, No School
	23-25	No School
May	8	Culture Day, P.M.; Mid-quarter 4
	9	Culture Day, A.M. – 12:30 p.m. dismissal
	23	Oneida Code Talkers Day, No School
	26	Memorial Day, No School
June	09	High School Graduation
	10	End of Quarter 4 / 2nd Semester, Last Day of School –12:30 p.m. dismissal
	10	Eighth Grade Graduation
	11	Last Day for Staff; Teacher Trade-off Day

School Board Approved: March 04, 2024

2024-25 Household Application for Free and Reduced Price School Meals

APPLY ONLINE: https://oneida-nsn.gov/education/oneida-nation-school-system/oneida-nation-school-district-enrollment/
RETURN TO (School/District Name): Oneida Nation School System
ADDRESS: PO Box 365, N7125 Seminary Road, Oneida, WI 54155

Complete one application per household. Please use a pen (not a pencil). In Community Eligibility Provision Schools (CEP), receipt of free meals does not depend on returning this application; however, this information is necessary for other programs.

STEP 1 List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Grade	Check all that apply: Foster Child	Migrant	Runaway	Homeless
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 Do any household members (including you) participate in: FoodShare (SNAP), W-2 Cash Benefits (TANF), or FDPIR?

☐ **NO** → Go to STEP 3. ☐ **YES** → Write case number here and proceed to STEP 4. **PROGRAM NAME:** **CASE NUMBER (NOT EBT NUMBER):**

Badgercare, Medicaid, Summer EBT are not eligible. Write only one case number in this space.

STEP 3 List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)

List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual	Public Assistance, Child Support, Alimony	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received? Weekly	Every 2 Weeks	2x Month	Monthly
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	●	$	○	○	○	○

Required: Total Household Members (Children and Adults) ☐

Required: Last Four Numbers of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member or Check Box if No SSN ☐☐☐☐ Check Box if No Social Security Number ☐

Please see application's back for list of income sources.

B. Child Income

Sometimes children in the household earn or receive income.
Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income $ ☐ How often received? ○ Weekly ○ Every 2 Weeks ○ 2x Month ○ Monthly ○ Annual

STEP 4 Contact information and adult signature. RETURN COMPLETED FORM TO YOUR CHILD'S SCHOOL: Insert school address here

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | **Required**: Signature of Adult | Today's Date

Mailing Address (if available) | City | State | Zip | Phone (optional) | Email (optional)

Return completed form to your child's school.

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**	
• Salary, wages, cash bonuses, tips, commissions • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers' compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security/Disability (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	• A child has a regular full or part-time job where they earn a salary or wages • A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits • A friend or extended family member regularly gives a child spending money • A child receives regular income from a private pension fund, annuity, or trust

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.

DO NOT FILL OUT

For school use only. If all students listed on this application attend CEP schools, the processing of this application cannot be paid for by the nonprofit school food service account.

Annual Income Conversion: Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income

How often?

Weekly	Every 2 Weeks	2x Month	Monthly	Annual
○	○	○	○	○

Household size

Categorical Eligibility ☐

Eligibility

Free	Reduced	Denied
○	○	○

Determining Official's Signature | Date | Confirming Official's Signature | Date | Verifying Official's Signature | Date

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number' Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: **https://www.usda.gov/sites/default/files/documents/ad-3027.pdf,** from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

*MAIL: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

FAX: (833) 256-1665 or (202) 690-7442; or
EMAIL: program.intake@usda.gov

***Do not mail applications to this address, only complaints of discrimination.**

Return completed form to your child's school.

This institution is an equal opportunity provider.