ONEIDA NATION SCHOOL SYSTEM

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

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

Continuing Student Enrollment Application Checklist

REQUIRED DOCUMENTS

- ❒ Continuing Student Enrollment Application
- ❒ Student Health Form (include any new allergies, medication, medical information)
- ❒ Dental Consent Form
- ❒ Free / Reduced Meal Application (available in July)
- ❒ Parent Consent Form for Student Photographs/Videos
- ❒ Bus Transportation form

- ❒ *Student's Certificate of Indian Blood

  *If newly recognized into a tribe or if a verification was not previously submitted

- ❒ *Current Custody, Placement or signed Temporary Custody order/document

  *If there are new custody or placements changes from last school year

- ❒ *Background Clearance

  *If you are planning to volunteer, chaperone, or coach, etc.

  Everyone is considered ineligible if a background clearance is not approved by or before the event. Clearances are valid for one calendar year.

Please submit REQUIRED documents by or before July 31, 2025.

First day of school is August 25, 2025

ONEIDA NATION SCHOOL SYSTEM
2025-2026 Continuing Student Enrollment Application

Student Name	Grade	Date of Birth	Tribe	Roll Number

My child(ren) live(s) with: ☐ **Mother** Only ☐ **Father** Only ☐ **Both** ☐ ***OTHER Guardian: submit court order or signed consent**

***OTHER 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

Step-Mother ☐

Complete Name: _____

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

Street Address: _____ Apt ____

City: _____ State: _____ Zip: _____

Email address: _____

Cell #: _____ Home #: _____

Work #: _____ dept. _____ x._____

◯ I consent to allow this person to pick up my child/ren.

FATHER'S INFORMATION

Step-Father ☐

Complete Name: _____

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

Street Address: _____ Apt ____

City: _____ State: _____ Zip: _____

Email address: _____

Cell #: _____ Home #: _____

Work #: _____ dept._____ x._____

◯ I consent to allow this person to pick up my child/ren.

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

In case I am not reachable, please contact the following people. I understand that these contacts must be reliable and able to pick up my child/ren from school if needed. *Please keep all contact information up-to-date throughout the entire school year.*

_____ _____ _____ _____ ( )_____
Print First Name **M.I.** Print Last Name Relationship to Student Phone Number: Cell ☐ Home ☐

_____ _____ _____ _____ ( )_____
Print First Name **M.I.** Print Last Name Relationship to Student Phone Number: Cell ☐ Home ☐

_____ _____ _____ _____ ( )_____
Print First Name **M.I.** Print Last Name Relationship to Student Phone Number: Cell ☐ Home ☐

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

_____ _____ _____
Print Parent / Guardian Name **Signature** of Parent / Guardian **Date**

Rev. 5/30/2025

ONEIDA NATION SCHOOL SYSTEM

From the Office of the School Nurse

HEALTH FORM

Child's name: Date of Birth: Grade:

ALLERGY INFORMATION

Does your child have any of the below ALLERGIES? If yes, does your child require: ☐ epinephrine ☐ oral antihistamine

Food Allergens	Specify	Accommodations/Alternatives	Environmental Allergens	Specify
☐ Milk / Dairy		☐ Yes:	☐ Pollen	
☐ Eggs		☐ Yes:	☐ Dust Mites	
☐ Peanuts		☐ Yes:	☐ Animal Dander	
☐ Tree Nuts		☐ Yes:	☐ Mold	
☐ Soy		☐ Yes:	☐ Insects	
☐ Wheat		☐ Yes:	☐ OTHER	
☐ Fish, Shellfish		☐ Yes:	☐ Medication Allergens	
☐ OTHER		☐ Yes:	Specify:	

MEDICAL and HEALTH CONDITIONS

Has the student received vaccinations outside of WI? ☐ **No** ☐ **Yes, State:** _____ *(please submit the records)*

Does your child wear corrective lenses [glasses or contacts]? ☐ **No** ☐ **Yes**

Has your child had hearing testing or been recommended to have one completed? ☐ **No** ☐ **Yes**

Has your child been diagnosed with any of the following conditions by a Healthcare Provider? ☐ **No** ☐ **Yes**

☐ ADD/ADHD ☐ Emotional/Behavioral/Psych ☐ Heart Condition: _____
☐ Headaches/Migraines ☐ Epilepsy / Seizures ☐Nebulizer: is supply needed at school? ☐ **Yes** ☐ **No**
☐ Diabetes ☐ Orthopedic ☐ Auditory: does the student use Hearing Devices? ☐ **Yes** ☐ **No**
☐ Asthma ☐ Vision _____ ☐ Other _____

If your child uses an inhaler, does student self-carry inhaler:
☐ **Yes** ☐ **No** *(students in grades K-8, please discuss self-carry with School nurse)*

MEDICATION: Is your child currently taking any medication(s)? ☐ **Yes** ☐ **No**

Type of medication	Reason for medication	When is it given?

If medication will be administered at school, the medication(s) and delivery must: 1) be delivered by a parent/guardian, 2) be in the original medication container, 3) have an attached signed parent authorization consent form, and 4) if the medication requires a prescription, it must be able to be verified by the prescribing licensed professional.

Name of medical facility where child receives healthcare: _____
Provider's name and phone number: _____

_____ **Please INITIAL to verify understanding**: *The School Nurse, employed by the Oneida Comprehensive Health Division, has access to my child's health records at the Oneida Community Health Center. I understand my child's teachers will receive communication regarding my child's health and medical needs or requirements.*

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

Office Use Only: Teacher Name: _____ Grade: _____

2025 - 2026 School Dental Care Consent Form

Child's Last Name:_____First Name:_____ M.I.___

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

Home Phone:_____ Cell Phone: _____

Address: _____ City/ Zip Code: _____

Parent E-mail Address: _____

Emergency Contact Person and Phone #:

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

List medication(s) currently being taken: _____

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

Does your child have any allergies? _____

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

_____

Dental Insurance: ( ) Dental Insurance : Insurance Company Name: _____
( ) No Insurance ( ) Medical Assistance / BadgerCare

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 Oneida Community Health Center 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 a dentist of my choice.

_____ Yes, I understand I will not receive a bill for any dental services provided 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 #

Oneida Nation School System

Student Photograph Consent Form

School Year 2025 - 2026

This consent form is to allow Oneida Nation School System students to be photographed, video recorded, and or interviewed during school promoted events and activities throughout the school year. We also organize, sponsor, or host events with other organizations, who may also want to publish student photographs/videos.

To release or include your child's image/video in any publication, we must have your consent each academic school year.

☐ **I consent** to allow the Oneida Nation School System to photograph / video my child during normal school hours, field trips, recognitions, school events or activities.

☐ NO, I do not give the Oneida Nation School System consent to photograph / video my child during any school event or activity.

☐ **I consent** to allow the Oneida nation School System to use my child's photographs / videos in school newsletters, school recognitions, Oneida Nation School System's social media sites, displayed within the school system, etc.

☐ NO, I do not give the Oneida Nation School System consent to publish my child's photographs / videos on the school's social media sites, newsletters, displayed within the school system, etc.

☐ **I consent** the Oneida Nation School System to share my child's photographs / videos to a third-party organization's publication in which the Oneida Nation School System is a sponsor or host of an event.

☐ NO, I do not give consent to the Oneida Nation School System to share or publish my child's photographs / videos to any third-party.

Child's Name: _____ Grade: _____

PRINT Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

BUS TRANSPORTATION REQUEST FORM

Transportation Start Date Needed: _____

For ONSS and Lamer's to plan bus routes, this form needs to be completed at least three (3) school days in advance. Parents are responsible to monitor and coordinate transportation for students needing multiple drop-off or pick-ups.

For kindergarten students: an adult/caregiver **must be visible** at drop-off or student will be returned to school.

MY CHILD/REN WILL REQUIRE BUS TRANSPORTATION: YES ☐ NO ☐

CHILD'S NAME	Grade	Office only: Student I.D.	
_____	_____	#_____	New Active
_____	_____	#_____	New Active
_____	_____	#_____	New Active
_____	_____	#_____	New Active

Is this a new address – did the household move? YES ☐ NO ☐

Is the below bus pick up and or drop off address the new home address? YES ☐ NO ☐

If no, what is the new home address: _____ _____ _____
Street address APT/Unit City and Zip Code

Is the new address for: ☐ Mother ☐ Father ☐ Mother and Father ☐ **OTHER** GUARDIAN: _____
relationship to student(s)

Guardian/Mother: _____ Cell #_____

Guardian/Father: _____ Cell # _____

BUS PICK-UP ADDRESS: _____ _____ _____ _____
Street Address APT/Unit City Zip Code

Is this a daycare center? No ☐ Yes ☐, Name: _____

BUS DROP-OFF ADDRESS: _____ _____ _____ _____
Street Address APT/Unit City Zip Code

Is this a daycare center? No ☐ Yes ☐, Name: _____

_____ _____
PRINT Parent / Guardian's Name **Date**

For office use:

☐ Address Updated: _____ ☐ Bus Coordinator: _____ ☐ Lamer's: _____
(Infinite Campus) Date Date Date

Revised 6/09/2025