THE MUSCOGEE NATION

DAVID W. HILL
PRINCIPAL CHIEF

DEL BEAVER
SECOND CHIEF

Eufaula Dormitory
716 Swadley Drive | Eufaula, OK 74432
T 918.689.2522 | F 918.689.2438

June 5, 2024

Hensci and welcome to the Eufaula Dormitory Application page. We are glad that you are considering enrolling your child with us here at the Eufaula Dormitory. The following pages are the required application for admittance but in addition to the application, we will need the following items from you:

- Birth Certificate
- CDIB or Tribal Citizenship Card
- Updated Immunization Record
- Social Security Card
- Soonercare Card or Private Insurance Card
- Completed Physical (form included in application packet)

Once we review applications, we will be calling to set up an interview time with you and your child or children. Interviews generally take about 30 minutes and are an important part of the process to make sure the dorm is the right fit for your family. If you have any questions about the application, supporting documentation, or the interview process, please call the dormitory at (918) 689-2522.

Mvto!

Melanie Taylor

Melanie Taylor
Eufaula Dormitory Administrator

THE
MUSCOGEE (CREEK) NATION
P.O. Box 580 | OKMULGEE, OK 74447
918.732.7600 | 800.482.1979

THE MUSCOGEE (CREEK) NATION
EUFAULA DORMITORY
716 Swadley Drive
Eufaula, OK 74432
(918) 689 - 2522

UNITED STATES DEPARTMENT OF THE INTERIOR
Bureau of Indian Education

STUDENT ENROLLMENT APPLICATION

Failure to provide accurate information or falsification of information may result in your release from Muscogee (Creek) Nation Eufaula Dormitory.

Student Grade Level upon Entrance: _____

IDENTIFICATION: **Social Security Number:** _____

Name of Student: _____
Last *First* *Middle*

Address:

P.O. Box _____ Street _____
City _____ State _____ Zip Code _____
Miles from home to school: _____

Date of Birth: _____ Place of Birth: _____
Month Day Year *City and State*

Gender: □ Male □ Female □ Genderqueer/Non-Binary

Religious Affiliation (Optional): _____

Tribal Affiliation: _____ Degree of Indian Blood: _____ Enrollment/Citizenship Number: _____ **(a copy of student's CDIB must be attached)**

Dominant language spoken in the home: 1. _____ 2. _____

PARENT/GUARDIAN INFORMATION

With whom does the student live: □ Both Parents □ Mother □ Father □ Other _____

Father Name: _____ Mother Name: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Tribal Affiliation: _____ Tribal Affiliation: _____

Please mark one. □ Living □ Deceased Please mark one. □ Living □ Deceased

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If the student does not live with either parent, complete the following information for the guardian. If the student is a ward of the court, attach documents and provide information on the person responsible for the student. Students may not list themselves as guardians even if they are 18 or older. This form effective for duration of time student is enrolled at Muscogee (Creek) Nation Eufaula Dormitory.

Guardian Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

SIGNATURES

I am legally responsible for this student and hereby apply for his/her admission to Muscogee (Creek) Nation Eufaula Dormitory and the Eufaula Public School. I understand that additional information may be requested by Muscogee (Creek) Nation Eufaula Dormitory before this student is admitted. **Failure to provide inclusive and accurate information could result in denial of application or immediate dismissal.**

_____ _____

Parent/Guardian Signature Date

I agree to support all program policies and procedures while my student is in attendance at Muscogee (Creek) Nation Eufaula Dormitory. I agree that if I have a disagreement regarding a policy, procedure or the discipline of my child, I will contact the Administration Office. I **understand that any verbal abuse or harassment of staff/student can be a reason for termination of services for my child.**

_____ _____

Parent/Guardian Signature Date

I agree to abide by all program policies and procedures while I am in attendance at Muscogee (Creek) Nation Eufaula Dormitory. I understand that violation of program rules may result in disciplinary action including release from dormitory. **If I am suspended or expelled, I will not be allowed to be on campus or call and speak with students on the office telephone.**

_____ _____

Student Signature Date

CONSENT FOR DRUG SCREENING AND/OR DRUG TESTING

Muscogee (Creek) Nation Eufaula Dormitory has a zero (0) tolerance Substance Abuse policy. In keeping with this policy, it may be necessary to do random drug screening or drug testing as needed while your child is here on the dormitory campus. My signature below indicates that I give consent for my child to receive drug screens at Muscogee (Creek) Nation Eufaula Dormitory r if referred to Muscogee (Creek) Nation Behavioral Health Services to submit to drug testing. Results from this screening will be confidential and known only to necessary staff and that I will receive results if requested. Drug and alcohol counseling, suspension or expulsion will be determined by offense, by counseling professionals and administrator.

_____ _____

Parent/Guardian Signature Date

AUDIO/VISUAL RELEASE

I grant permission to Muscogee (Creek) Nation Eufaula Dormitory for use of the above student's photograph and name for historical records and promotional purposes as deemed appropriate by representatives of MCN Eufaula Dormitory. This includes MCN Eufaula Dormitory yearbooks, videotapes, student record and activities, announcements, brochures and web page internet displays. It is clearly understood that no royalty, fee or other compensation of any kind will become payable to me by reason of such use or release.

_____ _____

Parent/Guardian Signature Date

NOTICE TO PARENT AND STUDENT

CONSENT TO SEARCH: For reasonable cause and essential in assuring the health and safety of all students, Muscogee (Creek) Nation Eufaula Dormitory staff, acting in loco parentis as legal custodians may at their discretion, exercise search and seizure activities. Such search and seizure activities shall be in compliance with 25 CFR - Part 42.3, (b), "Rights of the Individual Student."

VANDALISM POLICY: Muscogee (Creek) Nation Eufaula Dormitory student and parents are hereby notified that all student acts of vandalism against the property of Muscogee (Creek) Nation Eufaula Dormitory will be the financial responsibility of the student/family.

SHOPLIFTING POLICY: The store/vendor may demand full reimbursement and damages. The vendor demand letter will be forwarded to the student and parent/guardian.

A. CRITERIA FOR BOARDING SCHOOL

Favorable action is recommended upon this application because this case conforms to the following criteria for boarding school or out of boundary enrollment. If this application is for an off-reservation boarding school and for social reasons, a social summary should accompany this application.

Check all applicable criteria.

EDUCATIONAL FACTORS
Federal/public schools near student's home:

- □ Grade level not offered.
- □ Are severely overcrowded.

SOCIAL FACTORS
In his/her family environment, the student:

- □ Was rejected or neglected.
- □ Does not receive adequate parental supervision.

- □ Exceed ½ mile walking distance to school or bus route.
- □ Do not offer special vocational – preparatory training necessary for gainful employment.
- □ Do not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences.
- □ Receiving School offers special academic program needed by student.
- □ Well-being was imperiled due to family behavioral problems.
- □ Has siblings or other close relative enrolled who would be adversely affected by separation?

B. SCHOOL APPLICATION:

Approved: _____ Not Approved: _____

_____ _____

Principal/Registrar Date

Privacy Act Statement: This information is collected as provided by 5 U.S.C. 552A. The Bureau of Indian Education is authorized to collect this information in accordance with Public Law 95-561; 98-511; 99-89; and 100-297. The information will be used to determine the level of funding to be distributed by formula to BIA-operated elementary and secondary schools. Weighted student units, the value of basic and specialized instructional and residential programs, are used to calculate the distribution of funds. The information may be disclosed to appropriate Department of the Interior and Congressional Offices for policy and budgetary purposes.

Paperwork Reduction Act Statement: This information is collected to identify each student's instructional and residential program classification. It will be used to al locate appropriated funds on a weighted student unit formula. The information is supplied by the respondent to obtain or retain a benefit that is to provide appropriate schooling and the needed funding. It is estimated that this form will take an average of 15 minutes to complete. This include the amount of time it takes to gather the information and fill out the form. If you wish to make comments on the form, please send them to Attn: Information Collection Clearance Officer - Indian Affairs, 1849 C Street, N.W. MS-4141, Washington, DC 20240. The control number and expiration date are at the top right corner of the form. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless there is a valid OMB control number.

SOCIAL SUMMARY

1. Student's Legal Name _____ Ph. Number (Home) _____
2. Date of Birth _____ (Work) _____
3. Parent/Guardian _____ Who has legal custody? _____
4. Address _____

   Directions to your home: _____
5. Explain in detail the reason for placement and did a specific event lead to this admission:

   _____

   _____

PERSONAL INFORMATION

FAMILY STRUCTURE

1. Mother _____ Step-Parent: _____
2. Father _____ Step-Parent: _____
3. Brothers and Sisters:

_____	□ Male	□ Female	DoB _____
_____	□ Male	□ Female	DoB _____
_____	□ Male	□ Female	DoB _____
_____	□ Male	□ Female	DoB _____

4. How many people live in the home? Children _____ Adults _____
5. Was the pregnancy normal? Yes ___ No ___ If no, explain: _____
6. Was alcohol or drugs used during pregnancy? Yes ____ No ____
7. During the child's development stages, was any behavior unusual? Yes ____ No ____

   If yes, please specify: (Ex. Problems with toilet training or difficulty with language) _____

   _____
8. Explain child/parent relationship: _____
9. What is the form of discipline used on the child? _____
10. What is the child's response to discipline? _____
11. Who disciplines the child? _____
12. Tell us about the relationships in the family, the current living situation, and how the child feels toward his/her sisters and brothers. _____

    Father (or adult male in the home) _____

    Mother (or adult female in the home) _____
13. How will you, the parents contribute to the child's emotional well-being? _____

    _____
14. Check those behavioral area(s) in which your child is experiencing difficulties.

☐ Lying	☐ Running Away from Home	☐ Curfew
☐ Verbal Abuse	☐ Physical Abuse to Others	☐ Sexual Abuse
☐ Throw/Break Things	☐ Sleeping Patterns	☐ Sneaking Out
☐ Trust	☐ Mood Swings	☐ Eating Problems
☐ Self-Esteem	☐ Tantrums	☐ Anger
☐ Fire Setting	☐ Vandalism	☐ Blames Others
☐ Deliberately Annoys Others	☐ Easily Annoyed by Others	☐ Argues with Adults
☐ Swearing	☐ Refuses to Follow Rules	☐ Violent
☐ Sexually Active	☐ Inappropriate Sexual Behavior	☐ Self-mutilation / tattoos
☐ Inappropriate Cell Phone or Social Media Use	☐ Disrespect for Authority	☐ Problems with Peers

15. Describe what you believe to be your child's interests, talents, or special abilities. _____

_____Has

his/her hobbies recently changed? _____

16. Have you noticed any behavioral changes which could be linked to drug use? _____
17. As far as you know, has your child used drugs or alcohol? _____ If yes, what? _____
18. How often does your child use drugs? _____

How long has your child used drugs? _____

19. Has your child admitted to drug usage or ever been under the influence in front of you? _____
20. Does anyone in your family have a problem with alcohol or drugs? _____
21. Is your child involved in gang activity or associates with gang members? _____
22. Has your child ever been accused of or been a victim of bullying/intimidation? _____

COURT RELATED

1. Has your child ***ever*** had any contact with the court or juvenile authorities? (i.e. arrested, jail, DHS, child protection custody, Indian Child Welfare) □ **Yes** □ **No** If yes, why is child under a court order? _____

   _____

   What county? _____ (If yes, a copy of the court order is required as part of the application.)

2. Is the child being seen by a probation officer or social worker? □ **Yes** □ **No** If yes, what is the person's name, address (office) and telephone number? _____

   _____

3. Has the child seen or is now seeing a counselor, doctor, psychologist, psychiatrist or therapist?

   □ **Yes** □ **No** If so, what is the reason and who are they seeing? _____

4. Please complete evaluation information, if applicable.

   Psychiatric Evaluation: _____ Where: _____ Date: _____

Psychological Test(s): _____ Where: _____ Date: _____

IQ Tests: _____ Where: _____ Date: _____

List of ALL psychological medications over lifetime: _____

5. Has the child had a stressful even in his/her life such as, parental separation, divorce, death, hospitalization, abuse or emotional stress? _____
6. Number of family moves in child's life: _____ Length of residence in present home: _____
7. Does the child have any strong fears? _____
8. How does the child feel about living in a dormitory atmosphere? _____
9. Is there any family involvement or problems with the following?

   Substance/Alcohol Abuse [Who and explain] _____

   _____

   Child Abuse (includes physical, sexual, emotional) [Who and explain] _____

   _____

   Deprivation [Who and explain] _____

   Legal Problems [Who and explain] _____

   Incarceration [Who and explain] _____
10. Child is being raised by:

_____ Natural Parents	_____ Parent & Step-Parent	_____ Grandparents
_____ Single Parents	_____ Adoptive Parents	_____ Institution
_____ Foster Parents	_____ Relative	_____ Other

HEALTH RELATED

1. Is child allergic to any type of medication? □ **Yes** □ **No** If yes, what? _____
2. List ALL medications taken regularly. [Name & Dosage] _____

   _____
3. Does the child have any medical problems which might interfere with school attendance and/or needs medical care while in school? □ **Yes** □ **No** If yes, explain _____
4. Does the child wear glasses or contacts? □ **Yes** □ **No** Hearing and/or ear problems? □ **Yes** □ **No**
5. Has the child displayed any of the following? Suicidal thoughts / depression / violence / cutting or harm to self, etc.? □ **Yes** □ **No** If yes, please explain _____
6. Does the child have problems with personal hygiene, bathing, bedwetting, soiling self? □ **Yes** □ **No**
7. Does the child have any food allergies? □ **Yes** □ **No** If yes, please list allergies _____

   _____

EDUCATION RELATED

1. Has the child ever attended a dormitory before? □ **Yes** □ **No**

   If yes, when _____ and where _____

2. Has the child ***ever*** been suspended and/or expelled from public or boarding school? □ **Yes** □ **No** If yes, give the date and reason for the suspension/expulsion. _____

   _____

3. Please indicate the number of days of school your child has missed in the previous school year.

   ☐ 0-15 days ☐ 16-25 days ☐ 25-50 ☐ 50+

4. Has your child…

   Been retained in the same grade? □ **Yes** □ **No**
   Received speech therapy? □ **Yes** □ **No**
   Been tested for special education, attention deficit disorder and/or learning disabilities disorder? □ **Yes** □ **No**
   Been in special education classes or have classroom modifications? □ **Yes** □ **No**

5. What school subjects will the child need help? _____
6. What type of relationship did the child have with his/her teachers or principals? _____

   _____

7. What kind of relationship did the child have with his/her friends and other classmates? _____

   _____

8. Did the child participate in extracurricular activities at school? (i.e. band, sports, etc.) □ **Yes** □ **No**

   If yes, which activities? _____

9. Any other information our program may need to know regarding this student? _____

   _____

I, the parent/legal guardian of the above student hereby certify that the information provided is true and accurate to the best of my knowledge. I understand that Muscogee (Creek) Nation Eufaula Dormitory may call the student's previous schools or social agencies to confirm the information given on the application. **Any false statement or misrepresentation or omission of the above required information may result in denial of application or immediate dismissal.** We hereby agree to abide by the rules and regulations of The Muscogee (Creek) Nation Eufaula Dormitory throughout enrollment.

_____ _____

Student Signature Parent/Legal Guardian Date

MUSCOGEE (CREEK) NATION EUFAULA DORMITORY CONFIDENTIALITY INFORMATION AND RELEASE OF INFORMATION CONSENT FORM

Student Name: _____ Date of Birth: _____

I understand that my child may or may not receive behavioral health services, behavioral health evaluation, individual assessment, individual or group therapy, individual or group prevention services, drug and alcohol evaluation and counseling, prescribed medication by a physician or psychiatrist for behavioral health-related diagnosis.

I understand that Muscogee (Creek) Nation Eufaula Dormitory works directly with Muscogee (Creek) Nation Behavioral Health and Substance Abuse Services (BHSAS) and other behavioral health service providers. If your child needs additional services, such as extensive outpatient or inpatient programs, that individual will no longer be able to remain in our program without a written consent from a behavioral or mental health professional that provides documentation stating your child is able and compatible to return to our program.

I understand that I have signed a separate consent form provided by the BHSAS to authorize services to my child. Muscogee (Creek) Nation Eufaula Dormitory may or may not refer my child to BHSAS for behavioral health services while enrolled in the program. I give Muscogee (Creek) Nation Eufaula Dormitory permission to provide information regarding my child's behavioral health care with referring agencies that will be providing services and for case consultations with that specific agency. I authorize Muscogee (Creek) Nation Eufaula Dormitory to provide my child's CDIB and private insurance information to BHSAS in regard to services.

I understand that my child may receive services or continued services from BHSAS or any other behavioral health provider without the knowledge or authorization of Muscogee (Creek) Nation Eufaula Dormitory while enrolled in our program. For example, this would include checking the student in and out of the dormitory and transportation to and from appointments, meetings and participation with BHSAS providers, all aspects of medication as needed, financial and insurance. If the parent chooses this option, all of the services provided will be the sole responsibility of the parent.

If my child is no longer enrolled as a student, Muscogee (Creek) Nation Eufaula Dormitory will no longer provide behavioral health services yet it is the parent's option to continue services with BHSAS.

I understand that the staff at Muscogee (Creek) Nation Eufaula Dormitory will protect my child's privacy and the confidentiality of my records to the full extent allowed by law. I understand that the release of any information regarding the behavioral health and mental health aspects of my child will be according to legal and ethical standards. This information may be interchanged between the Health Services, Behavioral and Mental Health Services and Muscogee (Creek) Nation Eufaula Dormitory staff beginning _____and ending when the student is no longer enrolled or has graduated. Limitations to the confidentiality of records at Muscogee (Creek) Nation Eufaula Dormitory may include:

1. Crimes committed on the premises or crimes committed while the student is under the direct care and supervision of The Muscogee (Creek) Nation Eufaula Dormitory. Crimes committed against staff of Muscogee (Creek) Nation Eufaula Dormitory or other students enrolled at Muscogee (Creek) Nation Eufaula Dormitory.
2. A court order signed by a judge requiring the release of information or in response to a specific court order.
3. In case of an emergency while under the direct care of The Muscogee (Creek) Nation Eufaula Dormitory.
4. Audits by accreditation agency or Bureau of Indian Education.
5. Specific case consultation among Muscogee (Creek) Nation Eufaula Dormitory staff that is directly related to the student and the welfare of that child.
6. In cases where Muscogee (Creek) Nation Eufaula Dormitory staff member is named in a law suit for malpractice, negligence, or legal action taken against Muscogee (Creek) Nation Eufaula Dormitory.
7. In a case where a child has been harmed by abuse, in the case where the child is going to seriously harm another person, or in the case of where the child is going to harm him or herself.
8. In response to a related lawsuit or complaint to a licensing or accredited organization or board of licensure, supervisor, or director.

In addition, I agree:

1. To honor confidentiality of staff and other students;
2. That I will not disclose confidentiality information that may be revealed in group or individual sessions;
3. That violation of confidentiality will constitute grounds for termination of services.

I certify that I have legal standing or custody for professional services for child named above. I have legal custody and or legal standing to request and authorize professional mental health and/or substance abuse services.

I have read the above information and am in agreement with these services and confidentiality terms.

_____ _____

Date Parent/Legal Guardian

_____

Student

CONFIDENTIAL

Muscogee (Creek) Nation Behavioral Health & Substance Abuse Services

Consent for Treatment

Patient Name: _____ Date of Birth: _____

I hereby request and authorize Muscogee (Creek) Nation Behavioral Health & Substance Abuse Services (BHSAS) to provide mental health and/or substance abuse treatment, diagnosis, case management, and/or prevention services to me and/or my minor child (named above).

Confidentiality Statement:

I understand that my counselor and BHSAS staff will protect my privacy and the confidentiality of my records to the full extent provided by law. I understand that no information about me will be released or disclosed to others outside of the Muscogee (Creek) Nation health system by BHSAS without my explicit written consent or as otherwise provided by law. Conditions under which confidential information may be disclosed without my consent include, but are limited to:

1. Mandatory reporting of child abuse or elder abuse
2. If I am believed to present a risk of serious harm to myself or someone else
3. Reporting of crimes committed on the premises or against staff or other clients
4. In response to a specific court order
5. In the event of an emergency
6. Billing and provision of supporting documentation to insurance or other third-party payers
7. Audits by accrediting organizations or agencies
8. In response to a related law suit or complaint to a licensing or accrediting organization or board
9. Integration of primary care and behavioral health records (electronic)
10. Case Staffing/Treatment Team with BHSAS staff which may include Psychiatrist, Psychologist, Clinical Director, Therapists, and case manager.

In addition, I agree:

1. To honor the confidentiality of staff and other clients
2. That I will not disclose the identity others I meet in treatment or at the clinic
3. That I will not disclose any information revealed by any other patient in treatment or at the clinic
4. That violation of confidentiality will constitute grounds for termination of services
5. That if receiving a referral to the psychiatrist where I may be given a controlled substance, a clean urine drug screen will be required

Finally, I understand that any information in my records regarding alcohol or drug use are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Billing:

I understand that the services of BHSAS will be provided at no direct charge to anyone with a CDIB (Certified Degree of Indian Blood) card; however, when third part resources are available (e.g. Medicaid, Medicare, private insurance), Muscogee (Creek) Nation Behavioral Health & Substance Abuse Services will bill those resources for any reimbursement available. I authorize BHSAS to submit bills and furnish confidential information including but not limited to diagnoses and financial information to any insurer, third party payer, or welfare agency providing financial assistance for the services rendered. I assign and authorize payment directly to BHSAS of any insurance or health plan benefits otherwise payable to me. A photocopy of this authorization is to be considered as valid as the original.

Consent for authorization can be rescinded at any time should you choose. The patient or, if applicable, custodial/legal guardian will have to submit in writing to BHSAS the desire to rescind consent. Submission will have to be in person by the patient or custodial/legal guardian. This process will terminate future BHSAS services until consent has been received again.

I certify that I have legal standing to authorize these professional services for myself; and/or, that I have legal custody and/or other required legal standing to request and authorize professional mental health and/or substance abuse services for any child named above.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian/Representative Signature Date
Specify relationship to patient / authority to sign)

_____ _____

Signature & Title of MCNDH BHS Employee Date

AUTHORIZATION TO INITIATE DETENTION ORDER

(to be completed by Parent or Guardian)

I hereby give Muscogee (Creek) Nation Eufaula Dormitory staff authorization/responsibility to initiate proceedings for Detention Order, Missing Persons Report, Runaway Juvenile Report and/or any document/procedure needed in the event my child leaves Muscogee (Creek) Nation Eufaula Dormitory or Eufaula Public Schools; or any of Muscogee (Creek) Nation Eufaula Dormitory or Eufaula Public School activity without express permission from Muscogee (Creek) Nation Eufaula Dormitory staff. The permission is given so that my child may be located and returned to a safe environment as soon as possible.

In the event my child becomes violent, in danger of harming self or others, tribal or local law enforcement will be contacted. Upon law enforcement contact, arrest, or detainment, Muscogee (Creek) Nation Eufaula Dormitory is no longer responsible for child, once law enforcement initiates contact.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Witness Date

DESCRIPTION OF CHILD

(to be completed by Parent or Guardian)

PLEASE PRINT

NAME: _____ SEX: _____ SS#: _____

NICKNAME: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ HAIR COLOR: _____ HAIR LENGTH: _____

EYE COLOR: _____ TATTOOS: _____ SCARS: _____

REMARKS/DETAILS: _____

_____

_____

_____

_____

PLEASE ATTACH A CURRENT PHOTO OF YOUR CHILD.

PARENTAL CONSENT FORM

STUDENT'S NAME _____ DOB: _____

I (We), as parent(s)/legal guardian(s), have read this Consent form for Muscogee (Creek) Nation Eufaula Dormitory and fully understand its content.

I. ACKNOWLEDGEMENT OF CUSTODY

As the parent/legal guardian of the above named student, I hereby acknowledge that my child is in the custody of Muscogee (Creek) Nation Eufaula Dormitory. It is further acknowledged that, as custodian, Muscogee (Creek) Nation Eufaula Dormitory may act in the best interest of my child. Muscogee (Creek) Nation Eufaula Dormitory is responsible for the custody of this student from move in date the beginning of the school year through the move out date the last day of school. These custodial responsibilities pertain to all matters the parents might otherwise have in regards to academic (enrollment, special education, discipline, extracurricular activities, etc.)

Signature: _____ Date: _____

Address: _____ Telephone: _____

_____ E-Mail: _____

II. FIELD TRIPS/COMPETITIVE SPORTS

I (We) hereby grant permission for student to participate in organized school sponsored activity trips (i.e. recreational, school clubs, camping, town trips, religious overnight, out-of-state, extracurricular, other _____) as approved by Muscogee (Creek) Nation Eufaula Dormitory.

I (We) hereby grant consent/permission/authorization for my child to participate in the following competitive sports of interest to him/her: football, basketball, softball, volleyball, baseball, cheerleading, color guard, other _____.

I understand the students will be properly chaperoned and all precautions will be taken to insure his/her safety.

I understand that all trips and functions of the nature listed above is a privilege and may be taken away due to misbehavior or disciplinary problems.

Parent will be responsible for transportation if school sponsored activities interfere with transportation provided by Muscogee (Creek) Nation Eufaula Dormitory.

_____ _____

Signature of Student Signature of Parent/Guardian

Date: _____

III. MEDICAL

I (We) hereby grant consent/permission/authorization for the following: administer medication to student; transport student to medical facilities; hospital/clinic to provide student with health services; physical examination; immunizations (meningococcal is mandatory), including elective immunizations such as flu, HPV, COVID-19 & boosters; dental; emergency medical care; eye examinations (glasses); antibiotics.

With my full consent, Muscogee (Creek) Nation Eufaula Dormitory staff has my permission to administer medication to my child upon issuance by health services whether day or evening.

It is the parent/guardian responsibility to transport student to dental or medical procedure requiring sedation. If child/parent refuses medical treatment, student will be transported home on medical leave and parent will be responsible for treatment and medical services. Student may return to the dormitory with a written release by outside physician.

If a parent makes an appointment for a child, it is the parent's responsibility to take child to that appointment.

I understand all immunizations must be up to date before my child is allowed to move into the dormitory.

Date: _____ _____

Signature of Parent/Guardian

AUTHORITY TO TRANSFER EDUCATION RECORDS

I authorize _____

_____

_____

School District and all Educational Departments thereof to release all portions of my child's Educational records, which may be confidential or otherwise to:

Muscogee (Creek) Nation Eufaula Dormitory
716 Swadley Drive
Eufaula, OK 74432
Phone: 918.689.2522 | Fax: 918.689.2438

This would include, but not be limited to health, grades, cumulative folder, original transcript, test scores, confidential, IEP records and disciplinary records.

Student Name: _____ Date of Birth: _____

_____ _____
Signature of Parent/Legal Guardian Date

ATTENTION: According to the Family Educational Rights and Privacy Act of 1974 (PL. 93-380) the parents, guardian, or 18 year-old student has the right to make a written request to view any records released.

ATTENTION: The term, Educational Records, as used in this consent is that defined by PL. 93-380, Sec. 99.2, Definition as: Those records which (1) are directly related to a student and (2) are maintained by an educational agency or Institutions or by a party acting for the agency or institute.

SCHOOLS PREVIOUSLY ATTENDED

School Name: _____ Grade Completed: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Date(s) Attended: _____
Reason for Leaving: _____
Student Participated in Special Education Program: Yes _____ No _____
Student Participated in Gifted and Talented Program: Yes _____ No _____

School Name: _____ Grade Completed: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Date(s) Attended: _____
Reason for Leaving: _____
Student Participated in Special Education Program: Yes _____ No _____
Student Participated in Gifted and Talented Program: Yes _____ No _____

MUSCOGEE (CREEK)
NATION EUFAULA
DORMITORY 2024–2025
LEAVE PERMISSION

1. If a parent allows their child to be checked out with someone **not** on their checkout form, we must have permission in writing (note) or a fax (918-689-2438) by ***Wednesday, at 5:00 p.m.*** of the weekend to be checked out.
2. **Student cannot checkout during the week with anyone other than the parent/legal guardian.**
3. Student is to leave campus with authorized persons listed below: (***Only persons 25 years of age or older are allowed to check students off campus. Exception will be if the parent or guardian is less than 25 years of age).***
4. Check out privileges may be forfeited if student is not checked out properly or returned at the agreed upon time.
5. Muscogee (Creek) Nation Eufaula Dormitory reserves the right to deny check out privileges if it is not in the best interest of the student.

NAME & RELATIONSHIP	ADDRESS (Street & Town/City)	PHONE NUMBER for Emergency Purposes
1.		
2.		
3.		
4.		

I am legally responsible for my child and understand that Muscogee (Creek) Nation Eufaula Dormitory is released of responsibility whenever the student is checked out by above authorized persons.

I understand that the dormitory program is a 7-day a week program and it is my responsibility to arrange transportation home for my student on weekends, if I so desire. Otherwise, the dormitory will provide transportation to and from a designated bus stop on specified occasions that will include fall break, Thanksgiving break, Christmas break, spring break, and other times when Eufaula Public Schools is out of school for 4 days or more. A calendar will be provided to parents/guardians during a mandatory orientation on move-in day. On these occasions, I agree to be prompt in picking up/dropping off my child at the designated location. Should I fail to make arrangements for my child to be picked up from the bus stop, I understand that Muscogee Nation Lighthorse will be notified. If I fail to return my child to the bus stop in time to be transported back to the dormitory, I understand that it is my responsibility to transport my child to the dormitory.

Student's Name: _____ Parent/Guardian: _____

OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION

UPDATED APRIL 2024

PRE-PARTICIPATION PHYSICAL EVALUATION FORM AND PARENTAL CONSENT

No student shall be eligible to represent his/her school in athletics or marching band until there is on file with the school a physical examination and parental consent certificate.

All physicals for OSSAA participation must be given no earlier than May 1 of the preceding year in which the students are to participate and before the first day of practice in that student's particular activity. The physical will be valid from the date of the physical given until the next required physical. Parent(s) or guardian(s) must sign the parental consent form each year before the student participates in any organized athletic practice session including contest participation.
The pre-participation evaluation form is designed to identify risk factors prior to participation by way of a thorough medical history and physical examination. A qualified physician, physician's assistant, or an advanced practice nurse covered by professional liability insurance shall give the physical examinations.

1. The most current version of the OSSAA PPE form should be used; any other form used must contain a minimum of the information requested on the OSSAA PPE form.
2. The PPE Form must be signed and completed in its entirety. No pre-signed or pre-stamped forms will be accepted.
3. SIGNATURES
   - ❑ The person administering the PPE's signature must be hand-written and dated. No signature stamps will be accepted.
   - ❑ The parent/guardian signatures must be hand-written and dated.
   - ❑ The student-athlete signature must be hand-written and dated.
4. DISTRIBUTION
   - ❑ History Form retained by Physician/Healthcare Provider
   - ❑ Examination Form and Consent and Release Form signed and returned to member school.
   - ❑ PPE's should be held to HIPPA standards; however school medical personnel and coaches should be aware of any rescue medications or conditions relevant to the student.

OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION

PREPARTICIPATION PHYSICAL
HISTORY FORM

Students should complete and sign this form (with your parents if younger than 18) before your appointment. *History Form is retained by member school and health care provider.*

Name: _____ Date of birth: _____

Date of examination: _____ Grade: _____

Sex at birth (Female or Male): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie. Medicines, pollens, food, stinging insects).

_____

Are your required vaccinations current? _____

		(CIRCLE ONE)	
1.	Do you feel stressed out or under a lot of pressure?	YES	NO
2.	Do you ever feel sad, hopeless, depressed, or anxious?	YES	NO
3.	Do you feel safe at your home or residence?	YES	NO
4.	Have you ever tried cigarettes, chewing tobacco, snuff, or dip?	YES	NO
5.	During the last 30 days, did you use chewing tobacco, snuff, or dip?	YES	NO
6.	Have you ever taken anabolic steroids or use any other appearance/performance supplement?	YES	NO
7.	Have you ever taken any supplements to help you gain or lose weight or improve your performance?	YES	NO

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly-morphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of food and food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

OKLAHOMA SECONDARY SCHOOL ACTIVITIES ASSOCIATION

PHYSICAL EXAMINATION

(Physical examination must be performed on or after May 1 for the following school year.)

Name _____ Date of Birth _____ Grade _____ School Name: _____

EXAMINATION		
Height	Weight	Sex at Birth: Male Female
BP / (/)	Pulse	Vision R 20/ L 20/ Corrected? Y N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span height, hyperlaxity, myopia, MVP, aortic insufficiency		
Eyes/ears/nose/throat		
Pupils equal		
Hearing		
Lymph nodes		
Heart		
Murmurs (auscultation standing, supine, +/- Valsalva)		
Location of point of maximal impulse (PMI)		
Pulses		
Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Skin		
HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		

MUSCULOSKELETAL

	NORMAL	ABNORMAL FINDINGS		NORMAL	ABNORMAL FINDINGS
Neck			Knee		
Back			Leg/ankle		
Shoulder/arm			Foot/toes		
Elbow/forearm			Functional		
Wrist/hand/fingers			Duck-walk, single leg hop		
Hip/thigh					

☐ Cleared for all sports without restriction ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

☐ **Not cleared** ☐ Pending further evaluation ☐ For any activities

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the activities outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Health Care Professional (print/type) _____ Date _____

Address _____ Phone _____ License # _____

Signature of Health Care Professional _____

PARENT/GUARDIAN CONSENT FORM

(To be retained by member school with history and parent consent forms)

STUDENT NAME:_____

DATE OF BIRTH:_____

SCHOOL:_____

The above information is correct to the best of my knowledge. I hereby give my informed consent for the above-mentioned student to participate in activities. I understand the risk of injury with participation. If my son/daughter becomes ill or is injured, necessary medical care can be instituted by physicians, coaches, athletic trainers or other personnel properly trained. I further acknowledge and consent that, as a condition for participating in activities, identifying information about the above-mentioned student may be disclosed to OSSAA in connection with any investigation or inquiry concerning the student's eligibility to participate in/or any possible violation of OSSAA rules. OSSAA will undertake reasonable measure to maintain the confidentiality of such identifying information, provided that such information has not otherwise been publicly disclosed in some manner.

SIGNATURE OF PARENT/ GUARDIAN_____DATE_____

SIGNATURE OF STUDENT_____DATE_____

PATIENT REGISTRATION QUESTIONAIRE

PATIENT'S FULL NAME: _____ OTHER NAMES USED: _____

SEX: M ____ F ____ DATE OF BIRTH _____ SOC. SEC. NUMBER: _____

PLACE OF BIRTH: _____ TRIBAL MEMBERSHIP: _____

DEGREE OF INDIAN BLOOD: _____ ROLL NUMBER: _____

PATIENT'S MAILING ADDRESS/P.O. BOX _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ MESSAGE PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____

PATIENT'S FATHER'S NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY # _____

FATHER'S TRIBAL MEMBERSHIP_____ DEGREE OF INDIAN BLOOD: _____

PATIENT'S MOTHER'S NAME: _____ MAIDEN NAME: _____

MOTHER'S TRIBAL MEMBERSHIP: _____ DEGREE OF INDIAN BLOOD: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

PATIENT'S FATHER'S EMPLOYER: _____ WORK NUMBER: _____

PATIENT'S MOTHER'S EMPLOYER: _____ WORK NUMBER: _____

(PLEASE CHECK INSURANCE STATUS): MEDICARE ____ MEDICARE # AND MEDICARE NAME _____

MEDICAID ____ MEDICAID # AND MEDICAID NAME _____

PRIVATE ____ PATIENT'S RELATIONSHIP TO INSURED _____ NAME OF INSURANCE _____

PERSONS LIVING IN HOME (IF ADDITIONAL SPACE IS NEEDED, CHECK HERE ____ AND LIST ON BACK OF FORM):

NAME	**BIRTHDATE**	**RELATIONSHIP**

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE ANSWERS TO THE ABOVE QUESTIONS ARE TRUE AND COMPLETE.

_____ _____

PARENT/GUARDIAN'S SIGNATURE DATE

Optometry Department Health History Questionnaire

Name: _____ DOB/Age: _____ Date: _____

Name of Optometrist/Ophthalmologist_____
Approximate date of last eye exam _____
Do you wear glasses? YES / NO

Do you wear contact lenses? YES / NO

Are you interested in LASIK? YES / NO / MAYBE

Are you currently using eye drops? YES / NO
Please list any eye surgeries you have had:
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____
Reason for today's visit:

_____

_____

Are you bothered by any of the following?

☐ Headaches

☐ Double vision

☐ Dry/Burning Eyes

☐ Itchy Eyes

☐ Sensitivity to light

☐ Problems with glare

☐ Floaters or flashes of light

☐ Other kinds of discomfort _____

I would describe my vision as:

_____

☐ Stable

☐ Worsening

_____

Does anyone in your family have: (list relation)

☐ Diabetes: Type 1 _____

☐ Diabetes: Type 2 _____

☐ Stroke / TIA _____

☐ Heart Disease _____

PERSONAL AND FAMILY MEDICAL HISTORY

Does anyone in your ***immediate family*** have:

☐ Glaucoma_____ ☐ Cataracts_____

☐ Diabetes _____ ☐ Macular Degeneration_____

Do YOU have or have YOU had any of the following eye problems?

☐ Glaucoma ☐ Macular degeneration _____

☐ Cataract ☐ Eye surgery/injury _____

☐ Lazy eye or eye turn ☐ Retinal Detachment R / L

▪ R / L ☐ Uveitis/Iritis R / L

Please indicate if YOU have any of the following health conditions:

Systemic Conditions

☐ Lupus ☐ Diabetes Type 1
☐ Environmental Allergy ☐ Diabetes Type 2
☐ Rheumatoid Arthritis ☐ Thyroid Dysfunction
☐ Sjogren's Syndrome ☐ Sleep Apnea
☐ Sarcoidosis ☐ Migraines
☐ Lung Cancer ☐ Other Cancer _____
☐ Other _____

List medications you are currently taking (if not filled by a Creek Nation facility):

_____

_____

_____

Name of Primary Care Physician (if not Creek Nation):

_____ Date of last visit: _____

Are you currently pregnant or nursing? Yes ____ No ____

_____

Continue on back..

MUSCOGEE NATION
DEPARTMENT OF HEALTH ESTABLISHED 1970

Dental Health History

Have you had any of the following?	YES	NO
17. Rheumatic fever/heart murmur		
18. Damaged heart valves		
19. Heart valve replacement		
20. Heart Surgery		
21. Heart Attack		
22. Cardiac pacemaker/stent		
23. High Blood Pressure		
24. Chest Pain		
25. Abnormal bleeding		
26. Anemia		
27. Blood transfusion		
28. Stroke		
29. Artificial joint		
30. Arthritis/rheumatism		
31. Ulcer		
32. Intestine or colon disorders		
33. Tuberculosis or lung disease		
34. Asthma or breathing problem		
35. Sinus trouble or allergies		
36. Do you have any disease, condition, or problem not listed?		

	YES	NO
1. Cancer or tumors		
2. Epilepsy or seizures		
3. Kidney problems		
4. Hepatitis/Liver problems		
5. Sexually transmitted disease		
6. Exposure to HIV or AIDS		
7. Behavioral or mental disorder		
8. Attention Deficit Disorder (ADD or ADHD		
9. Sleep Apnea		
10. Adverse reaction to anesthetic		
11. Diabetes		
12. Family history of Diabetes		
13. Do you use tobacco?		
14. If yes, do you want to quit?		
15. Do you use alcohol?		
16. Do you use recreational drugs?		
FEMALES ONLY – ARE YOU:		
Pregnant? How many weeks?		
Nursing?		
Taking Birth Control?		

Name of Medical Doctor and last medical visit: _____

List hospital stays or surgeries: _____

Medications and/or therapy (Past or Present)	YES	NO
Are you allergic to any medications? List:		
Are you allergic to latex, any foods or environmental substances?		
Have you ever had chemotherapy medication? (Actonel, Aredia, Fosamaz, Zometa, etc.)		
Have you ever had radiation?		
Have you ever had steroid therapy?		
Have you ever had medication for osteoporosis? (Fosamax, etc.)		
Do you take blood thinners?		
List all current medications:		

PATIENT INFORMATION – CONSENT FOR DENTAL GENERAL PROCEDURES

Name: _____ Date of Birth: _____ Home/Cell Phone#: _____
Address: _____ City: _____ State: _____ Zip: _____ Work Phone#: _____

I/We consent for myself/my child to receive dental treatment deemed necessary by the providers at MCN dental clinics. These procedures include, but are not limited to; examinations, dental x-rays, teeth cleaning, fluoride treatments, sealants, dental fillings, periodontal (gum) treatments and the usage of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia.

Patient/Parent or Legal Guardian _____ Date: _____

Dentist: _____ Date: _____

MUSCOGEE NATION
DEPARTMENT OF HEALTH ESTABLISHED 1970

Patient Name: _____

Date: _____

Pediatric Health Questionnaire

A. Delivery

1. Any difficulties at the time of delivery or after delivery? _____

B. Family Background

2. Child lives with. Please list name and relation:
   - □ Mother: _____
   - □ Father: _____
   - □ Other relative: _____
   - If other relative, do you have guardianship? Yes ____ or No ____
   - How long have you had guardianship? _____
   - Other members in home: _____
3. Please **mark** if your **child's blood relatives** have ever had any of the following conditions. Please list who has any marked conditions. (i.e. maternal grandmother – diabetes, parental uncle high blood pressure) Use back of sheet if needed:
   - Anemia (Sickle Cell) _____
   - Bleeding disorders (Hemophilia) _____
   - Thyroid disease (Goiter, Nodule) _____
   - Diabetes _____
   - High blood pressure _____
   - Rheumatic fever or Rheumatic heart _____
   - Cystic Fibrosis _____
   - Heart attack before age 55 _____
   - High Cholesterol _____
   - Allergies (Eczema, Hay fever, Hives) _____
   - Seizures (Epilepsy) _____
   - Alcoholism or drug abuse _____
   - Cancer or Leukemia _____
   - Sudden or unexplained death _____
   - Mental illness _____
   - Kidney/liver disease _____
   - Obesity _____
   - Other _____

C. Nutrition

4. Any dietary concerns: _____
5. History of skipping meals/purging/restricting behavior? □ Yes or □ No, if YES, Explain:

   _____

6. Development: Any history of developmental delay in your child? □ Yes or □ No, if YES, Describe: _____
7. Growth: Any concerns about your child's growth, weight, or failure to thrive? □ Yes or □ No, if YES, Describe: _____

D. <u>Medical History</u>: Indicate the age(s) at which your child might have had any of the following illnesses:

- Mumps _____
- Chickenpox _____
- Whooping Cough _____
- Rheumatic Fever _____
- Asthma _____
- Anemia _____
- Convulsions _____
- Heart Disease _____
- Pneumonia _____
- ADHD/ADD _____
- Allergic Rhinitis _____
- Hepatitis (Jaundice) _____
- Regular (Red, Hard) Measles _____
- Scarlet Fever _____
- Kidney/Urinary disease _____
- Rubella (German, 3-day) Measles _____
- Constipation _____
- Hearing loss _____
- Vision Problems _____
- Eczema _____
- Diabetes _____
- High blood pressure _____

Has the child ever been seriously injured? □ Yes or □ No Date: _____

Has the child had tonsils or adenoids removed? □ Yes or □ No Date: _____

Has the child ever had a blood transfusion? □ Yes or □ No Date: _____

List other serious illnesses/hospitalizations/ or surgeries (description & date)

_____

Is your child regularly taking any medicine(s) including Over the Counter? □ Yes or □ No
Please list below or on separate sheet:

_____

_____

Is your child allergic to any medicines/foods, etc. □ Yes or □ No, if YES please list below:

_____

Are there behavior problems at home? □ Yes or □ No, if YES, please describe:

_____

Is there any history of learning difficulties/disabilities or problems at school? □ Yes or □ No Describe:

_____

_____

Are there any concerns you would like to discuss with your child's doctor today? □ Yes or □ No Describe:

_____

Does your family have enough to eat? □ Yes or □ No
If no, do you want information to help? □ Yes or □ No

Date: _____ Signature: _____

THE
MUSCOGEE (CREEK) NATION

DEPARTMENT OF HEALTH
P.O. Box 580 | OKMULGEE, OK 74447
T 918.756.0310 | 918.759.2079

DAVID HILL
PRINCIPAL CHIEF
DEL BEAVER
SECOND CHIEF

Attention,

In order for us to complete any Referrals, Eufaula Indian Health Center needs to become this patient's medical home (primary care provider). If you applied for Soonercare and did not choose a medical home you may do so by calling the Soonercare helpline 800-987-7767 or contact a Patient Benefit Coordinator at the facility. Sometimes your health care needs require you to see a specialist. When this happens, your medical home will make the referral for you.

How it Works:

- You must get a referral before you go to the specialist.
- Your medical home will send the specialist the referral form. You can only get a form from them.
- Sometimes the medical home's office will make your appointment to a specialist for you or let you know that you can make one once the referral has been sent.
- You cannot ask your medical home for a referral after you have seen the specialist.
- If your medical home gives you a referral for a service not covered under Soonercare, you will have to pay for it.
- A referral is not a guarantee of payment.
- If you do not keep your appointment, the specialist may not give you another appointment.

Choosing a Medical home will speed up the process of a referral and not delay any healthcare needs.

Please contact:

Kristi Heneha – Roubidoux
Eufaula Indian Health Center
Patient Benefit Coordinator
P: 918-689-2547 ext. 5040
DL: 918-490-7022
F: 918-689-1123

Chinea Rockwell
Eufaula Indian Health Center
Patient Benefit Coordinator
P:918-689-2540 ext. 5055
F: 918-689-1123

New Provider Action Form - Fax Number: (405) 917-7374

For Contracted Capacity and/or Age Restriction Overrides Only

Check Appropriate Reason(s)
Capacity Override – _____
Age Override – _____

Date: _____

Provider Name: _____ SoonerCare Provider #: _____ Provider Email: _____

Providers: An action form is to be used only when a PCP is requesting a member override to their contracted capacity and/or because of member age restriction. It does not change the capacity or age restrictions to your PCP contract. Member enrollment changes for all other reasons must be initiated and completed by the member utilizing the SoonerCare Helpline (1-800-987-7767).

Please make sure your provider name and provider location code is correct. Fax this form when completed to (405) 917-7374. Incomplete action forms or requests other than capacity or age reasons will not beprocessed. If you would like to be notified if there are issues with your form, include youremail address above.

1. Complete the form below. Be sure to include all information requested.
2. The member or member's parent or legal guardian, must sign this form. Provider cannot sign the form for the member.
3. Only a provider's office can fax this form.

Please print legibly in black ink – Use another form for more than four (4) members requesting a PCP change:

	Member(s) SoonerCare ID number	Mbr. DOB (required) mm/dd/year	Member(s) Social Security Number
1.		/ /	- -
2.		/ /	- -
3.		/ /	- -
4.		/ /	- -

Member address: _____ Apt. # _____ City _____ State _____ Zip _____

Adult Member Signature _____ Date _____ Phone number or message phone + area code (___) _____ - _____

SoonerCare Helpline Use Only:

Date Received _____ Completed by: _____ Reason not processed: _____

For Member Services Use Only: Reason not processed: _____

Date Received: _____ Date completed: _____ Completed by: _____

General Consent for Treatment – Clinic

MUSCOGEE NATION
DEPARTMENT OF HEALTH ESTABLISHED 1970

_____ _____

Patient Name (please print) Date of Birth Date

Initial

_____ **General Consent for treatment**. I request and authorize the Muscogee (Creek) Nation Department of Health (MCNDH), its employees, nursing staff and any physician or allied health professional as necessary to provide emergency, outpatient, and/or general treatment and care at any MCNDH facility to the patient indicated above.

_____ **Assignment of Benefits**. I hereby assign MCNDH such insurance benefits, including Medicare, Medicaid, and other third parties (if any) that I may have pertaining to payment for medical services, prescriptions, and supplies furnished to me by the MCNDH. I authorize payment of such benefits directly to the MCNDH. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization.

_____ **E-prescribing Consent**. By signing this consent MCNDH care share, request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Also you give MCNDH permission to enroll you in the ePrescribe program.

_____ **Student Participation**. MCNDH participates in the education of students in healthcare; our medical team may be assisted in patient care by students in healthcare training. I understand I have the right to refuse students involved in my care and will notify my care provider(s) of any such decisions.

_____ **Health Information Exchange (HIE).** MCNDH participates in HIE which is the transfer of healthcare information electronically across physician offices and affiliates to MCNDH. I understand that: my healthcare providers will access externally available electronic health records including but not limited to medication history and medication prescribing information; MCNDH will transmit/receive electronic health information between affiliated physicians and organizations who are involved in my care using HIE.

_____ **Patient Portal.** MCNDH utilized a web portal as part of the electronic health record, which communicates information including but not limited to test results and visit summaries. You may activate your patient portal by providing your clinic with a current email address and completing the user registration process through NextGen Patient Portal.

Adult Patient: I authorize MCNDH to provide my ☐ medical and/or ☐ billing information (check appropriate box) to:

Minor Patient: I do hereby consent to any care determined by a clinician to be necessary for the welfare of my child while said child is under the care of Muscogee (Creek) Nation Department of Health or when I am not reasonably available by telephone. I authorize the following person(s) to give consent during my absence.

_____ *relationship* _____

_____ *relationship* _____

_____ *relationship* _____

_____ _____

Signature of Patient, Parent or Legal Guardian Relationship to Patient

**This document will remain active in your electronic health record for one year from the date above and will not be cancelled unless there is written authorization from the patient to do so or a new consent form is submitted*

Appointment of Personal Representative Form

This form identifies a person who has authority to act on a patient's behalf in making decisions related to their health care. The federal HIPAA Privacy Rule requires your Health Care Provider to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health condition.

This form does not give your Personal Representative the right to request personal health information or any other legal rights beyond those listed below:

I, _____ Date of Birth: _____
(Patient Name)

Mailing Address: _____ hereby
Designate: _____ to act on my behalf.
(Print Name of Personal Representative)

I authorize my Personal Representative to:

- **Receive** any protected health information that I may request as a patient;
- **Communicate** with my health care provider on my behalf.

Effective: This appointment of a Personal Representative is effective upon completing and signing this form.

Expiration: This appointment of a Personal Representative will not expire unless indicted by the patient in writing or by appointing a different Personal Representative.

Right to Revoke: I understand that I may revoke this authorization in writing. I understand that even if I revoke this appointment, any disclosures made before this appointment prior to the effective date of my revocation will be covered and protected by this appointment.

Patient Name: _____ Date: _____
(Print Name)

Signature: _____

Witness: _____ Date: _____
(Print Name)

Signature: _____

Notice of Privacy Practices and Patient Rights & Responsibilities Muscogee (Creek) Nation Department of Health

Muscogee (Creek) Nation Department of Health (MCNDH) must collect timely and accurate health information about you and make that information available to members of your health care team, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to medical providers outside the Department of Health for services that MCNDH cannot provide. It is the legal duty of MCNDH to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care, and for other services relating to your health care.

The purpose of this *Notice of Privacy Practices* is to inform you about how your health information may be used within MCNDH, as well as reasons why your health information could be sent to other service providers outside of this agency.

This *Privacy Notice* describes your rights in regards to the protection of your health information and how you may exercise those rights. This *Privacy Notice* also gives you the names of contacts should you have questions or comments about the policies and procedures MCNDH uses to protect the privacy of your health information.

Please review this document carefully and ask for clarification if you do not understand any portion of it.

Patient Acknowledgement

I have received Muscogee (Creek) Nation Department of Health's *Notice of Privacy Practices*, which describes this agency's methods for protecting the privacy of my health information that is used in providing health care services to me. I have received a copy of Muscogee (Creek) Nation Department of Health's Patient Rights & Responsibilities, which describes my rights as a patient.

_____/_____

Patient (or Personal Representative) Date

Note: MCNDH retains this signed page.
Patient retains the Notice of Privacy Practices document.

Origination 05/14/2013 Revision 09/19/2017