

# School Year 2022-2023

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**SHERMAN INDIAN HIGH SCHOOL  
RIVERSIDE, CALIFORNIA  
STUDENT ENROLLMENT APPLICATION**

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Thank you for applying to Sherman Indian High School. Below you will find a check off list to help you send in a complete application. If you have any questions, you can reach us at 951-276-6325 ext. 200.

- 1) Is the student's social security number correct? **(Page 2)**  Yes
- 2) Has the Parent/Guardian signed the Loco Parentis Permission section? **(Page 3)**  Yes
- 3) Has the Parent/Guardian and student signed the Prohibiting Alcohol/ Illegal Substances & Gang Activity sections? **(Page 4)**  Yes
- 4) Has the Parent/Guardian signed the Permission to Obtain/Release School Records? **(Page 6)**  Yes
- 5) Is the acknowledgement of Acknowledgement of Official Travel signed by parent/guardian? **(Page 7)**  Yes
- 6) Has the Parent/Guardian signed the Social Information page? **(Page 8)**  Yes
- 7) Has the Parent/Guardian signed the Student Check Out Sheet? **(Page 9)**  Yes
- 8) Has the Parent/Guardian signed the Medical Insurance Information? **(Page 10)**  Yes
- 9) Has the Parent/Guardian signed the Consent of Medical Release? **(Page 11)**  Yes
- 10) Has the Parent/Guardian signed the Behavioral Health Consent? **(Page 12)**  Yes
- 11) Physical Evaluation – Date of physical must be within the last 6 months  Yes  
**Take pages 13, 14, 15, 16 to your physical appointment.**
- 12) Did you request for a Teacher, Principal, or Counselor to complete the School Reference Form? **(Page 17)**  Yes
- 13) Did you provide a 1<sup>st</sup> and 2<sup>nd</sup> choice for the SIHS Pathways Program? **(Page 18)**  Yes
- 14) Did the School Records Release get sent to the last school attended? **(Page 19)**  Yes
- 15) Have you included the following documents?
  - a) Copy of Certificate of Indian Blood (CIB)  Yes
  - b) Copy of Birth Certificate  Yes
  - c) List of Immunizations- Dated after January 01, 2022  Yes
  - d) Copy of Official/Unofficial High School Transcripts  Yes  
(8<sup>th</sup> Graders: send copy of diploma, standardized test scores and 7<sup>th</sup> & 8<sup>th</sup> grade reports cards)
  - e) Copy of Health Insurance Card (both sides)  Yes
  - f) Attach copy of custody/legal documents and provide information on the person(s) who are responsible for the applicant.  Yes

You can mail, fax, or email your completed application to:

Attn: Applications  
9010 Magnolia Avenue  
Riverside, CA 92503  
Fax: 951-276-6055

To send by email, please call 951-276-6326, Extension 200

Student Name: \_\_\_\_\_

**STUDENT IDENTIFICATION**

**Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle (Month/Day/Year)

Mailing: \_\_\_\_\_ Age: \_\_\_\_\_  
Address City/State Zip

Residential: \_\_\_\_\_ Gender:  Male  Female  
Address City State/Zip

Student Email address \_\_\_\_\_ Student cell phone # \_\_\_\_\_

In which tribe is the student enrolled? \_\_\_\_\_

**PARENT / GUARDIAN INFORMATION:**

A. \_\_\_\_\_ Father Mother Guardian Other  
Parent/Guardian Name Circle Relationship

Address City State Zip Tribal Affiliation

Email address: \_\_\_\_\_ Legal Guardian:  No  Yes

Home Phone: ( ) \_\_\_\_\_ Contact Allowed  No  Yes

Cell Phone: ( ) \_\_\_\_\_ Lives with student:  No  Yes

Work Phone: ( ) \_\_\_\_\_ Receive student mailings:  No  Yes

B. \_\_\_\_\_ Father Mother Guardian Other  
Parent/Guardian Name Circle Relationship

Address City State Zip Tribal Affiliation

Email address: \_\_\_\_\_ Legal Guardian:  No  Yes

Home Phone: ( ) \_\_\_\_\_ Contact Allowed  No  Yes

Cell Phone: ( ) \_\_\_\_\_ Lives with student:  No  Yes

Work Phone: ( ) \_\_\_\_\_ Receive student mailings:  No  Yes

**ANY GUARDIANSHIP OR CUSTODIAL ARRANGEMENTS MUST  
INCLUDE PROPER NOTARIZED/COURT DOCUMENTATION**

Student Name: \_\_\_\_\_

**SECONDARY CONTACT INFORMATION**

**CHILD PROTECTION SERVICE/ CASE WORKER INFORMATION: (IF APPLICABLE)**

|                            |            |                      |           |  |
|----------------------------|------------|----------------------|-----------|--|
| Name _____                 |            | Agency _____         |           |  |
| Address _____              | City _____ | State _____          | Zip _____ |  |
| Office Phone: (    ) _____ |            | Email Address: _____ |           |  |

**EMERGENCY CONTACTS (OTHER THAN PARENTS/GUARDIANS):**

A. \_\_\_\_\_

|                              |                               |                          |             |           |
|------------------------------|-------------------------------|--------------------------|-------------|-----------|
| Emergency Contact Name _____ | Relationship to student _____ | City _____               | State _____ | Zip _____ |
| Home Phone: (    ) _____     |                               | Cell Phone: (    ) _____ |             |           |

B. \_\_\_\_\_

|                              |                               |                          |             |           |
|------------------------------|-------------------------------|--------------------------|-------------|-----------|
| Emergency Contact Name _____ | Relationship to student _____ | City _____               | State _____ | Zip _____ |
| Home Phone: (    ) _____     |                               | Cell Phone: (    ) _____ |             |           |

**TRIBAL EDUCATION OFFICE (NAME OF THE TRIBE): \_\_\_\_\_**

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

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

City, State, and Zip: \_\_\_\_\_

**IF SHERMAN CANNOT CONTACT A PARENT, GUARDIAN OR EMERGENCY CONTACT, SHERMAN WILL CONTACT SOCIAL SERVICES AND/OR LAW ENFORCEMENT.**

**LOCO PARENTIS PERMISSION**

I agree, for reasonable cause and assurance for the health and safety of all students, Sherman Indian High School staff may act in *loco parentis*. They may, at their discretion, exercise search, seizure and drug testing while my student is in attendance at Sherman Indian High School. Such activities shall be in compliance with 25 CFR-Part 42.3, (b), "Rights of the Individual Student," and 34 CFR-Part 86.200, (b-e), "Drug Free Schools and Campuses."

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

Student Name: \_\_\_\_\_

**PROHIBITING ALCOHOL/ ILLEGAL SUBSTANCES AND GANG ACTIVITY**

**PROHIBITING ALCOHOL/ILLEGAL SUBSTANCES**

Sherman Indian High School (SIHS) prohibits the use and possession of alcohol or illegal substances. Students under the influence of alcohol or illegal substances may, at administrative discretion, either be sent home on Administrative Leave or remain on-campus depending on the severity of the offense. Students who exhibit other negative behaviors may also be sent home on Administrative Leave pending a hearing. Students under the influence of alcohol or illegal substances, or having drug paraphernalia, are subject to drug testing. Refusal to test is considered a positive test in the state of California. Students who refuse to be tested or searched will be sent home pending an Administrative Hearing. Possession of a controlled substance on school property in the state of California is a felony and subject to intervention by local law enforcement.

|                           |      |                   |      |
|---------------------------|------|-------------------|------|
| Parent/Guardian Signature | Date | Student Signature | Date |
|---------------------------|------|-------------------|------|

**PROHIBITING GANGS AND GANG ACTIVITY:**

The visibility of gang and gang-related activities at SIHS causes a substantial disruption and/or interference with school and school activities. Gangs and gang-related activities are prohibited on SIHS school property or at SIHS school affiliated activities. Signing the following agreement is a condition of enrollment at SIHS.

I hereby agree that I will not engage in the following activity or behavior while a student at Sherman Indian High School;

1. I will not wear, possess, use, distribute, display, or sell any clothing, jewelry, emblems, badges, symbols, signs or any item deemed by administration which is evidence of membership or affiliation in any gang;
2. I will not communicate, either verbally or non-verbally, any gesture, slogan, or drawing to show membership or affiliation in a gang;
3. I will not commit any act which furthers gang activity including, but not limited to:
  - a. Soliciting others for membership in any gang;
  - b. Requesting any person to pay protection or otherwise intimidating or threatening any person;
  - c. Committing any illegal act or violation of SIHS policies;
  - d. Inciting other students to act with violence upon any other person.

I understand and agree to the provisions of this agreement.

|                           |      |                   |      |
|---------------------------|------|-------------------|------|
| Parent/Guardian Signature | Date | Student Signature | Date |
|---------------------------|------|-------------------|------|

Student Name: \_\_\_\_\_

**CRITERIA FOR BOARDING OR OUT-OF-BOUNDARY ENROLLMENT**

Favorable action is recommended upon this application because this case conforms to the following criteria for boarding school.

**Please check all that apply: MUST check at least one factor.**

**EDUCATIONAL FACTORS**

Name of Federal/Public/Local school(s) that the student would attend: \_\_\_\_\_

- Grade level not offered.
- Severely overcrowded.
- Exceeds 1 1/2 miles walking distance to school or bus route.
- Does not offer special vocational/preparatory training necessary for gainful employment.
- Does not offer adequate provisions to meet academic deficiencies or linguistic/cultural differences.
- SIHS offers special academic program needed by student.

**SOCIAL FACTORS**

In his/her environment, the student:

- Was rejected or neglected.
- Does not receive adequate parental supervision.
- Well-being was imperiled due to family behavioral problems.
- Has behavioral problems too difficult for solutions by family or local resources.
- Has siblings or other close relative(s) enrolled at SIHS who would be adversely affected by separation.

**Other Factors:**     Parent Choice     Homeless     Student     Other \_\_\_\_\_

**ALUMNI INFORMATION:**

Have any family members attended Sherman Indian High School? Please Check all that apply and write their name.

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Grandmother _____ | <input type="checkbox"/> Sister _____ |
| <input type="checkbox"/> Grandfather _____ | <input type="checkbox"/> Aunt _____   |
| <input type="checkbox"/> Mother _____      | <input type="checkbox"/> Uncle _____  |
| <input type="checkbox"/> Father _____      | <input type="checkbox"/> Cousin _____ |
| <input type="checkbox"/> Brother _____     |                                       |

Student Name: \_\_\_\_\_

**PERMISSION TO OBTAIN/RELEASE RECORDS**

I do hereby give my permission for Sherman Indian High School, a BIE school, to obtain and/or release a copy of my child's grades, transcripts, social/legal records, Title I, Special Education, 504 Plan and Special Academic Program records.

Applicant Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**SCHOOL HISTORY**

**FOR STUDENTS WHO'S LAST ACADEMIC YEAR WAS 8<sup>TH</sup> GRADE:**

Name of Middle School: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Year student was promoted: \_\_\_\_\_

You **MUST** send your 8<sup>th</sup> grade promotion certificate/diploma, standardized test scores and your 7<sup>th</sup> and 8<sup>th</sup> grade report cards.

Did you complete any foreign language classes? Please list: \_\_\_\_\_

Please explain any D's and F's that are on your transcripts: \_\_\_\_\_

**FOR STUDENTS WHO HAVE PREVIOUSLY ATTENDED HIGH SCHOOL**

Have you previously attended Sherman Indian High School? (Circle)      YES      NO

If "yes" write years attended \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

Number of high schools you have attended? (Circle)                      1      2      3      4      4+

List all high schools you have attended (use back if necessary):

Name of school: \_\_\_\_\_

City, State: \_\_\_\_\_ Grade(s) attended: \_\_\_\_\_

Name of school: \_\_\_\_\_

City, State: \_\_\_\_\_ Grade(s) attended: \_\_\_\_\_

Name of school: \_\_\_\_\_

City, State: \_\_\_\_\_ Grade(s) attended: \_\_\_\_\_

Name of school: \_\_\_\_\_

City, State: \_\_\_\_\_ Grade(s) attended: \_\_\_\_\_

**PLEASE ATTACH TRANSCRIPTS**

Student Name: \_\_\_\_\_

### EDUCATIONAL INFORMATION

My child has received the following services in school:

- GATE (Gifted & Talented Education)  
Bilingual Education
- AVID
- Section 504 Plan

Special Education:

- I have an IEP (Individual Education Plan).
- Special Education/Resource Room

Date of current IEP: \_\_\_\_\_

Date of current Psych Eval: \_\_\_\_\_

Please submit with application.

What is the first language you learned? \_\_\_\_\_

List any other languages spoken in your home: \_\_\_\_\_

### TRAVEL INFORMATION

REAL ID for airline: This federally mandated identification is needed for all passengers to board an aircraft. The deadline has been extended to May 3, 2023. In preparation of your students travel needs please keep this in mind. More information will be forth coming.

Please note:

- ALL public transportation travelers, under the age of 15 years, are required to travel with a companion over the age of 15 years. If needed, Sherman will provide the escort for official travel days **ONLY**. Sherman will not provide pick up or drop off at Los Angeles International Airport (LAX). Please use Ontario Airport (ONT) for airline travel.
- One (1) luggage will be pre-paid for each student traveling via airline.
- Students are limited to 2 (two) large suitcases for buses or SUV pickups.

If the student misses any travel arrangements, the parent/guardian's may be responsible to pay any and all additional fees. **Students missing assigned travel will be put on a wait list and possibly lose their spot for enrollment.** All other travel during the school year is at the expense of the student's family.

Will you be under the age of 15 as of August 1 of this year?      Yes      No

Which airport is closest to your residence (City, State)? \_\_\_\_\_

Which bus station and/or Amtrak is closest to your residence (City, State)? \_\_\_\_\_

### ACKNOWLEDGEMENT OF OFFICIAL TRAVEL

**I (parent/guardian) understand that Sherman will only pay for official travel:**

*\*the beginning of the year; \*round trip at Winter Break; \* return home at the end of the year*

**All other travel is the responsibility of the parent/guardian of the student. Students who are parentally withdrawn are responsible for return travel expenses.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date





Student Name: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Complete the following:

\_\_\_\_\_  
(Print full name of student)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Date of Birth)

Is your child covered under any medical or dental insurance? (Circle one)      YES      NO

If yes, please complete the following:

*For private insurance holders:*

\_\_\_\_\_  
Name of insurance company

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Effective date

\_\_\_\_\_  
Group Number

*For Medicare holders:*

\_\_\_\_\_  
Claim number

\_\_\_\_\_  
Effective Date

I hereby assign to the IHS, insurance benefits (if any) that I may have, pertaining to payment for medical services and supplies furnished to my child by IHS. I authorize payment of such benefits directly to IHS. I understand that if any payments come directly to me, that I must remit them to the Phoenix Indian Medical Center Business Office or other designated IHS Business Office.

I have been provided a copy of the IHS Notice of Privacy Practices (HIPAA).

I certify that the information given is true and accurate.

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Phone Number where parent or guardian can be reached during the day

Student Name: \_\_\_\_\_

**CONSENT OF MEDICAL RELEASE**

\*\*\*Note that according to California law, "effective January 1, 2016, parents or guardians of children in any school or child care facility, whether public or private, will no longer be allowed to submit a personal beliefs exemption to currently-required immunization requirements. SB 277 retains the medical exemption provided by a licensed physician." \*\*\*

Indian Health Service can arrange for and/or provide the following health services for my child:

- Health care including medical examinations, treatment, routine laboratory studies, x-ray procedures, skin tests, immunizations and all medications.
- Medications administered by school dormitory personnel prescribed by Indian Health Service provider.
- Emergency health care for accidents or illnesses.
- Emergency dental care.
- Surgical Procedures.
- Mental health services including evaluation and treatment as necessary.
- Psychiatric services to include assessment, treatment, and medication as necessary.
- Transportation of child to and/or from another health facility for these services.

I hereby give consent for all of the services listed above.

Exceptions or Special Instructions: \_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ the parent/legal custodian/legal guardian of \_\_\_\_\_  
(print parent/guardian's name), (print student's name)

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

\_\_\_\_\_  
Home Phone Number Work/Alternate Phone Number

**DO HEREBY AUTHORIZE SHERMAN INDIAN HIGH SCHOOL STAFF TO:**

Act in loco parentis, in the best interests of the child, in authorizing medical care or mental health care for him/her. To include any vaccinations, radiologic images, laboratory, anesthetic, medical, surgical or dental diagnoses and/or treatments. Care to be rendered to the above named minor under supervision and upon advice of a qualified health care provider. In giving this consent, I recognize and understand that in situation where the above named student required immediate medical or hospital care, it may not be possible to contact me. In such situations, I authorized a qualified health care provider to exercise his/her professional judgement and assess the risks and choose the treatment deemed necessary by his/her professional judgement for the health and safety of the above named student.

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
(Date)

Valid for two years from date signed

Student Name: \_\_\_\_\_

**BEHAVIORAL HEALTH CONSENT FOR TREATMENT**

I have been informed of the following:

*Treatment Policy:* The Behavioral Health Department provides individual, couples, and group counseling on a voluntary basis: Students may request counseling services or may be referred by medical staff, dorm staff, academic staff and/or parent/guardian. Under some circumstances, services may be provided via electronic media, in which case, patient will be verbally informed of the associated limitations and risks. A provider will complete a detailed personal history and determine an effective treatment plan which may include the use of therapy, community resources, traditional healing, and the use of medications. Students cannot be forced to participate in any part of the treatment plan or forced to take medications. The provider will verbally review possible risks, benefits and limitations of any course of treatment and the risks of refusing treatment.

Court ordered treatment or evaluations are not provided.

*Rights and Responsibilities:* I have been informed of my Patient's Rights and Responsibilities and Privacy Practices at the IHS Clinic at Sherman Indian High School. I understand if I have any concerns or complaints about my treatment, I may contact the supervisor, the Patient Advocate or Department Chief at Phoenix Indian Medical Center (PIMC) at any time.

SIHS IHS Clinic phone number: (951) 509-8780      PIMC Phone Number: (602) 263-1518

*Limits of Confidentiality:* I understand I have a right to privacy and limited confidentiality regarding my treatment in the Behavioral Health Department. No information about myself will be released without my signed consent for such release, within the limits allowed by applicable federal and state law. I understand confidentiality cannot be provided if I am feeling suicidal (want to hurt/kill myself), homicidal (thought or desire to hurt or kill others), or if there is a suspicion of child, elder, or disabled adult abuse. I understand that patient and treatment information may be shared and discussed with other health providers to optimize my mental health care. My behavioral health documentation will be documented in the EHR (Electronic Health Record) and can only be viewed by authorized providers within the clinic or Phoenix Indian Medical Center.

*Patient Responsibilities:* I understand that it will be my responsibility to keep my appointments and actively participate in my treatment plan. Should I fail to show for 2 consecutive appointments without canceling, my active behavioral health chart will be closed, which means I will need to begin another initial treatment process. For any patient presenting for treatment (child or adult who has a legal guardian), I will need to have written verification of my guardianship status in order to begin treatment.

I agree to all of the above treatment consents and understand their meanings.

Name of Student (please print): \_\_\_\_\_

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT/GUARDIAN QUESTIONNAIRE FOR ADOLESCENT PHYSICAL EVALUATION**

Exam date: \_\_\_\_\_

Adolescent name: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Grade: \_\_\_\_\_

Student's Primary Care Provider: \_\_\_\_\_

Permission to send Sherman IHS records to Primary Care Provider: YES / NO

Does the adolescent have allergies to any medicine, pollen, food or stinging insect? YES / NO

If yes, please provide the name of allergen, reaction and treatment plan (EpiPen, etc).

| <b>Allergen</b> | <b>Reaction</b> | <b>EpiPen (Y/N)</b> |
|-----------------|-----------------|---------------------|
|                 |                 |                     |
|                 |                 |                     |

Please list the following information for medications the adolescent takes:

| <b>Name of medication</b> | <b>Dose</b> | <b>Frequency</b> | <b>Reason for taking</b> |
|---------------------------|-------------|------------------|--------------------------|
|                           |             |                  |                          |
|                           |             |                  |                          |

Has the adolescent had any inpatient or outpatient treatment for mental health concerns, alcohol or drugs?

If yes, please provide the following information:

| <b>Name of treatment facility/therapist</b> | <b>Age</b> | <b>Length of treatment</b> | <b>Reason</b> |
|---|------------|----------------------------|---------------|
|   |            |                            |               |
|   |            |                            |               |

With whom does the adolescent live most of the time?

|   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Both parents         | <input type="checkbox"/> Stepmother | <input type="checkbox"/> Sisters (Ages _____)  |
| <input type="checkbox"/> Mother               | <input type="checkbox"/> Stepfather | <input type="checkbox"/> Brothers (Ages _____) |
| <input type="checkbox"/> Father               | <input type="checkbox"/> Guardian   | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Other adult relative | <input type="checkbox"/> Alone      |  |

Has a doctor ever denied or restricted the adolescent's participation in sports for any reason? Y N

Does the adolescent have any ongoing medical condition (like diabetes or asthma)? Y N

Does the adolescent's heart race or skip beats during exercise? Y N

Has a doctor ever told you that your adolescent has:

High blood pressure    A heart murmur    High Cholesterol    A heart infection

Has the adolescent ever spent the night in a hospital? Y N

Has the adolescent ever had surgery? Y N

Has the adolescent had any broke/fractured bones or dislocated joints? Y N

Has the adolescent had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? If yes, please list affected area below:

|                                       |                                |                                     |                                    |                                |                                    |
|---------------------------------------|--------------------------------|-------------------------------------|------------------------------------|--------------------------------|------------------------------------|
| <input type="checkbox"/> Head         | <input type="checkbox"/> Neck  | <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Elbow | <input type="checkbox"/> Foot/Toes |
| <input type="checkbox"/> Hand/Fingers | <input type="checkbox"/> Chest | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Lower Arm | <input type="checkbox"/> Knee  |                                    |
| <input type="checkbox"/> Calf/Shin    | <input type="checkbox"/> Ankle | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Thigh     | <input type="checkbox"/> Hip   |                                    |

Student Name: \_\_\_\_\_

**Adolescent applicant please complete:**

|  | YES | NO |
|--|-----|----|
| Have you ever had an injury that caused you to miss practice or a game?  |     |    |
| Have you ever had a stress fracture?   |     |    |
| Have you ever been told that you have atlantoaxial (neck) instability?   |     |    |
| Have you ever had an X-ray for atlantoaxial (neck) instability?  |     |    |
| Do you regularly use a brace or assistive device?  |     |    |
| Has a doctor told you that you have asthma or allergies?   |     |    |
| Do you cough, wheeze, or have difficulty breathing during or after exercise?   |     |    |
| Is there anyone in your family who has asthma?   |     |    |
| Have you ever used an inhaler or taken asthma medication?  |     |    |
| Were you born without, are you missing, or do you have a non-functioning kidney, eye, testicle, or any other organ?  |     |    |
| Have you had infectious mononucleosis (mono) within the last month?  |     |    |
| Do you have any rashes, pressure sores or other skin problems?   |     |    |
| Have you had a herpes skin infection?  |     |    |
| Have you ever had an injury to your face, head, skull, or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your “bell rung” or getting “dinged”)? |     |    |
| Have you ever had a seizure?   |     |    |
| Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?   |     |    |
| While exercising in the heat, do you have severe muscle cramps or become ill?  |     |    |
| Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?   |     |    |
| Have you ever been tested for sickle cell trait?   |     |    |
| Have you had any problems with your eyes or vision?  |     |    |
| Do you wear glasses or contact lenses?   |     |    |
| Do you wear protective eyewear, such as goggles or a face shield?  |     |    |
| Are you happy with your weight?  |     |    |
| Are you trying to gain or lose weight?   |     |    |
| Has anyone recommended you change your weight or eating habits?  |     |    |
| Do you limit or carefully control what you eat?  |     |    |
| <b>COVID-19</b>  |     |    |
| Did you receive the COVID-19 vaccine?  |     |    |
| Have you been tested for COVID-19?   |     |    |
| Have you been diagnosed with COVID-19?   |     |    |
| If yes, are you still having symptoms from their COVID-19 infection?   |     |    |
| Were you hospitalized as a result for complications of COVID-19?   |     |    |
| Have you been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?  |     |    |
| Did you have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?   |     |    |
| Have you returned back to full participation in sports?  |     |    |
| Have you had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?   |     |    |

|  |  |
|--|--|
| <p style="text-align: center;"><b><u>Females Only</u></b></p> <p>Have you ever had a menstrual period? Y N</p> <p>How old were you when you had your first menstrual period? _____</p> <p>How many periods have you had in the last 12 months?</p> | <p>Use this space to explain any “YES” answers from above.</p> |
|--|--|

**SHERMAN INDIAN HIGH SCHOOL ADOLESCENT PHYSICAL EXAM**

The provider should fill out this form with the assistance from the parent or guardian.

PATIENT HISTORY QUESTIONS

- |   |     |
|---|-----|
| 1. Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?                   | Y N |
| 2. Has your child ever had extreme shortness of breath during exercise?                                 | Y N |
| 3. Has your child had extreme fatigue associated with exercise (different from other children)?         | Y N |
| 4. Has your child ever had discomfort, pain or pressure in his/her chest during exercise?               | Y N |
| 5. Has a doctor ever ordered a test for your child’s heart?   | Y N |
| 6. Has your child ever been diagnosed with an unexplained seizure disorder?                             | Y N |
| 7. Has your child ever been diagnosed with exercise induced asthma not well controlled with medication? | Y N |

Explain yes answers here:

FAMILY HISTORY QUESTIONS

- |  |     |
|--|-----|
| 1. Are there any family members who had sudden/unexpected/unexplained death before age 50?<br>(Including: SIDS, car accidents, drowning and near-drowning) | Y N |
| 2. Are there any family members who died suddenly of “heart problems” before age 50?   | Y N |
| 3. Are there any family members who have unexplained fainting or seizures?   | Y N |
| 4. Are there any relatives with certain conditions such as:  |     |

|                                      |   |   |  |   |   |
|--------------------------------------|---|---|--|---|---|
| Enlarged Heart                       | Y | N | Catecholaminergic Polymorphic Ventricular Tachycardia  | Y | N |
| Marfan Syndrome                      | Y | N | Hypertrophic Cardiomyopathy (HCM)                      | Y | N |
| Long QT Syndrome                     | Y | N | Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC) | Y | N |
| Short QT Syndrome                    | Y | N | Dilated Cardiomyopathy (DCM)                           | Y | N |
| Brugada Syndrome                     | Y | N | Heart Rhythm Problems                                  | Y | N |
| Deaf at Birth                        | Y | N | Heart Attack, Age 50 or younger                        | Y | N |
| Pacemaker or Implanted Defibrillator |   |   |  | Y | N |

Explain “Yes” answers here:

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I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

\_\_\_\_\_  
Signature of Applicant (Adolescent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of MD/DO/ND/NMD/NP/PA-C/CCSP

\_\_\_\_\_  
Date

Student Name: \_\_\_\_\_

**SHERMAN INDIAN HIGH SCHOOL ADOLESCENT PHYSICAL EXAM**

|                |               |                |  |
|----------------|---------------|----------------|--|
| Name           | Date of Birth |                |  |
| Age            | Sex           |                |  |
| Height         | Weight        | BMI            |  |
| Blood pressure | Pulse         | RR             |  |
| Vision R 20/   | L 20/         | Corrected? Y N |  |
| Pupils Equal   | Unequal       |                |  |

**CURRENT IMMUNIZATION RECORD AND THE FOLLOWING IMMUNIZATIONS ARE REQUIRED**

Rotavirus (3 doses)      Hepatitis B (3 doses)      DTAP (5 doses)      MMR (2 doses)      Hib (3 doses)      MCV4 (2 doses)  
 Polio (4 doses)      Hepatitis A (2 doses)      Tdap (1 dose)      Varicella (2 doses)      PCV (4 doses)  
 Age ≥16: Men B (1-2 doses)      HPV is highly recommended (3 doses)      COVID-19 is highly recommended (2-3 doses)  
 PPD or Quant GOLD (Annual Requirement)

|                       | Normal | Abnormal Findings | Initials |
|-----------------------|--------|-------------------|----------|
| Medical               |        |                   |          |
| Appearance            |        |                   |          |
| Eyes/Ears/Throat/Nose |        |                   |          |
| Hearing               |        |                   |          |
| Lymph Nodes           |        |                   |          |
| Heart                 |        |                   |          |
| Murmurs               |        |                   |          |
| Pulses                |        |                   |          |
| Lungs                 |        |                   |          |
| Abdomen               |        |                   |          |
| Genitourinary         |        |                   |          |
| Skin                  |        |                   |          |
| Musculoskeletal       |        |                   |          |
| Neck                  |        |                   |          |
| Back                  |        |                   |          |
| Shoulder/Arm          |        |                   |          |
| Elbow/Forearm         |        |                   |          |
| Wrist/Hands/Fingers   |        |                   |          |
| Hip/Thigh             |        |                   |          |
| Knee                  |        |                   |          |
| Leg/Ankle             |        |                   |          |
| Foot/Toes             |        |                   |          |

**NOTES:**

- Cleared for boarding school without restriction
- Cleared for boarding school with the following restrictions:
- Not cleared for: All Sports      Certain Sports: \_\_\_\_\_ Reason: \_\_\_\_\_
- Medically eligible for all sports without restriction with recommendations for further evaluation and treatment of: \_\_\_\_\_

Name of Provider (print): \_\_\_\_\_ Exam Date: \_\_\_\_\_

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

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP: \_\_\_\_\_

Student Name: \_\_\_\_\_

**SCHOOL REFERENCE FORM**

**MUST BE COMPLETED BY A COUNSELOR OR PRINCIPAL**

The above student has applied for admission to Sherman Indian High School. Please fill out the following and return it directly to the school. Reference forms returned by the student will not be accepted.

How long have you known the student? \_\_\_\_\_

Current Grade Level: \_\_\_\_\_

What discipline and attendance problems, if any, have you encountered with the student?

Has student ever been suspended? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, for what? Be specific: \_\_\_\_\_

Has student ever been expelled? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, for what? Be specific: \_\_\_\_\_

What is the student's Cumulative Grade Point Average?  
How is the student's classroom behavior? (Be specific)

Is the student in the Special Education Program? Yes No  
Is the student in the Gifted & Talented Program (GATE)? Yes No  
Does Applicant have a 504 plan? (If yes, please send) Yes No

| Rate the student in terms of the following: | Poor | Average | Good | Superior |
|---|------|---------|------|----------|
| Integrity/Honesty                           |      |         |      |          |
| Responsibility                              |      |         |      |          |
| Consideration/concern for others            |      |         |      |          |
| Overall ability                             |      |         |      |          |
| Motivation                                  |      |         |      |          |
| Maturity                                    |      |         |      |          |
| Attentiveness/Listening                     |      |         |      |          |
| Ability to reason                           |      |         |      |          |
| Desire to learn                             |      |         |      |          |

Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature & Title: \_\_\_\_\_

If you should have any questions, please contact the Registrar at 951 276-6326, Extension 382.  
Thank you for taking the time to complete this form. Please send or fax completed reference forms to:

**Sherman Indian High School**  
**Attention: Registrar**  
**9010 Magnolia Avenue**  
**Riverside, California 92503**  
**Fax: 951-276-6055**

**To send by email, please call (951)276-6326, Extension 200**

**SIHS Pathways Programs**  
Real-World Education, Real-World Experiences

Please identify your top 2 Pathways you're interested in from the list below and check your 1<sup>st</sup> Choice and 2<sup>nd</sup> Choice:

|  | 1 <sup>st</sup><br>Choice | 2 <sup>nd</sup><br>Choice |
|--|---------------------------|---------------------------|
| <b>Administration of Justice, Public Service</b> (Mr. Heard) The Public Service program has introduced the BIA Wildland Fire Academy on the Sherman High School campus. The students are considered Fire Cadets, and learn Fire Science, Basic Fire Terminology, Fire Fighting Preparedness, and Fire Eradication. On completion of the course, they will earn a BIA Wildland Fire Certification status.   |                           |                           |
| <b>Animal Husbandry &amp; Veterinary Science</b> (Mrs. Trapp) Students are introduced to animal husbandry concepts to help with livestock production, growth, and care. They also learn Veterinarian concepts of animal health and grooming animals to maintain the health of the animal. Students in this program are part of the Future Farmers of America, (FFA), to prepare them for career development events and leadership. Our students compete in local livestock fairs where they will raise and sell an animal and other leadership activities through the FFA Organization.  |                           |                           |
| <b>Carpentry &amp; Construction</b> (Mr. Hayden) These classes provide a foundation within the building and construction industry. Students gain hands-on experience, technical skills, and career preparation that allow them to explore construction trades. Advanced classes provide students with additional skills, such as career study, prop making, welding, plumbing, and campus projects.  |                           |                           |
| <b>Culinary Arts</b> (Mr. Moreno) Culinary uses ProStart's career and technical education program that unites the foodservice industry and the classroom to teach high school students' culinary skills and restaurant management principles, as well as employability skills such as communication, teamwork, professionalism, and time management. Students can also work towards entering the "CA ProStart Cup" cooking competition in Long Beach, CA – where they can pitch a new restaurant concept to a panel of restaurateurs or put the finishing touches on a three-course meal as a crowd of people watch. Additionally, students will gain a National Food Services Certification to help with finding an entry level or Management jobs. |                           |                           |
| <b>Computer Literacy &amp; Graphic Design</b> (Ms. Townsend) In Computer Literacy, students gain insight into data & technology; then, upon successful completion, they may advance to Graphic Design. Advanced students will gain an introduction to Principles in Graphic Design and construct finished products using gradients of color on (Starbucks) cups and Origami projects, which will be submitted to the Heard Museum for their Student Art Exhibit.   |                           |                           |
| <b>Floral Design, Plant &amp; Soil Science</b> (Mrs. Hasson) Students will learn Art Principles to create various floral designs and have the ability to sell their projects. In Plant & Soil Science, they will learn soil properties, parts & functions of plants, grow a garden and then harvest for sales or consumption. Students in this program are part of the Future Farmers of America, (FFA), to prepare them for career development events and leadership. Floral counts as Fine Art credit, while Plant and Soil counts as science credit.  |                           |                           |
| <b>Health</b> (Mrs. McMorris) This Pathway is designed to get students interested in entering a Health career. Each course has a different focus to help them understand the endless amounts of avenues they may choose. A hands-on approach to learning will open their eyes to their personal wellness and start them brainstorming ways they can help others.   |                           |                           |
| <b>Mechanics and Electricity</b> (Mr. Harrington) Students learn about the design and operation of small gas engines and how to build or repair one. In <b>Electricity</b> , students learn what electricity is and how it is used. Students learn about different electric circuits and will build a running electric motor from scratch.   |                           |                           |

The Pathways are funded by a generous grant from the San Manuel Band of Mission Indians.

Student Name: \_\_\_\_\_

**SCHOOL RECORDS RELEASE**

***Please remove this form and send to the last school attended***

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am requesting educational records from: **(last school of attendance)**

Name of School: \_\_\_\_\_ Phone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Progress Records:                      Include transcript of grades, test results related to achievement and measurement, records of attendance (including NWEA/MAP testing and state assessments).

Special Education Records:        To include speech and language evaluations, educational assessment, Student Study Team reports, most recent IEP, Signed psychological reports, other eligibility data/determinations and behavior intervention plans.

504 Plans                                      all 504 Plans

**PLEASE DO NOT SEND CUMULATIVE FILE**

To be sent to                                **Sherman Indian High School**  
**Attn: Registrar**  
**9010 Magnolia Ave**  
**Riverside, CA 92503**  
**Telephone: 951-276-6326, Extension 382**  
**Fax: 951-276-6055**

I hereby authorize the release of all records for the above named student.

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

\*Student signature is requested if 18 years or older.

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