



APPLICATION FOR ADMISSION

Stone Child College
8294 Upper Box Elder Road
Box Elder, MT 59521
(406) 395-4875 ext. 264
Fax: (406) 395-5017
Website: www.stonechild.edu

Please print clearly, check all that apply. An incomplete application will not be processed.

Social Security Number: _____

Freshman: _____

Sophomore: _____

Veteran: Yes _____ Branch _____ Year _____ No _____

Transfer: _____

Name: _____
Last Name First Middle Initial

Mailing Address: _____ City _____ County _____ State _____ Zip Code _____

Email address: _____

Home Phone: _____ Other contact Phone: _____

Male: _____ Female: _____ Single: _____ Married _____

Birth Date: _____ American Indian Yes _____ No _____ Tribe: _____

Emergency
Contact: _____
Name Address Phone

Are you a United States citizen? Yes _____ No _____

Semester you expect to enroll: Fall _____ Spring _____ Summer _____ Year _____

Have you completed your Financial Aid packet? Yes _____ No _____

Which state are you a resident of? _____

What year and state did you last file taxes? _____

Have you ever been convicted of a felony? Yes _____ No _____ if yes, convicted for? _____

Are you the first person from your family to attend college? Yes _____ No _____

Did you attend Head Start as a Child? YES _____ NO _____

Please Check One:

EDUCATIONAL HISTORY

____ Please indicate last time you attended Stone Child College. Year graduated: ____ (if a prior graduate)

____ Ability to Benefit (No High School Diploma, HSE or GED Certificate)

Please circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12

Name of school attended: _____

____ High school graduate. Official HS transcripts must be on file.

High school name/location: _____

Year graduated: _____

____ GED Certification or HSE: Official GED or HSE must be on file.

Location City/State Obtained: _____

Year earned: _____

Other college credits earned and/or degrees earned:

Name of College	Address, Website	Dates Attended	# Credits Earned	Degree Earned

Application Process:

1. Student must have requested all transcripts from previous college, high school or GED program, before registration for courses is allowed.
2. Student must have official Certificate of Indian Blood if enrolled in a U.S. federally recognized Indian tribe.
3. Proof of immunization record showing student has received Measles, Mumps, Rubella 1 and 2 (MMR 1 and MMR 2). Applies to student born after January 1, 1957. If you claim immunization exemption, please notify the Registrar/Admission's Office for the proper immunization exemption form.
4. Student must take the ACT/COMPASS test prior to Registration for courses.
5. Application for Admission must be completed, signed, and dated. Incomplete Applications for Admissions will be put on hold and will not be processed until completed by the student.
6. Conditional Admission is granted through Registrar/Admission's Office Only.

I hereby apply for admissions at Stone Child College and agree to abide by the institution's regulations, policies and procedures. To the best of my knowledge all information provide on this application is true.

Student Signature

Date

DRUG FREE WORK PLACE

Stone Child College hereby notifies all employees/students that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited on the premises and within the boundaries of Stone Child College.

All employees/students are further notified that as a condition of employment/College enrollment, you are required to abide by this policy.

Any employee/students convicted of any criminal statue occurring in the workplace shall be subject to termination by Stone Child College.

I, _____, have been given a copy of the Stone Child College Drug Free Workplace Policy and understand the policy, conditions of employment/enrollment and penalties of said policy. I will abide by the terms of the Drug-Free Workplace Policy and will notify Stone Child College of any criminal drug statue conviction for a violation occurring in the workplace no later than 5 days after such conviction. I am aware of the available drug/alcohol counseling, rehabilitation, and employee/students assistance programs available in the community.

Employer
Stone Child College
8294 Upper Box Elder Road
Box Elder, MT 59521

Signature

Date

Release of All Claims

(Please Print)

Release made this _____ day of _____, 2020

By: _____ city of Box Elder, County of Hill, State of
Montana, as a student of Stone Child College.

In consideration of permission granted to me by Stone Child College to participate in College courses during the _____ - _____ school year. I hereby release and discharge Stone Child College of 8294 Upper Box Elder Road, City of Box Elder, County of Hill, its agents, employees, and officers, from all claims, demands, actions, judgements, and executions which the undersigned ever had, or now has, or may have, or which the undersigned's heirs, executors, administrators, or assigns, for all personal injuries, known or unknown, and injuries to property, real or personal, caused by, or arising out of, the above described activities.

I, the undersigned, have read this release and understands all its terms. I execute it voluntarily and with full knowledge of its significance.

In witness whereof, I have executed this release at Stone Child College the day and year first above written.

Student's signature

Declaration of Major

Place an X in front of your MAJOR area of study and concentration, if applicable. (You may select up to 2 (two) majors, indicating 1st and 2nd choice)

Bachelor of Science Teachers Education (BSD)

☐ Elementary Education K-8

Associate of Arts Degree (AAD)

General Studies:

☐ Native American Studies

☐ Math

☐ Liberal Arts

☐ Studio Art

Teacher Education:

☐ Elementary Education

☐ Early Childhood Education

Associate of Science Degree (ASD)

Human Services:

☐ Addiction Studies

☐ Rural Public Health

Natural Resource:

☐ Natural Resources/Geospatial Technology

Science:

☐ General Science

☐ Allied Health

Business:

☐ General Business

☐ Office Administration

Computer Science:

☐ Information Systems

Certificate of Completion

☐ Accounting/Information Management (1 year)

☐ Building Trades (1 year)

☐ Building Trades (2 year)

☐ Rural Public Health

☐ Pre-Engineering (1 year)

☐ Pre Nursing (1 year)

☐ Information Management (1 Year)

Endorsements

☐ Certified Nursing Assistant – 1 semester

☐ Peer Mentoring

☐ Historical Trauma

Non-Degree

☐ Other Please Specify: _____

Federal law requires financial aid recipients to be enrolled in a program leading to a degree or certificate

Has this been your major since initial enrollment at Stone Child College? _____

If no, what was your major at that time? _____

Student's Signature: _____ Date: _____

FERPA Consent to Release Student Information

Stone Child College

Please provide information from the educational records of _____ to:

_____ (Name of person) to whom the educational records will be released and if appropriate the relationship to the student such as parents or persons.

The only type of information that is to be released under this consent is:

_____ Transcripts

_____ Disciplinary records

_____ Recommendations for employment or admission to other schools

_____ All records

_____ Other (Specify) _____

The information is to be released for the following purpose:

_____ Family communications about college experience

_____ Employment

_____ Admission to an educational institution

_____ Other (specify) _____

I understand the information may be released orally or in the form of copies of written Records, as preferred by the requester. I have the right to inspect any written records released pursuant to the Consent (except for parents' financial records and certain letters of recommendation for which the student waived inspection rights). I understand I may revoke this Consent upon providing written notice to _____ (name of person listed above) as the College Official permitted to release the educational records. I further understand that until this revocation is made, this consent shall remain in effect and my educational records will continue to be provided to _____ (person listed above to whom the educational records will be released) for the specific purpose described above.

Name: (Print) _____

Signature; _____

Student ID Number _____ Date: _____

Release of Information Form

As Per FERPA Guidelines

I authorize release of my grades, transcripts, immunizations records and SAT or ACT scores an any other educational records to:

**Registrar's Office
Stone Child College
8294 Upper Box Elder Road
Box Elder, MT 59521**

For **ALL** semesters attended.

Signature of Student

Date Signed



Stone Child College

8294 Upper Box Elder Road
Box Elder, MT 59521
(406) 395-4875

TRIBAL CERTIFICATION RELEASE

PLEASE PRINT

TO BE COMPLETED BY THE STUDENT

Enrolled Name _____ Date of Birth _____

Name of Agency _____ Enroll # or Census # _____

Agency Location _____
City _____ State _____

Place of Birth _____ SS# _____
City _____ State _____

Mother's Maiden Name _____

Mother's Tribe _____

Father's Name _____

Father's Tribe _____

I HEREBY GRANT PERMISSION TO RELEASE TRIBAL CERTIFICATION TO:

Stone Child College
Admission/Registrar
8294 Upper Box Elder Road
Box Elder, MT 59521

Date _____ Signature _____

TO BE COMPLETED BY TRIBAL ENROLLMENT OFFICER

I certify that _____ is an enrolled member of the

Enrollment Number _____ Blood Degree _____

Agency Name _____

Agency Address _____

Certifying Official's Signature _____

Date _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I, _____, hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

II. The information is to be disclosed by:

NAME OF FACILITY

Rocky Boy Health

ADDRESS

6850 Upper Box Elder Road

CITY/STATE

Box Elder, MT 59521

And is to be provided to:

NAME OF PERSON/ORGANIZATION/FACILITY

Stone Child College

ADDRESS

8294 Upper Box Elder Road

CITY/STATE

Box Elder, MT 59521

III. The purpose or need for this disclosure is:

- ☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (Specify) _____

IV. The information to be disclosed from my health record: (check appropriate box(es))

☒ Only information related to (specify) Immunizations

☐ Only the period of events from _____ to _____

☐ Other (specify) (CHS, Billing, etc.) _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is:
(1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)

DATE

SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)

DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME (Last, First, MI)

RECORD NUMBER

ADDRESS

CITY/STATE

DATE OF BIRTH

STONE CHILD COLLEGE

Student File Check List

Initial when Completed after entering in Admission/student records Database

_____	Certificate of Indian Blood: _____
_____	(Descendent of member need Birth Certificate)
_____	Social Security Card
_____	Immunizations: MMR 1 and MMR 2 Delay _____
_____	Blue Form for MMR Exemption
_____	Official high School Diploma Delay: _____
_____	Official College Transcripts Delay: _____
_____	Admission Application/Re admit Application
_____	Release Form
_____	Drug Free Form
_____	Declaration of Major
_____	FERPA Consent Release
_____	Accuplacer/SAT/ACT or Compass Test
_____	Official Hi Set/GED Test Scores and Certificate
_____	Name Change/Address Change/Marriage Certificate
_____	Letter of Acceptance
_____	Letter of Academic Status (warning, probation.suspension
_____	Specify: _____

Once you are finished, please hit the Finish button. This will prompt you to save your file and then close. Please email to gtorres@stonechild.edu