INDEPENDENT FIRST NATIONS ALLIANCE
EDUCATION SERVICES

SIOUX LOOKOUT OFFICE
P.O. Box 5010, 56-D Front Street, Sioux Lookout, ON P8T 1K6
Toll Free: 1-888-253-IFNA | Tel: (807) 737-1902 | Fax: (807) 737-3501

Student Status: ☐ New ☐ Returning

Academic Year ____ / ____

Deadline for Applications:
1st Semester: March 31
2nd Semester: November 15

HIGH SCHOOL EDUCATION ASSISTANCE APPLICATION

Section I – Demographic Information

The following documents MUST be attached to the EA, or the application will be put ON HOLD:

Academic Transcript ☐ Medical Form ☐ Immunization Form ☐ Social History Form ☐

Registry # (10 digits)	Last Name(s)	Given & Middle Name(s)

Gender: ☐ Female ☐ Male

Y: ____ / M: ____ / D: ____ Date of Birth

Health Card Number: _____

Mother: _____ Father: _____

Parents ___ Guardians ___ Married ___ Separated/Divorced ___

Do you reside with your Parents/Guardians? ☐ Yes ☐ No

Mailing Address:

_____

_____

_____

_____

Home Phone: _____ - _____ - _____

Work Phone: _____ - _____ - _____

Cell Number: _____ - _____ - _____

E-Mail Address: _____

Do you normally reside in your home community?	☐ Yes	☐ No
Do you have any dependents?	☐ Yes	☐ No
Do you have any legal issues (ie. probation conditions)	☐ Yes	☐ No
Are you fully vaccinated for COVID-19?	☐ Yes	☐ No

Emergency/Alternate Contact:

Name:	Relationship:	Phone Number:

Are you a CFS Ward? ☐ Yes ☐ No

Name of Child/Family Services (CFS) Agency _____

IFNA.CA

Section II – Academic History

Last High School Attended: # of Credits:

☐ Sioux North ☐ DFC

☐ Pelican Falls ☐ Wahsa ☐ Other _____

Section III – Current Education Plan

1st Choice: _____ Location: _____

2nd Choice: _____ Location: _____

Grade Applying to:

☐ 09 ☐ 10

☐ 11 ☐ 12

Semester:

☐ Both

☐ First ONLY

☐ Second ONLY

Are you applying for a space at an IFNA residence? ☐ Yes ☐ No

If no, do you have a boarding home arranged for your child? ☐ Yes ☐ No

Name: _____ Phone: _____

Address: _____

_____

_____

I understand that acceptance into the program is subject to review and acceptance by IFNA officials. I also understand, that being put on a tentative list for an IFNA site does not constitute placement at that particular site. This Education Form must be complete in whole, not in part, before final confirmation of assistance is official.

Parent/Guardian Signature: _____ Y: ____ /M: _____ / D: _____

Section IV – Student Declaration

☐ I agree that full disclosure to IFNA on any medical conditions, whether they be physical or mental may affect my education assistance eligibility. I further agree that this information will be shared with my band official representatives or other IFNA representatives under existing IFNA reporting protocol.

☐ I agree to abide by all the rules and regulations of IFNA. I understand that the consequences of not abiding by the rules and regulations may affect my sponsorship including suspension and termination of funding.

☐ I intend to work to the best of my ability, attend classes regularly and consistently, abide by school and boarding home rules, and will strive to complete the academic year. I agree to have IFNA report all occurrences, social, academic, and personal, to the designated band officials as required under IFNA policy.

Student Signature: _____ Y: ____ /M: _____ / D: _____

IFNA.CA

Section V – Authorization, Release, and Indemnity of Parent/Guardian

☐ We understand and acknowledge that the staff, officers, employees, and agents of IFNA act in the place and position of a parent or guardian of my child while my child is in attendance at an IFNA sponsored program. Recognizing this, I authorize each or any of them to provide my child with any medical treatment that they consider to be reasonable or necessary.

☐ Without limiting the foregoing, I further authorize IFNA to act on my behalf, and on behalf of my child:

1. To transport my child/ward to and from his/her community to the centre in which he/she will be attending school.
2. To grant permission for my child/ward to travel, as required, to participate in supervised activities organized for students (individual unsupervised travel must be authorized by parent/guardian, in writing, before it will be permitted).
3. To obtain copies of my child/ward's report cards for the purpose of education assistance and suitable placement in a provincial school.

   In consideration of their willingness to assist my child, I release, remise, and discharge, indemnify, and save harmless IFNA, its Board of Directors, officers, employees and agents from any and all liability, claims or causes of action which may rise by virtue of application or non-application of medical treatment, or by virtue of my child's participation in, or travel to and from, any IFNA sponsored program.

☐ This authorization is to remain in effect from August to June of each school year, or until it has been cancelled in writing by either party, or the student is discharged or withdraws from the program.

Parents/Guardian Comments (please comment on placement, social and/or medical history):

Section VI – On Reserve Social Counsellor/Band Official

Social Counselor/Band Official Comments (Please involve Band Officials in recommendation regarding social history and social readiness for placement)

Section VII – Consent/Information

☐ We understand that in order to effectively assist students to achieve academic success and emotional and physical well-being, IFNA requires complete information regarding a student's physical and emotional health and academic achievement. Probation conditions and legal obligations (i.e. Court dates) must be disclosed, as well. (hereafter referred to as "information")

☐ We confirm that the information provided in this document is complete and accurate. We acknowledge and agree that IFNA officers, employees and agents need to share the information amongst each other and with officials of the Band which the student belongs to in order to assist the student.

☐ Without limiting the foregoing, we acknowledge and agree that IFNA officers, employees or agents may, if they consider it reasonable or necessary, to discuss issues related to the student's academic performance, physical or emotional well-being with the appropriate Band Official and the parents of the student.
In addition, if a student is absent from his/her boarding home or leaves his/her living quarters without permission, the student's absence will be reported to his/her parents and Band officials as per IFNA Reporting Policies.

☐ We acknowledge that if IFNA, in its discretion, determines that a student's physical or emotional well-being is at risk, IFNA may discharge the student from his/her program.

☐ We have read and agree to the terms and conditions governing IFNA financial assistance. We understand that all required supplementary documentation must be submitted by the intake deadline date of March 31 of each year, or second semester deadline date of November 15 of each year. If the required supplementary documentation is not provided by the deadline date, the EA may be referred to the next intake date.

☐ We the undersigned, agree that all information provided above is accurate and true to the best of our knowledge.

Student Signature: _____ Y: _____ /M: _____ / D: _____

Parent/Guardian Signature: _____ Y: _____ /M: _____ / D: _____

Band Official Signature: _____ Y: _____ /M: _____ / D: _____

IFNA Intake Signature: _____ Y: _____ /M: _____ / D: _____

Section VIII – IFNA Use Only

Supplementary Checklist:

- ☐ Medical Documentation
- ☐ Academic Documentation
- ☐ Personal History Form

Approval Priority:

- ☐ P1 – New
- ☐ P2 – Returning
- ☐ P3 – Voluntary Withdrawal
- ☐ P4 – Health & Safety
- ☐ P5 – High Risk

Site:

- ☐ SNHS
- ☐ PFFNHS
- ☐ DFCHS
- ☐ Other _____

Application Status:

- ☐ Approved
- ☐ Wait list
- ☐ Not Approved

Re-entry Requirements:

☐ Counseling Agreements/Documents ☐ Other _____

* Note: Please refer to termination – documentation for required documents.

Intake Panel Designate/ Database Intake#

IFNA Authorizing Signature: _____ Clerk Initials: _____ _____

IFNA.CA

INDEPENDENT FIRST NATIONS ALLIANCE
EDUCATION SERVICES

SIOUX LOOKOUT OFFICE
P.O. Box 5010, 56-D Front Street, Sioux Lookout, ON P8T 1K6
Toll Free: 1-888-253-IFNA | Tel: (807) 737-1902 | Fax: (807) 737-3501

MEDICAL INFORMATION FORM

MEDICAL INFORMATION

Student Name: _____ **Date of Examination:** _____

Health Card #: _____ **Status Card #: (10 digits)** _____

Expiry: _____ **Expiry:** _____

For students who are sponsored by IFNA, we need to ensure that all necessary medical information is provided so that we may provide supports as required.

Authorization for Release of Patients Information and Permission for Emergency Medical Treatment

I hereby authorize Sioux Lookout Meno-Ya-Win Health Centre, Thunder Bay Regional Health Sciences Centre, Sioux Lookout First Nations Health Authority, First Nations Family Physician Health Services or Health Canada to release the following information: any surgical, medical, including outpatient/clinic treatment, hospital admissions, and results of examinations or tests to:

Independent First Nations Alliance (IFNA),
Box 5010, 56-D Front Street, Sioux Lookout ON P8T 1K6

From records of: _____ _____

Name **D.O.B. (YY/MM/DD)**

I understand that this information is to be used by the recipient for the purpose of ensuring proper medical care and follow up. On rare occasions, an emergency may arise requiring treatment in a hospital and/or surgery. In most cases, administration of an anesthetic, treatment of an injury or operation upon an individual cannot be done without consent of the patient (and/or parent/legal guardian). In order to prevent a dangerous delay in an emergency situation where IFNA is either unable to contact my parent or guardian, or if I am unconscious or otherwise unable to give my consent, I hereby authorize the IFNA delegated representative to secure whatever medical treatment is deemed necessary.

Date: _____ **Expiry Date of Authorization:** _____

(YY/MM/DD) (YY/MM/DD)

Signed by: _____

(student if over 18 or parent/legal guardian ONLY)

Signature of Witness: _____

STUDENT MEDICAL FORM

Students entering secondary school should have a health examination by the community physician or head nurse. The examination is to be recorded on this form.

FULL NAME OF STUDENT: _____

ADDRESS: _____

PARENT/GUARDIAN NAME: _____

Community Physician or Head Nurse to complete this section:

1. Does this student have any allergies? ❑ Yes ❑ No
   If yes, please provide details/type(s) of reactions:

   _____

2. Has this student had any illness, operations, allergies, or injuries since beginning elementary school that require any medical attention? ❑ Yes ❑ No
   If yes, please provide details:

   _____

3. Does this student have any disability or restriction(s) that prevents his/her full participation in school play or physical education activities? ❑ Yes ❑ No
   If yes, please give details:

   _____

4. Height: _____ Weight: _____

5. Does the student normally wear corrective lenses? ❑ Yes ❑ No

If yes,	Right	Left	Both
Vision with glasses	20/_____	20/_____	20/_____
Vision without glasses	20/_____	20/_____	20/_____

   When was his/her last visit to the optometrist? _____

6. Are there any defects of?
   a) Sight _____
   b) Hearing _____
   c) Nose _____
   d) Heart _____

e) Chest _____

f) Blood _____

g) G.I. System _____

h) G.U. System _____

i) Teeth* _____

j) C. N. S. _____

k) Skin _____

l) Orthopedic _____

*Last dental visit: _____

7. Physical description (Distinguishing marks, features, tattoos?)

_____

8. Does this student have any disability (including learning disabilities), or other conditions which should be observed periodically by the School Nurse?
❑ Yes ❑ No If yes, please explain:

_____

9. During the last two years, has the student consulted, or been treated by, a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional for any mental, emotional or psychological conditions, including eating disorders and substance abuse? ❑ Yes ❑ No
If yes, please give details:

_____

_____

_____

10. Does this student have any prior suicide attempts: ❑ Yes ❑ No
If yes, please give details:

_____

11. Please list any medications the student is currently taking: (name/dose/frequency/time)

_____

_____

_____

12. Is student on any special diet? ❑ Yes ❑ No
If yes, please explain:

_____

13. Diabetic? _____ Smoke cigarettes? _____

14. Status Card / Health Card photocopy attached? ❑ Yes ❑ No

15. Are immunizations up to date? ❑ Yes ❑ No

Last TdP: _____

***Note:**

Before any student can enter the provincial systems, immunization records must be on file. This is not a choice but the LAW. A student can be refused entrance into a provincial school if there are no records on the school file.

Before any student will be placed in September, the counsellor must have received the immunization records. A photocopy of the Yellow Immunization Card is acceptable.

DATE (YY/MM/DD)	IMMUNIZATION	DATE (YY/MM/DD)	IMMUNIZATION

REMEMBER: NO IMMUNIZATION RECORD NO PLACEMENT

Name of Medical Examiner: _____ Date (YY/MM/DD): _____

Medical Examiner's Signature: _____

PLEASE ATTACH PHOTOCOPY OF HEALTH CARD AND STATUS CARD

INDEPENDENT FIRST NATIONS ALLIANCE
EDUCATION SERVICES

SIOUX LOOKOUT OFFICE
P.O. Box 5010, 56-D Front Street, Sioux Lookout, ON P8T 1K6
Toll Free: 1-888-253-IFNA | Tel: (807) 737-1902 | Fax: (807) 737-3501

PERSONAL HISTORY FORM

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ Community: _____

1. Does he/she smoke cigarettes, drink alcohol, or use any drugs? ❑ Yes ❑ No ❑ Unsure
   Describe: _____
2. Has he/she had any involvement with the police or courts? * ❑ Yes ❑ No ❑ Unsure
   Describe: _____
   **Please attach probation conditions, court orders, etc.*
3. Has he/she experienced any of the following traumatic events?
   - ❑ Sexual Abuse
   - ❑ Physical Abuse
   - ❑ Emotional Neglect
   - ❑ Domestic Violence
   - ❑ Family Drug/Alcohol Abuse
   - ❑ Chronic Illness of Parent
   - ❑ Family Incarceration
   - ❑ Divorce/Separation of Parent
   - ❑ Death of Family Member/ Close Friend
   - ❑ Other _____

   Comments: _____
4. Has he/she been treated/evaluated for mental health issues? ❑ Yes ❑ No ❑ Unsure
   If yes, list name of counsellor and dates treated:
   _____
5. Do you have any additional information that you would like to share with us to ensure his/her safety and enjoyment while he/she is attending school? (allergies, likes/dislikes, hobbies, interests, favorite foods etc.)
   _____
   _____
   _____

Parent/Guardian Signature: _____ Date(YY/MM/DD):_____

TO BE COMPLETED BY CURRENT TEACHER AND SOCIAL COUNSELLOR:

School History:

Has he/she received any type of Special Education or tutoring?	❑ Yes ❑ No
Does he/she generally like school?	❑ Yes ❑ No
Will he/she be socially promoted this year, based on age?	❑ Yes ❑ No
Will he/she be able to handle college level courses?	❑ Yes ❑ No
Did he/she have any incidents while in school?	❑ Yes ❑ No
Has he/she had any mental health issues? (i.e. suicidal ideation)	❑ Yes ❑ No

Is there anything else we should know about this student to ensure his/her success, safety and well-being?

_____

_____

_____

_____

Student Signature: _____

Teacher Signature: _____

Social Counsellor Signature: _____

INDEPENDENT FIRST NATIONS ALLIANCE
EDUCATION SERVICES

SIOUX LOOKOUT OFFICE
34 Prince Street, Sioux Lookout, ON P8T 1K6
Toll Free: 1-888-253-IFNA | Tel: (807) 737-1902 | Fax: (807) 737-3501

Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)
&
Freedom of Information and Protection of Privacy Act, R.S.O 1990,c. F.31

I, _____, _____,
(Print your name) (Date of Birth)

Hereby consent and authorize the release and disclosure by (Print name of Person, Agency, or institution)

1. _____

2. _____

3. _____

4. _____

Any Health/Police/School information, report, document, assessment, record, material, statements, concerning myself to representatives of, Independent First Nations Alliance (IFNA) Secondary Student Services Program, its employees, as may be required for the purpose of: my Supervisor and Care while I am attending school under their care.

I also understand that I can withdraw my consent in writing at any time and that I can restrict the nature and type of information shared.

This consent is considered valid for the _____ school year.

_____ _____
Student Name (Please Print) Signature

_____ _____
Parent/Legal guardian (If under 16) Signature

_____ _____
Witness (IFNA Employee) Date

INDEPENDENT FIRST NATIONS ALLIANCE
EDUCATION SERVICES

SIOUX LOOKOUT OFFICE
34 Prince Street, Sioux Lookout, ON P8T 1K6
Toll Free: 1-888-253-IFNA | Tel: (807) 737-1902 | Fax: (807) 737-3501

Student Agreement and Acknowledgement Form

IFNA Home Away Program or IFNA Boarding Home Students

KEY POINTS	PARENT INITIALS
All parties agree to work in the best interest of the students.	
The IFNA Education Department Policy Guidebook has been received and reviewed. • Each party knows and agrees to their roles and responsibilities – as outlined in the IFNA Education Department Policy Guidebook.	
Students, guardians and IFNA partner communities understand and agree they do not have to send their kids out for school. • Students are allowed to remain home and study online if this is more comfortable.	
Each party agrees to the steps required to file any formal complaint, concern, or request for additional support. • The Education Leadership in the community will be the first point of contact for all concerns, which must be submitted in writing, using the appropriate form.	
Parents, guardians and Community Education Leadership understand that their students are committing to their academics. • The student must be registered in 4 credit courses each semester and remain in good academic standing with grades and attendance • Education takes priority over extracurricular activities and/or sports • Failure to focus on academics could result in academic probation to sponsorship being revoked.	

Date (yy/mm/dd): _____ School Year / Semester:

Student Name: _____ Signature:

Parent/Guardian Name: _____ Signature:

IFNA Director, Student Services _____ Signature:

Community Education Contact: _____ Signature:

Community Name:

Boarding Home Parent (if applicable): _____ Signature:

IFNA.CA