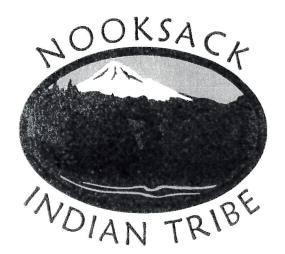
Nooksack Tribe Youth Program Application

Valid: June 2025 through June 2026



Please complete each section of this application

Incomplete applications will not be accepted for Youth Department registration

Nooksack Youth Department • 360.966.9696 • 5604 Mission Rd, Bellingham, WA 98226

For Office Use Only:	
Date/Time Rec'd	

Policy Agreement
In-person policy agreements must be adhered to upon entry to our program. Policy agreement will ensure the enrolled youth will abide by rules to ensure safety and efficiency of our program.
Please initial each statement after you have read each policy
My child will attend Nooksack Youth Program regularly. In the matter whereas my child is not attending regularly, he/she will be removed from Nooksack Youth Program to allow youth on our waitlist to enter the programMy child will participate in the Nooksack Indian Tribe Behavior Health sessions that are offered.
My child will participate in the NITYP classrooms and NIT Tribal library in a respectful manner and will follow all health & safety precautions.
I will pick up my child on-time. In case of emergency I will notify the front desk of any tardiness.
I will call the front desk to make any changes to the location of my child's Drop off.
I allow the authorized Youth Program/Education Department staff to take photos of my child while participating in on-campus activities. I understand this may be shared to the Nooksack Tribe Social Media, Nooksack Tribe Newsletter and the Nooksack Tribe website.
My child will be respectful to themselves, staff and the other students. There is Zero Tolerance for Bullying at NITYP.
I understand that Youth Program staff are not permitted to administer medications to my child. If child has a medical condition that requires medication there must be a Medical Plan in place that is created and signed by the child's doctor on file for our staff to follow.
I understand NITYP is not responsible for personal belongings. If my child brings electronic devices/money/valuable items, it is at their own risk. NITYP only allows cellphones for emergent use and must remain in child's backpack/coat.
If I have any complaints or concerns regarding social well-being, bullying, protocols of NITYP, I will fill out the designated NITYP Complaint Form and/or contact the NITYP Receptionist or Youth Program Manager.
FIELD TRIP CONSENT I give my full authorization and consent for my child to participate in every field trip that is scheduled for the 2025/26 year. I give my consent for NITYP to transport my child off campus.
**NITYP fieldtrips & on-site activities may involve water sprinklers and the children's clothing may become wet. It is recommended that all children bring extra clothes daily. NITYP staff are not authorized to apply sunscreen to youth participants. It is recommended that you apply sunscreen to your child prior to arriving to ensure UV protection.
Parent/Guardian Signature Date

Nooksack Indian Tribe Release of Information

The Family Educational Rights And Provacy Act (FERPA) is a federal law that protects the privacy of student records, FERPA normally requires that the school district (the "District") obtain written consent from a parent/guardian or eligible student before disclosing the student's personally identifiable information from such records. This form is intended to satisfy the requirements of FERPA and enable the District to communicate with the Nooksack Tribe (the "Tribe"), as authorized by the parent/guardian or eligible student. By signing this form, the parent/guardian or eligible student authorizes the District officials to disclose the education records specified herein as requested by the Tribe.

AUTHORIZATION FOR RELEASE OF EDUCATIONAL RECORDS

Student Name:	DOB:
	DATE:
Parent/Guardian Name: Contact Number:	
	Authorized Representations of The Nooksack Tribe 5016 Deming Road P.O. Box 157 Deming, WA 98244 Phone (360) 592-5176 Fax (360) 592-2125 AND Authorized Representatives of
Address Phone:_ Examples of educational records to Attendance records, grades, assignments	be disclosed on a need-to-know basis only: nents, notes related to student academic success, discipline etc. ademic support for the above student between the Nooksack Tribe
Should I withdraw my consent, it does 2. Unless revoked by undersigned parent the child is continuously enrolled in th	
specified above.	rict to disclose information from my child's or my education records as
Parent/Guardian OR Student signature	Date

Name of Child:First	Middle Initi	al Last	
SSN:	Race:		
☐ Nooksack Tribal Member	☐ Federally Recognized	Tribal Member Non-Tribal Member	
Birthdate:	Age:	Gender: 🗆 Male 🗆 Female	
School Attended:	Grade (2025):		
Parent/Guardian Name:			
Actual Address:			
		Phone number:	
	Work:	Cell:	
Етаії:	Type of	Device:	
Provider One Card (Medicaid):	□ Yes □ No	Must Attach Insurance Card	
Medical Insurance:		Policy #:	
Primary Care Physician:		Phone Number:	
Emergency Contact:		Phone Number:	
Previous Counseling? Yes	.⊑ No if yes, with whom ε	and for what purpose (Name of the counselor)	
Signing this form also acknowledg billed for services rendered for the		guardian consents to having their insurance	
Signature:		Date:	

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Client's Rights

- 1. To be treated with respect and dignity.
- 2. To be provided professional care and services.
- 3. To Refuse any participation in service.
- 4. To receive care, which does not discriminate against me and is sensitive to my gender, race spiritual beliefs, national origin, language, age, disability and sexual orientation.
- 5. To be free of any sexual exploitation or harassment.
- 6. To review any record of service I have received with professional staff member of Nooksack Behavioral Health.
- 7. To receive services which we hold as completely confidential.
- 8. To lodge a complaint with Nooksack Health Director or Nooksack Behavioral Health Unit (Dr. Khan) if you believe your rights have been violated. A staff member from the Nooksack Behavioral Health Office may, at your request, assist you in filing a grievance.

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Programs Used: After School, Public School and Summer Groups

Informed Consent for Services

Name:				
	First	MI	Last	

- I voluntarily consent for my child to participate in services from the Nooksack Behavioral Health staff.
- A counselor will develop a plan aimed at improving my child's mental health
- A copy of the Client's Rights is included in this packet. If a crisis arises that is not during office hours, please call 911.
- A counselor will consult with all providers (including Medical) involved in my child's care in order to provide collaborative care for better outcome and keeping me safe
- My information can be used anonymously (your name will not be disclosed) for research purposes
- Communication with my Clinician: I understand NIT staff only use email communication and text messaging with my permission and only for administrative purposes unless we have made another agreement. Therefore, I understand no discussions of any clinical information will be exchanged by email or text, by myself or by my Clinician. Also, I understand that my clinician does not regularly check email or texts, and may not respond immediately. I understand these methods should not be used if there is an emergency.
- **Urgent Communication**: I understand, if I need to speak to my clinician on urgent issue I should feel free to attempt to reach my clinician by contacting the front office phone number at **360-966-2376**. I understand my clinician will try to return my call within 24 hours except on weekends and holidays.
- Confidentiality: I understand my clinician has a legal and ethical responsibility to make best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that no guarantee can be made where communications will be kept completely confidential or that other people may not gain access to these types of communications.
- Technological Connection Failure: I understand if the session is interrupted for any reason and I am having an emergency, that I will not call clinician back; and instead, I will call 911 or go to the nearest emergency room. I agree to call my clinician back after I have called or obtained emergency services.
- Session Interrupted: I understand if my session is interrupted and I am not having an emergency. I will disconnect from the session and wait two (2) minutes, for my clinician to re-contact me via the telepsychology platform on which we agreed to conduct therapy. I understand that if I am not contacted within two (2) minutes, then I will call the front desk phone at (360)-966-2376.

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- Records: I understand the telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I understand my clinician will maintain a record of our session in the same way records have been maintained if my session was in-person in accordance with Behavioral Health policies.
- **Disclosure without consent or authorization:** Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Nooksack Behavioral Health welcomes you. We are glad we can be of service to you and look forward to working with you. If you have any questions, please feel free to call.

I have read and understand this and my signature indicates that I agree for my child to receive mental health services from Nooksack Behavioral Health and to participate in counseling.

Signing this form also acknowledges that I have received and read a copy of the Client Rights.

Print Full Name	
Client Signature	Date
Counselor Name & Signature	Date

Consent to Release Confidential Information between NIT Behavioral Health After School and Public Schools

I hereby give my permission for any/all (need-to-know basis) information to be released between Nooksack Behavioral Health and the Tribal Youth Program, as well as my child's school:

(Check your child's school for Fall 2025)			
Acme Elementary	Harmony Elementary	☐ Kendall Elementary	
☐ Everson Elementary☐ Nooksack Middle School	☐ Nooksack Elementary☐ Mount Baker Junior High	Other	
☐ Nooksack High School	☐ Mount Baker High School	⊠ NIT Tribal Youth Program	
*Any shared information between your child's school and Nooksack Behavioral Health will be used for the sole purpose of maintaining and improving your child's academic success.			
Parent/Guardian Signature	Print Name	Date	
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