ELIZABETH HIGH SCHOOL

"A Commitment to Excellence"

Dear Parent/Guardian:

Welcome to Elizabeth High School! In order to enroll your student, you will need to provide the following documents at the time of your appointment with the counselor:

REQUIREMENTS FOR REGISTERING A STUDENT

Proof of Residency – Copies of a residential building contract, a deed of trust, a real estate buyer contract, a contract for lease/rent (with a recent utility bill), or a most recent utility bill that has your name and physical street address on it. A driver's license cannot be accepted as proof of residency because the Motor Vehicle Division does not require a proof of residency.

Birth Certificate (copy only)

Transcript – The most recent **transcript and withdrawal grades** from the previous school of attendance.

Immunization Record – All students must be fully immunized as dictated by Colorado State Law in order to attend a public or private educational institution. Proof of immunization **must** be provided.

504 Plan or IEP – All students who are identified as being on a 504 Plan or in Special Education will need to bring a current copy of their 504 Plan or IEP (Individual Education Plan).

The custodial parent/guardian is the individual authorized to sign documents and enroll the child. Individuals sharing custodial responsibilities as outlined in court documentation must provide a copy of the custodial paperwork. In the event you are not the birth parent of the child enrolling, you must bring the **original document outlining custody or guardianship, or a Power of Attorney (For Guardianship)** (this form can be obtained from the Counseling Office).

Presentation of these documents at the enrollment interview is **MANDATORY** and will expedite your child's admission to EHS. If you have any questions, please contact our office at 303-546-1767.

Sincerely,

EHS Counseling Department

Elizabeth High School ◆ Elizabeth School District
P.O. Box 660 ◆ Elizabeth, Colorado 80107 ◆ (303) 646-4616 ◆ Fax (303) 646-6030

ELIZABETH HIGH SCHOOL

"A Commitment to Excellence"

RELEASE OF RECORDS

DATE: _____ GRADE:_____

STUDENT NAME: _____
BIRTHDATE: _____

NAME OF LAST SCHOOL ATTENDED:

_____

SCHOOL'S MAILING ADDRESS **(city & state required)**:

_____

_____

TELEPHONE NO.: _____ FAX NO.: _____

Please forward student records to Elizabeth High School Counseling Office. Student records should include **ALL** of the following (unless indicated otherwise):

- Official transcript (signed & sealed)/report cards
- Immunization/medical records
- Scholastic, achievement, test scores
- Teacher/counselor observations
- Physician, hospital, psychological, special education information
- Discipline report
- Attendance record (for current year)
- Birth Certificate
- Any individualized plans (IEP, 504, Gifted IEP)

If you have any questions, please feel free to call the Counseling Office at (303) 646-1767. Thank you.

Send all information to:

Elizabeth High School
ATTN: Counseling Office
P.O. Box 660
Elizabeth, CO 80107
Fax Number – (303) 646-1698

I hereby state that I have legal custodial rights for this student, and as such, give permission for the release of all information relating to this student.

_____ _____
Parent/Guardian Signature Date

ELIZABETH HIGH SCHOOL

"A Commitment to Excellence"

DISCLOSURE STATEMENT

STUDENT'S NAME: _____

BIRTHDATE: _____ HOME PHONE NO.: _____

LAST SCHOOL ATTENDED: _____

TELEPHONE NO.: _____

1. Has your child ever been enrolled in a Special Education program? Yes _____ No _____ If yes, what services did he/she receive?
_____

2. Is your child under the care of a specialist (i.e. medical doctor, vision/hearing specialist, psychologist, psychiatrist, speech/language specialist)? Yes _____ No _____

3. Does your child have any known physical disabilities? Yes _____ No _____ If yes, please explain:
_____

4. Is your child on medication? Yes _____ No _____ If yes, please explain: _____
_____

5. Has your child ever been suspended? Yes _____ No _____ If yes, please explain: _____
_____

Name of school involved: _____
City & State: _____ Phone No.: _____

Has your child ever been expelled? Yes _____ No _____ If yes, please explain: _____
_____

Name of school involved: _____
City & State: _____ Phone No.: _____

To the best of your knowledge, the above information is correct.

_____ _____
Parent/Guardian Parent/Guardian

_____ _____
Date Date

Elizabeth High School ♦ Elizabeth School District
P.O. Box 660 ♦ Elizabeth, Colorado 80107 ♦ (303) 646-4616 ♦ Fax (303) 646-6030

ELIZABETH HIGH SCHOOL

"A Commitment to Excellence"

AFFIDAVIT OF PROOF OF RESIDENCY
ELIZABETH C-1 SCHOOL DISTRICT

PROPERTY OWNER/LESSOR

I, _____ (print full name) hereby affirm that I own, rent/lease (circle one) the property at:

Address: _____

City/Zip/State: _____

Home Phone: _____ Office Phone: _____

Student Name(s): _____,

_____, as residence(s) of stated property.

Attached to this document is Proof of Residency: **(At least one of the following is required.)**

_____ Warranty Deed/Deed of Trust (dates, addresses, and signatures must be present).
_____ Closing papers with current operational local telephone number and/or utility contract or bill.
_____ Lease or rental agreement with a utility contract or bill under the lessee's name.
_____ Notarized co-residency form with letter from the resident family attached.

****

WARNING

A person commits perjury in the second degree if, with an intent to mislead a public servant in the performance of his/her duty, he/she makes a materially false statement, which he/she does not believe to be true. Perjury in the second degree is a class 1 misdemeanor punishable by a minimum sentence of six months imprisonment, or $500.00 fine, or both, up to a maximum sentence of 24 months imprisonment, or $5,000.00 fine, or both. Colorado Revised Statutes, §§ 18-8-503, 18-1-106.

Under penalty of perjury, I affirm that all information given above is true and current. I further understand and agree that if it is later determined that we are not legal residents of Elizabeth School District C-1, such student(s) will be withdrawn immediately from Elizabeth High School. I further agree to pay Elizabeth High School any and all applicable tuition charges which may be due, together with the cost of collection, including reasonable attorney's fees.

_____ _____
Signature of Property Owner/Lessor Date

Subscribed and sworn to before me this _____ day of _____, 20___.

Elizabeth High School • Elizabeth School District
P.O. Box 660 • Elizabeth, Colorado 80107 • (303) 646-4616 • Fax (303) 646-6030

ELIZABETH HIGH SCHOOL

"A Commitment to Excellence"

AFFIDAVIT OF CO-RESIDENCY

PROPERTY OWNER/LESSOR

I,_____(print full name)
hereby affirm that I own, rent/lease (circle one) the property at:

Address_____

City/State/Zip_____

Home Phone_____Office Phone_____

The family listed below is residing with me until_____(date), and is using my address to establish residency for the purpose of enrollment in Elizabeth High School. I agree to notify Elizabeth High School Office when the family is no longer living at my residence.

CO-RESIDENT INFORMATION

Parent/Guardian_____(print full name)
Home Phone_____ Office Phone_____

(Print first, middle initial, last name)
Student_____
Student_____
Student_____

WARNING

A person commits perjury in the second degree if, with an intent to mislead a public servant in the performance of his/her duty, he/she makes a materially false statement, which he/she does not believe to be true. Perjury in the second degree is a class 1 misdemeanor punishable by a minimum sentence of 6 months imprisonment, or $500.00 fine, or both, up to a maximum sentence of 24 months imprisonment, or $5,000.00 fine or both. *Colorado Revised Statues, Sec. 18-8-503, 18-1-106.*

Under penalty of perjury, I affirm that all information given above is true and current. I further understand and agree that, it is later determined that one or more students enrolled with this Affidavit of Co-Residency are not legal residents of Elizabeth School District C-1, such students will be withdrawn immediately from Elizabeth High School. I further agree to pay Elizabeth High School any and all applicable tuition charges which may be due, together with the cost of collection thereof, including reasonable attorney's fees.

_____
Signature of Property Owner/Lessor *Date*

_____
Signature of Co-Resident Parent/Guardian *Date*

Subscribed and sworn to before me this _____day of _____, 20_____.

NOTARY PUBLIC_____

My commission expires_____

Elizabeth High School ◆ Elizabeth School District
P.O. Box 660 ◆ Elizabeth, Colorado 80107 ◆ (303) 646-4616 ◆ Fax (303) 646-6030

Elizabeth SCHOOL DISTRICT

STUDENT HEALTH INFORMATION **School Year:** _____

STUDENT NAME: _____ BIRTHDATE: _____ SCHOOL: _____

HEALTH CONCERNS	YES	NO	MEDICATION (name/dosage)	RESTRICTIONS/ MEDICAL EQUIPMENT	DESCRIPTION/COMMENTS
Asthma/Respiratory					
Severe Allergies				Foods, Latex, Insects, Nuts, Medications?	Type of Reaction: Date of last Reaction:
Diabetes				Equipment: Pump:	
Head Injury					Date of injury:
Seizures/Neurological Conditions/Migraines					Type of last episode: Date of last episode
Heart /Blood Conditions					
Muscle/Joint/Bone					
Skin Conditions					
Bladder/Kidney					
Stomach/Intestines					
Immune Conditions					
Hearing/Ear Concerns					
Vision/Eye Concerns					
Growth/Developmental Concerns					
Emotional/Behavioral/ Attention Concerns					
Accidents/Injuries					
Other Health Concerns					

If your child needs to take medication while at school, please provide a "Permission to Give Prescription Medication at School" form filled out by your child's physician. If your child has asthma, diabetes, severe allergies or seizures, please go to the Elizabeth School District Health page for the required forms.

_____ _____ _____

Parent/Guardian Signature Contact Phone # Date

Please contact the District Nurse if you would like to discuss any of the above information (303-646-6730)

Elizabeth SCHOOL DISTRICT

PERMISSION TO GIVE PRESCRIPTION/HOMEOPATHIC MEDICATIONS AT SCHOOL

The school nurse is required by Colorado State Law to have this form signed by a parent/guardian and the student's healthcare provider before any prescription or homeopathic medication may be given at school.

For safety reasons, parents/guardians are requested to bring the medication directly to the health office. If medication cannot be delivered to the health office by the parent/guardian, please contact the health office to make other arrangements. Prescription meds must be in the original pharmacy labeled container that includes the student's name, medication name, dosage, administration directions & provider's name. New forms must be completed with any changes in medication, dose or time to be given. Parent/guardian agrees to pick up expired or unused medication within 1 week of notification or it will be destroyed.

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY:

Student Name: _____ Date of Birth: _____

Medication: _____ Dosage: _____

Route: _____ To be given at the following time(s): _____

Purpose of medication: _____

Special Instructions: _____

Side effects that need to be reported (including adverse reactions: _____

_____

Starting Date: _____ Ending Date: _____

_____ _____

Signature of Health Care Provider with Prescriptive Authority License Number

_____ _____ _____

Print Name of Health Care Provider w/Prescriptive Authority Phone Fax

ATTENTION PRESCRIBERS: If this RX is for a rescue inhaler or epi pen:

☐ This student has been instructed by the healthcare provider in the proper use of this medication and the student is capable of carrying and self-administering this medication. _____

Signature of Health Care Provider

By signing this document, I give permission for the nurse or nurse designee to administer this medication as prescribed. Should the nurse have any concerns about this order, I give my permission for this Health Care Provider to share information about this medication's administration with the Registered Nurse

_____ _____ _____

Parent/Guardian Signature Phone Date

THIS FORM MUST BE RESUBMITTED AT THE BEGINNING OF EVERY SCHOOL YEAR.

Elizabeth SCHOOL DISTRICT

ELIZABETH C-1 SCHOOL DISTRICT
NON-PRESCRIPTION MEDICATIONS
PERMISSION FORM: 20_____ - 20_____

Name of Student: _____ Grade: _____ Weight: _____

This form is required before over-the-counter medications can be administered at school. No medication will be given unless absolutely necessary. This form needs to be competed yearly.

Please initial or check each over-the-counter medication for which you give your permission for your child to have at school, then sign below.

	Yes	No
1. Acetaminophen Regular Strength (Tylenol or Generic Substitute) (you may be asked to come get your child if problem persists or if your child has a fever of 101 or above)	_____	_____
2. Antibiotic Ointment or cream (Neosporin or generic substitute)	_____	_____
3. Oral Diphenhydramine (Benadryl or generic substitute for allergy or common cold symptoms)	_____	_____
4. Topical Benadryl or Hydrocortisone cream or generic substitute	_____	_____
5. Calcium Carbonate (Tums or Generic Substitute)	_____	_____
6. Ibuprofen (Advil, Motrin or generic substitute) (you may be asked to come get your child if problem persists or if your child has a fever of 101 or above)	_____	_____
7. Saline Eye Drops (Liquid Tears or generic substitute)	_____	_____
8. Cough drops (Only ages 6 and older)	_____	_____

These over the counter medications have been approved by a local physician and we have his/her authorization to administer them during the school year with parent/guardian permission. Dosages will be determined according to manufacturer's recommendations. **If this form is not returned to school, your child will not be given any of these medications. Please indicate if your child has an allergy or untoward side effect to a specific generic or brand name medication.** Please contact your school's office staff or health aide with questions.

Allergies/side effects: _____

Additional comments: _____

I have carefully read the information above and hereby authorize the school nurse or designee to administer the above medications during the current school year.

Signature of Parent/Guardian: _____ Date: _____

Spring 2006

English

Language Acquisition

Home Language Survey

Federal and State regulations require schools to determine, upon registration in the district, the language(s) spoken and understood by each student. This is in accordance with the English Language Proficiency Act of Colorado and the Office for Civil Rights to assist schools in developing equal opportunities for any student whose dominant language is not English. Thank you for providing this information.

Student's Name: _____

Grade: _____ School: _____

Country of Birth: _____ Date of Birth: _____

Parent's (Guardian's) Name: _____

Address: _____

Home Phone: _____ Work or Cell Phone: _____

1. What language or languages did your child use when he/she **first began to talk?**
   _____
2. What primary language does your **child speak** with you and others at home?
   _____
3. What language or languages can your child read? _____
4. What language or languages can your child write? _____
5. Did your child attend school in another country? ____ YES ____NO
   If YES: How many years? ____ What grade? ____ Which country? _____
6. Was your child ever in a bilingual or English as a Second Language program? ___YES ___NO
   If YES: What was the last grade that your child was enrolled in the program? _____

Parent/Guardian Signature: _____ Date: _____

RE: Original to cum folder
Copy to ESL teacher

Office use only:
Primary Language Code: _____

COLORADO
Department of Education

Colorado MEP Occupational Survey

Your child/children may qualify to receive supplemental educational services at no cost, such as tutoring, transportation, school supplies, and other services. Please answer the following questions to assist in determining your child's/children's eligibility. Once completed, please return this form to the school or your Regional MEP Office listed below.

CHILD'S FIRST NAME:	CHILD'S LAST NAME:	BIRTHDATE:
SCHOOL:		GRADE:
PARENT/GUARDIAN NAME:	Do you have more than one child? ☐ YES ☐ NO	

1) In the past three years, has your family moved to another state, city, school district, and/or county?
   ☐ YES ☐ NO

2) Do you or anyone in your immediate family currently work, or have worked, in the past three years, in any of the following occupations related to agricultural or fishing work?

   Mark **YES** and **CIRCLE** all that apply even if the work was only for a short period of time.
   ☐ YES ☐ NO

Processing & Packing (fruit, vegetables, chicken, eggs, pork, beef, lamb or other livestock, etc.)

Agriculture or Field Work (planting, picking, sorting crops, soil preparation, irrigation, fumigation, etc.)

Dairy & Cattle Raising (feeding, milking, rounding up, etc.)

Nursery or Greenhouse (planting, potting, pruning, watering, harvesting, etc.)

Forestry (soil preparation, planting, growing, cutting trees, etc.)

Fishing & Fish Processing (catching, sorting, packing, transporting fish, etc.)

If you answered "yes" to the questions above, please continue below. Otherwise, your form is complete.

HOME ADDRESS:	TODAY'S DATE:	
CITY:	STATE:	ZIP:
TELEPHONE (WITH AREA CODE):		
BEST DAY AND TIME TO CALL:	PREFERRED LANGUAGE:	

This form and the data recorded within protected to maintain family and child confidentiality. If you have any questions, please contact:

Centennial BOCES
2020 Clubhouse Dr.
Greeley, CO 80634
970-352-7404 Ext 1116

COLORADO
Department of Education

Encuesta de Colorado MEP

Sus hijos pueden ser candidatos para recibir servicios suplementarios gratuitos, como tutoría, transporte y útiles escolares, además de otros servicios. Le agradeceríamos responder las siguientes preguntas para poder determinar su elegibilidad. Una vez contestada, envíela a la escuela o a la oficina regional de MEP que se detalla al pie de la página.

NOMBRE DEL MENOR:	APELLIDO DEL MENOR:	FECHA DE NACIMIENTO:
ESCUELA:		GRADO:
NOMBRE DEL PADRE/TUTOR:	Tiene más de un hijo? ☐ SI ☐ NO	

1) Durante los últimos tres años, su familia se ha cambiado a otro estado, ciudad, escuela, y/o condado?
☐ SI ☐ NO

2) Usted o alguien de su familia directa está trabajando o ha trabajado durante los últimos tres años, en alguna de las siguientes ocupaciones relacionadas con el trabajo agrícola o pesquero?

Marque **SI** y **CIRCULE** todo lo que corresponda, incluso si el trabajo fue por un período corto.

☐ SI ☐ NO

Procesamiento & Empaquetado (fruta, vegetales, huevos, carne de pollo, cerdo, res, o cualquier otro tipo de ganado, etc.)

Agricultura o Trabajo de Campo (cosecha, recolección y clasificación de cultivo, preparación del suelo, riego, fumigación, etc.)

Lechería & Cría de Ganado (alimentar, ordeñar, acorralar/ arrear, etc.)

Vivero o Invernadero (cultivar, plantar, podar, regar, cosechar, etc.)

Silvicultura (preparación del suelo, cosecha y crecimiento, corte de árboles, etc.)

Pesca & Procesa-miento de Pescado (capturar, clasificar, empacar, transportar pescado, etc.)

*Si contestó "**sí**" a las preguntas anteriores, por favor continúe. De lo contrario, su encuesta está completa.*

DOMICILIO:	FECHA:	
CIUDAD:	ESTADO:	CODIGO POSTAL:
TELEFONO (CON CODIGO DE AREA):		
DIA Y HORA PARA COMUNICARNOS CON USTED:	IDIOMA PREFERIDO:	

Esta encuesta y los datos registrados en la misma están protegidos para mantener la confidencialidad de la familia y los menores.
Si tiene preguntas, comuníquese a:

Centennial BOCES
2020 Clubhouse Dr.
Greeley, CO 80634
970-352-7404 Ext 1116