ELIZABETH MIDDLE SCHOOL
AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS

Name of Last School Attended

Dates Attended:

School Mailing Address

From: _____ To: _____

City State Zip

STUDENT NAME: DATE OF BIRTH CURRENT GRADE

As parent or legal guardian of the pupil(s) named above, I do hereby authorize the above named school to release **all** records on the above pupil(s). These records are to include the following:

* Official Administrative Record
  (Name, address, birth date, grade level completed, grades, class standing, attendance records, etc.)
* Scholastic and Achievement Data
* Standardized Achievement Test Scores
* Intelligence and Aptitude Test Scores
* Teacher and Counselor Observations and Ratings
* Family Background Data
* Verified Reports of Serious or Recurrent Behavior Patterns
* Immunization and Medical
* Birth Certificate

Date

Signature of Legal Parent or Guardian

PLEASE FORWARD RECORDS TO:

ELIZABETH MIDDLE SCHOOL
34427 County Road 13 PO Box 369
Elizabeth, CO 80107

Main Office 303-646-4520
Registrar Direct Line 303-646-1781
Fax 303-646-0980
emsregistrar@esdk12.org

Elizabeth School District
Affidavit Affirming Legal Residence

To be completed at registration by parent or guardian of every student new to the school district and by parent or guardian of every student whose residency status has changed from the previous school year. (Example: lease expired or student has moved within the district).

I, _____, hereby certify that I am a legal resident of the Elizabeth School District C-1 and /or that my child legally resides in the Elizabeth School District C-1 at the following address:

Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____

Attached to this document is proof of residency.

1. Warranty Deed/Deed of Trust, OR
2. Closing papers with currently operational telephone number or closing papers with a utility contract or bill, OR
3. A lease or rental agreement accompanied by a utility contract or bill under the lessee's name OR
4. A notarized co-residency letter from the resident family stating the names of the members of the guest family and the approximate length of the arrangement.

I also agree that if the legal residence of my child changes, I will notify the school district's office of the Assistant Superintendent in writing. I affirm that all information given is true and correct. I further understand and agree that if it is later determined that we are not legal residents of Elizabeth School District C-1, such students will be withdrawn immediately from Elizabeth Public Schools. I further agree to pay Elizabeth School District C-1 any and all applicable charges which may be due, together with the cost of collection thereof, including reasonable attorney's fees.

_____ _____
Signature of Property Owner/Lessor Date

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, 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, Sec 18-8-503, 18-1-106

PLEASE COMPLETE / MUST BE RETURNED AT REGISTRATION

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

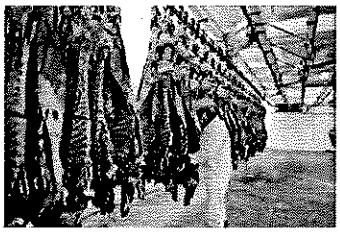
Your child may qualify to receive supplemental educational services at no cost, such as tutoring, transportation, school supplies, and other services. Please answer the following questions to assist in determining your child's eligibility. Once completed, please return this form to the school or your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

CHILD'S FIRST NAME:	CHILD'S LAST NAME:	BIRTHDATE:
PARENT/GUARDIAN NAME:	How many children under the age of 22 live with you in your household?	
CITY:	STATE:	ZIP CODE:
BEST DAY AND TIME TO CALL:	PREFERRED LANGUAGE:	

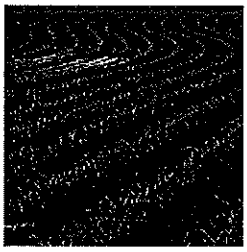
1) In the past three years, has your family moved to another state, city, school district, and/or county?
   ☐ YES ☐ NO

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?
   ☐ YES ☐ NO

CIRCLE all that apply below, even if the work was only for a short period of time.



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



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

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

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

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

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

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

[Regional MEP Office contact info here]
[Street]
[City, CO, ZIP]
[Phone Number]

COLORADO
Department of Education

Encuesta Ocupacional del Colorado MEP

Su hijo puede ser candidato 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:
NOMBRE DEL PADRE/TUTOR:	¿Cuántas personas de menos de 22 años viven en su domicilio?	
CIUDAD:	ESTADO:	CÓDIGO POSTAL:
DÍA Y HORA PARA COMUNICARNOS CON USTED:	IDIOMA PREFERIDO:	

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

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

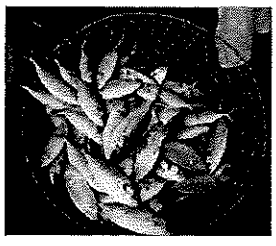
Procesamiento & Empaquetado (fruta, vegetales, huevos, carne de pollo, cerdo, res, o cualquier otro tipo de ganado)

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

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

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

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



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

Esta encuesta y los datos registrados èn la misma están protegidos para mantener la confidencialidad de la familia y los menores.
Si tiene preguntas, comuníquese a:
[Regional MEP Office contact info here]
[Mailing Address]
[City, CO ZIP Code]
[Regional Phone Number]

Elizabeth SCHOOL DISTRICT

Student Health Information Form

20_____ - 20_____

Student Name: _____ **Birth Date:**_____ **School:** _____ **Grade:**_____

Will your student be riding a bus this school year? Yes_____ No_____

Does your child wear glasses/contacts or require any form of hearing supports? (Please circle which) Yes_____ No_____

Would you like know *EVERY* time your child comes to the health office this year? Yes____ No____ Only as needed ____

Does your student have any non-life threatening allergies? Yes_____ No_____

If yes, please list the allergies, reactions, and how you treat at home:

_____

_____

Please list current medications your child is taking routinely at home (prescribed, over the counter, and supplements):

_____

_____

Will daily medication need to be given at school? *Yes_____ No_____

If yes, list medication(s): _____

"Permission to Give Prescription/Homeopathic Medications at School" form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received

CHECK THE CONCERN(S) YOUR CHILD HAS BELOW, OR (initial)_____ MY CHILD HAS NO KNOWN HEALTH CONDITIONS

(You may stop here if there are no known medical conditions. Please sign on page 2 and return form).

___ Accidents/Injuries	___ Cerebral Palsy	___ Head Injury/Concussion	___ Mobility Impairments
___ **ADD/ADHD** (See below)	___ Crohn's Disease/IBS	Date Diagnosed:_____	___ Neuromuscular Disease
___ **Allergies, Severe** (See below)	___ Cystic Fibrosis	Fully recovered?:_____	___ Orthopedic Disability
___ Allergies, seasonal	___ **Diabetes** (See below)	___ Heart Conditions	___ Daily Oxygen use **(requires provider order)**
___ **Asthma** (See below)	___ Down Syndrome	Type:_____	___ Renal/Kidney/Bladder
___ Autism	___ **Epilepsy/Seizures** (See below)	___ Hemophilia/Bleeding Disorder	___ Skin Conditions
___ Behavior Concerns	___ Gastric Reflux/Ulcers	___ Immune Conditions	___ Stomach/Intestines
___ Cancer/Leukemia	___ Genetic Disorder	___ **Mental Health Diagnosis** (See below)	___ Tracheostomy
Date Diagnosed: _____	___ G-Tube or other type of feeding tube **(requires tube feed authorization form)**	___ **Migraines/Headaches** (See below)	___ Vision/Hearing Problem
Treatment Status: _____			___ Other:
___ Developmental Delays			_____

If yes to any of the above, please provide additional details:

_____

_____

_____

_____

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION **(Additional conditions on back)**

Severe Allergies Notify Nurse immediately if anaphylaxis may occur.	What is your child allergic to? _____ Is medication needed at school for allergies? Yes____ No ____ If yes, name: _____ Location of Medication: Carried by student **(requires self-carry form)** _____ or Health Office **(requires anaphylaxis action plan)** _____ Type of reaction (difficulty breathing, hives etc): _____

	Date of last reaction:_____
Asthma	Is medication needed at school for asthma? Yes____ No____ If yes, name:_____ Location of Medication: Carried by student **(requires self-carry form)** _____ or Health Office **(requires CO asthma action plan)** _____ Date of last episode: _____ Triggers (exercise etc.): _____
Epilepsy/Seizures	Type:_____ Date of last seizure: _____ Is emergency medication needed at school? *Yes____ No _____ If yes, name:_____ ***Requires Seizure Action Plan***
Diabetes	Type I _____ Type II _____ Date of diagnosis: _____ Insulin by: Pump (list type) _____ Injections _____ Pen _____ CGM: Yes (list type) _____ No _____ Type of rescue medication (Baqsimi, glucagon etc.): _____ Is your student independently managing? Yes **(requires Self-Management Plan)** _____ No _____ **Please call to schedule conference with District Nurse – notify immediately if newly diagnosed.**
ADD/ADHD Mental Health	ADD _____ ADHD _____ Anxiety _____ Depression _____ Other: _____ Is medication needed at school? *Yes_____ No _____ If yes, name: _____ ***Requires Permission to Give Meds at School Form***
Migraine/ Headaches (Please specify which)	How often does your child experience migraines: _____ Triggers/aura: _____ Is medication needed at school? *Yes _____ No _____ If yes, name: _____ ***Requires provider orders or headache/migraine action plan***

Is there anything else you would like for us to know to better care for your child?

_____

_____

_____

_____

_____

Parent/Guardian Signature _____

Contact Phone # _____

Date _____

The following forms can be found on the Elizabeth School District Health page:

1. Permission to Give Prescription/Homeopathic Medications at School
2. Allergy and Anaphylaxis Action Plan &
    a. Self-Carry Agreement **(Middle and High School Students only)**
3. Asthma Action Plan &
    a. Self-Carry Agreement **(Middle and High School Students only)**
4. Tube Feeding Authorization Form
5. Seizure Action Plan
6. Permission for Nursing Procedure

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

Elizabeth SCHOOL DISTRICT

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

New forms must by completed every year

Student Name: _____ DOB: _____ School: _____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter". This form is required before OTC medications can be administered at school. Exceptions to this are homeopathic/herbal medications and OTCs not included in this list, which require completing the form **"Permission to Give Prescription/Homeopathic Medication at School".**

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.

_____ **I approve all medications listed below**

Oral:

_____**Acetaminophen** (Tylenol or generic substitute)
_____**Benadryl** (Diphenhydramine)
_____**Claritin** (Loratadine)
_____**Cough Syrup** (Delsym/Robitussin)
_____**Ibuprofen** (Motrin, Advil or generic substitute)
_____**Throat Lozenges**
_____**Tums** (Calcium Carbonate)
_____**Zyrtec** (Cetirizine Hydrochloride)

Topical:

_____**Antibiotic Cream** (Bacitracin)
_____**Benadryl Cream**
_____**Burn Gel** (Lidocaine)
_____**Contact Solution**
_____**Saline Eye Solution**
_____**Sunscreen**
_____**Unscented Lotion**
_____**Vaseline** (Petroleum Jelly)

_____**I do not want *any* OTC meds given to my student**

If this form is not returned to school, your child will not be given these medications. Please indicate if your child has an allergy or an unusual or unpleasant side effect to a specific generic or brand name medication. Please contact your school's health office with questions.

Allergies/side effects:

_____

Additional comments:

_____

I/we attest that I/we have a standing medical order from the student's healthcare provider that authorizes the administration of the above identified over-the-counter medications during the school year by the school nurse or nurse's designee.
It is understood that the medication is given solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my child or I/we sustain arising out of the administration of the non-prescription medication identified above to my child.

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: _____

Name of Parent/Guardian: _____

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 health care 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: _____

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 with Prescriptive Authority Phone Fax

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

____ This student has been instructed by the health care 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.