WELCOME TO SINGING HILLS ELEMENTARY STUDENT SURVEY

Please provide the following information so that we may place your child in a class that is most beneficial to him/her.

STUDENT NAME_____**BIRTHDATE**_____

GRADE_____

MOST RECENT PRIOR SCHOOL THE CHILD ATTENDED

NAME_____

STATE_____

DESCRIBE THIS CHILD'S PAST ACADEMIC ACHIEVEMENTS IN READING/WRITING/MATH

DID THIS CHILD RECEIVE ANY SPECIAL SERVICES IN THE PAST (SPECIAL EDUCATION, ILP, SPEECH, COUNSELLING)?

DESCRIBE THIS CHILD'S PAST ATTENDANCE RECORD

DESCRIBE THIS CHILD'S PAST SCHOOL BEHAVIOR

PROVIDE ANY INFORMATION THAT YOU WOULD LIKE FOR US TO KNOW

****

OFFICE USE ONLY:
ASSIGNED TEACHER _____

AFTER SCHOOL ROUTINE

Your child's safety after school is very important to us! Please fill out this form with your child's daily routine. If your child will be picked up by someone other than a parent, please include this information at the bottom of the page. Please remember that your child will be released to only those noted on this sheet unless prior notification is given to the front office. Please remember, if there are any changes to your child's daily routine you need to call the main office at 303-646-1858 no later than 2pm to ensure your child receives the change of plans.

Your child's daily routine will be followed, even in the event of an emergency school closure, unless we receive direct communication from you.

My Child is to:

RIDE BUS # _____ KID'S CLUB YES NO

PARENT PICK-UP YES NO

Parent's home phone_____

Mom's work/cell phone _____Dad's work/cell phone _____

Mom's E-mail _____Dad's E-mail _____

AUTHORIZED ADDITIONAL PICK-UP

NAME_____ Relationship _____

NAME_____ Relationship _____

STUDENT'S NAME_____

TEACHER_____

GRADE_____

OTHER SIBLINGS IN SCHOOL _____

_____

Parent or Guardian Signature Date

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_____

Will your student be participating in school sponsored after school activities this school year (sports, clubs, before/after care)? Yes ___ No ____ If yes, which activities: _____

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 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 CONCERNS(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	___ Hearing loss or aids	___ **Migraines/Headaches** (See below)
___ **ADD/ADHD** (See below)	___ Crohn's Disease/IBS	___ Head Injury/Concussion	___ Neuromuscular Disease
___ **Allergies, Severe** (See below)	___ Cystic Fibrosis	Date Diagnosed:_____	___ 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	___ Glasses/Contacts	___ **Mental Health Diagnosis** (See below)	___ Tracheostomy
Date Diagnosed: _____	___ G-Tube or other type of feeding tube **(requires tube feed authorization form)**		___ Other: _____
Treatment Status: _____			
___ Developmental Delays			

Further details(s) if needed:

_____

_____

_____

_____

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**) _____ Date last reaction: _____ Type of reaction (difficulty breathing, hives etc.):_____

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	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 C-1
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

Elizabeth School District

Request for Student Records

Date of Request: _____

Originating School or Institution

Name of Previous School or Agency: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Student's Information

Legal Name:	
Last	
First	
Middle	

Birth Date: _____ Colorado ID # (SASID#): _____

Grade Level: _____ Last date of attendance (approx.): _____

Signature of Parent/Guardian (if available) _____

The following records are hereby requested:

- ☐ Transcripts or report cards
- ☐ Test data / standardized test scores
- ☐ English Language (ELL) test score (if applicable)
- ☐ List of courses and grades at time of withdrawal
- ☐ Attendance records
- ☐ Individual Literacy Plan (if applicable)
- ☐ IEP (Individual Education Plan) if applicable
- ☐ 504 Plan (if applicable)
- ☐ Discipline records
- ☐ Immunization records
- ☐ Health / medical records
- ☐ Sports physical documentation
- ☐ Psychological records
- ☐ Sociological records
- ☐ Copy of birth certificate
- ☐ Other _____

Signature of Requesting School Representative:

_____

Signature Title Date

PLEASE MAIL TO:

Singing Hills Elementary
41012 Madrid Drive Parker, Co 80138
303-646-1858
Fax 303-841-9732

The Family Educational Rights and Privacy Act (20 U.S.C. § 1232g; 34 CFR Part 99), as revised, states (a) An educational agency or institution may disclose personally identifiable information from an education record of a student without the written consent of the parent of the student or the eligible student if (1) The disclosure is to other school officials, including teachers, within the agency or institution has determined to have legitimate educational interests. (2) The disclosure is to officials of another school or school system in which the student seeks or intends to enroll.

cde
Colorado Department of Education

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

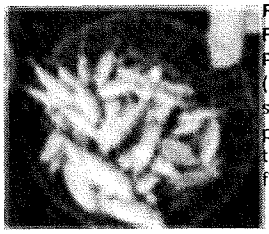
Processing & Packing (fruit, vegetables, chicken, eggs, pork, beef, lamb or other livestock, etc.)

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	

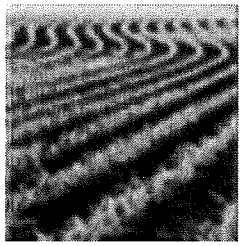
1) Durante los últimos tres años, su familia se ha cambiado a otro estado, ciudad, escuela, y/o condado?
☐ SI ☐ NO

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.)

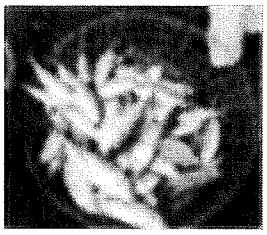


Agricultura o Trabajo de Campo (cosecha, recolección y clasificación de cultivo, preparación del suelo, riego, fumigación, etc.)

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

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: _____

English

Adquisición de Lenguaje

Información Casera

Regulaciones Felerales y Estatales requieren que las escuelas determinen la lengua primaria en casa de los estudiantes matriculados. Esto está de acuerdo con el acto del Conocimiento de Idiomas Ingleses de Colorado y es para que la oficina de los derechos civiles asista a las escuelas en el desarrollo de las oportunidades iguales para cualquier estudiante del cual la lengua dominante no sea inglés. Gracias por proporcionar esta información.

Nombre del Estudiante:_____

Grado:_____ Escuela:_____

País de Nacimiento:_____
Fecha de Nacimiento:_____

Nombre de Padre o Tutor: _____
Número de Celular o del Trabajo:_____

1. Cuál lengua aprendió su hijo(a) cuando primeramente empezó a hablar? _____
2. Primer idioma que su hijo(a) habló en casa?_____
3. Cuál idioma o idiomas puede leer su hijo(a)?_____
4. Cuáles idiomas puede escribir su hijo(a)?_____
5. Su hijo asistió a otra escuela fuera del país? _____ Sí _____ No si la contestación es sí: Cuantos anos? _____ Que grado?_____ Que país? _____
6. Estaba su hijo(a) en un programa de segunda legua? _____ Sí _____ No Si la respuesta es sí: Cual fue el último grado que su hijo(a) asistió en el programa? _____

Firma de Padre o Tutor:_____ Fecha:_____

Solo para uso de oficina
Codigo de Primer Idioma: