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 of release /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.

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 303-646-1609 or email Laurie Burke, LBurke@esdk12.org.

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

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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
- 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
- Mental Health (SRA screenings, Threat Assessments)

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
PO Box 660
Elizabeth CO 80107
Fax Number: 303-646-1698
Laurie Burke: LBurke@esdk12.org

_____ _____

Parent/Guardian Signature Date

ELIZABETH HIGH SCHOOL

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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

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ELIZABETH HIGH SCHOOL

PARKING PERMIT FORM

- Parking permits are available to all eligible students and must be displayed on any vehicle parked in the EHS parking lot.
- Students must park in the designated parking spots. Students are not to park irregularly, and may not block other vehicles.
- **THE STAFF PARKING LOT IS OFF LIMITS TO STUDENTS AT ALL TIMES.**
- Students who park in non-designated areas risk being ticketed and/or towed at the owner's expense, in addition, students are subject to disciplinary action based on the discretion of Campus Security and EHS Administrators. Non-designated areas include, but are not limited to, handicapped areas, teacher lots, bus loop, fields and dirt areas.
- The opportunity to park your vehicle at Elizabeth High School is a privilege, which can be revoked at any time.
- This privilege may be lost by speeding, driving carelessly, or parking improperly.
- **ALL VEHICLES PARKED ON EHS PROPERTY ARE SUBJECT TO RANDOM SEARCHES, AT ANY TIME.**

I, _____, agree to abide by the expectations and
(Student Print Name) responsibilities set forth in this contract.

I understand that failure to do so may result in the loss of my parking privileges.

Student Signature: _____

Driver's License #: _____

Make/Model/Color of Vehicle	License Plate #
_____	_____
_____	_____

THE ABOVE INFORMATION MUST BE COMPLETED BEFORE TURNING THIS IN FOR A PERMIT

Office Use Only:

Parking Permit #: _____

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

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.

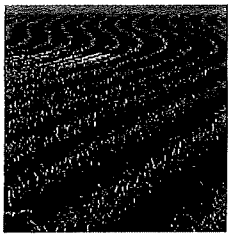
CHILD'S FIRST NAME:	CHILD'S LAST NAME:	BIRTHDATE:
SCHOOL:		GRADE:
PARENT/GUARDIAN NAME:	Do you have more than one child? ☐ YES ☐ NO	

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.)

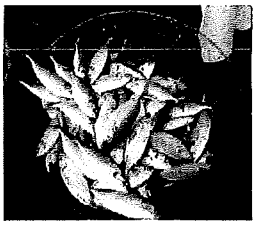


Agriculture or Field Work (planting, picking, sorting crops, soil preparation, irrigation, fumigation, etc.)

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

Elizabeth SCHOOL DISTRICT

OVER-THE-COUNTER MEDICATIONS PERMISSION FORM:

20 _____ - 20_____

New forms must be completed every school year

Student Name: _____ DOB: _____ School: _____

Over-the-counter (OTC) medications are medications that do not require a prescription and can be purchased "over-the-counter". This form is required before OTC medications can be administered at school. **Your child will not be given these medications without this form on file.**

Homeopathic/herbal medications, supplements, prescription medications and/or any other OTC medication not listed on this form will require completion of the **"Permission to Give Prescription/Homeopathic Medication at School"** form prior to administration in the school setting.

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)
_____ **Cetirizine Hydrochloride** (Zyrtec HCl)
_____ **Diphenhydramine** (Benadryl or generic substitute)
_____ **Guaifenesin and/or Dextromethorphan** (Cough medicine - ages 6 and up only)
_____ **Ibuprofen** (Advil, Motrin or generic substitute)

Topical:

_____ **Contact Solution** (Opti-Free or generic substitute)
_____ **Diphenhydramine Cream** (Benadryl Cream)
_____ **Eye Wash**
_____ **Petroleum Jelly** (Vaseline or generic substitute)
_____ **Sunscreen**
_____ **Unscented Lotion**

_____I do not want *any* OTC meds given to my student

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

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 ___ **ADD/ADHD** (See below) ___ **Allergies, Severe** (See below) ___ Allergies, seasonal ___ **Asthma** (See below) ___ Autism ___ Behavior Concerns ___ Cancer/Leukemia Date Diagnosed: _____ Treatment Status: _____ ___ Developmental Delays	___ Cerebral Palsy ___ Crohn's Disease/IBS ___ Cystic Fibrosis ___ **Diabetes** (See below) ___ Down Syndrome ___ **Epilepsy/Seizures** (See below) ___ Gastric Reflux/Ulcers ___ Genetic Disorder ___ G-Tube or other type of feeding tube **(requires tube feed authorization form)**	___ Head Injury/Concussion Date Diagnosed:_____ Fully recovered? YES or NO ___ Heart Conditions Type:_____ ___ Hemophilia/Bleeding Disorder ___ Immune Conditions ___ **Mental Health Diagnosis** (See below) ___ **Migraines/Headaches** (See below)	___ Mobility Impairments ___ Neuromuscular Disease ___ Orthopedic Disability ___ Daily Oxygen use **(requires provider order)** ___ Renal/Kidney/Bladder ___ Skin Conditions ___ Stomach/Intestines ___ Tracheostomy ___ Vision/Hearing Problem ___ Other: _____

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**) _____ 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 (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)