2019-2020 Registration Check List

Please note that **ALL** of the items listed below must be returned to Legacy Point Elementary prior to us accepting registration and enrolling your student in a class.

- Student Enrollment Form
- Health Information Form
- Student Residency Questionnaire
- Media Consent Form
- Eligibility Survey for Free Services *(required by Colorado Dept. of Education, may mark as N/A)*
- State Certified Birth Certificate
- Proof of Residence *(warranty deed, deed of trust, current lease agreement or notarized letter)*
- Immunization Records

Student’s Name__________________________________________

Parent’s Name__________________________________________

Phone Number__________________________________________

**Kindergarten preference:**

- ½ day (9:10 am – 12:10 pm)
- ¾ day (9:10 am – 2:00 pm)
- Full day (9:10 am – 4:00 pm)

**Grade:**

- 1st
- 2nd
- 3rd
- 4th
- 5th

Douglas County School District requires a BOOK FEE to be paid at the time of registration.

- $10 Book Fee

*Office Use Only*

Date Received: ____________ Time: ____________ Received By: ____________________
Legends:

□ Learning Disabilities
□ Speech/Language
□ Physical Therapy
□ Occupational Therapy
□ Counseling
□ Psychological
□ Behavioral Difficulties
□ Hearing/Visual Impaired
□ Gifted & Talented
□ Remedial Reading (Title 1)
□ 604 Services
□ Other

Notice to Parents and Students - Parents and students should be aware that if they choose not to answer the two-part question, school districts are required to identify an ethnicity and race on behalf of the student, based on several factors, including observation, in accordance with U.S. Department of Education and Colorado Department of Education Guidelines.

Part A. Is this student Hispanic / Latino? (choose only one)
□ No, NOT Hispanic
□ Yes, Hispanic/Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

The above part of the question is about ethnicity, not race. No matter what you selected in Part A above, please provide an answer to Part B by marking one or more boxes below to indicate what you consider your child’s race to be.

Part B. Which of the following groups describe the student’s race? (choose one or more)
□ American Indian or Alaskan Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
□ Black or African American - A person having origins in any of the black racial groups of Africa.
□ Asian - A person having origins of any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
□ Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
□ White - A person having origins in any of the original peoples of Europe, the Middle East or North Africa

Has the student attended another Douglas County School District school? Y □ N □

If Yes, School ___________________________ Grade _________ School Year _________

Last school attended outside the Douglas County School District:

School ___________________________ City ___________________________ State _________ Grade _________

Is your child presently under an expulsion order from any other school district? Y □ N □

Is your child presently under consideration for expulsion? Y □ N □

Is your child presently involved in the Juvenile Justice system? Y □ N □

What is/was the student’s first language? ___________________________

Does the student speak a language(s) other than English? Y □ N □

Not including language learned in school courses or academic enrichment programs (i.e., world language classes or clubs)

If yes, specify the language(s). ___________________________

What language(s) is/are spoken in your home? ___________________________

Is your child currently on an Individual Educational Plan for Special Services? Y □ N □

Has your child received any previous testing, evaluations or services in any of the following areas?

□ Learning Disabilities
□ Speech/Language
□ Physical Therapy
□ Occupational Therapy
□ Counseling
□ Psychological
□ Behavioral Difficulties
□ Hearing/Visual Impaired
□ Gifted & Talented
□ Remedial Reading (Title 1)
□ 604 Services
□ Other

Parent/Guardian Signature ___________________________ Date _______________
**Household Information**

**Registration Form**

**2019-2020**

**Residence Address:**
City: ____________________________  State: ______  Zip: ______

**Household Telephone:** ____________________________  Unlisted?  Y ☐  N ☐

**Name:** ____________________________  **Relationship to Student:** ____________________________

**Residence Address:** ____________________________  **City:** ____________________________  **State:** ______  **Zip:** ______

**Mailing Address:** ____________________________  **City:** ____________________________  **State:** ______  **Zip:** ______
**(if different from above)**

**Phones:**
- **Home:** ____________________________
- **Work:** ____________________________
- **Cell:** ____________________________
- **Pager:** ____________________________  **Email:** ____________________________  **Receive Mailings:**  Y ☐  N ☐

**Does Student reside with?**  **Parent** ☐  **Legal Guardian** ☐  **Step-Parent** ☐

**Name:** ____________________________  **Relationship to Student:** ____________________________

**Residence Address:** ____________________________  **City:** ____________________________  **State:** ______  **Zip:** ______

**Mailing Address:** ____________________________  **City:** ____________________________  **State:** ______  **Zip:** ______
**(if different from above)**

**Phones:**
- **Home:** ____________________________
- **Work:** ____________________________
- **Cell:** ____________________________
- **Pager:** ____________________________  **Email:** ____________________________  **Receive Mailings:**  Y ☐  N ☐

**Does Student reside with?**  **Parent** ☐  **Legal Guardian** ☐  **Step-Parent** ☐

**Note:** When a student does not reside with both parents, additional information must be on file so that the school can determine who is responsible for the student. If there are applicable legal documents, such as custody papers, a copy should be provided to the school.

**Note:** "Step-parents are not considered legal guardians unless they have legal guardianship paperwork which must be provided to the school. A parent/guardian can identify the step-parent as someone that will be attending meetings, calling student in sick, portal access, etc.

**Other Children Under Age 18 in the Home - Names MUST be from Birth Certificate**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name (If)</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Relation to Student</th>
<th>School Attending</th>
<th>County</th>
</tr>
</thead>
</table>

---

**Parent/Guardian Signature** ____________________________  **Date** ____________________________
Emergency Contacts are not the Parent/Guardian and should be a Colorado Resident

Please provide at least one (1) local emergency contact.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Student</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Information: __________________________  Gender: M □ F □

Phones

- Home: __________________________  Work: __________________________  Cell: __________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Student</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Information: __________________________  Gender: M □ F □

Phones

- Home: __________________________  Work: __________________________  Cell: __________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Student</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Information: __________________________  Gender: M □ F □

Phones

- Home: __________________________  Work: __________________________  Cell: __________________________

Doctor's (full) Name: __________________________  Gender: M □ F □

Name of Practice / Group: __________________________

Phone: __________________________  Extension: __________________________

Address: __________________________

City: __________________________  State: __________________________  Zip Code: __________________________

Parent/Guardian Signature: __________________________  Date: ________________
Is your student taking any medications at home or at school? □ Y □ N List:
If your student needs to take medication at school, the "Provider Medication Authorization Form" or "Permission to Carry" form is available at the school office. These forms must be completed for any medication a student will need to take during school hours. They are also available at www.dcsdk12.org - search "medication form." (Contained in the Nursing Services web page.)

Does your student have any known allergies?

☐ Seasonal Reaction: ____________________________ Reaction: ____________________________
☐ Insect Sting Reaction: ____________________________ Reaction: ____________________________
☐ Latex Reaction: ____________________________ Reaction: ____________________________
☐ Food ______________ Reaction: ____________________________
☐ Other ______________ Reaction: ____________________________
☐ Other ______________ Reaction: ____________________________

Does your student (please check applicable boxes):

☐ Wear glasses/contacts? ☐ Have heart problems? ☐ Hearing Impaired?
☐ Have asthma/respiratory ailments? ☐ Have convulsions/seizures? ☐ Have diabetes?
☐ Had a head injury/significant bump to the head? ☐ Have physical activity limitations?

Please explain any conditions marked above:

________________________________________

Other medical conditions the school needs to be aware of:

Please note: Health information will be shared with school personnel to provide for the health and safety of your student. By signing below, you indicate your agreement with sharing this information.

Parent/Guardian Signature ____________________________ Date ________

I give consent and authorize the Douglas County School District Re. 1 to release to Health Care Policy and Financing (HCPF), information related to Medicaid services delivered to my child, if/when my child is enrolled in the Medicaid program. I understand that the school district is entitled to receive partial reimbursement from Medicaid for services provided to my child, including but not limited to: audiology; counseling; nursing; occupational/physical therapy; orientation and mobility; psychological; social work; speech; and targeted case management.

Parent/Guardian Signature ____________________________ Date ________

The information contained on this Student Registration form is true and correct. In accordance with Colorado Revised Statutes Sections 22-33-104 and 22-33-107, I acknowledge my obligation to ensure that every child between the ages of 6-17 under my care and supervision shall attend school. The only exceptions shall be illness and other absences excused by the Principal.

Notice to Parents and Students - All students new to the district shall be enrolled conditionally until records, including discipline records, from the schools previously attended by the student are received by the district. In the event the student's records indicate a reason to deny admission, the student's conditional enrollment status shall be revoked. State law requires immunization records be submitted at the time of registration.

THIS PAGE MUST BE SIGNED EVERY SCHOOL YEAR.
HEALTH INFORMATION – (NEW students)

This information will be reviewed and maintained in a confidential manner
by the School Nurse assigned to your student’s school.

<table>
<thead>
<tr>
<th>STUDENT NAME:</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>BIRTH DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHOOL:</td>
<td></td>
<td></td>
<td></td>
<td>GRADE / TRACK:</td>
</tr>
</tbody>
</table>

EARLY CHILDHOOD HEALTH HISTORY
Were there any significant problems during the pregnancy, labor or delivery?  No □ Yes □
If yes, is this concern a current issue? No □ Yes □
If yes, please explain: ________________________________________________________________

PLEASE CHECK ALL HEALTH CONDITIONS THAT APPLY TO YOUR STUDENT. IF A HEALTH CONDITION PERTAINING TO YOUR STUDENT HAS A COMMENT FIELD, PLEASE PROVIDE ADDITIONAL INFORMATION IN THE FIELD.

Dietary Needs – Comment required
☐ Student has Special Dietary Needs
Comment: ________________________________________________________________

Allergies – Life Threatening – Comment required
☐ Life threatening allergy – Dairy
Comment: ________________________________________________________________
☐ Life threatening allergy – Food
List Food(s): ________________________________________________________________
☐ Life threatening allergy – Insect Sting
Comment: ________________________________________________________________
☐ Life threatening allergy – Latex
Comment: ________________________________________________________________
☐ Life threatening allergy – Peanut
Comment: ________________________________________________________________
☐ Life threatening allergy – Tree Nuts
Comment: ________________________________________________________________
☐ Life threatening allergy – Other
List: ________________________________________________________________
☐ Life threatening allergy – Unknown
Comment: ________________________________________________________________

Allergies – Comment required where indicated
☐ Animal
☐ Environmental/Seasonal
☐ Food
List Food(s): ________________________________________________________________
☐ Insect Sting
☐ Latex
☐ Medication
List Medication(s): __________________________________________________________
☐ Non-Specific

Other Conditions – Comment required where indicated
☐ ADD/ADHD – Name of medication: ______________________________________________
☐ Alopecia
☐ Arthritis Juvenile
☐ Asthma
Comment: ________________________________________________________________
☐ Autism Spectrum
Comment: ________________________________________________________________
☐ Auto-Immune Condition
Comment: ________________________________________________________________
☐ Blood Disorder
Comment: ________________________________________________________________
<table>
<thead>
<tr>
<th>Condition</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Celiac Disease</td>
<td></td>
</tr>
<tr>
<td>Cerebral Palsy</td>
<td></td>
</tr>
<tr>
<td>Chromosomal Anomalies</td>
<td></td>
</tr>
<tr>
<td>Crohn’s Disease</td>
<td></td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Down Syndrome</td>
<td></td>
</tr>
<tr>
<td>Emotional Condition</td>
<td></td>
</tr>
<tr>
<td>Encopresis</td>
<td></td>
</tr>
<tr>
<td>Enuresis</td>
<td></td>
</tr>
<tr>
<td>Fetal Alcohol Syndrome</td>
<td></td>
</tr>
<tr>
<td>Frequent Headaches</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal Disorder</td>
<td></td>
</tr>
<tr>
<td>Head Injury/Concussion</td>
<td></td>
</tr>
<tr>
<td>Hearing Impaired</td>
<td></td>
</tr>
<tr>
<td>Heart Condition – No Restriction</td>
<td></td>
</tr>
<tr>
<td>Heart Condition – Restrictions</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Carrier</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C Carrier</td>
<td></td>
</tr>
<tr>
<td>History of Injuries</td>
<td></td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td></td>
</tr>
<tr>
<td>Immune Compromised</td>
<td></td>
</tr>
<tr>
<td>Kidney Problem</td>
<td></td>
</tr>
<tr>
<td>Lactose Intolerant</td>
<td></td>
</tr>
<tr>
<td>Long QT Syndrome</td>
<td></td>
</tr>
<tr>
<td>Migraine Headaches</td>
<td></td>
</tr>
<tr>
<td>Myalgia Myositis Fibromyalgia</td>
<td></td>
</tr>
<tr>
<td>Neurologic Disorder</td>
<td></td>
</tr>
<tr>
<td>Nosebleeds</td>
<td></td>
</tr>
<tr>
<td>Orthopedic – Physical Limitation</td>
<td></td>
</tr>
<tr>
<td>Orthopedic – No Restrictions</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>List:</td>
</tr>
<tr>
<td>Paraplegia</td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td></td>
</tr>
<tr>
<td>Scoliosis</td>
<td></td>
</tr>
<tr>
<td>Seizure Disorder</td>
<td></td>
</tr>
<tr>
<td>Shunt/Hydrocephalus</td>
<td></td>
</tr>
<tr>
<td>Skin Condition</td>
<td></td>
</tr>
<tr>
<td>Syncopeal Episodes</td>
<td></td>
</tr>
<tr>
<td>Syndrome</td>
<td></td>
</tr>
<tr>
<td>Thyroid Condition</td>
<td></td>
</tr>
<tr>
<td>Tourette Syndrome</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy</td>
<td></td>
</tr>
</tbody>
</table>

620 Wilcox Street Castle Rock, Colorado 80104 303-387-0100
Revised 10/29/18
HEALTH INFORMATION – (NEW students)

☐ Traumatic Brain Injury  Comment: ____________________________
☐ Urinary Problem  Comment: ____________________________
☐ Wears Glasses/Contacts  Comment: ____________________________
☐ Vision Impaired  Comment: ____________________________
☐ Von Willebrand's Disease  Comment: ____________________________
☐ Wolff Parkinson White Syndrome

ADDITIONAL INFORMATION

☐ List any illness, hospitalization, surgery, accidents your student had in the past year.  None □

Date: ____________________________  Date: ____________________________  Date: ____________________________

☐ List any emotional, social or other conditions that might affect your student’s school performance.  None □

Date: ____________________________  Date: ____________________________

☐ Is your student currently taking any medication, including over-the-counter medication?  No □  Yes □

☐ If your student will need to be given medication at school, a Provider Medication Authorization Form for each medication will be needed. If your student is a middle school student and will self-carry prescription medication, a Permission to Carry Form must be completed for each medication. High school students may self-carry and self-administer one-day supply of medication, carried in a pharmacy labeled container.

☐ Is your student currently receiving alternative therapies (acupuncture, homeopathic, herbal, biofeedback, etc)?  No □  Yes □

If yes, please explain: ____________________________

☐ Is there anything else you would like us to know about your student?  No □  Yes □

Parent/Guardian Name (please print) ____________________________

Parent/Guardian Signature ____________________________  Date ____________________________
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 at the bottom of the document.

<table>
<thead>
<tr>
<th>CHILD'S FIRST NAME:</th>
<th>CHILD'S LAST NAME:</th>
<th>BIRTHDATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCHOOL:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>GRADE:</td>
</tr>
<tr>
<td>PARENT/GUARDIAN NAME:</td>
<td>How many children under the age of 22 live with you in your household? __________</td>
<td></td>
</tr>
</tbody>
</table>

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)

If you answered “yes” to either question above, please continue below. Otherwise, your form is complete.

<table>
<thead>
<tr>
<th>HOME ADDRESS:</th>
<th>TODAY’S DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY:</td>
<td>STATE:</td>
</tr>
<tr>
<td></td>
<td>ZIP:</td>
</tr>
<tr>
<td>TELEPHONE (WITH AREA CODE):</td>
<td></td>
</tr>
<tr>
<td>BEST DAY AND TIME TO CALL:</td>
<td></td>
</tr>
<tr>
<td>PREFERRED LANGUAGE:</td>
<td></td>
</tr>
</tbody>
</table>

This form and the data recorded within are protected to maintain family and child confidentiality. School district staff: You may mail or fax the form to the contact information below. If you have any questions, please contact:

Metro Migrant Education Program
14707 E 2nd Ave, Suite 180
Aurora, CO, 80011
P. 303-365-5817 F. 303-856-7294
Student Residency Questionnaire

Douglas County School: ________________________________

Student's Legal Name: ________________________________

Date of Birth: __________________ Age: ________ Grade: ________ Gender: M __ F __

Parent(s) / Legal Guardian(s): ________________________________ Phone/Pager: ____________________

Address: __________________ City: __________________ State / Zip Code: __________________

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? (check one box)

   [ ] Section A
   [ ] Section B

   [ ] Choices in Section B do not apply
   [ ] In an Emergency Shelter
   [ ] In a motel, car or campsite
   [ ] With friends or family members due to the loss of housing or financial hardship
   [ ] A student not living with parent or legal guardian
   [ ] Other? Explain: ________________________________

2. The student lives with:

   [ ] 1 (one) parent
   [ ] 2 (two) parents
   [ ] 1 parent & another adult
   [ ] a relative, friend(s) or other adult(s)
   [ ] alone with NO adults
   [ ] an adult that IS NOT the parent or the legal guardian

Signature(s) of Parent(s) / Legal Guardian(s) ____________________________ Date: ____________

Signature(s) of Parent(s) / Legal Guardian(s) ____________________________ Date: ____________

Notes:

Section B - If Section B is checked, this form MUST be completed and returned to school personnel.

**** Completed form is kept in the student's cum file. ****

School Contact who may know of the family's situation:

Name / Title: ____________________________ Phone: ____________________________