CLEAR CREEK
SCHOOL DISTRICT RE-1

P.O. Box 3399, Idaho Springs, Colorado 80452
PHONE: 303-567-3850 FAX: 303-567-3861

JFBA-E

APPLICATION/REGISTRATION FORM

OPEN ENROLLMENT FOR OUT OF DISTRICT STUDENTS

We would appreciate your completing this form in its entirety. Renewal applications must be received by the last day of school of the current school year. Registration for new applications must occur before October 1st of the year for which you are requesting enrollment. Admittance will depend on space available in the building and classes the student wishes to take. Determination will be made by the Building Principal and the Superintendent of Schools. Transportation routes will not be adjusted to meet the need of the out of district student. Student(s) may, however, ride existing routes. NO extensions of bus routes will be considered

I request permission to change schools for the_____school year for the following student(s):

Student's name: _____

Address:_____

Home/Best Phone: _____

Parent(s) Name(s): _____

Grade student will be entering the NEXT school year: _____

School student wants to attend: _____

School student attending this year: _____

School student would normally attend under regular boundary restrictions: _____

Has student been denied admission to present district or another district based on disciplinary actions?
_____

Is student presently or in the past received special education services: _____
If yes, what type? *Please explain on the backside of this sheet.*

I acknowledge that I have received a copy of the Student Admission Policy and understand its provisions, and I agree to the terms and condition as outlined

_____ _____
Parent's Signature Building Principal's Signature

_____
Superintendent's Signature

Clear Creek School District
Health Information Form

Student's Name _____ (Last) _____ (First) _____ (Middle) _____ (Grade)

Parent/Guardian Name _____ Signature _____ Date _____

Medication Information:

Is your child taking any medications regularly? ☐ Y ☐ N

If yes, please list Medication name: _____ Associated health condition: _____

Medication name: _____ Associated health condition: _____

Medication name: _____ Associated health condition: _____

Is your child allergic to any medication? ☐ Y ☐ N

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

If your child must receive medication OF ANY TYPE (including prescription, non-prescription (over-the-counter), and homeopathic medications) during school hours, we ask you to consider one of the following options: (1) YOU MAY COME TO THE SCHOOL to give the medication to your child at the appropriate time; or (2) YOU MAY OBTAIN A MEDICATION ADMINISTRATION FORM from the school or online and HAVE YOUR DOCTOR indicate on the form the DRUG, DOSE, AND TIME to be given. Please be sure he/she SIGNS THE FORM. We also need a pharmacy-labeled bottle containing the medication and instructions. If the student will self-carry a medication, the physician must indicate this on the form.
YOU MAY DISCUSS WITH YOUR DOCTOR an alternative schedule of medication so that it can be given outside of school hours.
In order for your child to attend school, immunization documentation needs to be submitted to the school office by the first day of attendance. If immunization record is not complete, the student MUST see the school nurse or designee before enrollment can be completed.

Health Concerns:

Parents/Guardians are responsible for providing full details on any medical condition to the school nurse.

Please indicate below any health conditions your child has experienced, check all that apply.

☐ Allergies (list below)	☐ Fractures	☐ Prosthesis/Limb Braces	☐ Varicella (Chickenpox)
☐ Asthma	☐ Headaches	☐ Seasonal Allergies	☐ Vision Concerns
☐ ADD/ADHD	☐ Head Injury/Concussion	☐ Seizures	☐ Contacts
☐ Bowel/Bladder	☐ Hearing Concerns	☐ Skin Conditions	☐ Glasses
☐ Diabetes	☐ Hearing Aids	☐ Speech Concerns	☐ Other _____
☐ Emotional/Behavioral	☐ Heart	☐ Surgeries	☐ Other _____

If any health conditions were indicated above, please explain in detail. Specify if an individualized health care plan is needed this school year for the condition (e.g., Allergies, Asthma, Diabetes, Seizures), which must be completed annually by a physician, or if the condition has resolved.

Comments: _____

Medical Insurance Information

Insurance Company: _____ Policy # _____ Group # _____

Primary Insured's Name: _____ Relation to Insured: _____

If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911.
However, the Clear Creek School District will in no case accept financial responsibility for care, see consent on reverse side.

Special Services Information

Is your child receiving special education services? ☐ Y ☐ N

Please Indicate Disability: _____

Date of last IEP: _____

Does your child have a current 504 plan? ☐ Y ☐ N

Please indicate if related to academics or health. ☐ Academics ☐ Health

This form will be given to the School Nurse after registration

Medication Administration in School or Child Care

The parent/guardian of _____ ask that school/child care staff give the
(Child's name)

following medication _____ at _____
(Name of medicine and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

The Program agrees to administer medication prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization

Child's Name: _____ **Birthdate:** _____

Medication: _____

Dosage: _____ **Route** _____

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

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ **Ending Date:** _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____ / _____
Print Name of Health Care Provider **Phone** **Fax Number**

Please ask the pharmacist for a separate medicine bottle to keep at school/child care to ensure consistency in medication administration. Thank you!

FOR CHILD CARE USE ONLY

Copied information onto Medication Log _____ _____
Staff Signature Date

Final: Board Approved 02/16/2016

CLEAR CREEK SCHOOL DISTRICT

2017-2018 School Calendar

July 2017

Su	M	Tu	W	Th	F	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

August 2017

Su	M	Tu	W	Th	F	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

September 2017

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	C	23
24	25	26	27	28	29	30

October 2017

Su	M	Tu	W	Th	F	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

November 2017

Su	M	Tu	W	Th	F	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December 2017

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

January 2018

Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February 2018

Su	M	Tu	W	Th	F	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	C	17
18	19	20	21	22	23	24
25	26	27	28			

March 2018

Su	M	Tu	W	Th	F	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

April 2018

Su	M	Tu	W	Th	F	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

May 2018

Su	M	Tu	W	Th	F	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

June 2018

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

First Day of School (8/21)
Last Day of School (5/24)
School Closed
Red Font is Qrt End
Graduation (5/26)
PT Conferences (9/20, 2/14)
PT Conferences / Mini Day (9/21, 2/15)

Mini Day Dismissal Times:
KM /Carlson 11:30 AM
CCMS / HS 11:35 AM

New Teacher Training (8/14,15)
.5 Tchr Plan / .5 Dist Prof Day (8/16)
District Prof Days/No Students
Teacher Workdays in Buildings/No Students
C Teacher Comp Days (9/22, 2/16)

Student Days = 166
Teacher Days = 180
Qrt 1 = 36.5 Days
Qrt 2 = 41 Days
Qrt 3 = 40.5 Days
Qrt 4 = 48 Days

STUDENT EMERGENCY INFORMATION

Last Name _____ First _____ Middle _____ Male _____ Female _____

Mailing Address _____ City _____ Zip _____ Grade _____

Physical Address _____ City _____ Zip _____ Birth Date _____

Home Phone _____ Mother Cell Phone _____ Father Cell Phone _____

Birthplace: City _____ State _____ Social Security # _____

To Parents - That we may be of greatest service to your child in case of accident or sudden illness, it is necessary that you give the following information.

Please check legal relationship to student.

___ Mother ___ Stepmother ___ Guardian _____ (Name) Occupation _____ Work Phone _____

Employed by _____ Address _____

___ Father ___ Stepfather ___ Guardian _____ (Name) Occupation _____ Work Phone _____

Employed by _____ Address _____

Name of person(s) with whom student lives: _____ Relationship _____

IN AN EMERGENCY WHERE NEITHER PARENT CAN BE REACHED, CALL:

Name _____ Home Phone _____ Cell Phone _____

Name _____ Home Phone _____ Cell Phone _____

CONSENT

In the event reasonable attempts to contact me or the emergency contacts at the above listed phone numbers have been unsuccessful, I hereby give my consent for:

- The transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.
- Do you have ambulance insurance? Yes / No With whom? _____

The school will attempt to reach one of the above persons, but if none of these can be reached the school nurse, principal, or teacher in charge, has our permission to use his or her discretion in securing medical aid in an emergency. IT IS UNDERSTOOD THAT NEITHER THE SCHOOL NOR THE PERSON RESPONSIBLE FOR OBTAINING THIS MEDICAL AID WILL BE RESPONSIBLE FOR THE EXPENSE INCURRED. This authorization does not cover surgery. In such cases, the provisions of Colorado Law governing informed consent and such other authorization(s) as may be required by law, shall apply.

Facts concerning the child's medical history including; allergies, medications, and any physical impairments to which a physician should be alerted are as noted on the reverse side of this form in the Health Information.

If Parent/Guardian fails to grant this consent, the school will call 911 in the event immediate medical care is indicated.

DATED _____ SIGNATURE OF PARENT OR GUARDIAN _____

ADDRESS _____

STUDENT INSURANCE

The school has the moral responsibility to encourage each participant in athletics to be covered by an accident insurance policy. The school does not provide a policy; however, the school provides an insurance option in which students may voluntarily participate. If you decide to take the school insurance option, the policy must be paid for before practice begins for that sport.

___ 1. I will carry the policy option offered by the school.

___ 2. I am carrying a policy outside of school insurance. I will assume the responsibility for costs occurred during athletic participation. The insurance company I will use is _____

DATED _____ SIGNATURE OF PARENT OR GUARDIAN _____

Clear Creek School District
Health Information Form

Student's Name _____
Last First Middle Grade

Parent/Guardian Name _____ Signature _____ Date _____

Medication Information:

Is your child taking any medications regularly? ☐ Y ☐ N

If yes, please list Medication name: _____ Associated health condition: _____

Medication name: _____ Associated health condition: _____

Medication name: _____ Associated health condition: _____

Is your child allergic to any medication? ☐ Y ☐ N

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

If your child must receive medication OF ANY TYPE (including prescription, non-prescription (over-the-counter), and homeopathic medications) during school hours, we ask you to consider one of the following options: (1) YOU MAY COME TO THE SCHOOL to give the medication to your child at the appropriate time; or (2) YOU MAY OBTAIN A MEDICATION ADMINISTRATION FORM from the school or online and HAVE YOUR DOCTOR indicate on the form the DRUG, DOSE, AND TIME to be given. Please be sure he/she SIGNS THE FORM. We also need a pharmacy-labeled bottle containing the medication and instructions.
If the student will self-carry a medication, the physician must indicate this on the form.
YOU MAY DISCUSS WITH YOUR DOCTOR an alternative schedule of medication so that it can be given outside of school hours.
In order for your child to attend school, immunization documentation needs to be submitted to the school office by the first day of attendance. If immunization record is not complete, the student MUST see the school nurse or designee before enrollment can be completed.

Health Concerns:

Parents/Guardians are responsible for providing full details on any medical condition to the school nurse.

Please indicate below any health conditions your child has experienced, check all that apply.

☐ Allergies (list below)	☐ Fractures	☐ Prosthesis/Limb Braces	☐ Varicella (Chickenpox)
☐ Asthma	☐ Headaches	☐ Seasonal Allergies	☐ Vision Concerns
☐ ADD/ADHD	☐ Head Injury/Concussion	☐ Seizures	☐ Contacts
☐ Bowel/Bladder	☐ Hearing Concerns	☐ Skin Conditions	☐ Glasses
☐ Diabetes	☐ Hearing Aids	☐ Speech Concerns	☐ Other _____
☐ Emotional/Behavioral	☐ Heart	☐ Surgeries	☐ Other _____

If any health conditions were indicated above, please explain in detail. Specify if an individualized health care plan is needed this school year for the condition (e.g., Allergies, Asthma, Diabetes, Seizures), which must be completed annually by a physician, or if the condition has resolved.

Comments: _____

_____

_____

_____

_____

Medical Insurance Information

Insurance Company: _____ Policy # _____ Group # _____

Primary Insured's Name: _____ Relation to Insured: _____

If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911.
However, the Clear Creek School District will in no case accept financial responsibility for care, see consent on reverse side.

Special Services Information

Is your child receiving special education services? ☐ Y ☐ N

Please Indicate Disability: _____

Date of last IEP: _____

Does your child have a current 504 plan? ☐ Y ☐ N

Please indicate if related to academics or health. ☐ Academics ☐ Health

This form will be given to the School Nurse after registration

2017-2018 School Year

Clear Creek School District
Registration Form-Student Census/Enrollment Information

Student Census/Enrollment Information

Student's Full Legal Name _____
Last First Middle (Full)

Grade _____ Gender ☐ M ☐ F Birth date _____ State/Country of Birth _____
Month Day Year

Mailing Address _____
City State Zip

Physical Address _____
City State Zip

Household Telephone (____)_____Unlisted? ☐ Yes ☐ No Resident County_____

Student's Email _____ Student's Cell Phone (____)_____

Race and Ethnicity

Ethnic Background Is your child Hispanic or Latino? ☐ Yes ☐ No

Race – Please select all that apply

☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander

☐ Asian ☐ White

☐ Black or African American

Note: Failure to answer race and ethnicity questions will result in use of prior racial/ethnic data or an observer identifying for you.

Previous School Information

Has the student attended another Clear Creek School District school? ☐ Yes ☐ No
School _____ Grade _____ School Year _____

Last School Attended Outside the Clear Creek School District?

School _____ City _____ State _____ Grade _____ School Year _____

Has the student attended public school continuously, excluding Kindergarten, in CO for the last 3 years? ☐ Yes ☐ No

Date your child first or most recently enrolled in the United States_____ * Definition attached

Is your child presently under an expulsion/suspension order from any other school district in the last year? ☐ Yes ☐ No

Is your child presently under consideration for expulsion? ☐ Yes ☐ No

Is your child presently involved in the Juvenile Justice system? ☐ Yes ☐ No

If yes to any of these three questions, please explain:_____

ELA Information (All new students should fill out a Home Language Questionnaire)

1. Does the student speak a language other than English? ☐ Yes ☐ No
2. Is a language other than English regularly used by the student's parents or guardians? ☐ Yes ☐ No
3. What language does the student speak/understand? _____
4. The student speaks: ☐ No English ☐ Some English ☐ Another Language and English Equally ☐ Mostly or Only English
5. What language is spoken in the home by the parent/guardian? _____
6. Which language do you prefer for school communications? ☐ English ☐ Spanish ☐ Other

Special Services Information

Is the student receiving special education services?	**Does the student have a current 504 Plan?**	**Does your student have any medical alerts?**
☐ Yes ☐ No	☐ Yes ☐ No If yes, is it related to: ☐ Academics ☐ Health	☐ Yes ☐ No If yes, please list:

Registration Form - Household Information

Household Information Complete One Per Household Please Print

With Whom Does the Student Live?

☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Mother and Stepfather ☐ Father and Stepmother
☐ Foster Parents ☐ Relatives _____ ☐ Other _____

Current Residence Status

☐ House/Apt/Condo/Townhouse/Duplex ☐ Motel/Hotel ☐ Campground /RV/ Car ☐ Emergency Shelter
☐ Are you living with Friends or Family due to the loss of housing or financial hardship? ☐ Transitional Housing Program
☐ Are you a student not living with a parent or legal guardian? ☐ Other, explain? _____

** Residency is important as it can directly relate to rights under the McKinney-Vento Homeless Assistance Act*

Parent/Guardian Information

Name _____ Relationship to student _____
Last First Middle

☐ ***Check here if household information is same as student's*** **Call Priority** ☐ 1 ☐ 2

Mailing Address _____ Apt/Bldg _____ City _____ State _____ Zip _____

Physical Address _____ Apt/Bldg _____ City _____ State _____ Zip _____

Household Telephone (____) _____ Pager (___) _____

Work Telephone (____) _____ Ext. _____ Cell/Alt Telephone (____) _____

Parents/Guardian Email _____

Name _____ Relationship to student _____
Last First Middle

☐ ***Check here if household information is same as student's*** **Call Priority** ☐ 1 ☐ 2

Mailing Address _____ Apt/Bldg _____ City _____ State _____ Zip _____

Physical Address _____ Apt/Bldg _____ City _____ State _____ Zip _____

Household Telephone (____) _____ Pager (___) _____

Work Telephone (____) _____ Ext. _____ Cell/Alt Telephone (____) _____

Parents/Guardian Email _____

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. Where the arrangement is less formal, the school will provide the necessary form for the parent/guardian to complete.

Other Children Under Age 18 Living in the Home (Please Print)

First Name	Middle (Full)	Last Name	Birthdate	Gender	Relation to Student	School Attending

Parent/Guardian Signature _____ Date _____