

STUDENT NAME: \_\_\_\_\_

Pine Grove  
**Required** Paperwork Checklist

- \_\_\_ Birth Certificate (Copy of the State Certificate)
- \_\_\_ Immunization Record
- \_\_\_ Proof of Residency (Warranty Deed, Assessor Deed or Lease Agreement)
- \_\_\_ 2018-19 Registration Form (4 pages)
- \_\_\_ 2018-19 Health Information (3 pages)
- \_\_\_ Release of Records (Grades 1-6 only)
- \_\_\_ Student Residency Questionnaire
- \_\_\_ DCSD Migrant Education Program





Registration Form

For Office use Only

Date of Enrollment: \_\_\_\_\_ Start Date: \_\_\_\_\_
Student ID #: \_\_\_\_\_ Grade: \_\_\_\_\_ Room: \_\_\_\_\_
Teacher/Counselor: \_\_\_\_\_ Track/Team: \_\_\_\_\_
Session: [ ] AM [ ] PM Permit Code: \_\_\_\_\_ Bus #: \_\_\_\_\_

School: [ Pine Grove Elementary ]
Use Dropdown to Select School

\*\*\* PLEASE PRINT \*\*\*

2018-2019

Student Information

Legal Name from Birth Certificate \_\_\_\_\_ Nickname \_\_\_\_\_
Last First Middle (full)
Grade \_\_\_\_\_ Gender M [ ] F [ ] Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_
Residence Address \_\_\_\_\_ Cell \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Race/Ethnicity

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 Phillipine 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

Previous School

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 [ ]

ESL

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? \_\_\_\_\_

Special Services

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 [ ] Counseling [ ] Gifted & Talented [ ] READ Plan
[ ] Speech/Language [ ] Psychological [ ] Remedial Reading (Title 1)
[ ] Physical Therapy [ ] Behavioral Difficulties [ ] 504 Services
[ ] Occupational Therapy [ ] Hearing/Visual Impaired [ ] Other

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



Douglas County School District  
**Household Information**  
**Registration Form**

For Office use Only

Student Name: _____
School: _____ Last _____ Grade: _____ First _____ Middle _____
Teacher/Counselor: _____ Student ID #: _____ Room: _____

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**2018-2019**

Household Info

Residence Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Household Telephone \_\_\_\_\_ Unlisted? Y  N

Parent/Guardian Info

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 Y  N  Legal Guardian Y  N  \*\*Step-Parent Y  N   
(Court Document)

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 Y  N  Legal Guardian Y  N  \*\*Step-Parent Y  N   
(Court Document)

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 Y  N  Legal Guardian Y  N  \*\*Step-Parent Y  N   
(Court Document)

**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**

First Name	Middle Name (full)	Last Name	Date of Birth	Gender	Relation to Student	School Attending	County

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



Douglas County School District  
**Emergency Information  
 Registration Form**

For Office use Only

Student Name: _____			
School: _____	Last Grade: _____	First Student ID #: _____	Middle _____
Teacher/Counselor: _____		Room: _____	

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**2018-2019**

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

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

Emergency Contact Info

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Additional Information \_\_\_\_\_

\_\_\_\_\_

Phones **Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Additional Information \_\_\_\_\_

\_\_\_\_\_

Phones **Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Additional Information \_\_\_\_\_

\_\_\_\_\_

Phones **Home** \_\_\_\_\_ **Work** \_\_\_\_\_ **Cell** \_\_\_\_\_

Doctor

Doctor's (full) Name \_\_\_\_\_ Gender \_\_\_\_\_

Name of Practice / Group \_\_\_\_\_

Phone \_\_\_\_\_ Extension \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



Health Information
Registration Form

\*\*\*PLEASE PRINT\*\*\*

For Office use Only

Student Name: School: Teacher/Counselor: Last Grade: First Student ID #: Middle Room:

2018-2019

Health Info

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.

Does your student have any known allergies?

Seasonal Reaction: Food Reaction: Insect Sting Reaction: Other Reaction: Latex 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.

Parent/Guardian Signature Date

Medicaid

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...

Parent/Guardian Signature Date

Interpreter Needed?

Do you need an interpreter for school meetings and events? This includes family events, parent-teacher conferences, formal plan meetings (IEP, 504, ALP, READ, ELLP), registration and enrollment, etc.

Acknowledgment

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.

Notice

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.

THIS PAGE MUST BE SIGNED EVERY SCHOOL YEAR.

Parent/Guardian Signature Date



**HEALTH INFORMATION – 2018-2019 (NEW students)**

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

**STUDENT NAME:** \_\_\_\_\_  
First Middle Last

**BIRTH DATE:** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_

**GRADE / TRACK:** \_\_\_\_\_

**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: \_\_\_\_\_



### HEALTH INFORMATION – 2018-2019 (NEW students)

<input type="checkbox"/> Cancer	Comment: _____
<input type="checkbox"/> Celiac Disease	
<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> Chromosomal Anomalies	Comment: _____
<input type="checkbox"/> Crohn's Disease	
<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/> Diabetes	Comment: _____
<input type="checkbox"/> Down Syndrome	
<input type="checkbox"/> Emotional Condition	Comment: _____
<input type="checkbox"/> Encopresis	Comment: _____
<input type="checkbox"/> Enuresis	Comment: _____
<input type="checkbox"/> Fetal Alcohol Syndrome	
<input type="checkbox"/> Frequent Headaches	Comment: _____
<input type="checkbox"/> Gastrointestinal Disorder	Comment: _____
<input type="checkbox"/> Head Injury/Concussion	Comment: _____
<input type="checkbox"/> Hearing Impaired	Comment: _____
<input type="checkbox"/> Heart Condition – No Restriction	Comment: _____
<input type="checkbox"/> Heart Condition – Restrictions	Comment: _____
<input type="checkbox"/> Hepatitis B Carrier	
<input type="checkbox"/> Hepatitis C Carrier	
<input type="checkbox"/> History of Injuries	Comment: _____
<input type="checkbox"/> Hypoglycemia	Comment: _____
<input type="checkbox"/> Immune Compromised	Comment: _____
<input type="checkbox"/> Kidney Problem	Comment: _____
<input type="checkbox"/> Lactose Intolerant	
<input type="checkbox"/> Long QT Syndrome	
<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> Myalgia Myositis Fibromyalgia	Comment: _____
<input type="checkbox"/> Neurologic Disorder	Comment: _____
<input type="checkbox"/> Nosebleeds	
<input type="checkbox"/> Orthopedic – Physical Limitation	Comment: _____
<input type="checkbox"/> Orthopedic – No Restrictions	Comment: _____
<input type="checkbox"/> Other	List: _____
<input type="checkbox"/> Paraplegia	
<input type="checkbox"/> Quadriplegia	
<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Seizure Disorder	Comment: _____
<input type="checkbox"/> Shunt/Hydrocephalus	Comment: _____
<input type="checkbox"/> Skin Condition	Comment: _____
<input type="checkbox"/> Syncopal Episodes	Comment: _____
<input type="checkbox"/> Syndrome	Comment: _____
<input type="checkbox"/> Thyroid Condition	
<input type="checkbox"/> Tourette Syndrome	Comment: _____
<input type="checkbox"/> Tracheostomy	Comment: _____



### HEALTH INFORMATION – 2018-2019 (NEW students)

- Traumatic Brain Injury      **Comment:** \_\_\_\_\_
- Urinary Problem              **Comment:** \_\_\_\_\_
- Wears Glasses/Contacts
- Vision Impaired              **Comment:** \_\_\_\_\_
- Von Willebrand's Disease
- 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**
- 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 \_\_\_\_\_



REQUEST TO OTHER EDUCATIONAL AGENCIES FOR RELEASE OF STUDENT INFORMATION TO THE DOUGLAS COUNTY SCHOOL DISTRICT RE. 1

Please send all designated records to:

PINE GROVE ELEMENTARY

10450 Stonegate Parkway
Parker, CO 80134
303-387-8075

FAX Phone: 303-387-8076
Counseling Phone: NA
Registrar Phone: 303-387-8084

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

I HEREBY AUTHORIZE:

Name of School: \_\_\_\_\_ Last Date Attended: \_\_\_\_\_
Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
Phone No.: \_\_\_\_\_ FAX No.: \_\_\_\_\_

TO RELEASE THE FOLLOWING RECORDS TO THE DOUGLAS COUNTY SCHOOL DISTRICT:

- Official Administrative Record (name, address, birth certificate, grade level completed, grades, grading scale, credits earned, attendance, discipline)
Scholastic/Achievement Record
Intelligence and Aptitude Test Scores
Standardized Test / ACT / SAT Data
Discipline File, including record of Suspension / Expulsion
Medical / Immunization Records
Personality and Interest Test Scores
Special Education / Section 504 / ILP Records
Gifted & Talented
Other

Has the above-mentioned student ever been suspended?

Yes No If Yes, please explain: \_\_\_\_\_

Has the above-mentioned student ever been expelled or recommended for expulsion?

Yes No If Yes, please explain: \_\_\_\_\_

Has this student received any previous testing, evaluations or services in any of the following areas?

- Individual Education Plan (IEP) Disability Area: \_\_\_\_\_
Individual Literacy Plan (ILP)
Counseling
Gifted and Talented
504 Services
Psychological
Other \_\_\_\_\_

FALSE INFORMATION ON THIS FORM MAY JEOPARDIZE THE STUDENT'S ENROLLMENT IN SCHOOL.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Student: (circle one) Parent/Guardian Student (18 years and older) Registrar Other \_\_\_\_\_

According to the Family Educational Rights and Private Act, a student's education records can be disclosed without parental consent to school officials of another school or school system where the student seeks to enroll. Under limited circumstances, Colorado law allows withholding only of a student's diploma, transcript, or grades for unpaid book fees. All other records must be provided.

(Office Use Only)
Records Requested \_\_\_\_\_ By \_\_\_\_\_ Via FAX [ ] Via Mail [ ] Received Records \_\_\_\_\_

## 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
<input type="checkbox"/> Choices in Section B do not apply  <b>STOP:</b> If you checked this section, you <b>do not</b> need to complete the remainder of this form. <b>Submit to school personnel.</b>	<input type="checkbox"/> In an Emergency Shelter <input type="checkbox"/> In a motel, car or campsite <input type="checkbox"/> With friends or family members due to the loss of housing or financial hardship <input type="checkbox"/> A student not living with parent or legal guardian <input type="checkbox"/> Other? Explain: _____

2. The student lives with:

- |   |  |
|---|--|
| <input type="checkbox"/> 1 (one) parent           | <input type="checkbox"/> a relative, friend(s) or other adult(s)               |
| <input type="checkbox"/> 2 (two) parents          | <input type="checkbox"/> alone with NO adults                                  |
| <input type="checkbox"/> 1 parent & another adult | <input type="checkbox"/> 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 A** - If Section A is checked, completion of form is not required. Signed form is returned to school personnel.  
**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: \_\_\_\_\_



### 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.

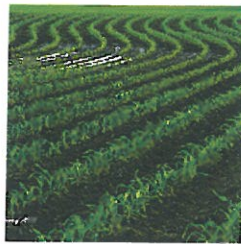
CHILD'S FIRST NAME:	CHILD'S LAST NAME:	BIRTHDATE:
SCHOOL:		GRADE:
PARENT/GUARDIAN NAME:		How many children under the age of 22 live with you in your household? _____

- In the past three years, has your family moved to another state, city, school district, and/or county?  
 YES                       NO
- 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.*

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 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 2<sup>nd</sup> Ave, Suite 180  
Aurora, CO, 80011  
P. 303-365-5817 F. 303-856-7294