Pine Grove Kindergarten
Required Paperwork Checklist

___ Birth Certificate (Copy of the State Certificate)

___ Immunization Record

___ Proof of Residency (Warranty Deed, County Assessor or Lease)

___ 2020-21 Registration Form (4 pages)

___ 2020-21 Health Information (3 pages)

___ Student Residency Questionnaire

___ DCSD Migrant Education Program

___ Programming Option Sheet
**Student Census Registration Form**

**School:** Pine Grove Elementary

**Legal Name from Birth Certificate**

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle (full)</th>
</tr>
</thead>
</table>

**Gender**

- [ ] M
- [ ] F

**Date of Birth**

**Residence Address**

**City**

**State**

**Zip**

**Email**

**Nickname**

**Phone**

**Cell**

**Do you need an interpreter for school meetings and events?**

- [ ] Yes
- [ ] No

---

**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?**

- [ ] 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?**

- [ ] 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?**

- [ ] Yes
- [ ] No

**Last school attended outside the Douglas County School District:**

- School __________
- City __________
- State __________
- Grade __________

**School Year**

**Previous School**

**ELD**

- [ ] Does the student speak a language(s) other than English?

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

- [ ] Yes
- [ ] No

If yes, specify the language(s). __________

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

**Is your child presently under an expulsion order from any other school district?**

- [ ] Yes
- [ ] No

**Is your child presently under consideration for expulsion?**

- [ ] Yes
- [ ] No

**Is your child presently involved in the Juvenile Justice system?**

- [ ] Yes
- [ ] No

---

**Special Services**

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

**Is your child currently on an Individual Educational Plan for Special Services?**

- [ ] Yes
- [ ] No

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

- [ ] READ Plan
- [ ] Gifted & Talented
- [ ] Remedial Reading (Title 1)
- [ ] 504 Services
- [ ] Other

**Parent/Guardian Signature** __________

**Date** __________
Residence Address
City
State
Zip
Household Telephone

Name
Relationship to Student
Residence Address
City
State
Zip
Mailing Address
(if different from above)
City
State
Zip
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
(if different from above)
City
State
Zip
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
(if different from above)
City
State
Zip
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 (Full)</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>
<th>Gender</th>
<th>M</th>
<th>F</th>
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Additional Information

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<th>Home</th>
<th>Work</th>
<th>Cell</th>
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</table>

Doctor's (full) Name

Name of Practice / Group

Phone Extension

Address

City State Zip Code

---

Parent/Guardian Signature Date
**Please Print**

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:  ☐ Food  Reaction:  ☐ Fire  Reaction:
☐ Insect Sting  Reaction:  ☐ Other  Reaction:  ☐ Other  Reaction:
☐ Latex  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.

Parent/Guardian Signature ____________________________ Date _____________

**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.

Parent/Guardian Signature ____________________________ Date _____________
HEALTH INFORMATION – (NEW students)

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

STUDENT NAME: ___________________________  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: ______________________

620 Wilcox Street  Castle Rock, Colorado 80104  303-387-0100

Revised 10/29/18
<table>
<thead>
<tr>
<th>Condition</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
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<tr>
<td>Celiac Disease</td>
<td></td>
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<tr>
<td>Cerebral Palsy</td>
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<tr>
<td>Chromosomal Anomalies</td>
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<tr>
<td>Crohn's Disease</td>
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<tr>
<td>Cystic Fibrosis</td>
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<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Down Syndrome</td>
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<tr>
<td>Emotional Condition</td>
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<tr>
<td>Encopresis</td>
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<tr>
<td>Enuresis</td>
<td></td>
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<tr>
<td>Fetal Alcohol Syndrome</td>
<td></td>
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<tr>
<td>Frequent Headaches</td>
<td></td>
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<tr>
<td>Gastrointestinal Disorder</td>
<td></td>
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<tr>
<td>Head Injury/Concussion</td>
<td></td>
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<tr>
<td>Hearing Impaired</td>
<td></td>
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<tr>
<td>Heart Condition – No Restriction</td>
<td></td>
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<tr>
<td>Heart Condition – Restrictions</td>
<td></td>
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<tr>
<td>Hepatitis B Carrier</td>
<td></td>
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<tr>
<td>Hepatitis C Carrier</td>
<td></td>
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<tr>
<td>History of Injuries</td>
<td></td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td></td>
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<tr>
<td>Immune Compromised</td>
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<tr>
<td>Kidney Problem</td>
<td></td>
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<tr>
<td>Lactose Intolerant</td>
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<tr>
<td>Long QT Syndrome</td>
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<tr>
<td>Migraine Headaches</td>
<td></td>
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<tr>
<td>Myalgia Myositis Fibromyalgia</td>
<td></td>
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<tr>
<td>Neurologic Disorder</td>
<td></td>
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<tr>
<td>Nosebleeds</td>
<td></td>
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<tr>
<td>Orthopedic – Physical Limitation</td>
<td></td>
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<tr>
<td>Orthopedic – No Restrictions</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Paraplegia</td>
<td></td>
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<tr>
<td>Quadriplegia</td>
<td></td>
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<tr>
<td>Scoliosis</td>
<td></td>
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<tr>
<td>Seizure Disorder</td>
<td></td>
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<tr>
<td>Shunt/Hydrocephalus</td>
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<tr>
<td>Skin Condition</td>
<td></td>
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<tr>
<td>Syncopal Episodes</td>
<td></td>
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<tr>
<td>Syndrome</td>
<td></td>
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<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>

List:
HEALTH INFORMATION – (NEW students)

- Traumatic Brain Injury
- Urinary Problem
- Wears Glasses/Contacts
- Vision Impaired
- Von Willebrand’s Disease
- Wolff Parkinson White Syndrome

ADDITIONAL INFORMATION

- List any illness, hospitalization, surgery, accidents your student had in the past year.

  ___________________________________________________________  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 ___________________
### Student Residency Questionnaire

Douglas County School: 

Student’s Legal Name:  

Date of Birth:  

Age: 

Grade:  

Gender:  

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)  

<table>
<thead>
<tr>
<th>Section A</th>
<th>Section B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choices in Section B do not apply</td>
<td>In an Emergency Shelter</td>
</tr>
<tr>
<td></td>
<td>In a motel, car or campsite</td>
</tr>
<tr>
<td></td>
<td>With friends or family members due to the loss of housing or financial hardship</td>
</tr>
<tr>
<td></td>
<td>A student not living with parent or legal guardian</td>
</tr>
<tr>
<td></td>
<td>Other? Explain:</td>
</tr>
</tbody>
</table>

2. The student lives with:  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (one) parent</td>
<td>a relative, friend(s) or other adult(s)</td>
</tr>
<tr>
<td>2 (two) parents</td>
<td>alone with NO adults</td>
</tr>
<tr>
<td>1 parent &amp; another adult</td>
<td>an adult that IS NOT the parent or the legal guardian</td>
</tr>
</tbody>
</table>

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:  

---

This is a copy of the student residency questionnaire for Douglas County School. It contains fields for personal information, residency status, and contact details. The questionnaire is designed to address the McKinney-Vento Act, which requires specific documents for enrollment. The form is to be completed and returned to school personnel for processing.
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>
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<tbody>
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<th>SCHOOL:</th>
<th>GRADE:</th>
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<table>
<thead>
<tr>
<th>PARENT/GUARDIAN NAME:</th>
<th>How many children under the age of 22 live with you in your household?</th>
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<tbody>
<tr>
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<td>1</td>
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</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>
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<table>
<thead>
<tr>
<th>CITY:</th>
<th>STATE:</th>
<th>ZIP:</th>
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<thead>
<tr>
<th>TELEPHONE (WITH AREA CODE):</th>
<th>PREFERRED LANGUAGE:</th>
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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
1. Complete one form per family.
2. Indicate preference for full day or half-day Kindergarten

The half-day option will only be offered if there is enough interest to support the class. In the event that half-day is not supported your child will be placed in a FDK class.

PROGRAM OPTIONS

Full Day Kindergarten ______ 8:20AM - 3:10PM M-F

Half-Day Kindergarten ______ A.M. 8:20 - 11:15 M-F

______ P.M. 12:15 - 3:10 M-F

Name of Kindergartener:

_________________________________________________________________

Name of Parents:

_________________________________________________________________

Phone ____________________  (Home)  ____________________  (Mother’s Cell)  ____________________  (Father’s Cell)