



## Required Enrollment Documents

Congratulations on your child's enrollment into one of our schools for the 2020-2021 school year.

In order to complete the registration process, please provide the following items to school staff by the end of May 2020:

- 1) Student birth certificate
- 2) Shot records
- 3) Health history form
- 4) Language Questionnaire
- 5) Signed records request
- 6) Copy of IEP or 504 (if applicable)

If your student has an IEP (Special Education Services) or a 504 plan from a previous school, our school staff will review these documents to ensure that we can meet the educational plan of your student. We will require 10 business days for this process and will contact you directly upon review of records.

You may turn in your enrollment documents at the following locations:

**Academy of Advanced Learning:** 431 Sable Blvd., Aurora  
9 a.m. to 4 p.m., Monday through Friday

**Coperni 2:** 525 E. Costilla, Colorado Springs  
9 a.m. to 4 p.m., Monday through Friday

**Coperni 3:** 755 Citadel Drive West, Colorado Springs  
9 a.m. to 4 p.m., Monday through Friday

Failure to submit the documents may result in your child being taken off our enrollment list in order to make room for a student on the waiting list.

Thank you for understanding and for working with us to provide your child a world-class education.

<b>HEALTH INFORMATION</b> Must be updated annually
-------------------------------------------------------

*'Confidential information will be shared with school staff on a need to know basis'*

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Teacher: \_\_\_\_\_

**Does your child currently have any of the following health concerns? (Please circle if applicable)**

Dr. Diagnosed ADD/ADHD Medication: _____	Dr. Diagnosed AUTISM SPECTRUM Medication: _____	Dr. Diagnosed Heart Condition WITH ACTIVITY restrictions	Dr. Diagnosed Emotional Condition Eating Disorder
Dr. Diagnosed ASTHMA Medication: _____	Bowel/Bladder Issues Diabetes: Type _____	Hearing Loss Head Injury	Migraine Headaches Seizures

Please describe the circled condition above in **greater** detail: \_\_\_\_\_

List any **other** current medical concerns: \_\_\_\_\_

**Is your child currently taking any other medication not listed above? Yes / No** (Use back of this paper for additional space if needed)

**Medication/Dose/Time Taken:** \_\_\_\_\_

**Medication/Dose/Time Taken:** \_\_\_\_\_

Does your child have any activity/dietary restrictions? **Yes / No** If yes, please list: \_\_\_\_\_

Does your child have any **significant life threatening allergies** that you feel school personnel need to know about? **Yes / No**  
 If yes, list allergy and reaction: \_\_\_\_\_

**Required Parent Information:** (circle one) **I WILL** or **I WILL NOT**  
 be providing rescue medication such as Epinephrine for severe allergy noted above.

I understand that by NOT providing rescue medication, EMS (911) will be called if an emergency arises and agree to Emergency Care Permit listed below.

Date/Location of the last vision exam: \_\_\_\_\_

Does your child wear glasses or contacts? **Yes / No** Vision Diagnosis: \_\_\_\_\_

Has your child had a hospitalization or surgery within the last year? **Yes / No** \_\_\_\_\_

Student's Physician / Phone #: \_\_\_\_\_

Does your child have Medicaid? **Yes / No**

**Emergency Care Permit:** In case of serious illness or injury, first aid will be rendered in accordance with local school policies. If ambulance service is necessary, parents must assume financial responsibility. If I cannot be reached by telephone in the event of an emergency, please send my child to (Hospital/Address) \_\_\_\_\_ or the nearest medical facility.

**Parent/Guardian Signature**

**Best Contact Phone Number(s)**

❖ *I am also giving the school health officials permission to talk our child's doctor about immunizations. This includes permission for the doctor's office to fax shot records to the school.*

**Form Completed by:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Last School Child attended: \_\_\_\_\_



## Request and Release of Student School Records

Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
(Students Last Name)      (Student First Name)      \_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_  
(Date of Birth)      (20-21 Grade)

### Former School Information:

\_\_\_\_\_  
(School Name)      (Address)      (City)      (State)

(\_\_\_\_\_) \_\_\_\_\_      (\_\_\_\_\_) \_\_\_\_\_  
(School Main Phone Number)      (School Fax Number)

### The following are student records that are hereby being requested:

- |                                                               |                                                 |                                             |
|---------------------------------------------------------------|-------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Transcripts (Official or Unofficial) | <input type="checkbox"/> Attendance             | <input type="checkbox"/> Discipline Records |
| <input type="checkbox"/> Grades                               | <input type="checkbox"/> Immunization Records   | <input type="checkbox"/> All Test Scores    |
| <input type="checkbox"/> READ Plan                            | <input type="checkbox"/> Reading Level Info.    | <input type="checkbox"/> TCAP/CSAP/ALP      |
| <input type="checkbox"/> ELL Info.                            | <input type="checkbox"/> Health/Medical Records | <input type="checkbox"/> Birth Certificate  |
| <input type="checkbox"/> Psychological/Sociological Records   | <input type="checkbox"/> Current IEP            | <input type="checkbox"/> Current 504 Plan   |
| <input type="checkbox"/> All of the above                     | <input type="checkbox"/> Other _____            |                                             |

**Please email all records to: [manager@aalk8.org](mailto:manager@aalk8.org)**

\_\_\_\_\_  
(Name of School Official Requesting—Printed)      (Signature of School Official)

\_\_\_\_\_  
(Parent/Guardian Signature)      \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date)

## Home Language Questionnaire

Our school needs to know the language(s) spoken and heard at home by each child. This information is needed in order for us to provide the best instruction possible for all students.

Name of child: \_\_\_\_\_  
Last First Middle Grade Age

1. Which language did your child first learn to speak? \_\_\_\_\_
2. What language does your child use most often at home? \_\_\_\_\_
3. What language do you most often use to speak to your child? \_\_\_\_\_
4. In what country was your child born? \_\_\_\_\_
5. If your child was not born in the USA, what date did they enter the USA? \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

---

## Preguntas del Lenguaje Hablado en Casa

Nuestra escuela necesita saber el lenguaje y oído en casa por cada niño/a. Esta información es necesaria para proveer la mejor instrucción posible para todos los alumnos.

Nombre del alumno: \_\_\_\_\_  
Apellido Primer nombre Segundo Grado Edad

1. Que idioma comenzó su hijo/a hablar primero? \_\_\_\_\_
2. Que idioma usa más su hijo/a en la casa? \_\_\_\_\_
3. Que idioma usa usted con más frecuencia para hablar con su hijo/a? \_\_\_\_\_
4. En que país nació su hijo? \_\_\_\_\_
5. Si no nació en los EEUU en qué fecha entró su hijo/a a los EEUU? \_\_\_\_\_

\_\_\_\_\_  
Firma del Padre o Guardian

\_\_\_\_\_  
Fecha