THE Vanguard School

AUTHORIZATION TO RELEASE STUDENT INFORMATION

TO: _____

(Name of School)

_____

(Street Address)

_____

(City, State, Zip Code)

I hereby authorize THE VANGUARD SCHOOL to receive all pertinent school academic, personal, and health records for:

Name of Student(s)	Date of Birth	Last Grade

Please mail records to:

The Vanguard School
1605 S. Corona Ave
Colorado Springs, CO 80905
Attention: Student Records
FAX: 719-634-4180

_____ _____

Date Parent Authorization

Office Use Only

Request Sent: Contact:
Date Received:

Cheyenne Mountain School District - Home Language Survey

TO BE COMPLETED BY PARENT OR GUARDIAN

Student Name: _____ Date of Birth_____/_____/_____
Last First Middle Month Day Year

School: _____ Grade: _____

Please answer the questions below accurately and completely. The Cheyenne Mountain School District is required by law to request this information on all students in order to provide the most appropriate placement and instruction for students who potentially qualify for English language learner services.

Thank you for taking time to complete this survey and returning it to your child's school.

1. What was the first language this student spoke?: _____

2. Is there a language other than English spoken in the home? ☐ NO ☐ YES

   Which language(s)?: _____

3. Does this student speak a language other than English? ☐ NO ☐ YES
   Do not include languages learned in school.

   Which language(s)?: _____

_____ _____/_____/_____ _____
Parent or Guardian SIGNATURE Date Print Parent or Guardian Name

Dear Parents and Guardians:

Federal education law requires that the Cheyenne Mountain School District collect data on home language usage for all students. Also, schools are required under federal civil rights laws to identify all students whose home language is not English. Since parents and guardians are most qualified to provide the school with this information we ask that you please take a few moments to complete this questionnaire so that we may have accurate records for all of our students.

Any data that we report from these questionnaires are reported as group data only and any individual information cannot be released without direct permission from you.

Please do not hesitate to call your school principal if you have questions about the survey. Thank you for your assistance in helping us meet this requirement.

Sincerely,

Dr. Carolena Guiral Steen
Assistant Superintendent for Student Services

Revised 01/14

The Vanguard School District 12

STUDENT HEALTH INFORMATION UPDATE - School Year: _____

Student Name:_____ Birthdate:_____ Grade:_____ School:_____

HEALTH CONCERNS	YES	NO	MEDICATION (Name, Dosage)	MONITORING REQUIRED IN SCHOOL?	COMMENTS
ALLERGIES:			HEALTHCARE PLAN REQUIRED IF STUDENT HAS EPINEPHRINE PEN - CONTACT SCHOOL NURSE		
FOOD					LIST FOOD:
INSECTS					
LATEX					
MEDICATION					LIST MEDICATION:
ENVIRONMENT					
OTHER					LIST:
ASTHMA/RESPIRATORY					HEALTHCARE PLAN REQUIRED IF STUDENT HAS INHALER - CONTACT SCHOOL NURSE
DIABETES					HEALTHCARE PLAN REQUIRED - CONTACT SCHOOL NURSE
SEIZURES					IF HEALTHCARE PLAN REQUIRED, CONTACT SCHOOL NURSE
PREVIOUS CONCUSSION/ HEAD INJURY					YEAR:
FREQUENT HEADACHES					DIAGNOSED MIGRAINES?
HEART / BLOOD					
MUSCLES/BONES/ JOINTS/SKIN					
BLADDER / KIDNEY					
STOMACH/INTESTINES/ BOWELS					
GROWTH / NUTRITIONAL					
AUTOIMMUNE					
AUTISM SPECTRUM DISORDER					
ADHD					
ANXIETY					
DEPRESSION					
VISION / HEARING					

- Other health concerns or medications not listed above: _____
- Activity restrictions in school: _____
- Significant health changes including new diagnosis, illness, hospitalization, accidents or injuries in the last year:

_____

- * If medication is required during the school day, a medication permission form must be submitted to the school nurse. No Epi-Pens, Inhalers, or Emergency Medications are allowed to be carried by students without a signed self-carry permit. Contact School Nurse.

School nurse may develop a Healthcare Plan each school year. All information is considered confidential and is shared only on a need-to-know basis. I give my permission to inform teachers and necessary staff about my child's identified health concerns.

Parent/Guardian Signature_____**Date**_____

Robin Smith, RN BSN School Nurse: 719-471-1999 x141 or robin.smith@thevanguardschool.com

The Vanguard School District 12
HEALTH HISTORY

Child's Name: _____ Grade: _____ School: _____
Person providing answers: _____ Date: _____
Medical Insurance: _____
Health Care Provider: _____

Current Health Status

How would you describe your child's current physical health? Excellent ❑ Good ❑ Fair ❑ Poor ❑
Does your child have a known medical diagnosis? No ❑ Yes ❑
What is the diagnosis? _____
Diagnosed at what age? _____

Is your child currently taking medication? No ❑ Yes ❑
Medication Name/Dose/Time/Purpose: _____
Medication Name/Dose/Time/Purpose: _____
Medication Name/Dose/Time/Purpose: _____
Medication Name/Dose/Time/Purpose: _____

Does your child have any allergies? None ❑ Environmental ❑ Medicine ❑ Food ❑ Other ❑
Please specify: _____
Last exposure and reaction: _____

Date of last physical: _____ Hospital of Choice: _____
Date of last eye exam: _____ Does your child wear glasses or contacts? No ❑ Yes ❑
Any vision concerns? _____ Any hearing concerns? _____
Date of last dental exam: _____ Any dental concerns? _____

How would you describe your child's current emotional health? Excellent ❑ Good ❑ Fair ❑ Poor ❑
Any mental health concerns or trauma? _____
_____

Would you say that your child is a: Good Eater ❑ Picky Eater ❑ Other ❑
Please explain: _____
How many hours of sleep does your child get each night? _____

Explain any other problems or concerns: _____
_____
_____
_____

Medical History

Has your child had any of the following? (Please check and comment on the lines below)

- ❑ Anemia
- ❑ Asthma
- ❑ Bladder/kidney problems
- ❑ Bone/orthopedic problems
- ❑ Concussion/head injury
- ❑ Convulsions/seizures
- ❑ Dental problems
- ❑ Eating/weight problems
- ❑ Frequent ear infections
- ❑ Frequent nose bleeds
- ❑ Frequent respiratory infections
- ❑ Frequent sore throat
- ❑ Frequent stomach aches
- ❑ Heart condition
- ❑ High fever
- ❑ Sleeping problems
- ❑ Special diet
- ❑ Significant accident/injury
- ❑ Minor/major surgery
- ❑ Social/emotional problems
  - ❑ Anxiety
  - ❑ Depression
  - ❑ Hyperactivity/short attention
  - ❑ Harming self or others

If checked please explain: _____

_____

_____

Surgical History: _____

Pre-Natal/Birth/Early Childhood History

During pregnancy, did mother:
- Receive prenatal care? No ❑ Yes ❑
- Smoke? No ❑ Yes ❑ How much? _____
- Use alcohol? No ❑ Yes ❑ How often? _____
- Take medications/drugs? No ❑ Yes ❑ List: _____

Did mother have any illness or difficulties during pregnancy? No ❑ Yes ❑ Explain: _____

_____

Was baby born: Premature ❑ Full-term ❑ Overdue ❑ Birth weight: _____ lbs. _____ oz.

Any complications at or right after birth? (such as oxygen, blood, breathing, infection, etc.):

_____

_____

As an infant, did your child have any difficulty with any of the following?

Feeding ❑ Allergies ❑ Colic ❑ Poor Weight Gain ❑ Sleeping ❑ Other ❑

Explain: _____

Growth & development milestones (crawl, walk, talk, potty train, etc): Early ❑ Normal ❑ Delayed ❑

Explain: _____

Is there anything else we should know about your child's health? _____

_____

_____

_____ _____

Signature of person completing form Date

Revised 2/25/20

Robin Smith, RN BSN School Nurse: 719-471-1999 x141 robin.smith@thevanguardschool.com