The Vanguard School

Enrollment Office
T: 719.471.1999 x134 F: 719.634.4180
Jennifer.Blanchard@TheVanguardSchool.com
Janet.LaLone@TheVanguardSchool.com

Parent/Guardian(s)

_____
Name of Previous School

_____
Address

_____
City, State, Zip

_____
Fax Number or Email Address of Registrar

_____ _____
Legal Name of Student Birth Date

Has been enrolled at The Vanguard School in the _____ grade.

_____
Parent/Guardian Signature (if available)

The Family Educational Rights and Privacy Act (20 U.S.C.S. § 1232g: 34 CFR Part 99), as revised, states (a) An educational agency or institution may disclose personally identifiable information from an education record of a student without the written consent of the parent of the student or the eligible student if (1) The disclosure is to other school officials, including teachers, within the agency or institution has determined to have legitimate educational interests. (2) The disclosure is to officials of another school or school system in which the student seeks or intends to enroll.

Previous School

Please email the following records:

- ☐ Withdrawal grades
- ☐ Unofficial transcript
- ☐ Immunization records
- ☐ Attendance records
- ☐ Discipline records
- ☐ Test data/standardized test scores
- ☐ Learning plan if applicable
- ☐ *504, ALP, IEP, RTI, etc*
- ☐ Threat assessment if applicable
- ☐ Psychological/socialogical records

High School Only

If the school is in Colorado, please indicate whether or not the student has met Colorado State's Graduation Guidelines. If yes, please include how the guideline was met.

English: N or Y _____
Math: N or Y _____

Please **mail** the official transcript to:
(faxed and emailed transcripts will not be accepted as offical)

Enrollment Office
The Vanguard School
1605 S. Corona Ave
Colorado Spring, CO 80905

SCHOOL DISTRICT TWO
HARRISON
Character Through Diversity, Challenge & Accomplishment

HOME LANGUAGE IDENTIFICATION FORM

CLDE

Date: _____

What language should the school use to communicate with you? _____

Student's Last Name: _____ **First Name** _____

M ____ **F** ____ **Date of Birth:** _____ **School:** _____ **Grade:** _____

Parent or Guardian's Name: _____

Address: _____ **Telephone No.** _____

1. What language(s) did your child use when he/she first began to talk? _____

2. What language(s) does your child speak with you at home? _____

3. Did your child ever receive English as a Second Language Instruction? _____

4. Is a language other than English spoken at home by a parent, sibling, or this child? YES or NO

If *YES*, please complete questions 5-7. If *NO*, proceed to question 8

5. What is the language? (other than English) _____

6. Who in the home communicates in this language? (Please respond to each statement)

a. This child	____ Always	____ Sometimes	____ Never
b. Mother/Guardian	____ Always	____ Sometimes	____ Never
c. Father/Guardian	____ Always	____ Sometimes	____ Never
d. Siblings (Brother/Sister)	____ Always	____ Sometimes	____ Never
a. Others living in the home	____ Always	____ Sometimes	____ Never

7. This Child: (Please respond to all statements: circle one)

Understands and speaks English fluently	Yes	No
Reads in English	Yes	No
Writes in English	Yes	No
Needs help in understanding English	Yes	No
Needs help in speaking English	Yes	No
Needs help in reading and writing in English	Yes	No

8. Did this child experience any problem or difficulty in learning to speak, read, or write in his/her first language? Yes or No

If *YES*, please explain: _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ **Date:** _____

This form is required for each new student

Revised August 24, 2020

SCHOOL DISTRICT TWO
HARRISON
Character Through Diversity, Challenge & Accomplishment

IDENTIFICACIÓN DEL IDIOMA DEL HOGAR

CLDE

Fecha: _____

Idioma de preferencia para llamadas y cartas de la escuela al hogar_____

Apellido del estudiante: _____ **Primer Nombre**_____

M ___ **F** ___ **Fecha de Nacimiento:** _____ **Escuela:** _____ **Grado:**___

Nombre de Padre/Tutor: _____

Dirección/Domicilio: _____ **Teléfono:** _____

1. ¿Qué idioma(s) hablo su hijo(a) cuando comenzó a hablar por primera vez? _____

2. ¿Qué idioma(s) habla su hijo(a) con usted en casa? _____

3. ¿Ha recibido su estudiante instrucción de inglés como segundo idioma? _____

4. ¿Hay algún otro idioma que no es inglés hablado en la casa por el padre o el estudiante? SI o NO

Si es SI, por favor complete las preguntas 5-7. Si es NO, pase a la pregunta numero 8

5. ¿Cuál es el idioma? (que no es inglés) _____

6. ¿Quién en la casa se comunica en este idioma? (Por favor responda cada una de las declaraciónes)

a. Su hijo/hija	____ Siempre	____ A Veces	____ Nunca
b. Madre/Tutor	____ Siempre	____ A Veces	____ Nunca
c. Padre / Tutor	____ Siempre	____ A Veces	____ Nunca
d. Hermanos/Hermanas	____ Siempre	____ A Veces	____ Nunca
a. Otros viviendo en la casa	____ Siempre	____ A Veces	____ Nunca

7. Su estudiante: (Por favor responda a todas las declaraciónes)

Comprende inglés o lo habla con fluidez	Sí	No
Lee en inglés	Sí	No
Escribe en inglés	Sí	No
Necesita ayuda comprendiendo inglés	Sí	No
Necesita ayuda para hablar en inglés	Sí	No
Necesita ayuda para leer y escribir en inglés	Sí	No

8. ¿Tuvo su hijo(a) problemas o dificultades al aprender, hablar, leer, o escribir en su primer idioma?

Sí o No

Si es SI por favor explique _____

Nombre del Padre/Tutor (Imprimir)_____

Firma del Padre/Tutor: _____**Fecha:** _____

Este formulario es requerido para cada nuevo estudiante

Revisado 24 de Agosto, 2020

The Vanguard School

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
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 9/2/21

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

COLORADO
Department of Education

Colorado MEP Occupational Survey

Your child 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 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:
PARENT/GUARDIAN NAME:	How many children under the age of 22 live with you in your household?	
CITY:	STATE:	ZIP CODE:
BEST DAY AND TIME TO CALL:	PREFERRED LANGUAGE:	

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)

This form and the data recorded within are protected to maintain family and child confidentiality. If you have any questions, please contact:

Southeast Regional MEP Office
24951 E. US Hwy 50
Pueblo, CO 81006
Cece Garcia - 719-695-2664, Harriet Roman - 719-696-2657, Maria De Lara - 719-696-2658, Amparo Briggs - 719-696-2660

COLORADO
Department of Education

Encuesta Ocupacional del Colorado MEP

Su hijo puede ser candidato para recibir servicios suplementarios gratuitos, como tutoría, transporte y útiles escolares, además de otros servicios. Le agradeceríamos responder las siguientes preguntas para poder determinar su elegibilidad. Una vez contestada, envíela a la escuela o a la oficina regional de MEP que se detalla al pie de la página.

NOMBRE DEL MENOR:	APELLIDO DEL MENOR:	FECHA DE NACIMIENTO:
NOMBRE DEL PADRE/TUTOR:	¿Cuántas personas de menos de 22 años viven en su domicilio?	
CIUDAD:	ESTADO:	CÓDIGO POSTAL:
DÍA Y HORA PARA COMUNICARNOS CON USTED:	IDIOMA PREFERIDO:	

1) ¿Durante los últimos tres años, su familia se ha cambiado a otro estado, ciudad, escuela, y/o condado?
☐ SÍ ☐ NO

2) ¿Usted o alguien de su familia directa está trabajando o ha trabajado durante los últimos tres años, en alguna de las siguientes ocupaciones relacionadas con el trabajo agrícola o pesquero?
☐ SÍ ☐ NO

CIRCULE todo lo que corresponda, incluso si el trabajo fue por un período corto.

Procesamiento & Empaquetado (fruta, vegetales, huevos, carne de pollo, cerdo, res, o cualquier otro tipo de ganado)

Agricultura o Trabajo de Campo (cosecha, recolección y clasificación de cultivo, preparación del suelo, riego, fumigación)

Lechería & Cría de Ganado (alimentar, ordeñar, acorralar/ arrear)

Vivero o Invernadero (cultivar, plantar, podar, regar, cosechar)

Silvicultura (preparación del suelo, cosecha y crecimiento, corte de árboles)

Pesca & Procesa-miento de Pescado (capturar, clasificar, empacar, transportar pescado)

Esta encuesta y los datos registrados en la misma están protegidos para mantener la confidencialidad de la familia y los menores.
Si tiene preguntas, comuníquese a:

Southeast Regional MEP Office
24951 E. US Hwy 50
Pueblo, CO 81006
Cece Garcia - 719-695-2664, Harriet Roman - 719-696-2657, Maria De Lara - 719-696-2658, Amparo Briggs - 719-696-2660