



2883 South Circle Drive
Colorado Springs, CO 80906
Phone (719) 635-6333
Fax (719) 380-6249

Attendance Line (719) 635-6333

<http://www.ppboces.org>

Returning Student Enrollment Packet

2021 – 2022

***2021-2022 Enrollment packet,
Immunizations and district paperwork must
be completed and submitted before your
child may start school.***

**Sped Director - Deirdre Shearer
Coordinator - Amber Bumgardner**

- Pikes Peak Pathways
- LIBERTY Program
- COLA Program

Student Hours

7:50 – 2:15

***No drop off before 7:50**

Pick up by 2:20

Office Hours

7:30 – 3:30

SOE contracts with Harrison School District for lunch. Lunch form is requested for all students.

SOE follows District #11 for weather cancellations and delays. Sign up for **Notify Me** at www.ppboces.org to receive additional notifications.

Parent/Student Handbook is available at ppboces.org or the front office of SOE.

Emergency Identification Information

Student Name _____ Date of Birth _____ Age _____

Height _____ Weight _____ Build _____ Ethnicity _____

Gender _____ Coloring _____ Hair color _____ Eye color _____

Braces? yes ___ no ___ Glasses? yes ___ no ___ Description _____

Contacts? yes ___ no ___ If colored, describe _____

Tattoo(s) location and description _____

Distinguishing marks/other features that would help identify the student:

Primary diagnosis(es) _____

Physician who made diagnosis(es) _____

Additional diagnosis(es) _____

Medications _____

Prescribing Physician's name _____

Known allergies _____

Does your child run/elope/hide? _____

In the event of an emergency, are there any language barriers staff need to be aware of when contacting parent/guardian?

Hospital of choice _____ Physician _____ Phone _____

Insurance carrier _____ Policy# _____

Pikes Peak BOCES School of Excellence does not assume responsibility for injury to your child at school, nor payment for doctor, hospital or ambulance fees if a medical emergency should occur on the grounds or at school-sponsored activities.

I do hereby authorize Pikes Peak BOCES School of Excellence to obtain emergency medical treatment in case parents(s)/guardian(s) cannot be contacted.

Signature of Parent/Guardian

Date

- ***Please notify the school promptly of any changes that may occur on this Emergency Information Form throughout the year.***

Consent to Photograph and Videotape

All students will have photographs taken for use in the student database program and for safety purposes. Students may be issued school ID cards as appropriate. Aside from these required photos, occasions may arise during the school year where photographing, videotaping and/or audio taping of your son/daughter would be desirable for educational, social or therapeutic purposes. Students generally enjoy seeing themselves in pictures or on videotape and we believe that learning can often occur during the development of audio-visual projects and by reviewing an activity or class that has been recorded.

I understand that my child will be photographed and that the photo produced will be placed in the student file, for the yearbook, emergency events and student IDs as appropriate. My student may be video/audio taped for therapeutic/educational purposes as deemed appropriate.

Parent/Guardian _____ Date _____

Permission for FAC/Field Trip

Pikes Peak BOCES School of Excellence must have the following signed permission slip in order for your child to participate in any field trip planned:

I hereby give permission for _____, to participate in field trips conducted by Pikes Peak BOCES School of Excellence. Transportation, when necessary, will be provided by the school vehicles or bus.

Parent/Guardian _____ Date _____

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Pikes Peak BOCES School of Excellence Movie/Film Permission

As part of our incentive program at school students may earn the privilege of watching a movie on Friday afternoon. Occasionally, teachers may also utilize films in the classroom for instructional purposes. These movies may be rated G or PG. This form allows students in the elementary program to view movies rated PG. For secondary students PG-13 films may be viewed.

I give my child permission to watch movies rated PG (elementary) PG-13 (secondary) while at school.

Parent/Guardian _____ Date _____

*Please note that approved videos will be used with the curriculum in the classroom for instructional support.

Permission for Gold Level Student Lunch Privilege (Pathways secondary students only)

If a high school student reaches gold level for 5 consecutive days, one of the privileges is to be permitted to leave campus during his/her lunch period.

I give permission for _____, to leave campus for gold level lunch privilege. I understand that this will be unsupervised.

Parent/Guardian _____ Date _____

Parent/Student Handbook

I _____ have been offered a copy of the handbook containing school policies, dress code, technology usage, immunization requirements, and procedures. In addition, I have been made aware that the handbook is available on the ppbores.org website and in the front office of the school.

Parent/Guardian _____ Date _____

SOE Annual Health Update (Return to School Nurse)

Child's Name _____ Grade _____

List any immunizations your child received in the past year.

Type _____ Date(s) _____

List if your child had any serious injury, illness, or hospitalization in the past year.

Describe _____

Are there any physical conditions limiting your child's activity in school? Yes No

Describe _____

List any prosthetic devices, hearing aids, crutches, wheelchair, knee brace, dental appliance, etc.

Describe _____

Does your child wear glasses or contacts? Yes No

For: (circle which) distance close work astigmatism other _____

When was last eye exam? _____ Doctor _____

List any dietary restrictions (food allergy) for your child?

To what? _____

Describe reaction _____

Please be advised Harrison School District 2's "Medical Disability Meal" form is required for the school food service program to provide a food substitution or modification:

<https://www.hsd2.org/Page/361>- Forms may also be found at the SOE front office

List all medications taken:

Name of medication(s): Dose: Time taken at home: Time taken at school:

Any medication administered by school staff must have signed medical provider and parent authorization. All medication administered at school must be provided in its' original pharmacy labeled container, brought to school by the parent and turned in to the office staff.

Please note:

- o All emergency costs are at the expense of the family.*
- o Please be advised that emergency care is provided by the most qualified school staff and the local emergency response system.*
- o In the event of an emergency all efforts will be made to contact parents or medical provider and then alternate emergency contacts.*

****Please circle if your child has any conditions listed below?**

Diabetes, epilepsy, asthma, heart problems, behavior/emotional problems, vision or hearing problems, severe allergy, seizure, high blood pressure, ADHD, ADD, tourettes, autism, cerebral palsy, depression, bi-polar, other(please list)_____.

Authorization to Administer Medication

STUDENT: _____ DOB: _____ GRADE _____

*****MEDICAL PROVIDER SECTION*****

No known medication allergies: _____ Medication allergies: _____
 Known condition(s)/diagnosis(es): _____

Pikes Peak BOCES School of Excellence houses educational programs for students with highly specific needs. Health condition/diagnosis documented by a medical provider is required to complete necessary educational documentation.

Please list all medication taken routinely, prescribed and over-the-counter:

Medication:	Dose:	Route:	Time given at home:	Time given at school:

**Medical Provider, over-the-counter medications listed below are available at school.
 Please indicate if school staff may administer OTC medication to this child/student, the dose and frequency.**

Oral medication(s):

Acetaminophen 500mg tablet for c/o pain or to reduce fever <101	Yes ___	No ___	_____ tablet(s) every _____ hours
Acetaminophen 80mg chewable tablet for c/o pain or to reduce fever <101	Yes ___	No ___	_____ tablet(s) every _____ hours
Cough Drops (menthol/eucalyptus flavored) for c/o sore throat or cough	Yes ___	No ___	_____ lozenge(s) every _____ hours
Tums 750mg antacid tablets for c/o heartburn, indigestion, sour stomach	Yes ___	No ___	_____ tablets every _____ hours

Topical medication(s)/application(s):

Triple antibiotic ointment apply to minor cuts/abrasions after cleaning with soap/water; cover with bandage	Yes ___	No ___
Sunscreen, broad-spectrum/SPF 30 apply to unbroken skin that is exposed to sun	Yes ___	No ___

Medical Provider signature _____ **Date** _____

Medical Provider print/stamp name, address, phone, fax:

**** PARENT SECTION: REQUEST THAT SCHOOL ADMINISTER MEDICATION****

- I understand that my child attending Pikes Peak BOCES School of Excellence does not self-carry or self-administer medication(s)
- I request and authorize that the medication(s) listed above be administered to my child by qualified school personnel in the manner specified as authorized by the medical provider.
- I understand that it is my responsibility to furnish the prescription medication to the school in its original pharmacy container with current labeling of medication, dose, frequency, and child's name.
- I understand that if my child requires prescribed emergency medication, the medication is available to him/her when needed.
- I will notify the school immediately if the medication is to be changed or terminated or if we change physicians.
- It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian.
- In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Pikes Peak BOCES School of Excellence, the undersigned parent or guardian hereby agrees to release Pikes Peak BOCES School of Excellence and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give permission for my child to take the above named prescription medication and/or OTC medication at school as prescribed.

Parent/Guardian Signature _____ Date _____

ANNUAL NOTIFICATION UNDER 34 CFR § 300.154(d)(2)(v)

The regulations implementing the Individuals With Disabilities Education Act (IDEA), afford parents of eligible students certain rights with respect to a school district's ability to access private insurance or public benefits, such as Medicaid, to help pay for certain services that are provided at school. These rights are as follows:

1. *YOU HAVE THE RIGHT TO RECEIVE NOTICE IN AN UNDERSTANDABLE LANGUAGE.*

The school district must give you an annual written notice of your rights, which must be written in language understandable to the general public; and also provided in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so.

2. *YOUR CHILD'S CONFIDENTIAL INFORMATION CANNOT BE DISCLOSED WITHOUT YOUR CONSENT.*

Parental consent must be obtained under the Family Educational Rights and Privacy Act (FERPA) regulations at 34 CFR part 99 and the IDEA regulations at §300.622 before the school district discloses, for claiming purposes, your child's personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid);

3. *YOUR CHILD HAS A RIGHT TO SPECIAL EDUCATION AND RELATED SERVICES AT NO COST TO YOU.*

This means that, with regard to services required to provide a Free Appropriate Public Education ("FAPE") to an eligible child under IDEA, the school district

- May not require parents to sign up for or enroll in public benefits or insurance programs in order for their child to receive FAPE;
- May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but may pay the cost that the parents otherwise would be required to pay;
- May not use a child's benefits under a public benefits or insurance program if that use would:
 - Decrease available lifetime coverage or any other insured benefit;
 - Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school;
 - Increase premiums or lead to the discontinuation of benefits or insurance; or
 - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

4. *YOU MAY WITHDRAW CONSENT AT ANY TIME.* Once you've given consent for disclosure of confidential information about your child to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid), you have a legal right under the FERPA regulations to withdraw that consent whenever you wish.

5. *IF YOU REFUSE CONSENT, OR WITHDRAW CONSENT, THE SCHOOL DISTRICT STILL HAS TO PROVIDE REQUIRED SERVICES AT NO COST TO YOU.*

If you refuse to provide consent for the disclosure of personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid), or, if you give consent but then later withdraw consent, that does not relieve the school district of its responsibility to ensure that all required services are provided at no cost to the parents.



Pikes Peak BOCES
Request to Release or Secure Confidential
Information
 (Not required for release to another Administrative Unit)

2883 South Circle Drive
 Colorado Springs, CO 80906
 (719) 635-6333

Legal Name of Student	DOB	SASID	Date
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This permission shall be valid beginning August 1, 2021 and shall terminate August 1, 2022.

Permission to release or secure the following records or information: Audiometric, Educational, IEP, Medical, Occupational Therapy, Psychiatric, Psychological, Physical Therapy, Social Work, Speech/Language

The purpose of the requested disclosure is as follows:

This student is enrolled at the Pikes Peak BOCES School of Excellence and the team here would like to be able to exchange information.

From: _____ To: _____

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent, except as provided by law.

Return Consent to Release Confidential Info to:
 Sharon Chidester / Administrative Assistant

2883 S Circle Dr, Colorado Springs CO 80906
 (719) 635-6333

Parental Consent

I understand that consent is voluntary and may be revoked at any time in writing. I hereby authorize the transfer of information as indicated above.

 Parent Signature

 Date

For Internal Use Only
 Date consent received by District/Administrative Unit:
 Outcome:

Authorization to Release/Exchange Information

I hereby authorize Pikes Peak BOCES School of Excellence to _____ release to _____ obtain from:

Name of individual, facility, organization Title (if pertinent)

Address Phone # Fax #

The following information:

1. Psychiatrist or prescribing physician
2. Medication information
3. Diagnosis by prescribing physician

Concerning _____
Name of student Date of birth

Federal Privacy law (HIPAA) requires a signed authorization for the disclosure of health information except for the purposes of treatment, payment or health care operations, and therefore disclosure of health information for these purposes may be made even without your signed authorization. Federal confidentiality rules (42 CFR) require a signed authorization for the disclosure of drug and alcohol records unless required by a court order, in a medical emergency, or for auditing purposes; and also prohibit re-disclosure of drug and alcohol records by the recipient without written consent, unless otherwise permitted by law.

I am aware that my medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases that is confidential and is protected by federal law. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

I understand that I have the right to revoke this authorization at any time by giving written notice to a Pikes Peak BOCES School of Excellence administrator, except to the extent that Pikes Peak BOCES School of Excellence has already taken action in reliance upon it. This authorization will be active through the current school year.

Student Signature (Required if student is 15 or over) Date

Signature of Parent/Guardian Date

Signature of Witness Date



Dear Parent/Guardian:

We are requesting your written consent to all the Pikes Peak BOCES School of Excellence to provide copies of your student's education and disciplinary records to the Colorado Springs Police Department and or the El Paso County Sheriff's Department (law enforcement agency).

The purpose of this disclosure is to comply with the Individuals with Disabilities Education Act requirement to transmit student records for consideration by appropriate authorities when a student with a disability is referred to authorities regarding possible commission of a crime. The sharing of your student's records will provide law enforcement a clear idea of your student's needs and disabilities.

34 C.F.R. § 300.535.

If you provide consent the School of Excellence will provide the agency with a copy of your student's most recent evaluation, current individualized education plan, disciplinary history, and documents relating to the alleged conduct that lead to the referral to law enforcement. If you do not sign consent, then the School of Excellence will not be able to disclose information to the agency.

If you have questions or concerns, please contact the school at 635-6333.

Sincerely,

Deirdre Shearer

_____ ***I do*** consent to the release of my student's special education and disciplinary records.

_____ ***I do not*** consent to the release of my student's special education and disciplinary records.

Parent Signature

Date