ELIZABETH HIGH SCHOOL

"A Commitment to Excellence"

ELIZABETH HIGH SCHOOL

PARKING PERMIT FORM

- Parking permits are available to all eligible students and must be displayed on any vehicle parked in the EHS parking lot.
- Students must park in the designated parking spots. Students are not to park irregularly, and may not block other vehicles.
- **THE STAFF PARKING LOT IS OFF LIMITS TO STUDENTS AT ALL TIMES.**
- Students who park in non-designated areas risk being ticketed and/or towed at the owner's expense, in addition, students are subject to disciplinary action based on the discretion of Campus Security and EHS Administrators. Non-designated areas include, but are not limited to, handicapped areas, teacher lots, bus loop, fields and dirt areas.
- The opportunity to park your vehicle at Elizabeth High School is a privilege, which can be revoked at any time.
- This privilege may be lost by speeding, driving carelessly, or parking improperly.
- **ALL VEHICLES PARKED ON EHS PROPERTY ARE SUBJECT TO RANDOM SEARCHES, AT ANY TIME.**

I, _____, agree to abide by the expectations and responsibilities set forth in this contract.

(Student Print Name)

I understand that failure to do so may result in the loss of my parking privileges.

Student Signature: _____

Driver's License #: _____

Make/Model/Color of Vehicle	License Plate #
_____	_____
_____	_____

THE ABOVE INFORMATION MUST BE COMPLETED BEFORE TURNING THIS IN FOR A PERMIT

Office Use Only:

Parking Permit #: _____

Elizabeth High School ♦ Elizabeth School District
P.O. Box 660 ♦ Elizabeth, Colorado 80107 ♦ (303) 646-4616 ♦ Fax (303) 646-6030

Elizabeth School District

Student Health Information Form

20_____ - 20_____

Student Name: _____ Birth Date:_____ School: _____ Grade:_____

Will your student be riding a bus this school year? Yes_____ No_____

Does your child wear glasses/contacts or require any form of hearing supports? (Please circle which) Yes_____ No_____

Would you like know *EVERY* time your child comes to the health office this year? Yes____ No____ Only as needed ____

Does your student have any non-life threatening allergies? Yes_____ No_____

If yes, please list the allergies, reactions, and how you treat at home:

_____

_____

Please list current medications your child is taking routinely at home (prescribed, over the counter, and supplements):

_____

_____

Will daily medication need to be given at school? *Yes_____ No_____

If yes, list medication(s): _____

"Permission to Give Prescription/Homeopathic Medications at School" form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received

CHECK THE CONCERN(S) YOUR CHILD HAS BELOW, OR (initial)_____ MY CHILD HAS NO KNOWN HEALTH CONDITIONS

(You may stop here if there are no known medical conditions. Please sign on page 2 and return form).

___ Accidents/Injuries ___ **ADD/ADHD** (See below) ___ **Allergies, Severe** (See below) ___ Allergies, seasonal ___ **Asthma** (See below) ___ Autism ___ Behavior Concerns ___ Cancer/Leukemia Date Diagnosed: _____ Treatment Status: _____ ___ Developmental Delays	___ Cerebral Palsy ___ Crohn's Disease/IBS ___ Cystic Fibrosis ___ **Diabetes** (See below) ___ Down Syndrome ___ **Epilepsy/Seizures** (See below) ___ Gastric Reflux/Ulcers ___ Genetic Disorder ___ G-Tube or other type of feeding tube **(requires tube feed authorization form)**	___ Head Injury/Concussion Date Diagnosed:_____ Fully recovered?:_____ ___ Heart Conditions Type:_____ ___ Hemophilia/Bleeding Disorder ___ Immune Conditions ___ **Mental Health Diagnosis** (See below) ___ **Migraines/Headaches** (See below)	___ Mobility Impairments ___ Neuromuscular Disease ___ Orthopedic Disability ___ Daily Oxygen use **(requires provider order)** ___ Renal/Kidney/Bladder ___ Skin Conditions ___ Stomach/Intestines ___ Tracheostomy ___ Vision/Hearing Problem ___ Other: _____

If yes to any of the above, please provide additional details:

_____

_____

_____

_____

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION (Additional conditions on back)

Severe Allergies Notify Nurse immediately if anaphylaxis may occur.	What is your child allergic to? _____ Is medication needed at school for allergies? Yes____ No ____ If yes, name: _____ Location of Medication: Carried by student (**requires self-carry form**) _____ or Health Office (**requires anaphylaxis action plan**) _____ Type of reaction (difficulty breathing, hives etc): _____

	Date of last reaction: _____
Asthma	Is medication needed at school for asthma? Yes____ No____ If yes, name:_____ Location of Medication: Carried by student (**requires self-carry form**) _____ or Health Office (**requires CO asthma action plan**) _____ Date of last episode: _____ Triggers (exercise etc.): _____
Epilepsy/Seizures	Type:_____ Date of last seizure: _____ Is emergency medication needed at school? *Yes____ No _____ If yes, name:_____ ***Requires Seizure Action Plan***
Diabetes	Type I _____ Type II _____ Date of diagnosis: _____ Insulin by: Pump (list type) _____ Injections _____ Pen _____ CGM: Yes (list type) _____ No _____ Type of rescue medication (Baqsimi, glucagon etc.): _____ Is your student independently managing? Yes (**requires Self-Management Plan**) _____ No _____ **Please call to schedule conference with District Nurse – notify immediately if newly diagnosed.**
ADD/ADHD Mental Health	ADD _____ ADHD _____ Anxiety _____ Depression _____ Other: _____ Is medication needed at school? *Yes_____ No _____ If yes, name: _____ ***Requires Permission to Give Meds at School Form***
Migraine/ Headaches (Please specify which)	How often does your child experience migraines: _____ Triggers/aura: _____ Is medication needed at school? *Yes _____ No _____ If yes, name: _____ ***Requires provider orders or headache/migraine action plan***

Is there anything else you would like for us to know to better care for your child?

_____

_____

_____

_____

_____

Parent/Guardian Signature _____

Contact Phone # _____

Date _____

The following forms can be found on the Elizabeth School District Health page:

1. Permission to Give Prescription/Homeopathic Medications at School
2. Allergy and Anaphylaxis Action Plan &
    a. Self-Carry Agreement **(Middle and High School Students only)**
3. Asthma Action Plan &
    a. Self-Carry Agreement **(Middle and High School Students only)**
4. Tube Feeding Authorization Form
5. Seizure Action Plan
6. Permission for Nursing Procedure

Please contact the District Nurse if you would like to discuss any of the above information (303-646-6730)

Elizabeth School District

ELIZABETH SCHOOL DISTRICT
NON-PRESCRIPTION MEDICATIONS
PERMISSION FORM: 20_____ - 20_____

New forms must be completed every year

Student Name: _____ DOB: _____ School: _____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter". This form is required before OTC medications can be administered at school. Exceptions to this are homeopathic/herbal medications and OTCs not included in this list, which require completing the form **"Permission to Give Prescription/Homeopathic Medication at School".**

Please initial or check each over-the-counter medication for which you give your permission for your child to have at school, then sign below.

_____ **I approve all medications listed below**

Oral:

_____**Acetaminophen** (Tylenol or generic substitute)
_____**Benadryl** (Diphenhydramine)
_____**Claritin** (Loratadine)
_____**Cough Syrup** (Delsym/Robitussin)
_____**Ibuprofen** (Motrin, Advil or generic substitute)
_____**Throat Lozenges**
_____**Tums** (Calcium Carbonate)
_____**Zyrtec** (Cetirizine Hydrochloride)

Topical:

_____**Antibiotic Cream** (Bacitracin)
_____**Benadryl Cream**
_____**Burn Gel** (Lidocaine)
_____**Contact Solution**
_____**Saline Eye Solution**
_____**Sunscreen**
_____**Unscented Lotion**
_____**Vaseline** (Petroleum Jelly)

_____**I do not want *any* OTC meds given to my student**

If this form is not returned to school, your child will not be given these medications. Please indicate if your child has an allergy or an unusual or unpleasant side effect to a specific generic or brand name medication. Please contact your school's health office with questions.

Allergies/side effects:

_____

Additional comments:

_____

I/we attest that I/we have a standing medical order from the student's healthcare provider that authorizes the administration of the above identified over-the-counter medications during the school year by the school nurse or nurse's designee.
It is understood that the medication is given solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my child or I/we sustain arising out of the administration of the non-prescription medication identified above to my child.

I have carefully read the information above and hereby authorize the school nurse or designee to administer the above medications during the current school year.

Signature of Parent/Guardian: _____ Date: _____

Name of Parent/Guardian: _____