Office Use Only
Date Received: _______________
Enrollment Phase: _____________

Please save your file often so you don't lose your work.

2020-2021
3-5 Enrollment Packet
Poudre School District Early Childhood Education Program

220 N. Grant Ave. Fort Collins, CO 80521
Phone: (970) 490-3204 Fax: (970)490-3134 bit.ly/PSDpreschool

INFORMATION VERIFICATION

By my signature below, I am verifying that the information provided to the Poudre School District Early Childhood Education Program in this enrollment packet is, to the best of my knowledge, complete and truthful.

______________________________ ______________________________ ______________

Parent/Guardian Signature **Print Name** **Date**

Who completed this application: ☐Mother ☐ Father ☐ Guardian

Child's Name:___________________________ Child's Date of Birth:__________

Please complete all information in black or blue ink

Phases	Communication about Placement
I. Early Application * **January 6, 2020 - February 28, 2020**	Mailed by April 10, 2020
II. Application* **March 1, 2020 - Last day of School (May 19, 2020)**	Mailed by June 10, 2020
III. Delayed Application* **May 20, 2020 - August 1, 2020**	Mailed prior to the first day of school
IV. Ongoing Year-Round Application* **Anything after** **August 2, 2020**	Varies based by Volume & Site Requested. (10-15 business days to process application, placement date unknown based on request)

*This applies to COMPLETE original applications, COMPLETE re-enrollment packets, classroom change requests, data changes/address changes.
*Eligibility and Placements within certain funded sources are limited.

2020-2021 3-5 Enrollment Packet

Child's Name: ____________________________Child's Date of Birth: __________

Please complete the following boxes with Parent/Guardian's current contact information and employer information. This information is necessary so that we can contact you in the case of an emergency. Primary and Secondary Guardians will be contacted first. Additional emergency contacts may be added on the following page.

Primary Guardian:	
Street Address: **City, State, Zip:**	
Primary's Phone(s):	**( ) ☐Home ☐ Cell** **( ) ☐Home ☐ Cell Texting Ok? ☐ Yes ☐ No**
Email Address:	
Employer:	
Street Address: **City, State, Zip:**	
Work Phone:	**( )**

Secondary Guardian:	
Street Address: **City, State, Zip:**	
Secondary's Phone(s):	**( ) ☐Home ☐ Cell** **( ) ☐Home ☐ Cell Texting Ok? ☐ Yes ☐ No**
Email Address:	
Employer:	
Street Address: **City, State, Zip:**	
Work Phone:	**( )**

Emergency Contact Information

Child's Name: ____________________________Child's Date of Birth: __________

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	( ) ☐ Home ☐ Cell ( ) ☐ Home ☐ Cell	Check all that apply ☐ Emergency contact ☐ Release child to Is this person at least 16 years old with a valid ID? ☐ Yes ☐ NO	

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	( ) ☐ Home ☐ Cell ( ) ☐ Home ☐ Cell	Check all that apply ☐ Emergency contact ☐ Release child to Is this person at least 16 years old with a valid ID? ☐ Yes ☐ NO	

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	( ) ☐ Home ☐ Cell ( ) ☐ Home ☐ Cell	Check all that apply ☐ Emergency contact ☐ Release child to Is this person at least 16 years old with a valid ID? ☐ Yes ☐ NO	

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	( ) ☐ Home ☐ Cell ( ) ☐ Home ☐ Cell	Check all that apply ☐ Emergency contact ☐ Release child to Is this person at least 16 years old with a valid ID? ☐ Yes ☐ NO	

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	( ) ☐ Home ☐ Cell ( ) ☐ Home ☐ Cell	Check all that apply ☐ Emergency contact ☐ Release child to Is this person at least 16 years old with a valid ID? ☐ Yes ☐ NO	

Emergency Contact (other than Primary & Secondary Guardian)		Relationship to child:	
Street Address: City, State, Zip:			
Phone #'s:	( ) ☐ Home ☐ Cell ( ) ☐ Home ☐ Cell	Check all that apply ☐ Emergency contact ☐ Release child to Is this person at least 16 years old with a valid ID? ☐ Yes ☐ NO	

Child's Name: ____________________________Child's Date of Birth: _________

Please read each box, initial and check Agree or Disagree

	Permission Contract	Initial or Check
Release of Information	I authorize the Poudre School District Early Childhood Education Program to release information to Partnering Community agencies/providers, contracted service providers, and to providers identified by the parent/guardian.	☐ **Agree** ☐ **Disagree**
Specific Information Shared	I understand that following PSD policy, I will need to complete a records release form every time I want to access copies of my child's records.	☐ **Agree** ☐ **Disagree**
Field Trips (3-5 year olds only)	I understand that my child will ride a Poudre School District bus when they go on supervised field trips as part of the program. Permission slips must be signed for each trip for my child to be able to participate.	☐ **Agree** ☐ **Disagree**
Sunscreen/hand lotion	I understand that sunscreen and lotion may be used on my child and in classroom activities. Product information for classroom sunscreen is available in the classroom.	☐ **Agree** ☐ **Disagree**
Telephone Contact	I give my permission for the program staff to give my telephone number to another parent for the purpose of program/classroom events and parent involvement only.	☐ **Agree** ☐ **Disagree**
Emergency Medical Care	In an emergency the Poudre School District Early Childhood Education Program will call 911 and access medical assistance for my child. I understand that all reasonable attempts will be made to contact myself and/or my emergency contacts. In the case that I cannot be reached, I give permission for Poudre School District Early Childhood Education Program to arrange emergency medical care for my child.	
Data Collection	I understand that the Poudre School District Early Childhood Education Program collects non-identifiable statistical information to be used for documentation, Program Information Report and funding purposes.	
Home Visits and Conferences	I understand that there will be six home visits (**for Head Start funded families**) and Parent/Teacher Conferences **(for all families)** during the school year. Home visits and/or teacher conferences may include support from Teacher & Education, Health and Family Mentor staff. If I am unable to make a scheduled visit, I must reschedule. I understand that lack of attendance at home visits will lead to a review of my child's enrollment and may lead to disenrollment.	
Quality Assurance	I understand that there may be a supervisor who comes into my home during a scheduled home visit with one of the staff members mentioned above for the purpose of quality assurance.	
Screenings	I understand that my child will be screened throughout the school year for the purpose of assessment in vision, hearing, dental, speech, growth and developmental needs.	
Poudre School District Cumulative File	I understand that if my child is enrolled in a Poudre School District Early Childhood Education Program my child's records will be transferred to his/her Poudre School District cumulative file.	
Custody and Court Order	I understand that I must provide Custody and Court Orders that pertain to my child to the Early Childhood Education Program for the school to be aware of and follow special instructions.	
Preschool Attendance Area	I understand that for my child to attend preschool in the Poudre School District our permanent home address must be in the Poudre School District boundaries. I verify that I have provided my child's actual home address.	
Attendance Policy	I understand that if my child is enrolled in the Poudre School District Early Childhood Education Program my child will be subject to the program's attendance policy. I understand that attendance issues will lead to a review of my child's enrollment and possible disenrollment. I understand that this is not drop-in care.	

This form is valid for the 2020-2021 school year.

____ ____ __________

Parent/Guardian Signature **Print Name** **Date**

Early Childhood
HOME LANGUAGE AND STUDENT RESIDENCY FORM

State and federal regulations **require** that schools identify and report the language(s) spoken and heard by each child in the home, and determine eligibility for immigrant, migrant, refugee or McKinney education services. This information is used to ensure that the educational rights of each child are met. Please take a few minutes to complete this questionnaire. **This confidential information is for school use only.**

Student's Last Name ______________________ Student's First Name ______________________ Student's Middle Name ______________________

Student's Date of Birth ______________________ Country of Birth ______________________

Date Student Entered Colorado ______________________ Date Student Entered USA ______________________

Address: ____

Parent or Guardian Name(s) ____

Home Phone #: ______________________

Work Phone #: ______________________

Home Language Information:

Was the language first spoken by the student a language other than English?	☐ No	☐ Yes	Language:
Does the student speak a language other than English?	☐ No	☐ Yes	Language:
Is a language other than English used in the home?	☐ No	☐ Yes	Language:
Will you need an interpreter for conferences, phone calls and other verbal communication?	☐ No	☐ Yes	Language:

Residency Information:

Have you been given "Refugee Status" paperwork? ☐ No ☐ Yes

Did you move to Colorado with the intent of working in agriculture, farming or fishing? ☐ No ☐ Yes

Do you work in agriculture, farming or fishing? ☐ No ☐ Yes

Housing Information

The McKinney-Vento Assistance Act protects and supports the educational rights of students who do not have permanent housing. Your answers help to determine the support the student may be eligible for.
*This **confidential information** is for school use only*

A. Please check which of the following situations the student resides in (you can choose more than one):

____Living with extended family members, non-family members, or friends
____Motel, car, campsite, or park
____Shelter (emergency, safehouse) or transitional housing program
____Inadequate housing (lacks proper kitchen, bathroom facilities, water or electricity, and/or infestations, mold, or other dangers)
____None of the above
____Other (Please Explain)

B. Please check all the following reasons that apply to the students living situation (you can choose more than one):

____Loss of housing
____Economic hardship
____Temporarily waiting for house or apartment
____Providing care for a family member
____Living with boyfriend/girlfriend/significant other/friend
____Loss of employment
____Parent/Guardian deployed
____None of the above
____Other (Please explain)

C. My student is living apart from his/her parents or guardians. ☐ Yes ☐ No

Educational Rights

1. Go to school no matter where they live or how long they have lived there
2. Choose between the local school where they are living, the school they attended before they lost their housing, or the school where they were last enrolled
3. Enroll in school without proof of address, immunizations, school records, or other documents
4. Have access to extracurricular activities
5. Get transportation to their school of origin (if feasible and in their educational best interest)
6. Get all the school services they need (including free breakfast/lunch, fees waived)
7. Be free from harassment and isolation
8. Have disagreements with the schools settled quickly

Any questions about these rights can be directed to the local McKinney-Vento Program Specialist at

Signature of parent or guardian Date

POUDRE SCHOOL DISTRICT
Early Childhood
EDUCATION PROGRAM

2020-2021 Health Conditions

Student Name: ____ Date of Birth: _______/_______/______

Health Care Provider/ Medical Clinic: ____________________________ Last exam date: _____________________

Dentist/ Dental Clinic: ____ Last exam date: _____________________

Are you enrolled in Supplemental Nutrition Assistance Program (SNAP) ☐ Yes ☐ No

Is your family currently on WIC ☐ Yes ☐ No

Medical Insurance:

☐ Medicaid/Health First ☐ Colorado Health Plan Plus (CHP+) ☐ None/Uninsured ☐ Other_______________

Hospital Preference:

☐ Poudre Valley Hospital ☐ McKee Medical Center ☐ Medical Center of the Rockies ☐ Banner Health

Health Conditions:

Response		Health Condition	Response		Health Condition
YES	NO	Allergy- Environmental / Animal	YES	NO	Hearing Impairment- Devices worn? YES NO
YES	NO	Allergy – Food	YES	NO	Heart Condition
YES	NO	Allergy – Insect	YES	NO	Kidney /Urinary
YES	NO	Allergy - Medication	YES	NO	Mental Health
YES	NO	Asthma	YES	NO	Neurological
YES	NO	Autism Spectrum Disorder	YES	NO	Orthopedic
YES	NO	Brain / Head Injury	YES	NO	Physical limitation/restrictions
YES	NO	Cancer	YES	NO	Premature or significant birth history
YES	NO	Chewing or swallowing troubles	YES	NO	Seizures/ Epilepsy
YES	NO	Diabetes	YES	NO	Special Diet
YES	NO	G-Tube	Yes	NO	Vision Problem – Glasses worn? YES NO
YES	NO	Genetic Disorder	OTHER:		

Explain any health condition(s) above:____

____

____

Does your child need medication at school? YES ☐ NO ☐

Name of Medication(s):____

**Print or request an *Authorization to Administer Medication* form from your school or from the PSD health services website:

Please list any other daily medication(s) that your child is taking at home: ________________________________

I voluntarily provide this information and understand I must provide the following health documents for my child's health file: Complete immunizations, current physical exam, dental exam and lead blood test results

____

Parent/Guardian Signature **Date**

Dental Screening – Early Childhood Permission Form

Children who are enrolled in the Poudre School District's Early Childhood Program have the opportunity to have their teeth examined by a local dentist from the community. This is a free service and is performed right in your child's classroom. This is a fun classroom activity that children really enjoy. With parent permission, a fluoride varnish will be applied to your child's teeth as well, in both the fall and spring of the 2020/2021 school year. This satisfies the program requirement for a dental exam. Written results of the exam will be sent home with each child. Parents will be informed if a child has cavities or needs further evaluation.

☐ **Yes** ☐ **No** **I give permission for a dental exam and evaluation.**

☐ **Yes** ☐ **No** **I give permission for fluoride varnish to be applied.**

For a copy of the Health District of Larimer County's Notice of Privacy Practices please visit their website at:
http://www.healthdistrict.org/sites/default/files/health-district-notice-of-privacy-practices-english-02-17.pdf

Parent/Guardian: ____ **Date:**____________________
(Signature required for children age 17 or under)

(Please print your information)

Student's Last Name:	**Student's First Name:**	**Student's Gender:** ☐ Male ☐ Female
Student's Date of Birth:	**Parent/Guardian Name:**	**Relationship to Student:**
Address:	**City, State, Zip:**	**Phone:**
Type of dental insurance? ☐ **Medicaid / DentaQuest** ☐ **CHP+**	☐ **None** ☐ **Private Dental Insurance** ☐ **Other:** ________________________	

Has your student seen a dentist before: ☐ No ☐ Yes: Date of child's last appointment:____________________________
Are your child's gums/teeth brushed at least once a day? ☐ No ☐ Yes
Does your child have any trouble with teeth, gums, or mouth that you know about? ☐ No ☐ Yes
Does your child have any cavities? ☐ No ☐ Yes
Does your child have trouble chewing or swallowing? ☐ No ☐ Yes

Child's dentist is at:

- ☐ **FoCo Kids**
- ☐ **Toothzone**
- ☐ **KidsFirst Dental**
- ☐ **Jennifer Hargleroad**
- ☐ **Keith Van Tassell (Ped. Dent. Of Rockies)**
- ☐ **Salud Dental Clinic**
- ☐ **Mountain Kids**
- ☐ **Big Grins**
- ☐ **Kindergrins**
- ☐ **Health District**
- ☐ **Drs. Gerken & Galm (Ped Dent. Of Loveland)**
- ☐ **Other (please specify):**___________________________

OFFICE USE ONLY:

Screening Date: ______/_______/_______

Number of cavities: __________

A____**B**____**C**____**D**____**E**____**F**____**G**____**H**____**I**____**J**____

T____**S**____**R**____**Q**____**P**____**O**____**N**____**M**____**L**____**K**____

Provider's Signature______________________________

Print Name______________________________________

Provider Comments

FREE Vision Screening
Colorado Lions KidSight Program

The local Lions Club in your community, in conjunction with the Colorado Lions KidSight Program, will offer free vision screening to your child at his/her preschool or kindergarten. The screening uses state-of-the-art technology and is 85-90% effective in detecting the vision problems that could lead to lazy eye. No physical contact is made with your child and no eye drops or medications are used. ***WHY VISION SCREENING?*** 1 in 20 children has an undetected vision problem that could turn into lazy eye if left untreated. Early detection and treatment is essential to prevent lazy eye.

Parent/Guardian: Please fill out the following. All information is kept confidential and is not sold to third parties. PLEASE PRINT CLEARLY and ANSWER ALL QUESTIONS.

Child's full name:____Male_____Female _____
First *Middle* *Last*

Child's date of birth: ____________________________________ Child's age: _______

Parent or Guardian: ____________________________________Email: ____________________________

Address:______________________________________City:____________________Zip code: _____________

Phone (INCLUDING area code) ______________________________

Is your child currently under the care of an eye doctor?
Yes____No_____ If yes, name of eye doctor: ____________________________________

I hereby give permission for my child to participate in the screening event. I have read and understood the following information regarding this program:

- The information obtained from this vision screening is preliminary only and does not constitute a diagnosis of vision problems.
- I may be communicated with by telephone or email if my child does not pass the vision screening.
- I understand that if my child does not pass the eye screening, I am responsible for arranging for an eye exam with an eye doctor of my choice. I understand that I am responsible for all costs of any eye exams.
- I will not hold the Lions organization, the Colorado Lions KidSight Program, their employees, agents, officers, and representatives liable for any injury which may accrue as a result of the vision screening, including but not limited to errors of commission, errors of omission, or other misdiagnosis.

Signature of Parent or Guardian____Date ____________________

RESULTS: **For Office Use Only**

____Pass We are unable to detect a vision problem at this time. The screening is not a substitute for a complete pediatric eye exam. Consult an eye care professional if a vision problem is suspected.

____Unreadable We were unable to get reliable vision screening results for this child. This can happen occasionally if the child looks away from the equipment during the screening. Consult an eye care professional if a vision problem is suspected.

____Refer Child should be examined by an eye care professional because he/she may have the following Condition:

____ Strabismus ____Anisometropia ____ Astigmatism
____ High Farsightedness ____ High Myopia
____ Other ____

Authorization for Disclosure of Protected Health Information

Poudre School District Early Childhood Education Program

Doctor

PARENT TO COMPLETE

I authorize ____

(Provider/Clinic Name)

____

(Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name ______________________ DOB ______________

Address ____

Phone Number ______________ Parent Name ______________________

PSD HEALTH STAFF TO COMPLETE

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Poudre School District Early Childhood Health Staff
220 North Grant Fort Collins CO 80521 Fax 970-490-3134

For the purpose of: PSD Early Childhood Health Requirements

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

- Entire medical record, from date __________ to date __________.
- Summary statement of diagnostic testing and treatment plan, from date ________ to date ________.
- Laboratory Result, from date __________ to date __________.
- Immunizations records, from date __________ to date __________.
- Well-child exam, from date __________ to date __________.
- Dental exam, from date __________ to date __________.
- Developmental reports and evaluations, from date __________ to date __________.
- Other: ____
- (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
- Verbal consultation as needed with ______________________________

PARENT TO READ AND SIGN

I understand this authorization will expire, without my express revocation one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that I have a right to a copy of this authorization. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on obtaining the individual's authorization. I understand that any disclosure of information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules.

____ ______________

Signature of Patient, Parent or Authorized Personal Representative **Date**

____ ______________

Printed Name of Patient, Parent or Authorized Personal Representative **Relationship** to Patient

This authorization reflects the requirements of HIPAA, 45 C.F.R.J 164.508.

EARLY CHILDHOOD EDUCATION PROGRAM
POUDRE SCHOOL DISTRICT
Early Childhood
EDUCATION PROGRAM

Authorization for Disclosure of Protected Health Information

Dentist

PARENT TO COMPLETE

I authorize ____

(Provider/Clinic Name)

____

(Provider/Clinic address and or Street)

to release the Health Information of the individual named below

Patient/Student Name ______________________ DOB ______________

Address ____

Phone Number ______________ Parent Name ______________________

PSD HEALTH STAFF TO COMPLETE

I authorize the information to be disclosed to and discussed with the following individual(s) or organization(s):

Poudre School District Early Childhood Health Staff
220 North Grant Fort Collins CO 80521 Fax 970-490-3134

For the purpose of: Early Childhood Health Requirements:

The type and amount of information to be disclosed is as follows: *(specify dates where appropriate):*

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- Summary statement of diagnostic testing and treatment plan, from date ________ to date ________.
- Laboratory Result, from date __________ to date __________.
- Immunizations records, from date __________ to date __________.
- Well-child exam, from date __________ to date __________.
- Dental exam, from date __________ to date __________.
- Developmental reports and evaluations, from date __________ to date __________.
- Other: ____
- (You must specifically indicate the release of records relating to drug or alcohol abuse, child abuse, HIV status, genetic testing, or mental health records. A separate authorization form is required for release of psychotherapy notes.)
- Verbal consultation as needed with ______________________________

PARENT TO READ AND SIGN

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____ ______________

Signature of Patient, Parent or Authorized Personal Representative **Date**

____ ______________

Printed Name of Patient, Parent or Authorized Personal Representative **Relationship** to Patient

This authorization reflects the requirements of HIPAA, 45 C.F.R.J 164.508.

-OPTIONAL-

Partnership & Volunteer Program
1630 S. Stover
Fort Collins, CO 80525
(970) 490-3208

Volunteer Agreement

Please carefully read each item governing terms and conditions of volunteer service in Poudre School District.

1. As a PSD volunteer, I have accepted the responsibility to be available as indicated on my Volunteer Application (which may be revised from time-to-time as necessary) and if unable to serve as scheduled, I will notify the school office as soon as possible.
2. I understand and agree that as a PSD volunteer, I will be subject to the direction and control of the Site Supervisor/Director or Principal of the school, or their designees.
3. I will wear my identification badge at all times when I am providing volunteer services for PSD schools.
4. For every child I interact with or observe as a volunteer, I understand that I am obligated to report any known or suspected child abuse to the Teacher, Counselor, Site Supervisor/Director, or Principal.
5. I WILL NOT transport children, staff or school guests in my own vehicle unless I have completed and submitted a Volunteer Field Trip Driver Application Form which is approved by the Site Administrator.
6. I understand and agree that I am not authorized to drive PSD vehicles.
7. I WILL NOT contact parents, guardians or emergency contact persons unless directed to do so by the Site Supervisor/Director or Principal or their designees.
8. I will conduct myself in a friendly, courteous manner and not show partiality toward any student, and will remain neutral in my speech and actions with respect or religion and politics at all times that I am engaged in volunteer activities with students.
9. I understand that it is my responsibility to inform the Site Supervisor/Director or Principal of any health/medical issues that may impair my ability to or prevent me from properly carrying out the duties and responsibilities of the volunteer service to which I have been assigned.
10. I understand and agree that as a PDS volunteer I am subject to all applicable PSD policies/regulations and to all directives from authorized PSD officials.
11. As a PSD volunteer, I understand I am covered by PSD liability insurance as long as I comply with applicable PSD policies/regulations and directives from authorized PSD officials, if I immediately notify the Site Supervisor/Director or Principal of any occurrence that may result in a claim.

Volunteer Confidentiality Agreement

1. As a volunteer in Poudre School District, I understand that I have been authorized by the Site Supervisor/Director or Principal to act as a "school official" subject to the directions and control of the school's administrators and teachers. As a school official, I may under limited circumstances, have access to student education records and other information in connection with my authorized duties. Student education records may include all records, files, documents and other materials that contain personally identifiable information on any student, as well as the personally identifiable information itself (including but not limited to student grades and test scores).
2. I will not discuss with others, while serving as a volunteer or when no longer in a volunteer role, the content of any specific student education records nor will I disclose student education records, personally identifiable student information in such records, or other information regarding any student that may reasonably be considered confidential.
3. While in the possession and control of student education records, and while handling, distributing, organizing mailing, or filing student education records, I understand and agree that I must protect those records from being viewed or obtained by non-authorized individuals.
4. I understand and agree that questions about the contenct of student education records must be directed to a PSD employee who is authorized to review the records and provide information regarding their content. As a volunteer, I understand and agree that I should state that I am not authorized to provide information regarding student records.
5. I will never take any student education records off campus unless authorized in writing by the Site Supervisor/Director or Principal, or his/her designee.
6. I must report any breach or suspected breach in the confidentiality of student education records immediately upon my discovery therof to the Site Supervisor/Director or Principal, or his/her designee. I understand and agree that my failure to maintain the confidentiality of student education records and personally identifiable information to which I am given access may disqualify me from further services as a volunteer in Poudre School District.

I have read the above Volunteer Agreement and Volunteer Confidentiality Agreement, have been given the opportunity to ask questons to ensure that I understand them, and agree to abide by their terms.

Volunteer Name (please print)____ **Date**________________________

Signature____

-OPTIONAL-

OFFICE USE ONLY
☐ Parent Refusal
☐ Parent will complete at home
☐ Already in the system

Child's Name____________________

PARTNERSHIP CENTER, 1630 SOUTH STOVER, FORT COLLINS, CO 80525
(970) 490-3208 - WWW.PSDSCHOOLS.ORG

VOLUNTEER APPLICATION
Please Print Clearly

Date: ________________

Applicant's Name (Last, First): ____

Email: ______________________________ Home Phone: ______________ Work Phone: ___________

Address: _______________________________City, State, Zip: ________________________________

Emergency Contact: ____ Phone:________________

Applicant's Date of Birth (required)**_________________________

As required by Policy KJ, Poudre School District will conduct a background check of all volunteer applicants at its expense. **Your date of birth is required in order to perform the background check.

Volunteer service in the Poudre School District is a privilege that may be granted, denied or revoked at any time in the District's sole discretion.

Type of Volunteer (check only one):

☐ Parent ☐ Grandparent ☐ Business ☐ Senior Citizen ☐ Faith Community

☐ Community Member ☐ PSD Student

Preferred Opportunities for Volunteer Service:

☐ Reading ☐ Tutoring ☐ Library/Media Center ☐ Math

☐ Writing ☐ Data Entry/Analysis ☐ Mentoring ☐ Science

☐ Work from home ☐ Other: ____

Preferred School - PLEASE LIST SCHOOL NAME

☐ Early Childhood _______________________ ☐ Elementary __________________________

☐ Junior High __________________________ ☐ Senior High _________________________

☐ No Preference

I certify that the above information is true to the best of my knowledge. I have read the Volunteer Agreement and the Volunteer Confidentiality Agreement and agree to abide by their terms if my volunteer service is approved.

___________________________________ _______________
Volunteer Signature **Date**

Media Opt-Out Form

This form is for parents who wish to designate that their child SHOULD NOT be in photos/video or articles published by PSD and/or its schools.

If this form is not completed and returned to the school by September 1 each year, PSD will assume that parent(s)/guardian(s) have given permission to publish their student's photo, video and/or name as specified below.

Please note: This form does not apply to students participating in public events, like academic competitions, performances and athletic events. Student photos and names from these events may be published by news media.

Photos, Articles and Videos Featuring Students
Published in Print and Electronic Media

Poudre School District staff often photograph, film and interview PSD students at events and school activities for promotional and publicity purposes.

This information is typically posted on the PSD website and featured on PSD social media channels including Facebook, Twitter, YouTube, Instagram and Snapchat.

Confidential student information is not shared, but information and photos may be published on websites, in social media and publications as follows:

- As a general rule, students are not identified in photos used on District website pages.
- Students' first and last names may be included in news items on the District website when it relates to participation in curricular and school activities.
- School websites may identify students in photos and/or news items (it is a site-based decision).
- Articles about individual students may include a photo identifying the student.

Special Considerations

- This form does not cover publication of student photos or names in the news media.
- This form does not apply to yearbooks, student newspapers or other student publications.

If you DO NOT want your child to be interviewed, photographed or filmed, complete and sign the form and return it to your child's school.

☐ Do not include my child in any articles, photographs, or videos published on the PSD/school websites or in district/school publications.

Student Name____ **School** ____

Grade_______________ **Student ID#**____

____ _______________________

Parent or Guardian Signature **Date**

Please complete these last three pages only if you have concerns.

Pregnancy & Birth

Birth weight: ______lbs. _____oz.	Child Born at:	❑ 40+ weeks ❑ Preterm at ________weeks due to __________________

7. Please share any difficulties during pregnancy, labor, or delivery:
8. Did your baby experience any difficulties after delivery (ie: seizures, trouble breathing):
9. Any medications used during pregnancy: ❑ Yes ❑ No - List medications and reason:
10. Describe how your child was as a baby:

Health & Developmental History

Toileting	
❑ Training started	❑ Diapered during the day
❑ Needs help toileting	❑ Toilet trained
Soiling or wetting concerns:	

Sleeping Habits
Do you feel like your child gets enough sleep? ☐ Yes ☐ No
Is your child easily soothed? ☐ Yes ☐ No Concerns:

Family Considerations

Have there been any changes in the child's life such as a new sibling, divorce, marriage or death in the family?

Please describe the child's reaction, if any. ____

____

____

Current Child Development

Does your child have an: ❑ IEP ❑ IFSP ❑ Private Therapy: ______________________________

If so, please provide us a copy or request to sign a Release of Information form so we can access a copy.

Do you have concerns about your child in any of the following areas?

❑ Yes	❑ No	MOTOR SKILLS (walking, drawing)	❑ Yes	❑ No	ADAPTIVE SKILLS (feeding and dressing self)
❑ Yes	❑ No	SOCIAL – EMOTIONAL (behavior, social skills)	❑ Yes	❑ No	EARLY LEARNING (engaging in play, early concepts)
❑ Yes	❑ No	COMMUNICATION (speech intelligibility, language comprehension)			

-- Developmental Inventory --

Thinking about the skills your child demonstrates consistently, does he or she:

Motor Skills

Does your child:	Yes	Not yet	N/A
Use crayons and/or markers to scribble, draw, or “write”			
Use scissors to snip the edge of a piece of paper			
Use one hand for most activities			
Run, walk, and jump			
Throw and kick a ball; try to catch a ball with both hands			

Social-Emotional

Does your child:	Yes	Not yet	N/A
Show an awareness of feeling, his/her own and those of others			
Want independence, but stills needs security of parents			
Enjoys playing with other children similar in age			
Verbally express what he/she wants or needs			
Show empathy toward familiar adults and friends			

Communication

Does your child:	Yes	Not yet	N/A
Listen and remember details of simple stories			
Understand simple 1-2 step directions			
Put 3-5 words together to speak in short sentences (“want more milk”)			
Ask lots of questions			
Speak clearly so that most family members and friends understand him/her			

Adaptive Skills

Does your child:	Yes	Not yet	N/A
Feed himself/herself using a fork and/or spoon			
Wash and dry his/her own hands			
Help with dressing and undressing			
Drink from a cup			
Open doors and cupboards			

Early Learning

Does your child:	Yes	Not yet	N/A
Enjoy looking at books with an adult or independently			
Play with toys in expected way (drive and crash cars, take care of a doll)			
Name and match colors			
Sing along with familiar songs			
Ask for help with difficult activities			

Your specific concerns:

When did you first notice concerns in this area?

Have you pursued private services through your child’s doctor?

Previous or Current Home-Based or Childcare/Preschool Provider

Name of Childcare or Preschool:	Month/Year Attending:
Street Address:	
City/State/ZIP:	Phone Number: ( )
Days/Hours:	❑ I agree to allow PSD to contact for further information
Your Child:	

Describe your child's personality:				
Share your child's favorite activities?				
Does your child have the opportunity to play with other children?	❑ Yes	❑ No	Explain (@ the park, with her cousins, etc.):	
My child attends to an engaging play activity (non-screen related) for:	❑ < 5 mins	❑ 5-10 mins	❑ 10-30 mins	❑ 30+ mins

How much time a day does your child spend watching/using screens? ______ hours ______ minutes
Does this concern you? ❑ Yes ❑ No

Behavior

N/A	Yes	No	
			Do you have behavior concerns at home?
			Does your childcare provider have behavior concerns at childcare?
			Has anyone else (family or friend) expressed concerns about your child's behavior?
			Has your child ever been asked to leave a childcare setting due to behavior?

Anything else you would like us to know about your child?

What do you hope your child will learn from the PSD Early Childhood Education Program?