

KIT CARSON SCHOOL DISTRICT R-1

**PARENTAL CONSENT FORM FOR MEDICAL INFORMATION AND TREATMENT**

I, \_\_\_\_\_, parent or legal guardian of \_\_\_\_\_ give my consent for medical and surgical treatment of this minor in a licensed hospital by a Colorado licensed physician should his/her condition so require in my absence. I understand that in such a case, reasonable attempts will be made to contact me, time and conditions permitting.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or condition involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, state **NONE**):

\_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_ Social Security Number \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Work) (719) \_\_\_\_\_ (Home) (719) \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Student's Date of Birth: \_\_\_\_\_

Contact Lenses? \_\_\_\_\_ yes \_\_\_\_\_ no

Known Chronic Illness or Condition:  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: (719) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Insured Member's Name: \_\_\_\_\_ Group Number \_\_\_\_\_

School Insurance Name & Policy Number: \_\_\_\_\_

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

# Enrollment Form for Kit Carson Elementary

## Student Personal Information

Student Name:	Middle:	Last:	Preferred:
Address:		City, State, Zip:	
Social Security #:	Birth Date:	Age:	
Phone:	Birthplace:	Grade Level:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pac Islander <input type="checkbox"/> American Indian/AK Native <input type="checkbox"/> Black <input type="checkbox"/> Hispanic	

## Family Information

Name:	Custodial Parent/Guardian	Custodial Parent/Guardian Spouse
Employer:		
Emp. Address:		
Work Phone:		
Cell Phone:		
Email:		
Home Address the Same? <input type="checkbox"/> Yes <input type="checkbox"/> No		(If No, enter on line below) Family Situation:

## Non-Custodial Parent Address:

(If Family Situation is other than Original, enter the additional parent information below.)

Name:	Non-Custodial Parent	Non-Custodial Parent Spouse
Home Address:		Home Phone:
Employer:		
Emp. Address:		
Work Phone:		Receive Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Emergency Contact Information

(Use this area to enter an additional contact in case of emergency.)

Emergency Contact Name:	Relationship to Student:
Emergency Contact Address:	Emergency Contact Home Phone:
Emergency Contact Work Phone:	Family Physician: Physician Phone:
Hospital Preference:	Emergency Treatment Form on File <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Notes:	

## Miscellaneous Information

Resident Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home District:	Home Area:
Elementary School Attended:	Mid Level School Attended:	
Distance in Miles One Way from Home to School:	Bus Transportation Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pick Up Point:		
Directions to Home from School:		
Restrict Name from publications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(For Office Use Only) Home Area Code:	Elementary Code:	Mid Level Code:

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW**

**IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.**

**MEDICAL EXEMPTION:** The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

*Medical exemption to the following vaccine(s):*

Signed \_\_\_\_\_

(Physician)

Date \_\_\_\_\_

**RELIGIOUS EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

*Religious exemption to the following vaccine(s):*

Signed \_\_\_\_\_

(Parent, guardian, emancipated student/consenting minor)

Date \_\_\_\_\_

**PERSONAL EXEMPTION:** Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

*Personal exemption to the following vaccine(s):*

Signed \_\_\_\_\_

(Parent, guardian, emancipated student/consenting minor)

Date \_\_\_\_\_

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Revised July 2003

# Enrollment Form for Kit Carson High School

## Student Personal Information

Student Name:	Middle:	Last:	Preferred:
Address:		City, State, Zip:	
Social Security #:	Birth Date:	Age:	
Phone:	Birthplace:	Grade Level:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pac Islander <input type="checkbox"/> American Indian/AK Native <input type="checkbox"/> Black <input type="checkbox"/> Hispanic			

## Family Information

Name:	Custodial Parent/Guardian	Custodial Parent/Guardian Spouse
Employer:		
Emp. Address:		
Work Phone:		
Cell Phone:		
Email:		
Home Address the Same? <input type="checkbox"/> Yes <input type="checkbox"/> No		(If No, enter on line below)      Family Situation:

## Non-Custodial Parent Address:

(If Family Situation is other than Original, enter the additional parent information below.)

Name:	Non-Custodial Parent	Non-Custodial Parent Spouse
Home Address:		Home Phone:
Employer:		
Emp. Address:		
Work Phone:		Receive Mailings? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Emergency Contact Information

(Use this area to enter an additional contact in case of emergency.)

Emergency Contact Name:	Relationship to Student:
Emergency Contact Address:	Emergency Contact Home Phone:
Emergency Contact Work Phone:	Family Physician:      Physician Phone:
Hospital Preference:	Emergency Treatment Form on File <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Notes:	

## Miscellaneous Information

Resident Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home District:	Home Area:
Elementary School Attended:	Mid Level School Attended:	
Distance in Miles One Way from Home to School:	Bus Transportation Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pick Up Point:		
Directions to Home from School:		
Restrict Name from publications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(For Office Use Only) Home Area Code:	Elementary Code:	Mid Level Code:

# Kit Carson School District R-1

P.O. Box 185, 102 W 5<sup>th</sup> Ave  
Kit Carson, Colorado 80825  
Phone (719)962-3219 Fax (719) 962-3317

## REQUEST FOR STUDENT RECORDS

STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

I hereby request that the following information concerning my child be released to the  
Kit Carson School District R-1:

- \_\_\_\_\_ Cumulative Records
- \_\_\_\_\_ Transcript of Grades
- \_\_\_\_\_ Health Records, include Immunization Records
- \_\_\_\_\_ Standardized Test Scores
- \_\_\_\_\_ Aptitude and Interest Inventories
- \_\_\_\_\_ Psychological Test Results
- \_\_\_\_\_ Special Education Records / IEP's / 504 Records
- \_\_\_\_\_ Athletic Eligibility
- \_\_\_\_\_ Withdrawal grades
- \_\_\_\_\_ Other : \_\_\_\_\_
- \_\_\_\_\_

Signature: \_\_\_\_\_  
Parent, Legal Guardian, or Eligible Student

*Robert Lee Framel*

\_\_\_\_\_ Date: \_\_\_\_\_  
Mr. Robert Framel, Superintendent