FALCONS

PLEASANT VIEW CHARTER SCHOOL
15238 COUNTY ROAD CC
PLEASANT VIEW COLORADO
NEW STUDENT APPLICATION

Welcome to Pleasant View Charter School. We are excited for you and your student to be part of our Adventure as a Charter School. Please return the following forms:

- New Student Application
- Student Health History
- Free and Reduced Lunch Application
- Emergency Medical Authorization Form
- All Year Field Trip Permission Slip
- Handbook Acknowledgement
- PVCS Publicity and Photo Release Form

The school will also need copies of the following (we can make copies for you)

- Student's Birth Certificate
- Current Immunization Records

Other Health forms that are applicable to your student:

- Permission for Medication Administration at School
- Medication Self-Carry Contract
- Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

PLEASANT VIEW CHARTER SCHOOL
15238 COUNTY ROAD CC
PLEASANT VIEW COLORADO
NEW STUDENT APPLICATION

Date_____

Student Information

Last Name_____ Age_____ Grade_____

First Name_____ Birthdate_____

Middle Name_____ Gender Female_____ Male_____

Parent Guardian Information

Father/Guardian_____ Mother/Guardian_____

Mailing Address_____ Mailing Address_____

Cell Phone_____ Cell Phone_____

Home Phone_____ Hone Phone_____

Work Phone_____ Work Phone_____

Email_____ Email_____

Emergency Contact Information

The individuals listed below have authorization to pick up my child and can be reached during school hours at the numbers listed below.

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Student Lives With Father_____ Mother_____ Both_____ Other_____

If the student does not live with Parents, please fill out the following information on the people with whom the student lives:

Name_____ Relationship_____

Address_____

Cell Phone_____ Home_____ Work_____

COOPERATION - RESPONSIBILITY

Community - Compassion - Character -

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Educational History

Last School Attended _____ Year _____

Last Grade Enrolled _____ School Phone _____

School Addrress _____

Has student ever been in Special Education? Yes_____ No_____

Is Student on a 504 Plan? Yes_____ No_____

Please sign below to indicate you have read the student application packet and agree to its content.

_____ _____

Parent/Guardian Date

The Pleasant View Charter School Board is committed to a policy of nondiscrimination in relation to race, gender, religion, national background, age, marital status, and handicaps. Respect and dignity of each individual shall be paramount in the establishment of all policies of the PVCS Board, Administration and Staff.

PLEASANT VIEW CHARTER SCHOOL
15238 COUNTY ROAD CC
PLEASANT VIEW, COLORADO

HEALTH HISTORY FORM

Dear Parents

We would like your child to gain the most from his/her school experience. To assist in accomplishing this, it is necessary for us to have a current health history. Please complete this form and sign at the bottom. Every student attending school will need to have this form completed each school year.

Student Name: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Phone number: _____

Medical History Family Physician: _____

Phone Number: _____

Medication Allergies: _____
Food Allergies: _____
Environmental Allergies : _____
Animals, Insects, etc: _____
Does your child require use of an Epi Pen? Yes _____ No _____
Explain if yes: _____
Mark what applies to your child: Asthma___ ADD/ADH___ Diabetes ___Epilepsy/Seizures ___ Dental Problems___ Ear Infections___ Vision Concerns/Glasses or Contacts___ Hearing Concerns/ hearing aids___ Explain if other:

_____

_____

List all prescription, over-the-counter (OTC), or herbal supplements that your child takes. This should include name, dosage, frequency and reason:

_____

_____

Explain if any medication is to be given at school: _____

_____

Does your child have any restrictions with activity: _____

_____

FALCONS

Please explain anything else about your child's health that you think is important that the school staff should be aware of. Use an additional page if necessary. _____

_____

According to the C.R.S. 22-1-116, the sight and hearing of all children in the kindergarten, first, second, third, and fifth grades will be tested.

Please indicate: YES_____, Please screen my child. NO_____, Please do not screen my child.

Parent signature: _____ Date: _____

All medications (prescription and over the counter) administered by staff at school on field trips and at sponsored school events must have a medication authorization form (if no care plan is present) signed by physician with prescribing authority and signed by parent or guardian. Please plan ahead with field trips and school sponsored events and have this documentation in place.

I attest that the information above regarding my child is true and accurate to the best of my knowledge. I authorize this health information to be shared with school staff members who may need it for the benefit of my child at any time during the school year. I hereby authorize the school nurse to discuss my child's health concerns and/or exchange relevant information with the health care providers listed on this form.

I authorize my students' school to share my child's immunization records with the Colorado Immunization Information System (CIIS), the state's secure, confidential immunization registry, as a way to track and update my child's immunization records.

Parent/Guardian Signature: _____ Date: _____

School Nurse Review Signature: _____ Date: _____

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PLEASANT VIEW CHARTER SCHOOL
15238 COUNTY ROAD CC
PLEASANT VIEW COLORADO

ALL YEAR PERMISSION SLIP

During the school year we will be taking field and activity trips. These activities may be walking trips, or a bus trip within the area or nearby community. We are asking you to sign (1) permission slip for all the field trips. Please list all the students' names on the slip. (For Bus Activity trips there will be a permission slip go home for each activity also. This will be used mostly for walking field trips to the Firehouse across the street and to Rustic Ranch down on the corner from the school.)

If you have more than one student, you need only sign one permission slip for all the field trips. Please list all the students' name on the slip.

The following student(s) have my permission to accompany his/her teacher or other supervisory personnel on field/activity trips authorized by Pleasant View Charter School. I hereby waive and release all claims against PVCS and any teacher, employee, or any other person engaged in field/activity trips during the school year. I agree to hold them harmless from all liability, relating to my child for any personal injury or illness that may be suffered or any loss of property that may occur.

Family Name: _____

I give permission for my child/children

_____ Grade_____

_____ Grade_____

_____ Grade_____

_____ Grade_____

In case of emergency, I give permission for my child to receive medical treatment. In case of such an emergency, Please contact:

Name_____ Phone_____

Parent Signature_____ Date_____

COOPERATION - RESPONSIBILITY

Community - Compassion - Character -

Pleasant View Charter School
Publicity and Photo Release Form

Pleasant View Charter School is making a concentrated effort to promote the positive activities, honors and work of our staff and students. These will include bulletin boards at the school as well as features in our own publications. These publications may appear on the School District website as well as in other forums. During the school year, there will be opportunities for various students to be photographed and identified by name and classroom or school. If you would prefer that your child's name and/or image are not used for these purposes, you may "opt out." It is important to note, however, that your child's image or likeness may appear in occasional candid photos without any type of name identification, and the use of these candid photos of your child is permissible.

_____I give permission for my child to be photographed for the above purposes.

_____I request that you do not photograph my child.

Parent/Guardian Signature:

_____

Date: _____

This form will be kept on file at your child's school. If a situation arises that may change your child's status regarding publicity, please notify our school in writing as soon as possible. New photo release forms will not be required each school year.
Pleasant View Charter School, 15238 County Road CC, Pleasant View, CO 81331
(970) 562-4286

PLEASANT VIEW CHARTER SCHOOL

Permission for Medication Administration at School and Child Care

The parent/guardian of _____ ask that school/child care staff give the
Child's Name

following medication _____ at _____
Name of Medicine & Dosage *Time(s)*

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, route, date medicine is to be stopped, and licensed Health Care Provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed Health Care Provider authorization, and medicine must be packaged in original container.

The school/child care agrees to administer medication prescribed by a licensed Health Care Provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff. All medication(s) left at the school will be discarded according to the most current state regulatory recommendations for safe medication disposal.

By signing this document, I give permission for my child's Health Care Provider to share information about the administration of this medication with the school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Alternate Phone

****

Health Care Provider Authorization

Child's Name:		Birthdate:
Medication:	Dosage:	Route:
To be given at the following times:	Start Date:	End Date:
Special Instructions:		
Purpose of Medication:		
Side Effects to be reported		

_____ _____
Signature of Health Care Provider with Prescriptive Authority Date

_____ _____/_____
Print Name of Health Care Provider Phone & Fax Number

_____ _____
Signature of Child Care Health Consultant or School Nurse Date

PLEASANT VIEW CHARTER SCHOOL

Allergy Self Carry Contract **Grade:** _____

STUDENT :_____ **DOB:**_____

☐ I plan to keep my Epi-pen with me at school rather than in the school health office.

☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office immediately if my Epi-pen has been used.

☐ I will not allow any other person to use my Epi-pen.

Student's Signature _____Date _____

PARENT/GUARDIAN:_____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.

☐ It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.

☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the health care plan.

☐ I will provide the school a signed medication authorization for this medication.

Guardian's Signature _____Date _____

Nurse Consultant _____ **School**_____

☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

☐ I will review the medication authorization provided by the parent and signed by the parent and health care provider.

Nurse Consultant's Signature _____Date _____

School Administrator's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

Health Assistant Signature: _____ Date: _____

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS*

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

I approve this care plan and give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), and to comply with board policies, if applicable. I am aware ***911 may be called if a quick relief inhaler is not at school*** and my child/youth is experiencing symptoms.

_____ _____

Parent/Guardian Signature **Date**

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ **Albuterol** ☐ **Other:** _____

Common side effects: ↑ heart rate, tremor ☐ **Use spacer with inhaler (MDI)**

Controller medication used at home: _____

TRIGGERS: ☐ **Weather** ☐ **Illness** ☐ **Exercise** ☐ **Smoke** ☐ **Dust** ☐ **Pollen** ☐ **Poor Air Quality** ☐ **Other:** _____

☐ **Life threatening allergy specify:** _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely Give **QUICK RELIEF MED** 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray/blue	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs ***Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

_____ _____ _____

Health Care Provider Signature **Print Provider Name** **Date**

Good for 12 months unless specified otherwise in district policy.

_____ _____ _____

Fax **Phone** **Email**

_____ _____

School Nurse/CCHC Signature **Date**

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

Revised: February 2021

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

_____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan
☐ NO

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following

LUNG:	Short of breath, wheeze, repetitive cough
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Swelling of the tongue and/or lips
HEART:	Pale, blue, faint, weak pulse, dizzy
SKIN	Many hives over body, widespread redness
GUT:	Vomiting or diarrhea (if severe or combined with other symptoms
OTHER	Feeling something bad is about to happen, Confusion, agitation

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:

NOSE:	Itchy, runny nose, sneezing
SKIN:	A few hives, mild itch
GUT:	Mild nausea/discomfort

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permiss on for school personnel to share this information, follow this plan, administer med cation and care for my child and, if necessary, contact our healt h care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compl ance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

To be completed by healthcare provider

Student Name: _____ DOB: _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

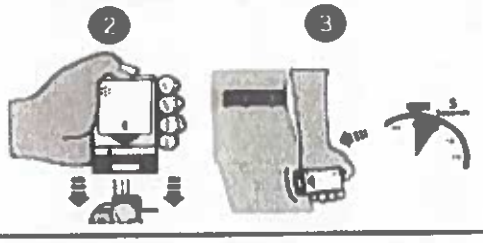
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.

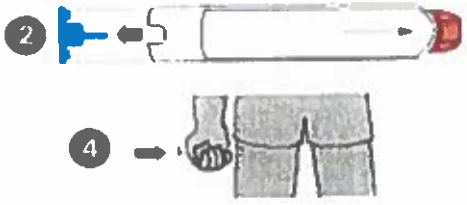


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information: _____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics. 2017

Seizure Emergency Care Plan and Medication Orders for School and Childcare Settings

PARENT/GUARDIAN complete and sign the top portion of form.

Child Name	Birth date:	Place child's photo here
Parent/Guardian Contact:	Phone:	
Emergency Contact:	Phone:	
School:	Grade:	

Triggers: ☐ tiredness ☐ flashing lights ☐ illness ☐ hunger ☐ temperature ☐ Other: _____

Seizure Aura (if any) _____

Seizure history: ☐ Convulsive ☐ Focal ☐ Absence Date of last known seizure _____

Describe _____

Antiseizure Medication Taken at Home	Common side effects

Other Seizure Treatments/Special Diet Therapy:

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and devices. I approve this Seizure Emergency Care Plan for my child.

PARENT SIGNATURE _____ DATE _____ SCHOOL NURSE SIGNATURE _____ DATE _____ ☐ 504 plan ☐ IEP

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

IF YOU SEE THIS:	DO THIS:
☐ **Convulsive Generalized Tonic Clonic**: You will see loss of consciousness. Stiffening of the body. Rhythmic jerking movements. Convulsive seizures may last 1-5 minutes. The child may have a warning (aura) before the seizure. Sleepiness and confusion may occur after the seizure.	1. Time the seizure 2. Keep calm. Provide reassurance. 3. Protect head, keep airway clear, turn on side if possible. 4. Do not place anything in mouth. 5. Call 911 if student is injured or has difficulty breathing. 6. Call parent. 7. Stay with student until recovered from seizure. 8. **Administer rescue treatments as marked below.**
☐ **Focal**: These seizures may begin with an aura. They may be partly alert or unconscious. You may see lip smacking, chewing, eye blinking, or picking at clothes. These seizures usually last 1-2 minutes.	1. Time the seizure 2. Gently guide child away from danger. 3. Stay with student and reassure them until recovered from seizure. 4. Do not treat staring that is stopped by a touch or a nudge. 5. Call parent. 6. **Administer rescue treatments as marked below.**
☐ **Absence**: You will see quick changes in alertness. May see eye flutter or small twitching. Usually last less than 10 seconds.	

Rescue Treatments

☐ Child has a VNS. Child/staff may swipe with aura. Staff may swipe at onset of seizure and every 60 seconds until seizure stops
Give rescue medications below if seizure does not stop within _____minutes.

If seizure lasts longer than ___ minutes administer:

☐ Diastat ___mg rectally	☐ Midazolam ___mg in the nose	☐ Clonazepam ___mg in the cheek

☐ Multistep seizure rescue plan – Please see attached letter for details.

If cluster of ___ or more seizures in _____ min administer:

☐ Diastat ___mg rectally	☐ Midazolam ___mg in the nose	☐ Clonazepam ___mg in the cheek

☐ Multistep seizure rescue plan – Please see attached letter for details.

If emergency medication is administered: ☐ **Call 911 immediately or** ☐ **Call 911 if seizure does not stop within 5 minutes**
Other:

If no emergency medication is at school and the child is experiencing seizures:
Call family to bring medications to school or pick up child. Call EMS if seizure lasts more than ___ min

Accommodations: Always take seizure action plan and emergency medication for school activities, sports and field trips. Close adult supervision when swimming or climbing.

HEALTH CARE PROVIDER SIGNATURE _____ PRINT PROVIDER'S NAME _____ PHONE/FAX _____ DATE _____

PVCS Handbook Acknowledgement Form

I have read and discussed the PVCS Student Handbook with my child/children. Your signature does not necessarily reflect agreement, just that you have read and discussed the handbook with your child.

Parent/Guardian Signature_____

Date_____