



Returning Student Checklist

PLEASE RETURN THE FOLLOWING TO SCHOOL BY 9/13/18

Family Name: _____

1st Child First & Last Name: _____ **Grade:** _____

2nd Child First & Last Name: _____ **Grade:** _____

3rd Child First & Last Name: _____ **Grade:** _____

_____ I have completed my annual "Info update" online (must complete EACH year - mandatory)

<https://infoupdate.eagleschools.net> – please refer to the two emails you should have received from the district office (search for emails from Lorri McGarvey on 7/23 & 8/3) with individual user names & passwords

_____ Permission to Release of Driver Records Form (must complete EACH school year if you wish to be a driver)

_____ Driving & Insurance Information Form (must complete EACH school year if you wish to be a driver)

_____ Copy of Auto Insurance ID card (must provide EACH school year if you wish to be a driver)

_____ Request for Administration Medication Form (to be completed by physician, if applicable)

_____ Volunteer Commitment & Background Check/ Fingerprint Form –See the office if you need to complete this paperwork (one per parent if you wish to volunteer. ONE TIME ONLY – do not complete if you have done this in the past)

*1105 Miller Ranch Road, Edwards CO 81632
(970) 926-0656*



DR 2559 (02/10/17)
COLORADO DEPARTMENT OF REVENUE
Division Of Motor Vehicles
Driver Control Section, Room 164
PO Box 173345
Denver, CO 80217-3345
www.colorado.gov/revenue

Permission to Release Driver Records to Self or Another Person

Driver's License offices provide only personal driving record information.
Records and/or other requests are available only at 1881 Pierce St., Lakewood, CO
Pursuant to §42-1-206(1)(b)(II) (7)(a) and (7)(b)(XIII), C.R.S.

I (Please Print Last Name)		First Name	
hereby authorize the release of personal information contained in records maintained by the Colorado Department of Revenue, Division of Motor Vehicles, to:			
Last Name Sassi		First Name Jennifer	☐ Check if to self
Pursuant to the Driver's Privacy Protection Act (18 USC 2721) and Colorado law (§24-72-204, §42-1-206 (1)(b)(II)).			
Driver			
Driver's Date of Birth		Driver's License Number	
Signature			Date
Signature of Parent or Guardian if Driver is a Minor			Date
Person Receiving Record			
Release Records to: Last Name Sassi		First Name Jennifer	
Driver's License Number N/A		State CO	
Company (if applicable) Eagle County Charter Academy			
Mailing Address 1105 Miller Ranch Road			
City Edwards		State CO	Zip Code 81632
If your check is returned for insufficient funds or a closed account, you may not be issued or renew any type of driver's license or identification card until the original check is redeemed and an administrative and short check fee are paid.			
Under penalty of perjury, I attest that I shall not obtain, resell, transfer, or use the information in any manner prohibited by law. I understand that motor vehicle or driver records that are obtained, resold, or transferred for purposes prohibited by law may subject me to civil penalties under federal and state law. All of the information provided is true and accurate to the best of my knowledge.			
Signature of Requestor Jennifer Sassi			Date 8/30/18

EAGLE COUNTY SCHOOL DISTRICT RE-SOJ
DRIVER AND INSURANCE INFORMATION FORM

The Eagle county school District RESOJ (District) DOES NOT PROVIDE primary insurance coverage for any school sponsored trips in privately owned vehicles. Risk of loss for bodily injury/property - damage will be the personal responsibility of the owner/driver of the private vehicle.

The driver of the private vehicle must be at least 21 years of age; must possess a valid Colorado Drivers License; and must have a driving history which is acceptable to the principal.

The owner must carry Comprehensive Automobile Insurance with limits of not less than \$100,000/\$300,000 for bodily injury, \$50,000 property damage, Colorado No-Fault and Uninsured Motorists.

TO BE COMPLETED BY CAR OWNER(s)/OPERATOR(s)

Automobile 1

Make, Model, Year of Car _____

Maximum Number of Passengers _____

Name of Insurance Company _____

Agents Name _____

Address _____

Limits of Coverage _____
(Bodily injury) (Property damage)

Automobile 2

Make, Model, Year of Car _____

Maximum Number of Passengers _____

Name of Insurance Company _____

Agents Name _____

Address _____

Limits of Coverage _____
(Bodily injury) (Property damage)

C. PLEASE ATTACH A CURRENT CERTIFICATE OF INSURANCE ISSUED BY THE INSURANCE COMPANY OR ITS AGENT.

3. Valid Colorado Drivers License: _____

Expiration date: _____

Valid Colorado Drivers License: _____

Expiration date: _____

RELEASE

I, understand that the District carries no insurance on privately owned vehicles or their operators. I hereby release the District, its directors, officers, employees and agents, from any and all liability, claims, demands or actions whatsoever arising out of any damage, loss of injury that might occur while transporting students in my private vehicle, whether or not such damage, loss or injury results from negligent operation or maintenance of a vehicle. I understand that if I do not sign this release, then I will not be permitted to transport students in my private vehicle.

Date: _____

Date: _____

Signature of Owner/ Operator of Private Vehicle (Guardian 1)

Signature of Owner/Operator of Private Vehicle (Guardian 2)

Printed Name

Printed Name

Address/ Telephone Number

Address/ Telephone Number

Student Registered Last Name: _____ Grade(s) _____



Request for Medication Administration at ECC A Fax No. 970 · 926 · 0786

Required by Colorado law for All Prescription or Over-the-Counter Medications

The parent/guardian of (student's name) _____ request that the school nurse or medication trained staff give the medication listed below according to the Health Care Provider's signed instructions below.

Per the Colorado Nurse Practice Act, the parent/guardian must:

1. Furnish medicine to the Health Office. Then, pick up expired or unused medication within one week or medication will be disposed. General medications are sent home the last week of school unless it is a controlled substance or an Epi-pen.

2. Prescription and/or Over the counter medication must come with a doctor's order, parent permission, plus be in the original, non-expired, container. Pharmacy-labeled container must have the name of the student, the medicine, time to be given, dosage amount, the date medicine is to be stopped, and the licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

3. Sharing of information: By signing this, I give permission for the school health staff to communicate with the health care provider(s), pharmacy, or other appropriate person/clinic re: this student's medical condition or medication (by phone, fax, email, or scan) on issues re: dosing, student's refusal to take meds, side effects, reports of suicidal thoughts, etc. It is understood that the medication is administered solely at the request of & as an accommodation to the undersigned parent or guardian. Note: A Health Care Plan may be required to be on file.

4. Release of liability: In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by PCS & it's district, the undersigned parent or guardian hereby agrees to release PCS, its district, 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 my permission for above student to take the prescription medication as ordered.

Parent/Legal Guardian's Printed Name

Grade: _____ Teacher: _____ Ext: _____ RM: _____

Parent/Legal Guardian's Signature

Home & Cell Phone: _____

Email: _____

Work Phone: _____

Health Care Provider Authorization to Administer Medication at School (to be filled out by prescribing provider)

Student: _____ Birth date: _____

Medication (one per form): _____ Dose: _____ Route: _____

To be given at the following time(s): _____ Allergies: Insects Food Unknown Other?: _____

Condition/Purpose of medication: _____ Special Instructions: _____

Reportable Side effects: _____ Other: _____

May Student self-carry? Yes No May Student 'self-administer'? Yes No

Starting Date: _____ Ending Date: _____ or ☐ until end of school year

Other medications student is on: _____

Print HCP Name: _____ License Number: _____ Office Phone: _____

Signature of HCP w/ Prescriptive Authority _____ Office FAX: _____

****Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!**