Welcome to Prairie Crossing Elementary

Please complete and return the following attached items:

1. Douglas County Registration Form (4 pages)
2. Student Release of Records
3. Douglas County Health Information (3 pages)
4. Douglas County Student Residency Questionnaire (1 page)
5. Douglas County Migrant Education Program (1 page)

In addition to the Registration Forms, copies of the following documents are needed to complete registration:

- Copy of Birth Certificate
- Copy of Current Immunizations
- Copy of Proof of Residence (Warranty Deed, Deed of Trust, Lease Agreement or Purchase Agreement)

Please contact Lori Strelow (Registrar) for assistance or with any questions. Email: lstrelow@dcsdk12.org Phone: (303)387-8200
Legal Name from Birth Certificate

Last Name
First Name
Middle (full)
Date of Birth

Gender
M ☐ F ☐

Residence Address

City
State
Zip
Email

Do you need an interpreter for school meetings and events? This includes family events, parent-teacher conferences, formal plan meetings (IEP, 504, ALP, READ, ELLP), registration and enrollment, etc.

Y ☐ N ☐

Notice to Parents and Students - Parents and students should be aware that if they choose not to answer the two-part question, school districts are required to identify an ethnicity and race on behalf of the student, based on several factors, including observation, in accordance with U.S. Department of Education and Colorado Department of Education Guidelines.

Part A. Is this student Hispanic / Latino? (choose only one)

☐ No. NOT Hispanic
☐ Yes. Hispanic/Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

The above part of the question is about ethnicity, not race. No matter what you selected in Part A above, please provide an answer to Part B by marking one or more boxes below to indicate what you consider your child’s race to be.

Part B. Which of the following groups describe the student’s race? (choose one or more)

☐ American Indian or Alaskan Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ Black or African American - A person having origins in any of the black racial groups of Africa.

☐ Asian - A person having origins of any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ White - A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

Has the student attended another Douglas County School District school?

Y ☐ N ☐

If Yes, School ________________ Grade ______

Last school attended outside the Douglas County School District:

School ________________ City ________________

State ______ Grade ______

Is your child presently under an expulsion order from any other school district?

Y ☐ N ☐

Is your child presently under consideration for expulsion?

Y ☐ N ☐

Is your child presently involved in the Juvenile Justice system?

Y ☐ N ☐

What is/was the student's first language?

If yes, specify the language(s).

What language(s) is/are spoken in your home?

Is your child currently on an Individual Educational Plan for Special Services?

Y ☐ N ☐

Has your child received any previous testing, evaluations or services in any of the following areas?

☐ Learning Disabilities ☐ Counseling ☐ Gifted & Talented
☐ Speech/Language ☐ Psychological ☐ READ Plan
☐ Physical Therapy ☐ Behavioral Difficulties ☐ Remedial Reading (Title 1)
☐ Occupational Therapy ☐ Hearing/Visual Impaired ☐ 504 Services
☐ Other

2021DCSD Reg Form 101019
**Please Print**

**2020-2021**

**Household Info**

**Residence Address** __________________________________________________________

City ____________________________ State _____ Zip ______

**Household Telephone** ____________________________ Unlisted? Y ☐ N ☐

**Name** ________________________ Relationship to Student ______________________

**Residence Address** __________________________________________________________

City ____________________________ State _____ Zip ______

**Mailing Address** (if different from above) ________________________________________

City ____________________________ State _____ Zip ______

**Phones:** Home __________ Work __________ Cell __________

Pager ______________ Email ____________________________________________________

Receive Mailings Y ☐ N ☐

Does Student reside with? Parent Y ☐ N ☐ Legal Guardian Y ☐ N ☐ **Step-Parent** Y ☐ N ☐

(Court Document)

**Parent/Guardian Info**

**Name** ________________________ Relationship to Student ______________________

**Residence Address** __________________________________________________________

City ____________________________ State _____ Zip ______

**Mailing Address** (if different from above) ________________________________________

City ____________________________ State _____ Zip ______

**Phones:** Home __________ Work __________ Cell __________

Pager ______________ Email ____________________________________________________

Receive Mailings Y ☐ N ☐

Does Student reside with? Parent Y ☐ N ☐ Legal Guardian Y ☐ N ☐ **Step-Parent** Y ☐ N ☐

(Court Document)

**Note:** When a student does not reside with both parents, additional information must be on file so that the school can determine who is responsible for the student. If there are applicable legal documents, such as custody papers, a copy should be provided to the school.

**Note:** **Step-parents are not considered legal guardians unless they have legal guardianship paperwork which must be provided to the school. A parent/guardian can identify the step-parent as someone that will be attending meetings, calling student in sick, portal access, etc.

**Other Children Under Age 18 in the Home - Names MUST be from Birth Certificate**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name (if)</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Relation to Student</th>
<th>School Attending</th>
<th>County</th>
</tr>
</thead>
</table>

Page 2 of 4

Parent/Guardian Signature ____________________________ Date __________
Emergency Contacts are not the Parent/Guardian and should be a Colorado Resident

Please provide at least one (1) local emergency contact.

Name __________________________ Relationship to Student __________________________
Additional Information __________________________________________________________
Gender M □  F □

Phones  Home __________ Work ___________ Cell _________

Name __________________________ Relationship to Student __________________________
Additional Information __________________________________________________________
Gender M □  F □

Phones  Home __________ Work ___________ Cell _________

Name __________________________ Relationship to Student __________________________
Additional Information __________________________________________________________
Gender M □  F □

Phones  Home __________ Work ___________ Cell _________

Doctor's (full) Name ______________________________________________________________
Gender M □  F □

Name of Practice / Group _________________________________________________________
Phone __________________________ Extension ______________
Address __________________________
City __________________________ State ___________ Zip Code __________
Is your student taking any medications at home or at school?  □ Y  □ N  List:

If your student needs to take medication at school, the "Provider Medication Authorization Form" or "Permission to Carry" form is available at the school office. These forms must be completed for any medication a student will need to take during school hours. They are also available at www.dcsdk12.org - search "medication form." (Contained in the Nursing Services web page.)

Does your student have any known allergies?
□ Seasonal  Reaction: __________
□ Insect Sting  Reaction: __________
□ Latex  Reaction: __________
□ Food  Reaction: __________
□ Other  Reaction: __________
□ Other  Reaction: __________

Does your student (please check applicable boxes):
□ Wear glasses/contacts?  □ Have heart problems?
□ Have asthma/respiratory ailments?  □ Have convulsions/seizures?
□ Had a head injury/significant bump to the head?  □ Have physical activity limitations?
□ Hearing impaired?  □ Have diabetes?

Please explain any conditions marked above:

Other medical conditions the school needs to be aware of:

Please note: Health information will be shared with school personnel to provide for the health and safety of your student. By signing below, you indicate your agreement with sharing this information.

Parent/Guardian Signature ______________________ Date ____________

I give consent and authorize the Douglas County School District Re. 1 to release to Health Care Policy and Financing (HCPF), information related to Medicaid services delivered to my child, if/when my child is enrolled in the Medicaid program. I understand that the school district is entitled to receive partial reimbursement from Medicaid for services provided to my child, including but not limited to: audiology; counseling; nursing; occupational/physical therapy; orientation and mobility; psychological; social work; speech; and targeted case management.

Parent/Guardian Signature ______________________ Date ____________

The information contained on this Student Registration form is true and correct. In accordance with Colorado Revised Statutes Sections 22-33-104 and 22-33-107, I acknowledge my obligation to ensure that every child between the ages of 6-17 under my care and supervision shall attend school. The only exceptions shall be illness and other absences excused by the Principal.

Notice to Parents and Students - All students new to the district shall be enrolled conditionally until records, including discipline records, from the schools previously attended by the student are received by the district. In the event the student's records indicate a reason to deny admission, the student's conditional enrollment status shall be revoked. State law requires immunization records be submitted at the time of registration.

THIS PAGE MUST BE SIGNED EVERY SCHOOL YEAR.
REQUEST TO OTHER EDUCATIONAL AGENCIES FOR RELEASE OF STUDENT INFORMATION TO THE DOUGLAS COUNTY SCHOOL DISTRICT RE. 1

Please send all designated records to:

**School Name:** Prairie Crossing Elementary
Address: 11605 S. Bradbury Ranch Drive
City, State, Zip Code: Parker, CO. 80134
School Phone #: (303)387-8200
FAX Phone #: (303)387-8201
Counseling Phone #: ______________________
Registrar Phone #: (303)387-8207

Name of Student: __________________________ Date of Birth: _______ Grade: ___

I HEREBY AUTHORIZE:

Name of School: __________________________ Last Date Attended:________
Address: ________________________________ State: __________ Zip Code: ______
City: _________________________________ FAX No.: ____________
Phone No.: ____________________________

TO RELEASE THE FOLLOWING RECORDS TO THE DOUGLAS COUNTY SCHOOL DISTRICT:

☐ Official Administrative Record (name, address, birth certificate, grade level completed, grades, grading scale, credits earned, attendance, discipline)
☐ Scholastic/Achievement Record
☐ Intelligence and Aptitude Test Scores
☐ Standardized Test / ACT / SAT Data
☐ Discipline File, including record of Suspension / Expulsion
☐ Medical / Immunization Records
☐ Personality and Interest Test Scores
☐ Special Education / Section 504 / ILP Records
☐ Gifted & Talented
☐ Other

Has the above-mentioned student ever been suspended?
☐ Yes ☐ No If Yes, please explain:

Has the above-mentioned student ever been expelled or recommended for expulsion?
☐ Yes ☐ No If Yes, please explain:

Has this student received any previous testing, evaluations or services in any of the following areas?

☐ Individual Education Plan (IEP) Disability Area: __________
☐ Individual Literacy Plan (ILP) ☐ Gifted and Talented ☐ Psychological
☐ Counseling ☐ 504 Services ☐ Other _________

FALSE INFORMATION ON THIS FORM MAY JEOPARDIZE THE STUDENT’S ENROLLMENT IN SCHOOL.

Authorized Signature: ______________________ Date: __________

Relationship to Student: (circle one) Parent/Guardian ☐ Student (18 years and older) Registrar Other _________

According to the Family Educational Rights and Privacy Act, a student’s education records can be disclosed without parental consent to school officials of another school or school system where the student seeks to enroll. Under limited circumstances, Colorado law allows withholding only of a student’s diploma, transcript, or grades for unpaid book fees. All other records must be provided.

Douglas County School District Re. 1, Castle Rock, Colorado ©DCSD 9/2009

Records Requested ________ By ___________ Via FAX ☐ Via Mail ☐ Received Records ________
HEALTH INFORMATION – (NEW students)

This information will be reviewed and maintained in confidential manner
by the School Nurse assigned to your student’s school.

STUDENT NAME: ___________________________  BIRTH DATE: ____________
SCHOOL: ___________________________  GRADE / TRACK: ____________

EARLY CHILDHOOD HEALTH HISTORY
Were there any significant problems during the pregnancy, labor or delivery?  No ☐  Yes ☐
If yes, is this concern a current issue?  No ☐  Yes ☐
If yes, please explain: ______________________________________

PLEASE CHECK ALL HEALTH CONDITIONS THAT APPLY TO YOUR STUDENT. IF A HEALTH CONDITION PERTAINING
TO YOUR STUDENT HAS A COMMENT FIELD, PLEASE PROVIDE ADDITIONAL INFORMATION IN THE FIELD.

Dietary Needs – Comment required
☐ Student has Special Dietary Needs  Comment: _______________________

Allergies – Life Threatening – Comment required
☐ Life threatening allergy – Dairy  Comment: _______________________
☐ Life threatening allergy – Food  List Food(s): _______________________
☐ Life threatening allergy – Insect Sting  Comment: _______________________
☐ Life threatening allergy – Latex  Comment: _______________________
☐ Life threatening allergy – Peanut  Comment: _______________________
☐ Life threatening allergy – Tree Nuts  Comment: _______________________
☐ Life threatening allergy – Other  List: _______________________
☐ Life threatening allergy – Unknown  Comment: _______________________

Allergies – Comment required where indicated
☐ Animal  _______________________
☐ Environmental/Seasonal  _______________________
☐ Food  List Food(s): _______________________
☐ Insect Sting  _______________________
☐ Latex  _______________________
☐ Medication  List Medication(s): _______________________
☐ Non-Specific  _______________________

Other Conditions – Comment required where indicated
☐ ADD/ADHD – Name of medication: _______________________
☐ Alopecia  Comment: _______________________
☐ Arthritis Juvenile  _______________________
☐ Asthma  Comment: _______________________
☐ Autism Spectrum  Comment: _______________________
☐ Auto-Immune Condition  Comment: _______________________
☐ Blood Disorder  Comment: _______________________

620 Wilcox Street  Castle Rock, Colorado 80104  303-387-0100
Revised 10/29/18
<table>
<thead>
<tr>
<th>Condition</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
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<tr>
<td>Celiac Disease</td>
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<tr>
<td>Cerebral Palsy</td>
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<tr>
<td>Chromosomal Anomalies</td>
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<tr>
<td>Crohn's Disease</td>
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<tr>
<td>Cystic Fibrosis</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Down Syndrome</td>
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<tr>
<td>Emotional Condition</td>
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<tr>
<td>Encopresis</td>
<td></td>
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<tr>
<td>Enuresis</td>
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<tr>
<td>Fetal Alcohol Syndrome</td>
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<tr>
<td>Frequent Headaches</td>
<td></td>
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<tr>
<td>Gastrointestinal Disorder</td>
<td></td>
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<tr>
<td>Head Injury/Concussion</td>
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<tr>
<td>Hearing Impaired</td>
<td></td>
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<tr>
<td>Heart Condition – No Restriction</td>
<td></td>
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<tr>
<td>Heart Condition – Restrictions</td>
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<tr>
<td>Hepatitis B Carrier</td>
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<td>Hepatitis C Carrier</td>
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<tr>
<td>History of Injuries</td>
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<tr>
<td>Hypoglycemia</td>
<td></td>
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<tr>
<td>Immune Compromised</td>
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<tr>
<td>Kidney Problem</td>
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<tr>
<td>Lactose Intolerant</td>
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<tr>
<td>Long QT Syndrome</td>
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<tr>
<td>Migraine Headaches</td>
<td></td>
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<tr>
<td>Myalgia Myositis Fibromyalgia</td>
<td></td>
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<tr>
<td>Neurologic Disorder</td>
<td></td>
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<tr>
<td>Nosebleeds</td>
<td></td>
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<tr>
<td>Orthopedic – Physical Limitation</td>
<td></td>
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<tr>
<td>Orthopedic – No Restrictions</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>List:</td>
</tr>
<tr>
<td>Paraplegia</td>
<td></td>
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<tr>
<td>Quadriplegia</td>
<td></td>
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<tr>
<td>Scoliosis</td>
<td></td>
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<tr>
<td>Seizure Disorder</td>
<td></td>
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<tr>
<td>Shunt/Hydrocephalus</td>
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<tr>
<td>Skin Condition</td>
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<tr>
<td>Syncopal Episodes</td>
<td></td>
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<tr>
<td>Syndrome</td>
<td></td>
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<tr>
<td>Thyroid Condition</td>
<td></td>
</tr>
<tr>
<td>Tourette Syndrome</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy</td>
<td></td>
</tr>
</tbody>
</table>
HEALTH INFORMATION – (NEW students)

☐ Traumatic Brain Injury Comment: ____________________________

☐ Urinary Problem Comment: ____________________________

☐ Wears Glasses/Contacts Comment: ____________________________

☐ Vision Impaired Comment: ____________________________

☐ Von Willebrand’s Disease Comment: ____________________________

☐ Wolff Parkinson White Syndrome

ADDITIONAL INFORMATION

- List any illness, hospitalization, surgery, accidents your student had in the past year. None ☐

  ____________________________________________ Date: ________

  ____________________________________________ Date: ________

  ____________________________________________ Date: ________

- List any emotional, social or other conditions that might affect your student’s school performance. None ☐

- Is your student currently taking any medication, including over-the-counter medication? No ☐ Yes ☐

If your student will need to be given medication at school, a Provider Medication Authorization Form for each medication will be needed. If your student is a middle school student and will self-carry prescription medication, a Permission to Carry Form must be completed for each medication. High school students may self-carry and self-administer one-day supply of medication, carried in a pharmacy labeled container.

- Is your student currently receiving alternative therapies (acupuncture, homeopathic, herbal, biofeedback, etc)? No ☐ Yes ☐

  If yes, please explain: ____________________________________________

- Is there anything else you would like us to know about your student? No ☐ Yes ☐

Parent/Guardian Name (please print) ________________________________

Parent/Guardian Signature ________________________________ Date ________________
Colorado MEP Occupational Survey

Your child/children may qualify to receive supplemental educational services at no cost, such as tutoring, transportation, school supplies, and other services. Please answer the following questions to assist in determining your child’s/children’s eligibility. Once completed, please return this form to the school or your Regional MEP Office listed at the bottom of the document.

<table>
<thead>
<tr>
<th>CHILD'S FIRST NAME:</th>
<th>CHILD'S LAST NAME:</th>
<th>BIRTHDATE:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SCHOOL:</th>
<th>GRADE:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PARENT/GUARDIAN NAME:</th>
<th>How many children under the age of 22 live with you in your household? ___________</th>
</tr>
</thead>
</table>

1) In the past three years, has your family moved to another state, city, school district, and/or county?  
☐ YES  ☐ NO

2) Do you or anyone in your immediate family currently work, or have worked, in the past three years, in any of the following occupations related to agricultural or fishing work?  
☐ YES  ☐ NO

CIRCLE all that apply below, even if the work was only for a short period of time.

- Processing & Packing (fruit, vegetables, chicken, eggs, pork, beef, lamb or other livestock)
- Agriculture or Field Work (planting, picking, sorting crops, soil preparation, irrigation, fumigation)
- Dairy & Cattle Raising (feeding, milking, rounding up)
- Nursery or Greenhouse (planting, potting, pruning, watering, harvesting)
- Forestry (soil preparation, planting, growing, cutting trees)
- Fishing & Fish Processing (catching, sorting, packing, transporting fish)

If you answered “yes” to either question above, please continue below. Otherwise, your form is complete.

<table>
<thead>
<tr>
<th>HOME ADDRESS:</th>
<th>TODAY'S DATE:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CITY:</th>
<th>STATE:</th>
<th>ZIP:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TELEPHONE (WITH AREA CODE):</th>
<th>BEST DAY AND TIME TO CALL:</th>
<th>PREFERRED LANGUAGE:</th>
</tr>
</thead>
</table>

This form and the data recorded within are protected to maintain family and child confidentiality. School district staff: You may mail or fax the form to the contact information below. If you have any questions, please contact:

Metro Migrant Education Program  
14707 E 2nd Ave, Suite 180  
Aurora, CO, 80011  
P. 303-365-5817 F. 303-856-7294
Student Residency Questionnaire

Douglas County School: ____________________________

Student’s Legal Name: _______________________________________

Date of Birth: ______________ Age: ______ Grade: ______ Gender: M ☐ F ☐

Parent(s) / Legal Guardian(s): ___________________________________ Phone/Pager: _______________

Address: __________________________________ City: ______ State / Zip Code: ______________

This questionnaire is intended to address the McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? (check one box)

<table>
<thead>
<tr>
<th>Section A</th>
<th>Section B</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Choices in Section B do not apply</td>
<td>☐ In an Emergency Shelter</td>
</tr>
<tr>
<td></td>
<td>☐ In a motel, car or campsite</td>
</tr>
<tr>
<td></td>
<td>☐ With friends or family members due to the loss of housing or financial hardship</td>
</tr>
<tr>
<td></td>
<td>☐ A student not living with parent or legal guardian</td>
</tr>
<tr>
<td></td>
<td>☐ Other? Explain ____________________________________________</td>
</tr>
</tbody>
</table>

2. The student lives with:

<table>
<thead>
<tr>
<th>Choices</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1 (one) parent</td>
<td>☐ a relative, friend(s) or other adult(s)</td>
</tr>
<tr>
<td>☐ 2 (two) parents</td>
<td>☐ alone with NO adults</td>
</tr>
<tr>
<td>☐ 1 parent &amp; another adult</td>
<td>☐ an adult that IS NOT the parent or the legal guardian</td>
</tr>
</tbody>
</table>

Signature(s) of Parent(s) / Legal Guardian(s) __________________________________ Date: ____________

Signature(s) of Parent(s) / Legal Guardian(s) __________________________________ Date: ____________

Notes:

Section B – If Section B is checked, this form MUST be completed and returned to school personnel.

**** Completed form is kept in the student’s cum file. *****

School Contact who may know of the family’s situation:

Name / Title: ____________________________ Phone: _______________
# Douglas County School District
## 2020-2021 School Calendar

<table>
<thead>
<tr>
<th>JULY</th>
<th>AUGUST (17)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>SEPTEMBER (20)</th>
<th>OCTOBER (17)</th>
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<tbody>
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<tr>
<th>NOVEMBER (15)</th>
<th>DECEMBER (13)</th>
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<table>
<thead>
<tr>
<th>JANUARY (18)</th>
<th>FEBRUARY (18)</th>
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<thead>
<tr>
<th>MARCH (18)</th>
<th>APRIL (20)</th>
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<table>
<thead>
<tr>
<th>MAY (17)</th>
<th>JUNE</th>
</tr>
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</tbody>
</table>

### KEY:
- **All-day session (173 student days)**
- **Saturdays and Sundays**
- **District Holidays**
- **N** New Teacher Orientation Day - (no students)
- **T** Teacher Work Day - (no students) for Staff Development, Grading and/or Planning
- **C** Compensated Day - (no students) for Parent Teacher Conferences
- **P** Professional Development Day - (no students)
- **No School**

Approved by the Board of Education - May 2018
Revised by the Board of Education – October 2019

If for any reason the school district must close schools, this calendar may be amended by the Board of Education to provide additional school days on Saturdays, during vacations or at the end of the present calendar.