Start Date: _____ **REGISTRATION INFORMATION** City of Thornton

Youth's Name: _____
Last First Middle

Home Phone Number:_____ Date of Birth:_____

Home Address: _____

Male ☐ Female: ☐ Hair Color:_____ Eye Color:_____

Parent/Guardian's Name: _____
Last First Middle

Address (if different than youth):_____

Place of Employment: _____
Name/Phone No. Address/City/State

Email Address: _____

Parent/Guardian's Name: _____
Last First Middle

Address (if different than youth):_____

Place of Employment: _____
Name/Phone No. Address/City/State

Email Address: _____

PERSON'S AUTHORIZED TO PICK UP YOUTH (include self):

1. _____ _____
Name/Phone No. Address/City/State
2. _____ _____
Name/Phone No. Address/City/State
3. _____ _____
Name/Phone No. Address/City/State

Youth's Doctor: _____ _____
Name/Phone No. Address/City/State

Youth's Dentist:_____ _____
Name/Phone No. Address/City/State

Youth's Insurance Provider:_____ **Group No. & I.D.**_____

Emergency contact to call if parent cannot be reached and medical authorization may be obtained:

Name: _____ Phone No.:_____

Address: _____ Relationship:_____

Name: _____ Phone No.:_____

Address: _____ Relationship:_____

Hospital of Choice: _____
Name/Phone No. Address/City/State

Any Allergies or Health Problems we need to be aware of: _____

_____

Special Instructions: _____

Emergency Medical Authorizations: I,_____, hereby give permission to the City of Thornton Staff to call a doctor for medical or surgical care for my youth,_____, should an emergency situation arise. It is understood that a conscious effort will be made to locate my spouse or me before any action will be taken, but if it is not possible to locate us, this expense will be excepted by us.

I understand that it is my responsibility to apply sunscreen to my youth before bringing him/her to school.

_____ _____
Signature of Parent or Legal Guardian Date

City of Thornton

PRESCHOOL & KIDCAMP FAMILY QUESTIONNAIRE

This information is intended to help us understand your family, your youth, and his/her development.

Youth's Name:_____ Nickname:_____

1. Has your youth had previous youthcare/preschool? Yes No

   If yes, what school? _____

2. What are your views on education and what is your reason for choosing preschool for your youth:_____

   _____

   _____

3. How does your youth adapt to new situations? _____

4. What are your youth's interests and/or what does your youth enjoy doing? _____

   _____

5. Are there any activities or foods your youth is unable to participate in due to medical, physical, social, or religious reasons? Please explain: _____

   _____

6. Who are the primary caregivers of the youth including parents (those who have significant contact with your youth and/or who may participate in your youth's care):

Name	Age	Living with youth?

7. Relationship with brothers, sisters, and other youth:

Name	Age	Living with youth?

8. Relationship with others living in the home:

Name	Age	Living with youth?

9. For the names listed in questions 6-8, what are the roles of these members of your family? _____

   _____

   _____

   _____

10. Does your youth have any problems with sleeping? How does your youth show that he/she is tired? Does your youth nap at home?_____

    _____

11. Is your youth afraid of anything (i.e. dogs, loud noises, bugs, etc.)? _____

_____

12. How does your youth express anger or react to frustration? How does your youth express pleasure, excitement, or joy?

_____

13. What do you expect of your youth? _____

_____

_____

14. What is your guidance strategy at home? _____

_____

15. What is your youth's primary language? How does your youth communicate his/her needs (please include primary language words for bathroom — urination and bowel movement, thirsty, hungry, tired, Mom, Dad, etc., if not English)?

_____

_____

_____

16. Does your youth speak a second language?_____ If yes, what language? _____

17. Are there any customs, traditions, holidays, or special occasions that you celebrate with your youth and/or your family? Please explain. _____

_____

_____

Would you be willing/able to come into class to share these traditions with all the kids? Yes No

18. Is there any other information we should know to best work with your youth (therapy your youth has, special needs, temperament, what you would like to see take place in class, etc.)? _____

_____

_____

_____

19. In order to complete this form, please attach a picture of your family and a photo of your youth for us to use in the classroom.

Attach family picture here.

(not representative of size)

Attach youth's picture here.

(not representative of size)

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

Child's Name: _____ **Birthdate:** _____

Allergies: ❑ None or Describe _____

Type of Reaction _____

Diet: ❑ **Breast Fed** ❑ **Formula** _____ ❑**Age Appropriate**

❑**Special Diet** _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

❑ **Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, _____ give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #: _____ **DATE:** _____

Parent/Guardian Signature _____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ **Weight @ Exam:** _____

Physical Exam: ❑ **Normal** ❑ **Abnormal** (Specify any physical abnormalities) _____

Allergies: ❑ None or Describe _____ Type of Reaction _____

Significant Health Concerns: ❑Severe Allergies ❑Reactive Airway Disease ❑Asthma ❑Seizures ❑Diabetes ❑Hospitalizations ❑Developmental Delays ❑Behavior Concerns ❑Vision ❑Hearing ❑Dental ❑Nutrition ❑ Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: ❑ None or Describe _____

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

❑Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

OR ❑Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: ❑Up-to-Date ❑ See attached immunization record ❑Administered today: _____

Health Care Provider: Complete

****Screenings Performed:** ❑**Vision:** ❑Normal ❑Abnormal ❑**Hearing:** ❑Normal ❑Abnormal ❑**Dental:** ❑Normal ❑Abnormal-

Recommended Follow-up _____

Provider Signature

Next Well Visit: ❑ Per AAP guidelines* or ❑ Age_____

This child is healthy and may participate in all routine activities in school sports, child care or camp program. Any concerns or exceptions are identified on this form.

_____

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp
Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: ..... **Date of birth:** .....

Parent/guardian: .....

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** - positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: ..... Date: .....

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: ..... Date: .....

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: October 2018

COLORADO
Department of Public Health & Environment
Advancing Colorado's health and protecting the places we live, learn, work and play

Dear parents/guardians of students in Colorado kindergarten – 12th grade schools for the 2020-21 school year:

We know you're thinking of all the things you need to do to make sure your student is ready for school. Getting vaccinated is an important part of their school readiness and keeps children from catching and spreading diseases that can make them sick. We wish you and your student a healthy school year!

Required and recommended vaccines

- Colorado law requires students who attend a public, private, or parochial kindergarten - 12th grade school to be vaccinated against many of the diseases vaccines can prevent, unless an exemption is filed. For more information, visit colorado.gov/cdphe/schoolrequiredvaccines (or cdphe.colorado.gov/schoolrequiredvaccines). Your student must be vaccinated against:
  - diphtheria, tetanus & pertussis (DTaP, DTP, Tdap)
  - polio (IPV)
  - measles, mumps, rubella (MMR)
  - hepatitis B (HepB)
  - varicella (chickenpox)
- Colorado follows recommendations set by the Advisory Committee on Immunization Practices. Students entering kindergarten must receive their final doses of DTaP, IPV, MMR and varicella. Students entering 6th grade must receive one dose of Tdap vaccine, even if they are under 11 years of age. You can view recommended vaccine schedules for children 0 - 6 years of age at cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf and preteens/teens 7 - 18 years of age at cdc.gov/vaccines/schedules/downloads/teen/parent-version-schedule-7-18yrs.pdf.
- Vaccines are recommended for hepatitis A, influenza, meningococcal disease and human papillomavirus, but are not required.

Exclusion from school

- Your student may be excluded from school if your school does not have an up-to-date vaccine record, exemption, or in-process plan for your student on file.
- If someone gets sick with a vaccine-preventable disease or there is an outbreak at your student's school and your student has not received the vaccine for that disease, they may be excluded from school activities. That could mean lost learning time for them and lost work and wages for you. For example, if your student has not received a measles-mumps-rubella (MMR) vaccine, they may be excluded from school for 21 days after someone gets sick with measles.

Have questions?

- You may want to talk to a healthcare provider licensed to give vaccines or your local public health agency about which vaccines your student needs or if you have questions. You can read about the safety and importance of vaccines at SpreadTheVaxFacts.com, ImmunizeForGood.com, and colorado.gov/cdphe/immunization-education (or cdphe.colorado.gov/immunization-education).

Paying for vaccinations

- If you need help finding free or low-cost vaccines and providers who give them, go to COVax4Kids.org, contact your local public health agency, or call the state health department's Family Health Line at 1-303-692-2229 or 1-800-688-7777. You can find your local public health agency at colorado.gov/cdphe/find-your-local-public-health-agency (or cdphe.colorado.gov/find-your-local-public-health-agency).

Vaccination records

- Please take your student's updated vaccine record to school every time they receive a vaccine.
- Need to find your student's vaccine record? It may be available from the Colorado Immunization Information System. Visit COVaxRecords.org for more information.

Exemptions

- If your student cannot get vaccines because of medical reasons, you must submit an official *Immunization Medical Exemption Form* to your school, signed by a health care provider licensed to give vaccines. You only need to submit this form once, unless your student's information or school changes. You can get the form at colorado.gov/vaccineexemption (or cdphe.colorado.gov/vaccineexemption).
- If you choose not to have your student vaccinated according to the current recommended schedule because of personal belief or religious reasons, you must submit a non-medical exemption to your school. Non-medical exemptions must be submitted at ages 2 months, 4 months, 6 months, 12 months and 18 months. The easiest way to file a personal or religious exemption is by using our online or downloadable non-medical exemption form available at colorado.gov/vaccineexemption (or cdphe.colorado.gov/vaccineexemption).

How's your school doing on vaccinations?

- Some parents, especially those with students who have weakened immune systems, may want to know which schools have the highest percent of vaccinated students. Schools must report immunization and exemption numbers (but not student names or birth dates) to the state health department annually. Immunization and exemption rates can be found at COVaxRates.org.

Please share Page 2 of this letter with your student's health care provider as it provides helpful information about vaccines required for school entry, per Colorado law.

COLORADO
Department of Public Health & Environment

Advancing Colorado's health and protecting the places we live, learn, work and play

Dear Colorado health care provider:

Colorado School Entry Immunization Law (25-4-901 et seq, C.R.S) and Colorado Board of Health rule (6 CCR 1009-2) require students who attend a public, private or parochial K - 12 school, licensed child care, preschool, or Head Start program to be vaccinated against many of the diseases vaccines can prevent, or have an exemption on file. For more information, visit, colorado.gov/pacific/cdphe/schoolrequiredvaccines (or cdphe.colorado.gov/schoolrequiredvaccines). Students must be vaccinated against:

- diphtheria, tetanus and pertussis (DTaP, DTP, Tdap)
- polio (IPV)
- measles, mumps, rubella (MMR)
- hepatitis B (HepB)
- haemophilus influenzae type b (Hib)
- pneumococcal (PCV13)
- varicella (chickenpox)

The number, timing and spacing of the required vaccine doses is set by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP). To be considered valid, a dose of vaccine must meet both the **minimum age and minimum intervals** as defined by ACIP. You can view the current ACIP vaccine schedule for persons 0 - 18 years of age at cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf. Vaccines are recommended for rotavirus, hepatitis A, influenza, meningococcal disease and human papillomavirus, but are not required for school attendance.

Colorado schools are required to review immunization records for school entry and can only accept valid doses of vaccine. Your patients may receive notification of noncompliance if a dose of vaccine does not meet the minimum age or minimum interval requirements, per the ACIP schedule. There are three ways a student can meet the compliance requirements established by Colorado law:

1) A student is considered fully immunized if he or she has received all doses of school-required vaccines according to the current ACIP schedule. Note: students are required to receive their final doses of DTaP, IPV, MMR and varicella by kindergarten entry and their Tdap by 6th grade entry, even if the student is under 11 years of age.
2) A student is in the process of becoming up-to-date on required vaccines and has a written plan from the parent/guardian on file with the school.
3) The student's health care provider (medical doctor, doctor of osteopathic medicine, advanced practice nurse or delegated physician assistant) has signed an official *Immunization Medical Exemption Form* because of a condition that precludes the student from receiving vaccine(s), or the student (emancipated or 18 years of age or older) or student's parent/guardian has submitted a signed non-medical exemption (religious or personal belief).

If students do not meet at least one of the compliance criteria, they are not permitted to attend school. If you have questions about the student's school immunization requirement, please communicate with the student's school nurse or school representative.

If you have questions about the ACIP immunization schedule, vaccines marked as invalid in your patient's immunization record, or about Colorado School Entry Immunization Law, please contact us at 303-692-2700 or cdphe.dcdimmunization@state.co.us. If you have questions about the Colorado Immunization Information System (CIIS), please contact us at 303-692-2437 (press 2), 1-888-611-9918 (press 1) or cdphe.ciis@state.co.us.

Other reliable clinical resources include:

- CDC Vaccines & Immunizations - cdc.gov/vaccines/default.htm
- CDC's *Epidemiology & Prevention of Vaccine-Preventable Diseases* - cdc.gov/vaccines/ed/webinar-epv/index.html
- The Immunization Action Coalition: Ask the Experts - immunize.org/askexperts/
- CDC Experts at the National Immunization Program - nipinfo@cdc.gov or 1-800-CDC-Info (1-800-232-4636)

City of Thornton

MEDICAL RELEASE FORM

Only fill out this and the following medical pages if your youth has allergies, asthma, or medical needs.

Please fill out:

1. This Medical Release Form

OR

1. Medication Administration in School or Youth Care (filled out by your youth's physician)
2. Colorado School Asthma Care Plan/Allergy and Ananphylaxis Action Plan and Medication Orders (filled out by your youth's physician)

My youth _____, DOB_____,

has various allergies and/or asthma. They consist of _____

_____

They do not require use of an EpiPen, inhaler or any other form of medication while at school. Therefore, I will not be providing the school with any medications.

Please watch for the symptoms listed below. Please contact me at the number below if my youth has been exposed to any of the above allergens. I agree to keep my youth home if they have any symptoms of these allergies and/or asthma.

_____

_____

_____

_____

_____

Names of people and numbers to call (in order):

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

Parent Signature: _____ _____ Date: _____

Medication Administration in School or Child Care

The parent/guardian of _____ **ask that school/child care staff give the**
(Child's name)

following medication _____ **at** _____
(Name of medicine and dosage) (Time(s))

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

The Program agrees to administer medication prescribed by a licensed health care provider.
It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and 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.

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 nurse or school staff delegated to administer medication.

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

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: _____ **Birthdate:** _____

Medication: _____

Dosage: _____ **Route** _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____

Starting Date: _____ **Ending Date:** _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____
Phone Number **Date**

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

City of Thornton

COLORADO SCHOOL ASTHMA CARE PLAN

Every line must be filled in!

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

Name	Birthdate
Teacher	Grade
Parent/Guardian	Cell Phone
Home Phone	Work Phone
Other Contact	Phone
Preferred Hospital	

TRIGGERS: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dog/Cat ☐ Dust ☐ Mold ☐ Pollen

Other _____

GREEN ZONE: Pretreatment Steps for Exercise (Health provider please complete section)

☐ Give 2 puffs of rescue med *(name)* _____ 15 minutes before activity.
(Circle indication: Phys Ed class, exercise/sports, recess)
Explanation _____
☐ Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: Sick Uncontrolled Asthma (Health provider complete dosing for rescue medication)

IF YOU SEE THIS:	DO THIS:
• Difficulty breathing • Wheezing • Frequent cough • Complains of chest tightness • Unable to tolerate regular activities but still talking in complete sentences • Other	• Stop physical activity • Give rescue med *(name)* _____ ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other _____ • If no improvement in 10-15 minutes, repeat use of rescue med. ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other _____ • If student's symptoms do not improve or worsen, call 911 • Stay with student and maintain sitting position • Call parents/guardians and school nurse • Student may resume normal activities once feeling better

RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for rescue medication)

IF YOU SEE THIS:	DO THIS:
• Coughs constantly • Struggles or gasps for breath • Trouble talking (can speak only 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips or fingernails are gray or blue • ↓Level of consciousness	• Give rescue med *(name)* _____ ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other _____ • If no improvement in 10-15 minutes, repeat use of rescue med. ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other _____ • Call 911 Inform attendant the reason for the call is asthma • Call parents/guardians and school nurse • Encourage student to take slower deeper breaths • Stay with student and remain calm • *School personnel should not drive student to hospital*

INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently

☐ Student is to notify his/her designated school health officials after using inhaler

☐ Student needs supervision or assistance to use his/her inhaler.

If not self carry, the inhaler is located _____

☐ Student has life threatening allergy, the epipen is loca\ed _____

_____ _____
Signature of Health Care Provider Date

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 physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____ ☐ 504 Plan or IEP
Signature of School Nurse Date

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

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 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 delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

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

1._____ Room _____

2._____ Room _____

3._____ Room _____

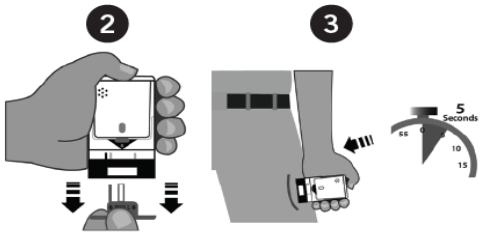
Self-carry contract on file: ☐Yes ☐No

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.

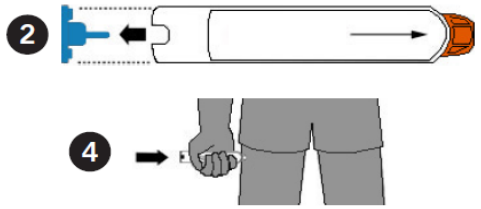


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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

City of Thornton

PRESCHOOL AND KID CAMP PARENT CONTRACT AND PERMISSIONS FORM

- I will abide by the rules set by the City of Thornton Licensed Programs in order to ensure the safety and well being of all participants and their families.

  INITIAL: _____

- I understand the process followed should disciplinary measures be necessary.

  INITIAL: _____

- I authorize my youth to participate in supervised walking field trips with the City of Thornton Licensed Programs.

  INITIAL: _____

- I authorize my youth to view a video selected and /or developed by the staff. Parent will be notified before video is shown.

  INITIAL: _____

- I have read and understand the policies and procedures outlined in the parent information packet.

  INITIAL: _____

- I agree to apply sunscreen with a minimum SPF of 15 according to manufacturer instructions not more than 15 minutes prior to the arrival of my youth to the facility. I understand that youth may go outside each day and will apply sunscreen every day the youth is attending class. I understand that the center does not provide sunscreen nor have any on site for youth's use.

  INITIAL: _____

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Youth's Name

City of Thornton

PRESCHOOL TUITION CONTRACT

TUITION PAYMENT

- Payment can be made in full or on a monthly basis for the entire school year, September – April.
- The $45 registration fee is due by June 1 or, if registering during the school year, at the time of registration. If paying monthly, May's payment is due August 1 or, if registering during the school year, at the time of registration. All remaining payments will be due on or before the fifth of each month. For example: October payment is due on or before October 5. You have the option to participate in the automatic credit card process or pay in person.
- The May tuition deposit is used to hold a participant's spot in a program. It is due by August 1, or if registering during the school year, is charged at the time of registration and is considered part of the cost of the program per participant, per program session (i.e. the entire school year). May's tuition is due August 1. If your youth remains registered through the end of the school-year (May), your deposit will be applied to May's tuition. If you cancel out of the program at any time after paying, your deposit becomes non-refundable.
- **A $15 LATE FEE WILL BE ASSESSED FOR ANY PAYMENT RECEIVED AFTER THE FIFTH OF THE MONTH. IF PAYMENTS ARE TWO WEEKS PAST DUE AND/OR HABITUALLY LATE, YOU WILL FORFEIT YOUR YOUTH'S SPACE FOR THE REMAINDER OF THE SCHOOL YEAR.**
- If you forfeit your youth's space, you may then meet with the director to discuss the option of putting your youth's name on a wait list or trying to get him/her into one of our other classes.

YOUTH WHO ARRIVE OR ARE PICKED UP LATE

Youth who arrive late should enter the classroom quietly and join in the ongoing activities. Please be prompt when picking up your youth from his/her class. Staff members have 15 minutes to clean and prepare the classroom before the arrival of the next class. If the youth is not picked up 5 minutes after the class has ended, the preschool staff will start making necessary phone calls from your information form.

- **You will be charged $1 per minute that you are late.**
- Payment must be made at the front desk before your youth can be picked up.
- A receipt will be given to you for your payment.
- A youth will never be left alone in the classroom.
- If the parents or emergency contacts can not be reached 30 minutes after class has elapsed, the Recreation or Community Center will then turn the youth over to the City of Thornton Police Department and Adams County Social Services. Every reasonable effort will be made to contact the parent/guardians or authorized contact person before this time.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Youth's Name

City of Thornton

EMERGENCY INFORMATION CARD

Youth's Name _____

Parent's Name _____

Address _____

Home Phone _____ Age:_____ Eye Color _____ Hair Color _____

Allergies _____

_____

_____

Special Needs or Health Notes and Special Instructions _____

_____

_____

Name of Preferred Hospital _____

IN CASE OF EMERGENCY CALL:

First: _____
Name Relationship Home Phone Work Phone

Second: _____
Name Relationship Home Phone Work Phone

Third: _____
Name Relationship Home Phone Work Phone

PICK-UP LIST:

_____
Name Relationship Home Phone Work Phone

_____
Name Relationship Home Phone Work Phone

_____
Name Relationship Home Phone Work Phone

City of Thornton

Licensed Programs MEDIA WAIVER/PHOTOGRAPH PUBLISHING POLICY

At times, different media groups (newspapers, television, public relations, etc.) will cover activities at the City of Thornton Preschool with articles, video or still photography that may be published. In addition, the Licensed Programs may want to include photographs in various artwork to be displayed in the preschool hallway.

If parents DO NOT want their youth to be photographed or videotaped for news media or preschool purposes, please complete an "opt-out media form" that may be obtained from the preschool director. Simply complete the form and return it to the preschool director so the preschool has a record of your request that your youth is NOT to be photographed or videotaped during class. **This opt out does not apply to other public programs, events or facilities.**

The City of Thornton preschool staff will make every reasonable effort to identify the primary subjects in photographs and to not publish preschool-related photos containing students on the opt-out list.

This form is effective for the current school year your youth is registered for.