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, date, and SIGN.

Child's Name: _____ Birthdate: _____

Allergies: ☐ None OR ☐ List food/medication: _____

Diet: ☐ Breastfed ☐ Age appropriate ☐ Special-Describe: _____

Skin Care: ☐ Sunscreen/creams may be applied as requested in writing by parent unless skin is broken or bleeding.

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

I, _____, give permission for my child's healthcare provider to share this form and applicable attachments with my child's school, childcare, or camp. Contact information for the person to receive this form:
Name:_____ Fax:_____ Email:_____ _____

Parent/Guardian Signature:_____Date:_____

HEALTH CARE PROVIDER

Please complete after parent section has been completed.

Date of most recent health appraisal: _____ Age:_____ Weight: _____

Physical Exam: ☐ Normal ☐ Abnormal-describe: _____

Allergies: ☐ None OR ☐ List food/medication: _____ Type of Reaction _____

Current Medications: ☐ None OR ☐ List:_____

A separate medication authorization form (**link**) is required for medications given in school, childcare, or camp.

Current Diet: ☐ Breastfed ☐ Age appropriate ☐ Special-describe: _____

A separate diet statement (**link**) is required for food provided at school, childcare, or camp.

Health Concerns: ☐ Severe Allergies ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Hospitalizations ☐ Behavior Concerns
☐ Developmental Delays ☐ Vision ☐ Hearing ☐ Oral Health ☐ Under/Overweight ☐ Other: _____

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

Immunizations: ☐ See attached immunization record or official exemption form ☐ Next vaccine due date: _____

HEALTH CARE PROVIDER

Please complete if appropriate. This information is required by Early Head Start and Head Start Programs per the State EPSDT Schedule.

Height: _____ B/P: _____ Head Circumference (up to 12 months): _____ HCT/HGB:_____

Lead Level: ☐ Not at risk OR ☐ Lead level: _____ TB: ☐ Not at risk OR Test Result: ☐ Normal ☐ Abnormal

Screens Performed: ☐ Vision: ☐ Normal ☐ Abnormal ☐ Hearing: ☐ Normal ☐ Abnormal
☐ Oral Health: ☐ Normal ☐ Abnormal Developmental Screen: ☐ ASQ ☐ PEDS ☐ Other: _____

Developmental Concerns: _____ 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, childcare, or camp. Any concerns or exceptions are identified on this form.

_____
Signature of Healthcare Provider (certifying form reviewed)

_____
Date

*The AAP recommends Well Child Visits at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, and annually after 3 years.

OFFICE STAMP

Or write Name, Address, Phone Number, Email

The form was created by the American Academy of Pediatrics, Colorado Chapter and Healthy Child Care Colorado to satisfy childcare and Head Start requirements in Colorado. While accepted by most schools, childcare programs and camps, this is not an official government form. Updated 01/2021.

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 attending Colorado child cares, preschools, and Head Start programs for the 2023-24 school year:

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

Required and recommended vaccines

- Colorado law requires children who attend a licensed child care, preschool, or Head Start program to be vaccinated against many of the diseases vaccines can prevent unless a *Certificate of Exemption* is filed. For more information, visit cdphe.colorado.gov/schoolrequiredvaccines. Your student must be vaccinated against:
  - Diphtheria, tetanus, and pertussis (DTaP).
  - Haemophilus influenzae type b (Hib).
  - Hepatitis B (HepB).
  - Measles, mumps, and rubella (MMR).
  - Pneumococcal disease (PCV13 or PCV15).
  - Polio (IPV).
  - Varicella (chickenpox).
- Colorado follows recommendations set by Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices. You can view the recommended vaccine schedule for children 0 through 6 years of age at www.cdc.gov/vaccines/schedules/easy-to-read/child-easyread.html.
- CDC also recommends vaccines are recommended for COVID-19, hepatitis A (HepA), influenza (flu), and rotavirus (RV), but these are not required for child care or school entry in Colorado.

Exclusion from child care and school

- Your student may be excluded from school if your child care or school does not have an up-to-date *Certificate of Immunization, Certificate of Exemption*, or an in-process plan on file for your student.
- If someone is ill 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 MMR vaccine, they may be excluded from school for 21 days after someone gets sick with measles.

Have questions?

Talk with a health care provider or your local public health agency (LPHA) about which vaccines your student needs or if you have questions. You can find a vaccine provider at cdphe.colorado.gov/immunizations/get-vaccinated. You can read about the safety and importance of vaccines at www.cdc.gov/vaccines/parents/FAQs.html, childvaccineco.org, ImmunizeForGood.com, and cdphe.colorado.gov/immunization-education. Staying up to date on routine immunizations is important for adults, as well as children. We encourage parents and guardians to find out what vaccines might be due. It's never too late for families to get back on track! Learn more about vaccines for adults at www.cdc.gov/vaccines/adults/rec-vac/index.html.

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 (find LPHA at cdphe.colorado.gov/find-your-local-public-health-agency), or call the Mile High Family Health Line at 303-692-2229 or 1-800-688-7777 to ask about Medicaid contact information and health clinics located in your area.

Vaccination records

- Share your student's updated *Certificate of Immunization* with their 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 (CIIS). Visit COVaxRecords.org for more information, including directions for how to use the CIIS Public Portal to view and print your student's vaccine record.

Exemptions

- If your student cannot get vaccines because of medical reasons, you must submit a *Certificate of Medical Exemption* to your school, signed by a physician (MD, DO), advanced practice nurse (APN), or delegated physician assistant (PA). You only need to submit this certificate once, unless your student's school or information changes. You can get the certificate at cdphe.colorado.gov/vaccine-exemptions.
- If you choose not to have your student vaccinated according to Colorado's school vaccine requirements for reasons that are nonmedical, you must submit a *Certificate of Nonmedical Exemption* to your school. Nonmedical exemptions must be submitted at ages 2 months, 4 months, 6 months, 12 months, and 18 months. These exemptions expire when the next vaccines are due or when the child enrolls in Kindergarten. There are two ways to file a nonmedical exemption.
    1. File the *Certificate of Nonmedical Exemption* WITH the signature from an immunizing provider in Colorado who is a physician (MD or DO), advanced practice nurse (APN), delegated physician's assistant (PA), registered nurse (RN), or pharmacist licensed in Colorado; OR
    2. File the *Certificate of Nonmedical Exemption,* which you will be able to access upon completion of the state's online immunization education module.

Downloadable certificates and a link to the online education module are available at cdphe.colorado.gov/vaccine-exemptions.

How's your child care or school doing on vaccinations?

Some parents/guardians/caregivers, especially those with students who have weakened immune systems, may want to know which child cares, preschools, and Head Start programs have the highest immunization rates. Annually, schools must report immunization and exemption numbers (but not student names or birth dates) to CDPHE. Schools do not control their specific immunization and exemption rates or establish the Vaccinated Children Standard described in §25-4-911, CRS. Schools must include their MMR immunization and exemption rates from the most recently completed school year in this letter. Schools may choose to also include immunization and exemption rates for other school-required vaccines. Additional immunization and exemption rates can be found at COVaxRates.org.

Child care/Preschool/Head Start name	2021-2022 MMR immunization rate REQUIRED IN LETTER	2021-2022 MMR exemption rate REQUIRED IN LETTER
Schools may also include the rates for the school-required vaccines shown below in this annual letter to parents/guardians		
Vaccinated Children Standard 95% immunization rate for all school-required vaccines	2021-2022 DTaP immunization rate	2021-2022 DTaP exemption rate
	2021-2022 Hib immunization rate	2021-2022 Hib exemption rate
	2021-2022 HepB immunization rate	2021-2022 HepB exemption rate
	2021-2022 IPV immunization rate	2021-2022 IPV exemption rate
	2021-2022 PCV13 immunization rate	2021-2022 PCV13 exemption rate
	2021-2022 Varicella immunization rate	2021-2022 Varicella exemption rate

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!

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

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Attach child's photo

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): _____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): _____ Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): _____ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____

Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: _____ **Date of plan:** _____

Additional Instructions:

Contacts

Call 911 / Rescue squad: _____

Doctor: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contacts

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

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/KID CAMP LATE PICK UP FEE AND PAYMENT AGREEMENT

PRESCHOOL & KID CAMP I 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.

- Late pick up fees will be charged to your household account if not paid immediately at the front desk.
- **You will be charged $1 per minute that you are late.**
- 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.

MONTHLY PAYMENT AGREEMENT FOR PRIVATE PAY PRESCHOOL TUITION

- 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 third of each month. For example: October payment is due on or before October 3. 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.

_____ _____

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.