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 camp.

_____ _____
Signature of Parent or Legal Guardian Date

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

FAMILY QUESTIONNAIRE

Every line must be filled in!

In order for us to best help meet your child's needs, please answer the following questions. Our goal is to meet the needs of all the campers.

Participant's Name _____ Nickname_____

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

   _____

2. Does your child have any issues participating in large group activities? Yes No

   If *Yes*, please explain_____

   _____

3. Are there any activities or foods your child is unable to participate in due to medical, physical, social or religious reasons?

   Please explain: _____

   _____

4. How does your child express anger or react to frustration? What strategy works best to help calm your child? (i.e. taking a break, asking for help, counting to 10, change location, etc.)?

   _____

   _____

   _____

5. What strategies are used at home or school to address disruptive behavior? _____

   _____

   _____

6. What items or activities are used to help motivate your child if they are struggling with structure?

   _____

   _____

7. When your child refuses to follow instruction, how do you address this? What items, phrases, or activities are used to reward your child when they follow instruction?_____

   _____

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

   _____

   _____

   _____

City of Thornton

PARTICIPANT PERMISSIONS SHEET

Every line must be filled in!

Participant's Name _____

PG MOVIES
I give my permission for my youth to watch PG movies during camp. All of the movies are screened BEFORE they are shown at camp.

_____ _____
Signature of Parent or Legal Guardian Date

PG-13 MOVIES
I give my permission for my youth to watch PG-13 movies during camp. All of the movies are screened BEFORE they are shown at camp.

_____ _____
Signature of Parent or Legal Guardian Date

NATURE WALKS AND WALKING FIELD TRIPS
I allow my youth to participate in supervised nature walks and walking field trips within one mile area surrounding the Thornton Community Center.

_____ _____
Signature of Parent or Legal Guardian Date

FIELD TRIPS AND PARTICIPATION
I give permission for my child to go on field trips and participate in program activities on site and away from the Thornton Community Center, whether on foot or by school or RTD bus, with the following exceptions (if any):

_____ _____
Signature of Parent or Legal Guardian Date

MEDIA RELEASE
I hereby grant the city of Thornton Recreation Department permission to utilize photos for media and promotion for use with Thornton Recreation Programs.

_____ _____
Signature of Parent or Legal Guardian Date

ARTS & CRAFTS
I allow my youth to participate in various arts and crafts during camp. I understand they will be using various tools and equipment including but not limited to scissors, glue, plaster, paint, small beads and markers.

_____ _____
Signature of Parent or Legal Guardian Date

CELL PHONE USE
I would like my youth to bring his/her cell phone to camp. We have discussed the policy and agree that, if staff feels that cell phone use interferes with camp activities, the phone will be confiscated and I will pick it up when I pick my youth up from camp.

_____ _____
Signature of Parent or Legal Guardian Date

If you have any questions or concerns about any of these matters, please contact Christine Sanford at 720-977-5963.

City of Thornton

PARENT/GUARDIAN & PARTICIPANT CONTRACT

Every line must be filled in!

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

  _____/ _____
  Parent or Legal Guardian's Initials Participant's Initials

- We will abide by the rules set by the camp staff in order to ensure the safety and well-being of all participants and their families.

  _____/ _____
  Parent or Legal Guardian's Initials Participant's Initials

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

  _____/ _____
  Parent or Legal Guardian's Initials Participant's Initials

PARENT/LEGAL GUARDIAN AND PARTICIPANT NEED TO INITIAL ABOVE AND SIGN BELOW.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Participant Date

REFUND AGREEMENT

I, _____, parent/guardian of _____

have read and understand the Refund Policy: *"Refunds will not be given after 5 p.m., May 5, 2023."*
The full policy is located on page 8 check page of the Licensed Program Handbook and page 53 of the Winter/Spring 2022 Thornton Activities Guide.

_____ _____
Signature of Parent or Legal Guardian Date

I have read and understand the payment policy found in the *Spring Break Camp, Adventure Club* and *My Escape* addendum. I understand that a $15 late fee will be assessed for any deposit program payment made 5 days late. If payments are two weeks past due and/or habitually late, I understand that my youth's space will be forfeited.

_____ _____
Signature of Parent or Legal Guardian Date

If youth is not picked up 5 minutes after the program ends for the day, staff will start making necessary phone calls from your information form. A youth will never be left alone in the classroom.

- You will be charged $1 per minute that you are late.
- Payment must be made at the front desk before your youth can return to camp.
- You will be given a receipt for your payment. You must show this receipt to camp staff at sign in.
- If the parents/guardians or emergency contacts can not be reached 30 minutes after class has elapsed, staff will then turn the youth over to the police department and Adams County Social Services. Every reasonable effort will be made to contact the parents/guardians or authorized contact people before this time.

_____ _____
Signature of Parent or Legal Guardian Date

City of Thornton

SUN PROTECTION AUTHORIZATION SHEET

Every line must be filled in!

I hereby authorize a camp staff member to supervise and/or assist in applying sunscreen to:

_____

Participant's name

The city of Thornton provides Rocky Mountain brand sunscreen for all participants. If your youth can not wear this brand, please provide him/her with a labeled personal bottle of sunscreen.

SELECT ONE:

_____ I agree to allow the camp staff to use Rocky Mountain brand sunscreen on my youth.

_____ I do not want the Rocky Mountain brand sunscreen to be used on my youth and I agree to supply my youth with sunscreen to be applied according to the instructions below.

Camp staff supervise/assist with the application of sunscreen to bare surfaces including the face, tops of ears, bare shoulders, arms, legs, back and tops of feet. Staff supervise/assist the application of sunscreen to all exposed skin. **Sunscreen is applied when we plan on being outdoors for more than 30-minutes and reapplied every hour.**

If you feel this guideline is not sufficient for your youth, please indicate specific instructions below.

SPECIAL INSTRUCTIONS _____

_____

_____

_____

_____ _____

Signature of Parent of Legal Guardian Date

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.

MEDICATION AUTHORIZATION FORM

Child's Name:	**Date of Birth:**
Medication:	**Dose:**

The program will administer medication to children for whom a plan has been made and approved by the Director. Medication in the facility can present a safety hazard, parents should check with the child's health care provider to see if a dose schedule can be arranged to be administered at home. Parent/guardian may come to administer medication to their own child during the day.

Procedures for Medication in Licensed Child Care of Group Care Settings:

1. All medications or treatments require a health care provider and parent/guardian to complete and sign this form.
2. The program's Child Care Health Consultant will review this Medication Authorization Form and sign.
3. Over-the-counter medication must be the original container and labeled with the child's name. Prescription medication must have a pharmacy label that corresponds with the written order from the health care provider.
4. All medications will be stored out of the reach of children and returned to the parents once prescription is completed or medication has expired. Parents are responsible for providing measuring devices (for example, a syringe) for accurate medication administration.
5. All medication administrations will be recorded by the staff administering the medication.
6. **Children with conditions such as asthma, severe allergies, diabetes, oxygen, feeding tubes and seizure disorder require a detailed health care plan in addition to, or in lieu of, this Medication Authorization Form. Please see staff for a copy of a health care plan.**

Medications:

- Are administered in accordance with the pharmacy/medication label directions and as prescribed by the written instructions from the child's health care provider.
- The instructions from the child's parent/guardian shall not conflict with the label directions or as prescribed by the child's health care provider.
- Require a written prescription or completed Medication Authorization Form from the child's health care provider.

AUTHORIZATION FOR MEDICATION ADMINISTRATION

Parent statement: I have read the above policy and hereby authorize delegated staff to administer the prescribed medication to my child as designated on this form.

☐ By checking this box, I give permission for my child's health care provider to share information about the administration of this medication with the program's nurse or school staff delegated to administer medication.

Parent/Guardian name_____ Telephone _____

Parent/Guardian signature _____ Date _____

In case of emergency, please contact _____ Telephone _____

This portion completed by child's health care provider

Medication:	Dosage:	Route:
Time of Administration:	Start date:	End date:
Special Instructions:		
Purpose of Medication:		
Side effects to be reported:		

Signature of Health Care Provider _____ Date: _____

Printed Name of Health Care Provider _____ Phone/Fax: _____/_____

Child Care Health Consultant signature _____ Date: _____

City of Thornton

Every line must be filled in!

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

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

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

Parent/Guardian Signature _____ **Date** _____

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

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

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

Controller medication used at home: _____

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

☐ **Life threatening allergy specify:** _____

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

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

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

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

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

Good for 12 months unless specified otherwise in district policy.

Fax _____ **Phone** _____ **Email** _____

School Nurse/CCHC Signature _____ **Date** _____

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

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

Revised: February 2021

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

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 _____

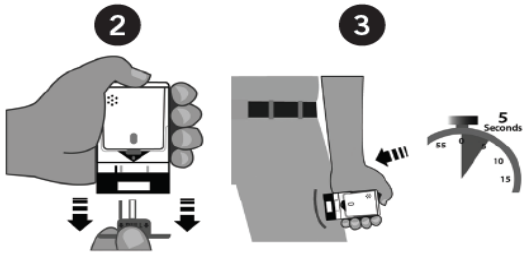
Self-carry contract on file: ☐Yes ☐No

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.

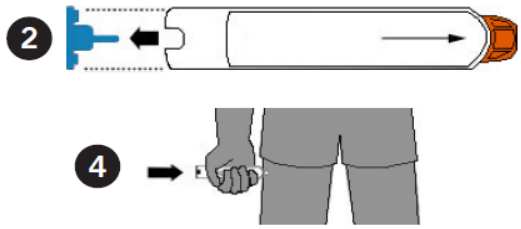


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

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

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

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							
COVID-19							
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: _____

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 kindergarten – 12th grade schools 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 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.

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 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, Tdap).
    - Hepatitis B (HepB).
    - Measles, mumps, and rubella (MMR).
    - Polio (IPV).
    - Varicella (chickenpox).
- Colorado follows recommendations set by Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices. **Prior to starting Kindergarten**, students must receive their final doses of DTaP, IPV, MMR, and varicella. **Prior to starting sixth grade,** students must receive one dose of Tdap vaccine, even if the student is younger than 11 years. You can view recommended vaccine schedules at: www.cdc.gov/vaccines/schedules/easy-to-read/child-easyread.html (birth through 6 years) or www.cdc.gov/vaccines/schedules/easy-to-read/adolescent-easyread.html (7 to 18 years).
- CDC also recommends vaccines for COVID-19, hepatitis A (HepA), human papillomavirus (HPV), influenza (flu), and meningococcal disease (MenACWY and MenB), but these are not required for school entry in Colorado.

Exclusion from school

- Your student may be excluded from school if your school does not have an up-to-date C*ertificate of Immunization, Certificate of Exemption*, or an in-process plan on file for your student.
- 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 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 contact information 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 C*ertificate 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 form 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 annually at every new school year (July 1 through June 30). 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, 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 school doing on vaccinations?

Some parents/ guardians/caregivers, especially those with students who have weakened immune systems, may want to know which schools have the highest immunization rates. Annually, schools must report immunization and exemption numbers (but not student names or birth dates) to the state health department. 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.

<table>
<tr><th>School name</th><th>2021-2022 MMR immunization rate
REQUIRED IN LETTER</th><th>2021-2022 MMR exemption rate
REQUIRED IN LETTER</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Schools may also include the rates for the school-required vaccines shown below in this annual letter to parents/guardians</td></tr>
<tr><td rowspan="8">Vaccinated Children Standard
95% immunization rate for all school-required vaccines</td><td>2021-2022 DTaP/Tdap immunization rate</td><td>2021-2022 DTaP/Tdap exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2021-2022 HepB immunization rate</td><td>2021-2022 HepB exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2021-2022 IPV immunization rate</td><td>2021-2022 IPV exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2021-2022 Varicella immunization rate</td><td>2021-2022 Varicella exemption rate</td></tr>
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