Start Date: ___________________________

REGISTRATION INFORMATION

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

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

OFFICE STAMP

Or write Name, Address, Phone Number, Email

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

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

cdphe.colorado.gov/immunization

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 Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at cdphe.colorado.gov/immunization/forms), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name: ________________ **Date of birth:** ________

Parent/guardian:(if student is under 18 years of age and not emancipated) ________________

Required Vaccines

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

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

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

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.

† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.

‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
RV Rotavirus							
MCV4 Meningococcal							
MenB Meningococcal							
HepA Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Health care provider printed name/signature: ________ / ________ Date: ________

Student is current on required immunizations for age (circle one): OR Yes No
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 child cares and preschools for the 2024-25 school year:
We know there's nothing more important than making sure your children stay healthy and learning all year long. Getting vaccinated keeps children from catching and spreading diseases that can make them sick and potentially keep them home from child care and preschool. This letter includes important information about Colorado's school and child care vaccine requirements, as well as other resources.

Required and recommended vaccines
Colorado law requires children who attend licensed child care and preschool 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.

To attend preschool and child care your child must be vaccinated against:

- Diphtheria, tetanus, and pertussis (DTaP)
- Haemophilus influenzae type b (Hib)
- Hepatitis B (HepB)
- Measles, mumps, and rubella (MMR)
- Pneumococcal disease (PCV)
- Polio (IPV)
- Varicella (chickenpox)

Colorado follows recommendations set by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. This committee is a group of medical and public health experts who study vaccines and recommend them for the public. View the recommended vaccine schedule for children through 6 years of age at www.cdc.gov/vaccines/schedules/easy-to-read/child-easyread.html.

CDC also recommends immunizations for COVID-19, hepatitis A (HepA), influenza (flu), respiratory syncytial virus (RSV), and rotavirus (RV) for child care-aged children, but these are not required for child care or school entry in Colorado.

This recommended schedule is safe and effective. It's based on how your child's immune system responds to vaccines at various ages, and how likely your child is to be exposed to a particular disease.

Exclusion from child care and school
Your child may be excluded if their program does not have an up-to-date Certificate of Immunization, Certificate of Exemption, or an in-process plan on file for your child.

If someone is sick or there is an outbreak of a vaccine-preventable disease at your child's school, and your child has not received the vaccine for that disease, they may be required to stay home. That could mean lost learning time for them and lost work and wages for you. For example, if your child has not received an MMR vaccine, they may need to stay home from their program for 21 days after someone gets sick with measles.

Have questions?
Talk with a health care provider or your local public health agency to ask questions and find out which vaccines your child needs. Find a vaccine provider at cdphe.colorado.gov/get-vaccinated. 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. It's never too late for families to get back on track! Learn more at www.cdc.gov/vaccines/adults/rec-vac/index.html.

Paying for vaccinations
If you need help finding free or low-cost vaccines, go to COVax4Kids.org, contact your local public health agency (cdphe.colorado.gov/find-your-local-public-health-agency), or dial 2-1-1 for information on Health First Colorado (Medicaid) and vaccine clinics in your area.

Vaccination records
Share your child's updated Certificate of Immunization with their program every time they receive a vaccine.

Need to find your child's vaccine record? It may be available from the Colorado Immunization Information System (CIIS). Visit COVaxRecords.org for more information, including directions on how to view and print your student's vaccine record.

Exemptions

If your child cannot get vaccines for medical reasons, you must submit a Certificate of Medical Exemption to your school, signed by an advanced practice nurse (APN), physician (MD, DO), or physician assistant (PA) licensed to practice in any state or territory in the United States. You only need to submit this certificate once, unless your student's school or information changes. Get the form at cdphe.colorado.gov/vaccine-exemptions.

If you choose not to have your child vaccinated according to Colorado's school vaccine requirements for nonmedical reasons, you must submit a Certificate of Nonmedical Exemption to your preschool or child care program. Nonmedical exemptions must be submitted at 2, 4, 6, 12, and 18 months of age. These exemptions expire when the next vaccines are due or when the child enrolls in kindergarten. There are two ways to obtain a nonmedical exemption.

1. Submit the Certificate of Nonmedical Exemption signed by an advanced practice nurse (APN), pharmacist, physician (MD or DO), physician assistant (PA), or registered nurse (RN), licensed in Colorado, or
2. Submit the Certificate of Nonmedical Exemption you will be able to access after completing the state's Online Immunization Education Module.

Find certificates and the Online Immunization Education Module at cdphe.colorado.gov/vaccine-exemptions.

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

Annually, programs must report immunization and exemption numbers (but not student names or birthdates) to CDPHE. Programs do not control their specific immunization and exemption rates or establish the Vaccinated Children Standard described in §25-4-911, CRS.

<table>
<tr><th colspan="3">Your child's program's immunization rates from the 2022-23 school year. Find previous years' data at COVaxRates.org.</th></tr>
<tr><th>Child care or preschool name</th><th>2022-23 MMR immunization rate (required)</th><th>2022-23 MMR exemption rate (required)</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Schools may choose to include rates for other school-required vaccines.</td></tr>
<tr><td rowspan="12">Vaccinated Children Standard
95% immunization rate for all school-required vaccines</td><td>2022-23 DTaP
immunization rate</td><td>2022-23 DTaP
exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2022-23 Hib
immunization rate</td><td>2022-23 Hib
exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2022-23 HepB
immunization rate</td><td>2022-23 HepB
exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2022-23 PCV
immunization rate</td><td>2022-23 PCV
exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2022-23 Polio
immunization rate</td><td>2022-23 Polio
exemption rate</td></tr>
<tr><td></td><td></td></tr>
<tr><td>2022-23 varicella immunization rate</td><td>2022-23 varicella exemption rate</td></tr>
<tr><td></td><td></td></tr>
</table>

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: ____________

CHILD HEALTH CONNECTION

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: ______________________________

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:____

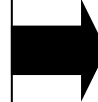
____

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan

☐ NO

◊ STEP 1: TREATMENT

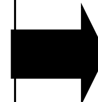
SEVERE SYMPTOMS: Any of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or 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 __________________________

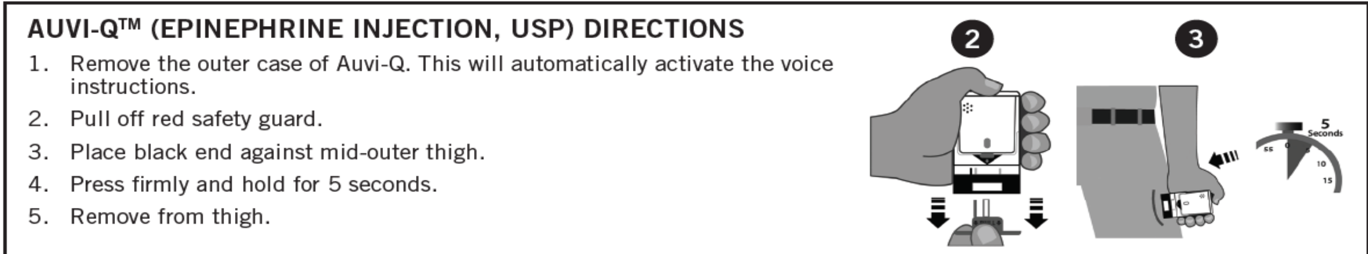
2.______________________________________ Room __________________________

3.______________________________________ Room __________________________

Self-carry contract on file: ☐ Yes ☐ No

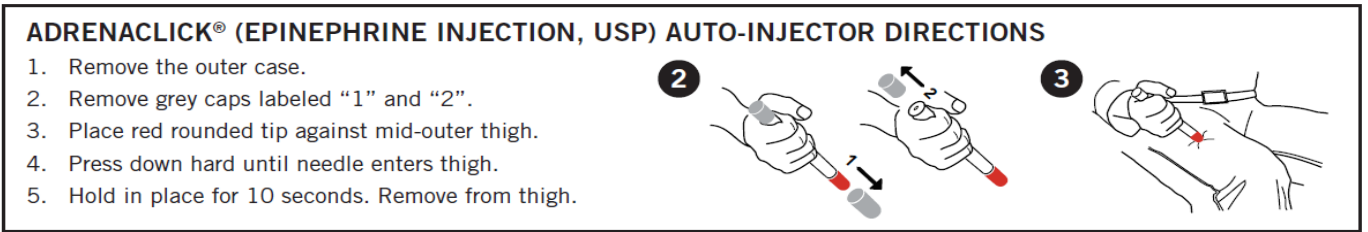
Expiration date of epinephrine auto injector: _______________________________

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.



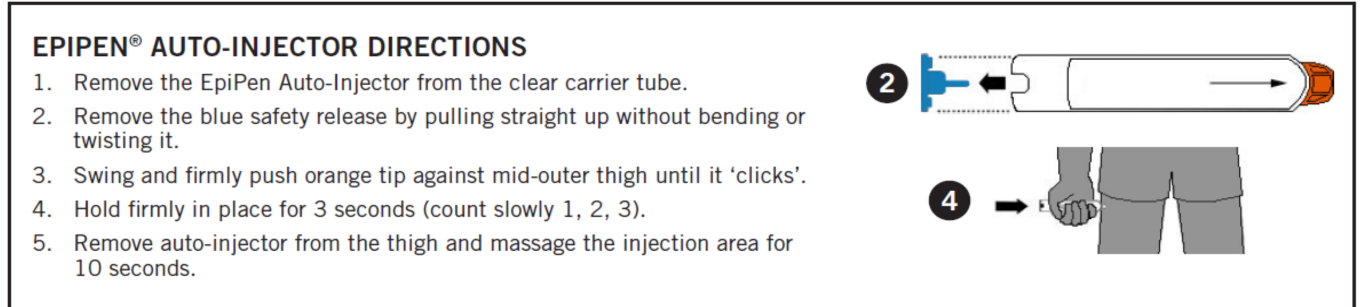
AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

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

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

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.
- Consistent and/or extended instances of late pick-ups may result in forfeiture of your child's spot in the program without a refund.
- 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

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

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.