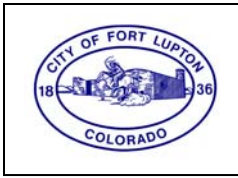


Enrollment Date: ____________

PRESCHOOL ENRICHMENT PROGRAM
EMERGENCY CARD

Gender: (Please circle)
M F

AGE: ________

Child's Full Name: ______________________________ Birth Date: ______________________________

Address: ______________________________ Home Phone: ______________________________

Mother's Name: ______________________________ Father's Name: ______________________________

Mother's Address: ______________________________ Father's Address: ______________________________

Mother's Home Phone: ______________________________ Father's Home Phone: ______________________________

Employer: ______________________________
____
Employer: ______________________________
____

Employer Address: ______________________________ Employer Address: ______________________________

Work Phone: ______________________________ Work Phone: ______________________________

Cell Phone: ______________________________ Cell Phone: ______________________________

Pager:______________________________ Pager:______________________________

Fax:______________________________ Fax:______________________________

Email:______________________________ Email:______________________________

INDIVIDUALS OTHER THAN PARENT/GUARDIAN AUTHORIZATION

Child's Full Name:____

ONLY these individuals have my authorization to care for my child in the event of an emergency and/or for drop-off and pick-up.

Parent / Guardians Initial: _____________

* Please advise these individuals that they are authorized and will need to present identification to staff.

Name / Relation: ________________________________ Phone Number: ______________________
Address: ________________________________

Name / Relation: ________________________________
Address: ________________________________ Phone Number: ______________________

Name / Relation: ________________________________
Address: ________________________________ Phone Number: ______________________

WAIVER

I acknowledge by signing below that I am the parent or legal guardian of the above named child, being allowed to participate in any way in the Fort Lupton Recreation Center Programs, related events and activities including travel to and from. Sponsored or co sponsored by the: Fort Lupton Recreation Department, City of Fort Lupton, the undersigned acknowledges, appreciates, and agrees that: the risk of injury to my child from the activities involved in these programs, is significant, including the potential for permanent disability and death, and while particular rules, equipment, and personal discipline may reduce the risk, the risk of serious injury does exist. For my child, I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases or others, and assume full responsibility for my child's participation. I willingly agree to comply with the program's stated and customary terms and conditions for participation. For my child, and on behalf of my/ours heirs, assigns personal representatives and next of kin, hereby indemnify and hold harmless all the above releases from any and all liabilities incident to my involvement or participation in these programs, even if arising from their negligence, to the fullest extent permitted by law.

_____________________________ ______________________ ____________
Parent/Guardian Signature Printed Name Date

MEDICAL HISTORY
AND INFORMATION FORM

Child's Full Name: ________________________________Gender:____________ Birthdate: __________________

Please check illnesses that your child has had:

Chicken Pox _____________Measles ____________ Rubella _____________ Hay Fever ___________

Rheumatic Fever __________Asthma ____________Epilepsy _____________ Mumps ____________

Poliomyelitis _____________ Whooping Cough __________ Diabetes ____________

Surgery/Accidents/Illnesses/Chronic Health Problems: ____

____

Describe any physical condition requiring special attention by center staff: ____________________________________

____

Check those allergies staff should be aware of and give the prescribed routine below.

Food (type) _______________________________ Insect bites/stings _______________________________________

Penicillin _________________________________ Other Drugs ____

____

Date of most recent examination of this child: ____

Please record immunizations and dates administered on the Colorado Department of Health Certificate or Immunization on the other side of this form or attach a copy from your records.

Physician/Health Care Professional: ________________________________ Phone: ________________________________

Address: ________________________________
____

Medical Insurance Co.: ________________________________ Phone: ________________________________
________________________________ ________________________________

Group #: ____

Dentist Name: ________________________________
Address: ________________________________ Phone: ________________________________
____

Hospital of Choice:
Address: ________________________________ Phone: ________________________________

Any intolerance to drugs, medication, sunscreen or food? ____

This health record and information is correct as far as I know and the person herein described has permission to engage in all prescribed activities, unless otherwise stated.

Parent/Guardian initial ________________

CHILD'S SOCIAL HISTORY
Part One

A description of your child's behavior and reaction to various incidents is desired. This information is confidential and will be reviewed by the Recreation Manager as a key to working with your child as an individual member of our program.

Child's Full Name: ____ Birthdate: _________________

Interaction with males: ____

Interaction with females: ____

Fears and dislikes: ____

Types of discipline used at home: ____

Reward system used at home: ____

Positive/negative school / camp experiences: ____

____

Child's favorite activity/hobbies/interest: ____

Briefly comment on the following:

Swimming ability:____

Athletic ability:____

Coordination:____

Play skills:____

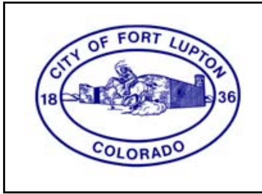
Peer interactions:____

Additional comments on child's social history: ____

____

____

PLEASE FEEL FREE TO DISCUSS ANY SOCIAL CONCERNS YOU MAY HAVE WITH THE RECREATION MANAGER.



CHILD'S SOCIAL HISTORY
Part Two

Does your child:

Wear: glasses	___Yes	___No
Hearing aid	___Yes	___No
Need assistance walking	___Yes	___No
Need assistance with toileting	___Yes	___No
Use a wheelchair	___Yes	___No
Feed Self	___Yes	___No
Dress Self	___Yes	___No

Use scissors, crayons, paint, paste, and small objects:
___Well ___Adequately ___Not at all

Communication abilities: How does your child make her/his needs known?____
____

Does your child currently have any emotional or behavioral problems? YES NO

What are some steps or rewards that work best at home for you and your child?____
____

Does your child prefer to play alone? ___Yes ___No

Name and ages of siblings:
____
____

If your child has special needs:
Diagnosis:
____
____

AUTHORIZATION TO
ADMINISTER MEDICATION

Note: For children who need to take over the counter or prescription medications during the after school enrichment program, this form needs to be completed in its entirety by a parent/ guardian and physician before any medication can be given by staff members. If the form is incomplete or not on file, the parent will be asked to return to the program to administer the medication regardless of the age of the child.

Parents, please complete this section

The parent/guardian of ______________________________ ask that the program staff give the
(child's first and last name)
following medication ____ at ______________
(Name of medication, one medication per sheet) (Time)
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in the original 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. Ask your pharmacist for a separate medicine bottle to keep at the facility.
Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packed 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 after school program staff.

____________________________________ ________________________________ __________
Parent/Guardian's Printed Name Parent/Guardian's Signature Date

_____________________________ ___________________________ _______________________
Home Phone Work Phone Cell Phone

Health Care Provider Authorization to Administer Medication at the After School Program

Child's Name ____ Birthdate ________________

Medication ______________________________________ Dosage ______________________

Route ______________________

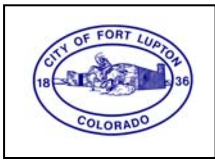
To be given at the following time(s) (be specific, we cannot use "as needed") ______________________
____

Special Instructions ____

Purpose of medication ____

Side effects that need to be reported ____

Physician/Health Care Professional Signature:



AUTHORIZATION TO
PARTICIPATE/EXCLUDE PARTICIPATION IN ACTIVITIES

I give permission for my child to participate in all preschool enrichment program activities with the following exceptions:

____

____ ______________________________
Signature of Parent / Guardian Date

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby give my permission to The Fort Lupton Recreation Center staff to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child ______________________________________ should an emergency arise. It is understood that the Fort Lupton Recreation Center preschool enrichment program staff will make a conscientious effort to locate the parent/guardian or the emergency contact listed on the registration document before any action will be taken. If it is not possible to locate the emergency contact listed, I will accept the expense of emergency medical or surgical treatment.

____ ______________________________
Signature of Parent / Guardian Date

PARENT MANUAL
RELEASE/STATEMENT OF UNDERSTANDING

I have read and understand the Fort Lupton Recreation Center's Preschool Enrichment Program Parent Manual and understand the policies contained within.

____ ______________________________
Signature of Parent / Guardian Date

SUNSCREEN PERMISSION FORM

Children will apply sunscreen to themselves under the direct supervision of a preschool enrichment program staff member 15-30 minutes before outdoor activities. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to parent/ guardian. It is the parent's responsibility to provide sunscreen with a specific amount of SPF they wish their child to have. Please have your child's first and last name clearly labeled on the bottle.

____ ___________________________________
Child's Name Name of Sunscreen and the SPF #

____ ______________________________
Signature of Parent / Guardian Date