FORT LUPTON
RECREATION CENTER
PARKS & RECREATION DEPARTMENT

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: _____

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: _____ Phone Number: _____
Address: _____

Name / Relation: _____ Phone Number: _____
Address: _____

**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 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

# 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 if Appropriate**

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam** _____ **** B/P** _____ ****Head Circumference (up to 12 months)** _____ ******

**** HCT/HGB** _____ **** Lead Level ☐Not at risk or Level** _____

****TB ☐Not at risk or Test Results ☐ Normal ☐ Abnormal**

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

**Recommended Follow-up**_____

**Provider Signature**

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

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

_____

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

**Office Stamp**

Or write Name, Address, Phone, #

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

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

# COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

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.

## 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: December 2017

Fort Lupton RECREATION

# PRESCHOOL Payment Policies

Effective with the 2020-2021 Preschool Enrichment Program, there are 2 payment options. The first is to pay the entire school year (September –May) in full. If you choose this option, you will receive a 10% discount. The second option is to set up your account with autopay. If you choose the autopay option, by signing below, you are authorizing the City of Fort Lupton and/or its agents and your financial institution to charge your credit/debit card for the total automatic payment due to the City of Fort Lupton Recreation Center for participation in the Preschool Program. You certify that you are the card holder. This authorization shall remain in effect until the full program fees have been paid in full or you have received authorization from The Fort Lupton Recreation Center to withdraw. If your payment fails to process, you will be terminated from the program until updated account information has been received. A list of scheduled payments for the 2020-2021 Preschool Program is described below.

**FULL TUITION DISCOUNTED FEE $1267.20 (3'S) $1524.60 (4'S)**

| MONTH of SERVICE | Auto Payment Date | FEE | |
|---|---|---|---|
| September 2020 | August 15, 2020 | $156.45 (3's) | $188.20 (4's) |
| October 2020 | September 15, 2020 | $156.45 (3's) | $188.20 (4's) |
| November 2020 | October 15, 2020 | $156.45 (3's) | $188.20 (4's) |
| December 2020 | November 15, 2020 | $156.45 (3's) | $188.20 (4's) |
| January 2021 | December 15, 2020 | $156.45 (3's) | $188.20 (4's) |
| February 2021 | January 15, 2021 | $156.45 (3's) | $188.20 (4's) |
| March 2021 | February 15, 2021 | $156.45 (3's) | $188.20 (4's) |
| April 2021 | March 15, 2021 | $156.45 (3's) | $188.20 (4's) |
| May 2021 | April 15, 2021 | $156.45 (3's) | $188.20 (4's) |

PRINT PAYEE NAME

PAYEE SIGNATURE

DATE

PARTICIPANT NAME