For Office Use:	Class	1/16

Foothills Christian Preschool & Kindergarten
6100 South Devinney Way Littleton, Colorado 80127
303-972-3162 or preschool@4fbc.org
www.fcpk.org

IDENTIFICATION & EMERGENCY INFORMATION

Child's Name ____________________ Phone ____________________

Name to be called at school ____________________ Birth date ____________________ Sex: Male/Female

Address ____
Street City Zip

Main Crossroads ____

Father's Information	**Mother's Information**
Name ____________________	Name ____________________
Home Phone ____________________	Home Phone ____________________
Cell Phone ____________________	Cell Phone ____________________
E-Mail Address ____________________	E-Mail Address ____________________
Employer ____________________	Employer ____________________
Employer Address ____________________	Employer Address ____________________
Business Phone ______________ EXT ______	Business Phone ______________ EXT ______
Occupation ____________________	Occupation ____________________

Siblings (Names, Male/Female and Ages): ____

____

Medical Professionals Who May Be Called In an Emergency

WE ARE REQUIRED BY LICENSING TO HAVE ALL THE FOLLOWING INFORMATION ALL LINES MUST BE COMPLETED.

____
Physician's Name Address Phone

____
Dentist's Name Address Phone

____
Hospital preference Address Phone

____
Insurance Company ID number

List any allergies, medical conditions or physical restrictions:

____

____

STATEMENT OF AUTHORIZATION

I, ____________________, as parent or legal guardian of said child, ________________, hereby give my permission to Foothills Christian Preschool & Kindergarten to call a doctor, dentist or 911 should an emergency situation arise. Permission is also granted for those emergency, medical, or hospital personnel to perform necessary care in the event it is not possible to locate us. We agree to accept all expenses incurred.

Parent or Guardian's Signature ____________________ Date ____________________

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www.foothillsbiblechurch.org

CHILD PICK-UP AUTHORIZATION FORM

Child's Name ______________________________

Name Three People (besides parents) who may be called and who can pick-up your child in an **Emergency**

Name	Relationship	Phone Number
1.		
2.		
3.		

I give permission for the following people to pick up my child from Foothills Christian Preschool and Kindergarten for the school year 2019-2020.

Name	Relationship	Phone Number
1.	Mother	
2.	Father	
3.		
4.		
5.		
6.		

Parent Signature ______________________ Date __________

PERSONAL & FAMILY HISTORY

Child's Name _________________________ Nickname __________________ Birth Date _____________________

Are both parents living in the home? Yes _________ No _________ Divorced? _________ Separated? ___________

Legal Custodian _______________________ Number of other children in the family? ________________________

List name, age and sex of other children in family: ____

Home church: ____

Does child have any allergies? Explain: ____

____

Are there any special foods or eating instructions? ____

Was your child full term or premature? ____

List any medical problems of which we should be aware of: ____

____

Has your child had any serious accidents, illness or surgery? _____________ Explain: ______________________

____

Is your child potty trained? Yes __________ No __________ (3's & older must be potty trained)

What words does the child use for toileting? ____

Does child have any bowel or bladder irregularities? ____

Has child had previous preschool or group experience? Yes _________ No _________

Where/When: ____

____

What aspects of our program made you select FCP&K? ____

____

PARENT'S/GUARDIAN'S SIGNATURE: ___________________________________ **DATE:** ____________

PERSONAL HISTORY

Child's Name: ______________________________

What are your expectations for this year? ______________________________

The best way to describe my child is: ______________________________

My child's strengths: ______________________________

My child's weaknesses: ______________________________

My child enjoys: ______________________________

My biggest concern for my child is: ______________________________

Is child right or left handed? ______________________________

Some of the things I would like to see the class do are: ______________________________

Some of the ways I would like to help the class are: ______________________________

How does child respond to changes or emergency situations: ______________________________

Does child have any fears? Explain: ______________________________

Does child enjoy being held or cuddled? ______________________________

Does child have a favorite song, story, etc. that they find comforting or relaxing? ______________________________

____

Does he/she speak plainly so that others (besides those at home) can understand? ______________________________

Are any foreign languages spoken in the home? ______________________________

Is there anything else you would like us to know about your child? ______________________________

____

What is your parenting and discipline style at home? ______________________________

____

PARENT'S/GUARDIAN'S SIGNATURE: ______________________________ **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.

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COLORADO
Department of Public Health & Environment

Certificate of Immunization

6 CCR 1009—The Infant Immunization Program and Immunization of Students Attending School
Schools shall have on file an official Certificate of Immunization for every student enrolled.

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name____________________ Date of Birth ____________________

Parent/Guardian ____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given						Titer Date
Hep B	Hepatitis B							
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)							
DT	Diphtheria, Tetanus (pediatric)							
Tdap	Tetanus, Diphtheria, Pertussis							
Td	Tetanus, Diphtheria							
Hib	*Haemophilus influenzae* type b							
IPV/OPV	Polio							
PCV	Pneumococcal Conjugate							
MMR	Measles, Mumps, Rubella							
Measles	Measles							
Mumps	Mumps							
Rubella	Rubella							
Varicella	Chickenpox			Provider Documentation Date of Disease		Positive Screen Date		
Vaccines recorded below this line are recommended. Recording of dates is encouraged.								
HPV	Human Papillomavirus							
Rota	Rotavirus							
MCV4/MPSV 4	Meningococcal							
Hep A	Hepatitis A							
Flu	Influenza							
Other								

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ A) Child Care Up to Date
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature ________ Date ________

☐ B) Child Care Up to Date
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature ________ Date ________

☐ C) Child Care/Pre-school/Pre-K*
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature ________ Date ________

☐ D) Complete for K–5th Grade
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature ________ Date ________

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.