

Foothills Christian Preschool & Kindergarten
 6100 South Deviney Way Littleton, Colorado 80127
 303-972-3162 or preschool@4fbc.org
 www.fcpc.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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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. _____	<u>Mother</u>	
2. _____	<u>Father</u>	
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: <input type="checkbox"/> None or Describe _____ Type of Reaction _____	
Diet: <input type="checkbox"/> Breast Fed <input type="checkbox"/> Formula _____ <input type="checkbox"/> Age Appropriate <input type="checkbox"/> Special Diet _____	
Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep. <input type="checkbox"/> 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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify any physical abnormalities) _____	
Allergies: <input type="checkbox"/> None or Describe _____ Type of Reaction _____	
Significant Health Concerns: <input type="checkbox"/> Severe Allergies <input type="checkbox"/> Reactive Airway Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Seizures <input type="checkbox"/> Diabetes <input type="checkbox"/> Hospitalizations <input type="checkbox"/> Developmental Delays <input type="checkbox"/> Behavior Concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Dental <input type="checkbox"/> Nutrition <input type="checkbox"/> Other _____	
Explain above concern (if necessary, include instructions to care providers): _____	
Current Medications/Special Diet: <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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: <input type="checkbox"/> Up-to-Date <input type="checkbox"/> See attached immunization record <input type="checkbox"/> 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 <input type="checkbox"/> Not at risk or Level _____	
** TB <input type="checkbox"/> Not at risk or Test Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
** Screenings Performed: <input type="checkbox"/> Vision: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Dental: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Recommended Follow-up: _____		

Provider Signature

Next Well Visit: <input checked="" type="checkbox"/> Per AAP guidelines* or <input type="checkbox"/> 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: _____
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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 1008—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						Titler Date
Hep B	Hepatitis B							
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)							
DT	Diphtheria, Tetanus (pediatric)							
Tdap	Tetanus, Diphtheria, Pertussis							
Td	Tetanus, Diphtheria							
Hib	<i>Haemophilus influenzae</i> type b							
IPV/DPV	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/MPV4	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-6th Grade
Up to date for K-6th 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.