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

Name ______________________

Home Phone ______________________

Cell Phone ______________________

E-Mail Address ______________________

Employer ______________________

Employer Address ______________________

Business Phone ______________________ EXT ________

Occupation ______________________

Mother's Information

Name ______________________

Home Phone ______________________

Cell Phone ______________________

E-Mail Address ______________________

Employer ______________________

Employer Address ______________________

Business Phone ______________________ EXT ________

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 case of an **Emergency**

Name	Relationship	Phone Number
1.		
2.		
3.		

Other people who have permission to pick up my child from FCP&K.

Name	Relationship	Phone Number
1.		
2.		
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, 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

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

OFFICE STAMP

Or write Name, Address, Phone Number, Email

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

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.

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

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							
COVID-19							
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: ____________