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Foothilis Christian Preschoof & Kindergarten 6100 South Devinney Way Littleton, Colorado 80127 303-972-3162 or preschool@4fbo.org www.fcpk.org

## IDENTIFICATION & EMERGENCY INFORMATION

Chlid's Name	Phone Phone					
Name to be called at school						
AddressStreet						
		Zlp				
Main Crossroads						
<u>Father's Information</u>	•	s Information				
Name						
Home Phone						
Cell Phone						
E-Mall Address						
Employer	Employer					
Employer Address						
Business PhoneEXT	Business Phone	EXT				
Occupation	Occupation					
Siblings (Names, Male/Female and Ages):						
Physician's Name	Address	Phone				
Dentlet's Name	Address	Phone				
Hospital preference	Address	Phone				
Insurance Company	ID number					
List any aflergies, medical conditions or physical restricti						
STATEME	NT OF AUTHORIZATION	1				
STATEME , as parent or legal guardle Poolhills Christian Preschool & Kindergarten to call a do also granted for those emergency, medical, or hospital p locate us. We agree to accept all expenses incurred.	NT OF AUTHORIZATION					

# Foothills Christian Preschool & Kindergarten 6100 South Devinney Way Littleton, CO. 80127 303-972-3162 preschool@4fbc.org 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 case of an Emergency				
Name	Relationship	Phone Number		
	,			
Name	Relationship			
Parent Signature		Date		

### PERSONAL & FAMILY HISTORY

Child's Namo	Nicknamo	Birth	Date	
Are both parents living in the home? Yes	No	Divorced?	Sopurated?	
Legal Custodian	Number of c	ther oblidren in the family	79	
List name, age and sex of other children in	family:			et-tonal
Home church;	<del></del> ;			_
Does child have any allergies? Explain:				
Are there my special foods or caling instru				-
Was your child full term or premature?				_
List any medical problems of which we sh				
Has your child had any serious accidents, i	liness, or surgery?	Explai		
Is your child potty trained? Yes				
What words does the child use for toileting	?			
Does child have any bowel or bladder irreg	gularlites?			
Has child had provious preschool or group Where/When:		···		
What aspects of our program made you sel	eot FCP&K7			
PARENT'S/GUARDIAN'S SIGNATUR	E:		DATE;	_,

### PERSONAL HISTORY

Child's Name;
What are your expectations for this year?
The best way to describe my child is:
My ohlid's strongths:
My ohild'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 unything 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**

Child's Name:	Birthdate:
Allergles: None OR List fo	pod/medication:
	appropriate Special-Describe:
Sleep: Your healthcare provider recr	s may be applied as requested in writing by parent unless skin is broken or bleeding. commends that all infants less than 1 year of age be placed on their back for sleep.
	on their back for sleep,
l, form and applicable attachments wi Name:	, give permission for my child's healthcare provider to share this rith my child's school, childcare, or camp. Contact information for the person to receive this formation for the person to receive this formation.
Parent/Guardian Signature:	Date:
HEALTH CARE PROVIDER	Please complete after parent section has been completed.
Date of most recent health appraisa	al;Welght:
Physical Exam: Normal Abno	ormal-describe:
Allergies: Mone OR List food	/medication:Type of Reaction
Current Medications: [_] None OR [	List;
A separate medication authorization	ion form ( <u>link</u> ) is required for medications given in school, childcare, or camp.
A conserte district and the Line Age	appropriate Special-describe:
A separate del statement limici ic	i fedulfed for food nrovided af school, childrera, ar camp
Hoolth Canarras Course Allerda	Asthma Cally Carry
Health Concerns: 🔲 Severe Allergie	es Asthma Selzures Diabetes Hospitalizations Behavior Concerns
Health Concerns:  Severe Allergie Developmental Delays  Visi	es Asthma Seizures Diabetes Hospitalizations Behavior Concerns Ion Hearing Oral Health Under/Overweight Other:
Health Concerns: Severe Allergie Developmental Delays Visiexplain above concerns (if necessar	es Asthma Seizures Diabetes Hospitalizations Behavior Concerns  lon Hearing Oral Health Under/Overweight Other:  rry, include instructions to care providers):
Health Concerns: Severe Allergie Developmental Delays Visies Explain above concerns (if necessar	es Asthma Seizures Diabetes Hospitalizations Behavior Concerns ion Hearing Oral Health Under/Overweight Other:  iry, include instructions to care providers):  imunization record or official exemption form Next vaccine due date:
Health Concerns: Severe Allergie Developmental Delays Visies Explain above concerns (if necessar	es Asthma Seizures Diabetes Hospitalizations Behavior Concerns ion Hearing Oral Health Under/Overweight Other:  ary, include instructions to care providers):  amunization record or official exemption form Next vaccine due date:  Please complete if appropriate, This information is required by Early Head Start and
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Health Concerns: Severe Allergie Developmental Delays Vision Explain above concerns (If necessar Immunizations: See attached important CARE PROVIDER HEALTH CARE PROVIDER Height: B/P: Lead Level: Not at risk OR Lead	Asthma Seizures Diabetes Hospitalizations Behavior Concerns Ion Hearing Oral Health Under/Overweight Other:  Inny, include instructions to care providers):  Innunization record or official exemption form Next vaccine due date:  Please complete if appropriate. This information is required by Early Head Start and Head Start Programs per the State EPSDT Schedule.  Head Circumference (up to 12 months):  Head Circumference (up to 12 months):  TB: Not at risk OR Test Result: Normal Abnormal
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Health Concerns: Severe Allergie Developmental Delays Vision Explain above concerns (if necessar Immunizations: See attached immunizations: Pee attached immunizations: See attached immunizations: Lead Level: Not at risk OR Lead Level: Not at risk OR Lead Level: Not at risk OR Abovelopmental Concerns: PROVIDER SIGNATURE	Asthma Seizures Diabetes Hospitalizations Behavior Concerns Ion Hearing Oral Health Under/Overweight Other:  Inny, include Instructions to care providers):  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption form Next vaccine due date:  Innunization record or official exemption f
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Health Concerns: Severe Allergie Developmental Delays Vision Explain above concerns (if necessar Immunizations: See attached immunizations: Pee attached immunizations: Pe	Asthma   Seizures   Diabetes   Hospitalizations   Behavior Concerns

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

cdphe.colorado.gov/immunization



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 Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at cdphe.colorado.gov/immunization/forms), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name:					Date of bir	th:	
Parent/guardian:(If student is under 18 year	rs of age and n	ot emancipated)					
Required Vaccines	Immunization date(s) MM/DD/YY						Titer Date*
HepB Hepatitis B	1		:	3		:	
TaP Diphtheria, Tetanus, Pertussis (pediatric)†		,				,	
dap Tetanus, Diphtheria, Pertussis†				1			
<b>d</b> Tetanus, Diphtheria				;	:	,	•
ib Haemophilus influenzae type b	1	) ) )	;				
V/OPV Polio							
CV Pneumococcal Conjugate			<u>.</u>	;			
MR Measles, Mumps, Rubella‡				1			
easies			<u> </u>				t t
iumps			, , ,,	1 1 4 1			t t
ubella							
aricella Chickenpox	t	***************************************	1				
nricella - date of disease		Varicella - pos date	itive screen		1	a under "Titer Dat proof of immunity	e" indicates that a titer is for this vaccine.
Recommended Vaccines PV Human Papillomavirus		n date(s) MM/DD	, , , , , , , , , , , , , , , , , , ,				, , , , , , , , , , , , , , , , , , ,
the contract of the contract o			, ,		!		
/ Rotavirus					ļ !		
CV4 Meningococcal	· {						
enB Meningococcal			<u> </u>		<u> </u>		
PPA Hepatitis A	. }		) :				
u Influenza DVID-19		:			<u>.</u>		
ther						. } }	
lealth care provider printed name/signa	ture	···	:		:	: Date:	
tudent is current on required immunizal	-	circle one): OR	Yes	No			
mmunization record transcribed/review		,					
chool health authority signature or stam	np:	***************************************				Date:	
Optional) I authorize my/my student's s					n state/local p	ublic health	agencies and the
Colorado Immunization Information Syste	•	·		,			
Parent/Guardian/Student (emancipated	or over 18 yrs	old) signature:			I	Date:	