

Foothills Christian Preschool & Kindergarten
 8100 South Devlinney 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 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 PCP&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

