For Office Use: Class Assigned

Foothills Christian Preschool
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 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 Foothills Christian Preschool.

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

cdphe.colorado.gov/immunization

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 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 birth: _____

Parent/guardian: (if student is under 18 years of age and not emancipated) _____

Required Vaccines

	Immunization date(s) MM/DD/YY							Titer Date* MM/DD/YY
HepB 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	

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

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.
† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.
‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
RV Rotavirus							
MCV4 Meningococcal							
MenB Meningococcal							
HepA Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Health care provider printed name/signature: _____ / _____ Date: _____

Student is current on required immunizations for age (circle one): OR Yes No
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: _____

Last Reviewed: May 2023