



PRESCHOOL HEALTH STATEMENT/RECORD FORM

This form is to be filled out by a licensed physician or a licensed nurse practitioner that has seen the child in the last 12 months.

Children who enroll in the City of Northglenn Preschool Program must submit (yearly) a signed and dated statement of the child's health status which indicates the child's abilities and/or limitations to participate in the regularly scheduled class associated with this program.

Child's Name: _____ Sex: _____ DOB: _____

Address: _____

Physician's Name: _____

Physician's Address: _____

HEALTH HISTORY(chronic or recurring)	ALLERGIES) (chronic or recurring)	IMMUNIZATIONS
Ear Infections	Hay Fever	PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD ON THE CARD IN THE PACKET
Diabetes	Plant Poisoning	
Heart Disease/Defect	Insect Bites	
Asthma	Penicillin	
Convulsions/Seizures	Food	
Nosebleeds	Other Drugs	
Other		

Operations or serious injuries (dates): _____

Is the child on any medications?: _____

Physical limitations: _____ Describe: _____

Accommodations (?): _____

Dietary limitations: _____ Describe: _____

Vision: _____ Hearing: _____

Date of my most recent well-child examination of child: _____

Signature of physician or licensed nurse practitioner

Date

This child is _____ is not _____ physically and/or emotionally able to participate in the Tiny Tot/Teeny Tot program.



AUTHORIZATION SIGNATURE PAGE

EMERGENCY MEDICAL CARE:

I hereby give my permission to the City of Northglenn Pre-School Staff to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency care for my child _____ should an emergency arise. It is understood that staff instructors will make a conscientious effort to locate the parents or emergency contacts listed on the registration information document when 911 action is taken. I/we accept all expenses associated with such emergency medical and/or surgical care. By the signature/s below, I/we release the City of Northglenn and its employees from any liability.

- INITIALS: _____

ILL CHILD STATEMENT:

I will not bring my ill child to pre-school. If your child has had a fever, vomited, had diarrhea within the last 24 hours, has green/brown nasal discharge and/or productive cough, please keep them home. Child may return after symptoms have resolved for 24 hours. Notices will be posted in classroom to alert parents of exposure to a contagious condition. Confidentiality will always be maintained. Staff have an obligation to check children upon entry to class, if they deem a child is ill, the child will not be allowed to remain for the day.

- INITIALS: _____

SUNSCREEN :

SPF 30 no additive sunscreen is provided by the program for parents to apply to their child at the beginning of class days that would require such. In the event that parents do not apply sunscreen themselves, permission is granted for staff to appropriately apply sunscreen to my child. If the sunscreen provided does not meet the needs of the parent, please provide sunscreen for your child with their name on the container.

- INITIALS: _____

FIELD TRIPS:

Pre-school classes do not leave the facility for field trips. We do however take occasional walking trips around the facility grounds. I give my permission for my child to participate in these activities. Monthly calendars will alert parents to upcoming walking trips.

- INITIALS: _____

VIDEO/TELEVISION VIEWING:

Video viewing will only take place when it directly enhances planned curriculum. I give my permission for my child to participate at those times. Monthly activity calendars will indicate when these activities are planned.

- INITIALS: _____

MEDIA WAIVER:

Occasionally, photos of children are taken by staff to enhance our environment or to put in brochure publications. I give my permission for my child's images to be used for these occasions.

- INITIALS: _____

Parent/Guardian Signature

Date

Print Parent/Guardian Name



PARENT CONTRACT
PRE-SCHOOL PROGRAMS

I have read and understand the policies and procedures set forth in the manual, have had all my questions answered. I agree with the policies and procedures as stated.

Parent Signature

Date

Please Print Name

MEDICATIONS:

IF YOUR CHILD REQUIRES MEDICATION TO BE GIVEN DURING CLASS TIME, PLEASE TALK TO THE INSTRUCTOR AND YOU WILL BE GIVEN APPROPRIATE FORMS TO BE FILLED OUT BY YOU AND YOUR PHYSICIAN.

Thank you for taking the time to properly fill out and return these necessary forms.

Sincerely,
Pre-School Staff

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
Hep B	Hepatitis B
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)
DT	Diphtheria, Tetanus (pediatric)
Tdap	Tetanus, Diphtheria, Pertussis
Td	Tetanus, Diphtheria
Hib	Haemophilus influenzae type b
IPV/OPV	Polio
PCV	Pneumococcal Conjugate
MMR	Measles, Mumps, Rubella
Varicella	Chickenpox
Vaccines recorded below this line are recommended. Recording of dates is encouraged.	
HPV	Human Papillomavirus
Rota	Rotavirus
MCV4/MPSV4	Meningococcal
Hep A	Hepatitis A
TIV/LAIV	Influenza
Other	

Healthcare Provider Documentation Date _____ Lab Verification Date _____

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–5th Grade**
Up to date for K–5th 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.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.
SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Medical exemption to the following vaccine(s):
La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):

Signed (Firma) _____ Date (Fecha) _____
Physician (Médico) _____ Hep B DTaP Tdap Hib IPV PCV MMR VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Religious exemption to the following vaccine(s):
Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor) _____ Hep B DTaP Tdap Hib IPV PCV MMR VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Personal exemption to the following vaccine(s):
Exención por creencias personales de la(s) siguiente(s) vacuna(s):

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor) _____ Hep B DTaP Tdap Hib IPV PCV MMR VAR

