Lafayette RECREATION PRESCHOOL

Early Childhood Preschool Program Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

CHILD INFORMATION

Start Date:

Child's Name: Date of Birth: (Circle) M / F

Address: City, Zip Code:

1. PARENT or LEGAL GUARDIAN The parent or guardian who registers this child for the Preschool Program is responsible for the monthly payments. Please sign below that you understand you are responsible for payment on your child's account. Any unpaid Preschool balances will be turned over to collections and your Recreation Center household account will be frozen until payment is received. Signature: _____	**2. PARENT or LEGAL GUARDIAN** The parent or guardian who registers this child for the Preschool Program is responsible for the monthly payments. Please sign below that you understand you are responsible for payment on your child's account. Any unpaid Preschool balances will be turned over to collections and your Recreation Center household account will be frozen until payment is received. Signature: _____
Name:	Name:
Relationship to Child:	Relationship to Child:
Address:	Address:
City, Zip Code:	City, Zip Code:
Home Phone:	Home Phone:
Employer:	Employer:
Address:	Address:
City, Zip Code:	City, Zip Code:
Work Phone:	Work Phone:
Alternative Phone:	Alternative Phone:
Email:	Email:

AUTHORIZED PICK UP AND EMERGENCY CONTACT INFORMATION (Persons other than parent, to be notified) :

1. Name:	2. Name:
Relationship to Child:	Relationship to Child:
Address:	Address:
City, Zip Code:	City, Zip Code:
Home Phone:	Home Phone:
Alternative Phone:	Alternative Phone:

PROHIBITED AUTHORIZATION (Names of persons, NOT authorized to pick up the child):

Name:	Name:
Relationship to Child:	Relationship to Child:
Phone:	Phone:

***If there are any custodial restrictions regarding this child the registering parent must provide copies of judicial orders documenting such restrictions to the City of Lafayette Early Childhood Preschool program prior to the child's participation**.

Early Childhood Preschool Program
Emergency Information Forms

Lafayette RECREATION PRESCHOOL

* All areas must be filled in, if not applicable write N/A.

CHILD INFORMATION

Child's Name: Date of Birth: (Circle) M / F

Date of my child's most recent health examination: _____

A copy of my child's immunization records are attached and on an CDPHE approved form: _____ (initial)

PAST ILLNESSES—CHECK THOSE THAT APPLY AND GIVE APPROXIMATE DATES:

_____	Chicken Pox	_____	Rubella	_____	Rheumatic Fever
_____	Asthma	_____	Hay Fever	_____	Whooping Cough
_____	Mumps	_____	Epilepsy	_____	Other
_____	Poliomyelitis	_____	Diabetes		

Comments: _____

Surgery / Accidents / Illnesses / Chronic Health Problems: _____

_____

Please list any medication (s) prescribed: _____

_____

Allergies: _____

Restrictions: _____

Dietary Restrictions: _____

INFORMATION REQUIRED BY LAW

Physicians Name: _____ Phone : _____

Address: _____ City / Zip Code: _____

Hospital Preferred for Emergency Treatment: _____ Phone: _____

Address: _____ City / Zip Code: _____

Health Insurance Company: _____ Policy or ID#: _____

Dentist: _____ Phone: _____

Address: _____ City / Zip Code: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, the undersigned, a parent or guardian of the above named child herein authorizes all adult sponsors, or any responsible adult person bearing this written authorization into whose care the above mentioned minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical diagnosis or treatment and hospital care. Such care is to be rendered to said minor under the general or special supervision and upon the advice of a physician, dentist, and/or surgeon licensed to practice in the State Of Colorado and to consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care. In addition, I authorize Lafayette Recreation Department staff to exchange relevant information about my child. Every effort will be taken to locate a parent/guardian before any action is taken. All medical expenses will be accepted by the parent/ guardian. The Lafayette Recreation Department is absolved of any or all liability for accidents or injuries received during any or all program-sponsored activities.

_____ _____

Parent or Legal Guardian Signature Date

EMERGENCY INFO CARD

Child's Last Name	Child's First Name	Birth Date
Home Address		
City	Zip	Home Phone
Father's Name	Home Phone	Alt. Phone
Mother's Name	Home Phone	Alt. Phone
Emergency Contact	Contact Phone	Preferred Hospital
Physician's Name	Address	Phone
Dentist's Name	Address	Phone
Health Concerns, Allergies, etc.		

This "Emergency Info Card" is <u>VERY Important</u>! Your child's counselor will carry this card with them at all times. Please have <u>ALL</u> information filled in.

I give my permission to the recreation center staff to call a physician or emergency service for medical, dental or surgical care for my child should an emergency arise. I understand that all expenses incurred for the care of my child will be assumed by myself, I give recreation center staff complete authorization to speak for me and sign the necessary paperwork in order to gain medical care for my child. _____

Parent/Guardian Initials

Height: _____ Eye Color: _____ Weight: _____Hair Color: _____

Securely Tape A Recent "Head Shot" Photo Here

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			Healthcare Provider Documentation Date _____		Lab Verification Date _____	
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							

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

Table 1. MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION

VACCINE [a]	Level of School/Age of Student											
	Child Care 2–3 mos	Child Care 4–5 mos	Child Care 6–7 mos	Child Care 8–11 mos	Child Care 12–14 mos	Child Care 15–18 mos	Child Care 19–23 mos	Pre-school 2–4 yrs	K Entry 4–6 yrs	Grades K to 5 5–10 yrs	Grades 6 to 12 11–18+yrs	College
Hepatitis B [l]	1	2	3						3	3	3	
Pertussis/Tetanus/ Diphtheria	1	2	3		see footnote b	4			5/4 [b]	5/4 [b c]	5/6 [c d]	
Haemophilus influenzae type b (Hib) [j]	1	2	2	3/2	3/2	3/2/1	3/2/1	3/2/1				
Pneumococcal Conjugate [k]	1	2	3/2		4/3/2	see footnote k						
Polio [e]	1	2	3						4/3 [f]	4/3 [f]	4/3 [f]	
Measles/Mumps/ Rubella [g]					1	see footnote g			2 [h]	2 [h]	2 [h]	2 [h i]
Varicella [m]					1	see footnote n			2 [n]	2/1 [n]	2/1 [n o]	
Meningococcal												[p]

a: Vaccine doses administered no more than 4 days before the minimum interval or age are to be counted as valid.

b: Five doses of pertussis, tetanus, and diphtheria vaccines are required at school entry in Colorado unless the 4th dose was given at 48 months of age or older (i.e., on or after the 4th birthday) in which case only 4 doses are required. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3, at least 6 months between dose 3 and dose 4 and at least 6 months between dose 4 and dose 5. The final dose must be given no sooner than 4 years of age (dose 4 may be given at 12 months of age provided there is at least 6 months between dose 3 and dose 4).

c: For students 7 years of age or older who have not had the required number of pertussis doses, no new or additional doses are required. Any student 7 years of age or older at school entry in Colorado who has not completed a primary series of 3 appropriately spaced doses of tetanus and diphtheria vaccine may be certified after the 3rd dose of tetanus and diphtheria vaccine (or tetanus, diphtheria, and pertussis vaccine if 10 or 11 years) if it is given 6 months or more after the 2nd dose.

d: The student must meet the minimum prior requirement for the 4th or 5th doses of diphtheria, tetanus, and pertussis vaccine and have 1 tetanus, diphtheria, and pertussis vaccine dose.

e: For polio, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

f: Four doses of polio vaccine are required at school entry in Colorado unless the 3rd dose was given at 48 months of age or older (i.e., on or after the 4th birthday) in which case only 3 doses are required. There must be at least 4 weeks between dose 1 and dose 2, at least 4 weeks between dose 2 and dose 3 and at least 6 months between dose 3 and dose 4. The final dose must be given no sooner than 4 years of age.

g: For measles, mumps, and rubella, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable for the specific disease tested. The 1st dose of measles, mumps, and rubella vaccine must have been administered at 12 months of age or older (i.e., on or after the 1st birthday) to be acceptable.

h: The 2nd dose of measles vaccine or measles, mumps, and rubella vaccine must have been administered at least 28 calendar days after the 1st dose.

i: Measles, mumps, and rubella vaccine is not required for college students born before January 1, 1957.

j: The number of Hib vaccine doses required depends on the student's current age and the age when the vaccine was administered. If any dose was given at 15 months of age or older, the Hib vaccine requirement is met. For students who began the series before 12 months of age, 3 doses are required of which at least 1 dose must have been administered at 12 months of age or older (i.e., on or after the 1st birthday). If the 1st dose was given at 12 to 14 months of age, 2 doses are required. If the current age is 5 years of age or older, no new or additional doses are required.

k: The number of pneumococcal conjugate vaccine doses depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered before 6 months of age, the child is required to receive 3 doses 2 months apart and an additional dose between 12–15 months of age. If started between 7–11 months of age, the child is required to receive 2 doses, two months apart and an additional dose between 12–15 months of age. If the series was started between 12–23 months of age, then the child is required to receive 2 doses, two months apart. If the current age is 2 years of age or older, no new or additional doses are required.

l: For hepatitis B, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable. The second dose is to be administered at least 4 weeks after the first dose, and the third dose is to be administered at least 16 weeks after the first dose and at least 8 weeks after the second dose. The final dose is to be administered at 24 weeks of age (6 months of age) or older and is not to be administered prior to 6 months of age.

m: For varicella, written evidence of a laboratory test showing immunity or a documented disease history from a health care provider is acceptable. The 1st dose of varicella vaccine must have been administered at 12 months of age or older (i.e., on or after the 1st birthday) to be acceptable.

n: If the second dose of varicella vaccine was administered to a child before 13 years of age, the minimum interval between dose 1 and dose 2 is three months, however, if the second dose is administered at least 28 days following the first dose, the second dose does not need to be repeated. For a child who is 13 years of age or older, the second dose of varicella vaccine must have been administered at least 28 calendar days after the 1st dose. See Table 2 for the school years/grade levels that the 1st and 2nd doses of varicella will be required.

o: If the 1st dose of varicella vaccine was administered at 13 years of age, 2 doses are required, separated by a minimum of 4 weeks or 28 calendar days.

p: Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new student or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed.

Table 2. TIMETABLE FOR IMPLEMENTATION OF REQUIREMENTS FOR SELECTED IMMUNIZATIONS FOR GRADES K TO 12

Refer to Table 1 for the minimum number of doses required for a particular grade level. Table 2 shows the year of implementation for a requirement from Table 1 and is restricted to varicella vaccine dose 1 (Var1) and dose 2 (Var2) and tetanus, diphtheria, and pertussis vaccine (Tdap). Requirements and effective dates for other vaccines are listed in Table 1. In this table, after a vaccine is required for grades K to 12, it is no longer shown, but the requirements listed in Table 1 continue to apply.

School Year	Grade Level												
	K	1	2	3	4	5	6	7	8	9	10	11	12
2007–08	Var2	Var1	Var1	Var1	Var1	Var1	Tdap Var1	Var1			Tdap		
2008–09	Var2	Var2	Var1	Var1	Var1	Var1	Tdap Var1	Tdap Var1	Var1		Tdap	Tdap	
2009–10	Var2	Var2	Var2	Var1	Var1	Var1	Tdap Var1	Tdap Var1	Tdap Var1	Var1	Tdap	Tdap	Tdap
2010–11	Var2	Var2	Var2	Var2	Var1	Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap Var1	Tdap	Tdap
2011–12	Var2	Var2	Var2	Var2	Var2	Var1	Var1	Var1	Var1	Var1	Var1	Var1	
2012–13 (Var1 required for grades K to 12)	Var2	Var2	Var2	Var2	Var2	Var2	Var1	Var1	Var1	Var1	Var1	Var1	Var1
2013–14	Var2	Var2	Var2	Var2	Var2	Var2	Var2						
2014–15	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2					
2015–16	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2				
2016–17	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2			
2017–18	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2		
2018–19	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	
2019–20 (Var2 required for grades K to 12)	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2	Var2

Medication Administration in School or Child Care

The parent/guardian of _____ ask that school child care staff give the
(Child's name)
following medication_____ at _____
(Name of medicine and dosage) (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication.
The parent agrees to pick up expired or unused medication within one week of notification by staff.

Prescription medications must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

_____ _____ _____
Parent/Legal Guardian's Name Parent/Legal Guardian Signature Date

_____ _____
Work Phone Home Phone

****

Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: _____ **Birthdate:**_____

Medication: _____

Dosage: _____**Route** _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____ _____

Side effects that need to be reported:

Starting Date: _____**Ending Date:** _____

_____ _____
Signature of Health Care Provider with Prescriptive Authority **License Number**

_____ _____
Phone Number **Date**

Please ask the pharmacist for a separate medicine bottle to keep at school/child care.
Thank you!

Lafayette RECREATION

Allergy & Anaphylaxis Action Plan

Place child's photo here

Student's Name: _____D.O.B. _____ Grade: _____
School: _____ Teacher: _____

ALLERGY TO: _____

History: _____

Asthma: ☐YES ☐NO *Higher risk for severe reaction

To be completed by healthcare provider

◊ STEP 1: TREATMENT

SYMPTOMS: GIVE CHECKED MEDICATION(S)		
➢Suspected ingestion or sting, but *no symptoms*	☐Epinephrine	☐Antihistamine
MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort		☐Antihistamine
MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth	☐Epinephrine	☐Antihistamine
SKIN: Flushing, hives, itchy rash	☐Epinephrine	☐Antihistamine
STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea	☐Epinephrine	☐Antihistamine
‡ THROAT Tightening of throat, hoarseness, hacking cough	☐Epinephrine	☐Antihistamine
‡ LUNG Shortness of breath, repetitive coughing, wheezing ☐ Inhaler	☐Epinephrine	☐Antihistamine
‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin	☐Epinephrine	☐Antihistamine
➢If reaction is progressing (several of the above areas affected), give	☐Epinephrine	☐Antihistamine

‡ Potentially life threatening: give epinephrine first, then can give antihistamine!
Remember - severity of symptoms can quickly change!

DOSAGE

Epinephrine: inject intramuscularly (check one):
☐EpiPen®0.3 mg ☐EpiPen®Jr.0.15 mg
☐ Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

Antihistamine: give_____
(Medication/dose/route

****ATTENTION..If Antihistamine given, the parents will be notified to pick up their child for closer observation!**

Asthma Rescue (if asthmatic): give_____
(Medication/dose/route)

Student has been instructed and is capable of self administering own medication. ☐Yes ☐No

Provider (print) _____Phone Number: _____

Provider's Signature: _____

Start Date: _____End Date:_____

◊ STEP 2: EMERGENCY CALLS :

If epinephrine given, **call 911.** State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

1. Parent: _____ Phone Number: _____
2. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____1) _____ 2) _____
   b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school and/or child care facility personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school and/or childcare facility with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child. **This Health Care Plan will be effective for one year or unless parents and/or physician request to have changes made sooner**

Parent/Guardian's Signature: _____Date:_____

School Nurse: _____ Date: _____

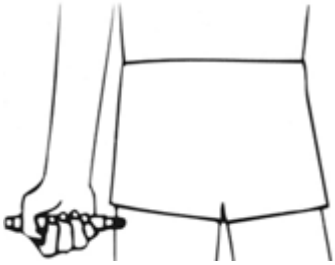
Student Name: _____ DOB: _____

EpiPen® and EpiPen® Jr. Directions

Expiration date: _____

- Pull off blue activation cap.

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit CALL 911
- Student to remain lying done

Lafayette RECREATION

COLORADO SCHOOL ASTHMA CARE PLAN:

Photo of Child

NAME:	BIRTH DATE:
TEACHER:	GRADE:
PARENT/GUARDIAN:	CELL PHONE:
HOME PHONE:	WORK PHONE:
OTHER CONTACT:	PHONE:
PREFERRED HOSPITAL:	

Triggers: ☐Weather(cold air, wind) ☐ Illness ☐Exercise ☐Smoke ☐Dog/Cat ☐Dust ☐Mold ☐Pollen Other:_____

☐Give 2 puffs of _____rescue med ☐15 minutes before activity. Indications: ☐Phys Ed class ☐exercise/sports ☐Recess

Explanation:

☐Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for rescue inhaler)	
IF YOU SEE THIS:	**DO THIS:**
• Difficulty breathing • Wheezing • Frequent cough • Complains of chest tightness • Unable to tolerate regular activities but still talking in complete sentences • Other:	• Stop physical activity • **GIVE RESCUE MED (NAME):_____** ☐ **1 PUFF** ☐ **2PUFFS** ☐ **OTHER:** ☐ **VIA SPACER** • If no improvement in 10-15 minutes, repeat use of rescue med: ☐ **1 PUFF** ☐ **2 PUFFS** ☐ **OTHER:** ☐ **VIA SPACER** • If student's symptoms do not improve or worsen, call 911 • Stay with student and maintain sitting position • Call parents/guardians and school nurse • Student may resume normal activities once feeling better
• **IF THERE IS NO RESCUE INHALER AT SCHOOL:** ➢ CALL PARENTS/GUARDIANS TO PICK UP STUDENT AND/OR BRING INHALER/MEDICATIONS TO SCHOOL ➢ INFORM THEM THAT IF THEY CANNOT GET TO SCHOOL, 911 MAY BE CALLED	
IF YOU SEE THIS: RED ZONE -SEVERE UNCONTROLLED ASTHMA	**DO THIS IMMEDIATELY:**
• Coughs constantly • Struggles or gasps for breath • Trouble talking (only able to speak 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips or fingernails are gray or blue • ↓Level of consciousness	• **GIVE RESCUE MED (NAME):_____** ☐ 1 PUFF ☐2 PUFFS ☐ OTHER: ☐VIA SPACER • **Call 911 Inform attendant the reason for call is ASTHMA** • Call parents/guardians and school nurse • Encourage student to take slower deeper breaths • Stay with student and remain calm • *School personnel should not drive student to hospital*

INSTRUCTIONS FOR RESCUE INHALER USE: HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX

☐Student has life threatening allergy, the EpiPen is located:_____

_____	_____	_____	_____
HEALTH CARE PROVIDER SIGNATURE	PLEASE PRINT PROVIDERS NAME	START DATE	END DATE

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____	_____	_____	_____
PARENT SIGNATURE	DATE	SCHOOL NURSE SIGNATURE	DATE

Copy of plan provided to: ☐ Teachers ☐ Phys Ed/Coach ☐ Principal ☐ Main Office ☐Bus Driver ☐ Other ☐ 504 Plan or IEP

Early Childhood Preschool Program
Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

SUNSCREEN PERMISSION FORM

The Preschool staff will assist children only when needed to bare surfaces upon request. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to parent/guardian. It is the parent's responsibility to provide sunscreen with a specific amount of SPF they wish their child to have. Please have your child's first and last name clearly labeled on the bottle. Preschool will be using Coppertone Sport with SPF 30.

_____ I do not want my child to use any sunscreen other than the one I will provide. The sunscreen I provide will be clearly marked with my child's name.

_____
Parent or Legal Guardian Signature

A NUTRITIOUS SNACK AND/OR LUNCH

The Colorado State Department of Childcare Licensing (7.712.54 Food and Nutrition) requires that all children who are at the Preschool program for 4 or more hours receive a meal that meets one-third of the child's daily nutritional needs. The requirement must be met regardless of whether the program or the parent provides the lunch. Preschool staff will be checking snacks and/or lunches provided by parents to make sure the requirement is met. If a child does not have a snack and/or lunch or if the program needs to supplement a child's snack and/or lunch to meet the requirement, the parent will be charged a fee of up to $10.00 for each instance.

I understand that my child will need nutritious snacks with a drink on all days unless otherwise notified. I understand that if my child does not bring a snack or if the snack does not meet the nutrition guidelines as stated in the State of Colorado Childcare Licensing Rules and Regulations, I may be charged a fee for the Preschool program supplementing or supplying my child's snack.

_____ _____
Parent or Legal Guardian Signature Date

CODE OF CONDUCT AGREEMENT

Every person that enrolls in our Preschool program, including the personnel, is a potential role model for the children present. As role models we are ALL expected to portray citizenship, kindness, respect for all, positive communication, problem solving behaviors, and appropriate regard of property.
Per State law, smoking, drug and/or alcohol use are never permitted. If suspected abuse occurs, the person (s) involved will be subject to removal from grounds.
UNRESOLVED ISSUES:
To address unresolved issues, a meeting may be planned to discuss the matter. In the event a solution can not be reached between the Recreation Specialist and the parent/guardian, a third party intervention may be requested. Parents may contact the following: Karen Snortland, Recreation Supervisor and/or Kathy Apjoke, Recreation Specialist at 303-665-0469.

I understand and agree to adhere to the "Code of Conduct Agreement"

_____ _____
Parent or Legal Guardian Signature Date

Early Childhood Preschool Program
Emergency Information Forms

* Payment, Policy & Procedures, Waivers Agreement

_____ I understand payment is due on or before the 1st of each month. I further understand if payment is not received by the 2nd, my child's placement will be forfeited and the $25.00 deposit is NON-refundable. These payments may be made online.

_____ I understand the Preschool program reserves the right to refuse service to anyone who has a delinquent balance on their household account.

_____ I understand there is a $5.00 transfer fee and all transfers must be made two weeks in advance.

_____ I understand if I choose to cancel my child's enrollment a written 30 day notice is required and the registration fee is non-refundable. The pre-paid last month's payment will be applied to my child's last month of attendance. If written notice is given in less than 30 days, a 25% cancellation fee will be charged on the last month's pre-paid payment and the current month will not be refunded.

_____ I have read and understand the parents' manual in its entirety and I am familiar with all the policies and procedures.

_____ I understand my child must be potty trained or I must stay in the Recreation Center during his/her class time.

_____ I understand the Preschool program reserves the right to refuse service and terminate care based on excessive behavioral issues.

_____ I understand the Preschool program is not liable or responsible for my child before he/she is signed in or after he/she has been signed out.

_____ I understand my child will need a nutritious snacks everyday, unless otherwise notified. I understand if my child does not bring a snack or if the snack does not meet the nutrition guidelines as stated in the State of Colorado Childcare Licensing Rules & Regulations, I may be charged a fee of up to $10.00 for each instance the Preschool program needs to supplement or supply my child with a snack.

_____ I understand if my child will not be attending the program for any reason on a scheduled day, it is my responsibility to ask the staff, for an "absence form". I will fill out this form and submit to staff in advance of the change in schedule. In emergency situations I will call the program directly and notify them of my child's absence. No credit will be given for absences, planned or otherwise.

_____ I understand the Preschool program staff are discouraged from watching children outside of the program.

_____ I give the Preschool program permission to take my child on any field trip away from the program location on foot for which advance notice has been given.

_____ I give the Preschool program permission to take appropriate photographs of my child during program activities to be displayed within the program or for promotion of the program.

_____ I give permission for my child to participate in all of the activities offered at the Preschool program. If there are any activities you do not wish your child to participate in please list them here:

_____

_____ I will provide my child with sunscreen with the specific amount of SPF I wish them to have. I will have their first and last name on it. If any skin reaction is observed by staff it will be promptly reported.

_____ I understand that the monthly newsletters are available for viewing on www.cityoflafayette.com/recreation.

Early Childhood Preschool Program
Emergency Information Forms

* All areas must be filled in, if not applicable write N/A.

A description of your child's behavior and reaction to various incidents is desired. This information is confidential and will be reviewed by the Preschool staff as a key to working with your child as an individual member of our program.

Interaction with males:

_____

Interaction with females:

_____

Fears and dislikes: _____

Types of discipline used at home: _____

Reward system used at home: _____

Positive/negative day care/preschool experiences: _____

_____

Child's favorite activity/hobbies/interest:

_____

Briefly comment on the following:

Athletic ability: _____

Coordination: _____

Play skills: _____

Peer interactions: _____

Additional comments on child's social history: _____

Does your child:

Wear: glasses ____ Yes _____ No

Hearing aid ____ Yes _____ No

Need assistance walking ____ Yes _____ No

Need assistance with toileting ____ Yes _____ No

Use a wheelchair ____ Yes _____ No

Feed self ____ Yes _____ No

Dress self ____ Yes _____ No

Use scissors, crayons, paint, paste, and small objects:

_____ well ____ adequately ____ not at all

Communication abilities: How does your child make her/his needs known?

_____

Does your child currently have any emotional or behavioral problems? YES NO

Does your child prefer to play alone? YES NO

Name and ages of siblings:

_____

If your child has special needs:

Diagnosis:

_____

PLEASE FEEL FREE TO DISCUSS ANY SOCIAL OR BEHAVIORAL CONCERNS

Early Childhood Preschool Program
Play Date Form

All of the information you have provided is confidential.

This form allows us to distribute your information for use of carpooling, play dates, and birthday parties.

** Remember if you wish to have another parent pick up your child you must provide in writing your authorization.

_____ **YES, add me to the list:**

_____
Child's name

_____
Parent's names

_____
Address

_____
Home Phone number

_____
Other phone number

_____
Email address

_____ **NO, I do not wish to release my information**

_____
Child's name

_____ _____
Parent or Legal Guardian Signature Date

Lafayette RECREATION PRESCHOOL

Early Childhood Preschool Program
Session Dates & Fee Schedule
2012-2013

Tiny Tots Classes

T/TH Classes	NO Class Dates	Auto Payment R/NR	Manual Payment R/NR	Payment Due Date
August 21— 30		$42/$52	$52/$62	8/1/2012
September 4— 27		$85/$95	$95/$105	9/1/2012
October 2—30		$95/$105	$105/$115	10/1/2012
November 1— 29	November 19-23	$74/$84	$84/$94	11/1/2012
December 4— 20	December 24—31	$64/$74	$74/$84	12/1/2012
January 8— 31, 2013	January 1—4	$85/$95	$95/$105	1/1/2013
February 5— 28	February 19	$74/$84	$84/$94	2/1/2013
March 5— 21	March 25—29	$64/$74	$74/$84	3/1/2013
April 2— 30		$95/$105	$105/$115	4/1/2013
May 2— 23		$74/$84	$84/$94	8/1/2012

Creative Play Classes

M/W/F Classes	NO Class Dates	Auto Payment R/NR	Manual Payment R/NR	Payment Due Date
August 20—29	August 31	$80/$90	$90/$100	8/1/2012
September 5—28	September 4	$175/$185	$185/$195	9/1/2012
October 1—31	October 12	$207/$217	$217/$227	10/1/2012
November 2—30	November 12 & 19-23	$95/$105	$105/$115	11/1/2012
December 3—21	December 24—31	$143/$153	$153/$163	12/1/2012
January 9—30, 2013	January 1—7 & 21	$143/$153	$153/$163	1/1/2013
February 1—27	February 18	$175/$185	$185/$195	2/1/2013
March 1—22	March 25—29	$159/$169	$169/$179	3/1/2013
April 3—29	April 1 & 19	$175/$185	$185/$195	4/1/2013
May 1—22		$159/$169	$169/$179	8/1/2012

T/TH Classes	NO Class Dates	Auto Payment R/NR	Manual Payment R/NR	Payment Due Date
August 21— 30		$64/$74	$74/$84	8/1/2012
September 4— 27		$127/$137	$137/$147	9/1/2012
October 2—30		$143/$153	$153/$163	10/1/2012
November 1— 29	November 19-23	$111/$121	$121/$131	11/1/2012
December 4— 20	December 24—31	$95/$105	$105/$115	12/1/2012
January 8— 31, 2013	January 1—4	$127/$137	$137/$147	1/1/2013
February 5— 28	February 19	$111/$121	$121/$131	2/1/2013
March 5— 21	March 25—29	$95/$105	$105/$115	3/1/2013
April 2— 30		$143/$153	$153/$163	4/1/2013
May 2— 23		$111/$121	$121/$131	8/1/2012

Lafayette RECREATION PRESCHOOL

Early Childhood Preschool Program
Session Dates & Fee Schedule
2012-2013

Kinder Prep Classes

M/W/F classes	NO Class Dates	Auto Payment R/NR	Manual Payment R/NR	Payment Due Date
August 20—29	August 31	$93/$103	$103/$113	8/1/2012
September 5—28	September 4	$204/$214	$214/$224	9/1/2012
October 1—31	October 12	$241/$251	$251/$261	10/1/2012
November 2—30	November 12 & 19-23	$111/$121	$121/$131	11/1/2012
December 3—21	December 24—31	$167/$177	$177/$187	12/1/2012
January 9—30, 2013	January 1—7 & 21	$167/$177	$177/$187	1/1/2013
February 1—27	February 18	$204/$214	$214/$224	2/1/2013
March 1—22	March 25—29	$186/$196	$196/$206	3/1/2013
April 3—29	April 1 & 19	$204/$214	$214/$224	4/1/2013
May 1—22		$186/$196	$196/$206	8/1/2012

T/TH classes	NO Class Dates	Auto Payment R/NR	Manual Payment R/NR	Payment Due Date
August 21— 30		$74/$84	$84/$94	8/1/2012
September 4— 27		$148/$158	$158/$168	9/1/2012
October 2—30		$167/$177	$177/$187	10/1/2012
November 1— 29	November 19-23	$130/$140	$140/$150	11/1/2012
December 4— 20	December 24—31	$111/$121	$121/$131	12/1/2012
January 8— 31, 2013	January 1—4	$148/$158	$158/$168	1/1/2013
February 5— 28	February 19	$130/$140	$140/$150	2/1/2013
March 5— 21	March 25—29	$111/$121	$121/$131	3/1/2013
April 2— 30		$167/$177	$177/$187	4/1/2013
May 2— 23		$130/$140	$140/$150	8/1/2012

Early Childhood Preschool Program ~ Auto Pay Authorization:

Child's Full Name: _____

Parent/Guardian: _____

Address: _____**City:**_____ **Zip** _____

Home Phone: _____ **Other Phone:** _____

In an effort to go GREEN Please provide your e-mail address.

E-Mail: _____

(Options, check all that apply)

_____ **E-Mail a receipt to me monthly.**

_____ **E-Mail me a childcare tax statement at the end of the year.**

****PLEASE READ CAREFULLY****

Your signature confirms your agreement to the following:

Bank Account or Credit/Debit Card Authorization:

I hereby authorize the City of Lafayette, Bob L. Burger Recreation Center to make monthly payments on my behalf from the checking, savings or credit card account listed below and transfers it to the Early Childhood Preschool Program.

***** The Early Childhood Preschool classes are continuous enrollment August 2012 through May 2013.
***** The first payment will include the first and last months fees.
***** The monthly fee will be automatically withdrawn from your bank account or credit card account on the 1st of each month. If your bank account has non sufficient funds (NSF) or your credit card is declined you will be notified and given 2 days to come in with, cash or check in the full amount. You will also be charged a $30 NSF service fee.
***** Payments not received by the due date will be charged a $10 late fee. If payment is not received within the two day grace period, enrollment will be cancelled.
* Fee to hold a space is $25.00 this is a reservation fee and is non-refundable and will NOT be applied to the session fee.

_____ _____

Parent/Guardian Signature Date:

Choose One:

_____ Checking Account Transfer **(voided check <u>must</u> be attached)**

_____Visa ____ MasterCard _____Discover Card_____American Express

Name on card _____

Card Number _____-_____-_____ _____3 Digit Security Code _____

Expiration Date _____/_____

Lafayette RECREATION PRESCHOOL

City of Lafayette
2012-2013
Absence Form

CHILD'S NAME: _____

TODAY'S DATE: _____

DATE(S) OF LEAVE

FIRST DAY OF CHANGE:_____

LAST DAY OF CHANGE:_____

REASON/EXPLANATION: _____

_____

_____

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Preschool Staff Signature Date

_____ _____
Recreation Supervisor Signature Date

Lafayette RECREATION PRESCHOOL

City of Lafayette
2012-2013
Absence Form

CHILD'S NAME: _____

TODAY'S DATE: _____

DATE(S) OF LEAVE

FIRST DAY OF CHANGE:_____

LAST DAY OF CHANGE:_____

REASON/EXPLANATION: _____

_____

_____

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Preschool Staff Signature Date

_____ _____
Recreation Supervisor Signature Date