Start Date: _____ **REGISTRATION INFORMATION** City of Thornton

Youth's Name: _____
Last First Middle

Home Phone Number:_____ Date of Birth:_____

Home Address: _____

Male ☐ Female: ☐ Hair Color:_____ Eye Color:_____

Parent/Guardian's Name: _____
Last First Middle

Address (if different than youth):_____

Place of Employment: _____
Name/Phone No. Address/City/State

Email Address: _____

Parent/Guardian's Name: _____
Last First Middle

Address (if different than youth):_____

Place of Employment: _____
Name/Phone No. Address/City/State

Email Address: _____

PERSON'S AUTHORIZED TO PICK UP YOUTH (include self):

1. _____ _____
Name/Phone No. Address/City/State
2. _____ _____
Name/Phone No. Address/City/State
3. _____ _____
Name/Phone No. Address/City/State

Youth's Doctor: _____ _____
Name/Phone No. Address/City/State

Youth's Dentist:_____ _____
Name/Phone No. Address/City/State

Youth's Insurance Provider:_____ **Group No. & I.D.**_____

Emergency contact to call if parent cannot be reached and medical authorization may be obtained:

Name: _____ Phone No.:_____

Address: _____ Relationship:_____

Name: _____ Phone No.:_____

Address: _____ Relationship:_____

Hospital of Choice: _____
Name/Phone No. Address/City/State

Any Allergies or Health Problems we need to be aware of: _____

_____

Special Instructions: _____

Emergency Medical Authorizations: I,_____, hereby give permission to the City of Thornton Preschool Staff to call a doctor for medical or surgical care for my youth,_____, should an emergency situation arise. It is understood that a conscious effort will be made to locate my spouse or me before any action will be taken, but if it is not possible to locate us, this expense will be excepted by us.

I understand that it is my responsibility to apply sunscreen to my youth before bringing him/her to school.

_____ _____
Signature of Parent or Legal Guardian Date

City of Thornton

PRESCHOOL & KIDCAMP FAMILY QUESTIONNAIRE

This information is intended to help us understand your family, your youth, and his/her development.

Youth's Name:_____ Nickname:_____

1. Has your youth had previous youthcare/preschool? Yes No

   If yes, what school? _____

2. What are your views on education and what is your reason for choosing preschool for your youth:_____

   _____

   _____

3. How does your youth adapt to new situations? _____

4. What are your youth's interests and/or what does your youth enjoy doing? _____

   _____

5. Are there any activities or foods your youth is unable to participate in due to medical, physical, social, or religious reasons? Please explain: _____

   _____

6. Who are the primary caregivers of the youth including parents (those who have significant contact with your youth and/or who may participate in your youth's care):

Name	Age	Living with youth?

7. Relationship with brothers, sisters, and other youth:

Name	Age	Living with youth?

8. Relationship with others living in the home:

Name	Age	Living with youth?

9. For the names listed in questions 6-8, what are the roles of these members of your family? _____

   _____

   _____

   _____

10. Does your youth have any problems with sleeping? How does your youth show that he/she is tired? Does your youth nap at home?_____

    _____

11. Is your youth afraid of anything (i.e. dogs, loud noises, bugs, etc.)? _____

_____

12. How does your youth express anger or react to frustration? How does your youth express pleasure, excitement, or joy?

_____

13. What do you expect of your youth? _____

_____

_____

14. What is your guidance strategy at home? _____

_____

15. What is your youth's primary language? How does your youth communicate his/her needs (please include primary language words for bathroom — urination and bowel movement, thirsty, hungry, tired, Mom, Dad, etc., if not English)?

_____

_____

_____

16. Does your youth speak a second language?_____ If yes, what language? _____

17. Are there any customs, traditions, holidays, or special occasions that you celebrate with your youth and/or your family? Please explain. _____

_____

_____

Would you be willing/able to come into class to share these traditions with all the kids? Yes No

18. Is there any other information we should know to best work with your youth (therapy your youth has, special needs, temperament, what you would like to see take place in class, etc.)? _____

_____

_____

_____

19. In order to complete this form, please attach a picture of your family and a photo of your youth for us to use in the classroom.

Attach family picture here.

(not representative of size)

Attach youth's picture here.

(not representative of size)

GENERAL HEALTH APPRAISAL FORM

PARENT please complete AND SIGN

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

Allergies: ❑ None or Describe_____

Type of Reaction _____

Diet: ❑ **Breast Fed** ❑ **Formula** _____ ❑**Age Appropriate**

❑**Special Diet** _____

Sleep: Your health care provider recommends that all infants less than 1 year of age be placed on their back for sleep.

❑ **Preventive creams/ointments/sunscreen may be applied as requested in writing by parent unless skin is broken or bleeding.**

I, _____ **give consent for my child's care health provider, school child care or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (& applicable attachments) to my child's school, child care or camp personnel. FAX #:** _____ **DATE:** _____

Parent/Guardian Signature_____

HEALTH CARE PROVIDER: Please Complete After Parent Section Completed

Date of Last Health Appraisal: _____ **Weight @ Exam:** _____

Physical Exam: ❑ **Normal** ❑ **Abnormal** (Specify any physical abnormalities)_____

Allergies: ❑ None or Describe_____ Type of Reaction _____

Significant Health Concerns: ❑Severe Allergies ❑Reactive Airway Disease ❑Asthma ❑Seizures ❑Diabetes ❑Hospitalizations ❑Developmental Delays ❑Behavior Concerns ❑Vision ❑Hearing ❑Dental ❑Nutrition ❑ Other _____

Explain above concern (if necessary, include instructions to care providers): _____

Current Medications/Special Diet: ❑ None or Describe _____

Separate medication authorization form is required for medications given in school, child care or camp

For Fever Reducer or Pain Reliever (for 3 consecutive days without additional medical authorization) PLEASE CHOOSE ONE PRODUCT

❑Acetaminophen (Tylenol) may be given for pain or fever over 102 degrees every 4 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

OR ❑Ibuprofen (Motrin, Advil) may be given for pain or for fever over 102 degrees every 6 hours as needed

Dose _____ or see the attached age-appropriate dosage schedule from our office

Immunizations: ❑Up-to-Date ❑ See attached immunization record ❑Administered today: _____

Health Care Provider: Complete

****Screenings Performed:** ❑**Vision:** ❑Normal ❑Abnormal ❑**Hearing:** ❑Normal ❑Abnormal ❑**Dental:** ❑Normal ❑Abnormal-

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 sports, child care or camp program. Any concerns or exceptions are identified on this form.

_____

Signature of Health Care Provider (certifying form was reviewed) Date: _____

Office Stamp
Or write Name, Address, Phone, #

The Colorado Chapter of the American Academy of Pediatrics (AAP) and Healthy Child Care Colorado have approved this form. 04/07

*The AAP recommends that children from 0-12 years have health appraisal visits at: 2, 4, 6, 9, 12, 15, 18 and 24 months, and age 3, 4, 5, 6, 8, 10 and 12 years.

COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

Child Care/Preschool/Head Start Required Immunizations - 2018-19 School Year

Dear parents and guardians of students in Colorado child cares, preschools and Head Start programs:

- Colorado law requires students who attend a licensed child care, preschool or Head Start program to be vaccinated against many of the diseases vaccines can prevent. Your student must be vaccinated against:
    - diphtheria, tetanus & pertussis (DTaP, DTP)
    - polio (IPV)
    - measles, mumps, rubella (MMR)
    - hepatitis B (HepB)
    - haemophilus influenzae type b (Hib)
    - pneumococcal (PCV)
    - varicella (chickenpox)

  Vaccines are recommended for rotavirus, hepatitis A and influenza, but are not required.
- The number, timing and spacing of the required vaccine doses is set by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP). You can view a parent-friendly version of the current ACIP vaccine schedule for children 0 - 6 years of age at www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf.
- Please take your student's updated vaccine record to school every time he or she receives a vaccine.
- If your student cannot get vaccines because of medical reasons, you must submit an official *Immunization Medical Exemption Form* to your school, signed by a health care provider licensed to give vaccines. You can get the form at www.colorado.gov/vaccineexemption.
- If you choose not to get your student vaccinated according to the current ACIP schedule for religious or personal belief reasons, you must submit a non-medical exemption to your school. Non-medical exemptions must be submitted at ages 2 months, 4 months, 6 months, 12 months and 18 months. You can either submit the state health department's non-medical form (online or paper copy) for inclusion in the Colorado Immunization Information System (CIIS), provide a paper copy of the state health department's non-medical exemption form to your student's school, or submit a signed non-medical statement of exemption to your student's school. Such a statement should include the following information: student's full name, age or date of birth, date the exemption was submitted, the vaccines declined, and which type of non-medical exemption is being taken (personal belief or religious). If you choose to include your student's information in CIIS, you may opt your student out of CIIS at any time. Your student's school may ask you to also provide them with a paper copy of the non-medical exemption if you submit online. You can get online and downloadable versions of the state health department's non-medical exemption form at www.colorado.gov/vaccineexemption.
- Some parents, especially those with students who have weakened immune systems, may want to know which child cares, preschools and Head Start programs have the highest percentage of vaccinated children. Schools must report vaccination and exemption numbers (but not student names or birth dates) to the state health department by December 1 every year. Vaccination and exemption rates will be posted on the state health department website in Spring 2018.
- You may want to talk to a health care provider licensed to give vaccines or a local public health agency (LPHA) about which vaccines your student needs or if you have questions. You can read about the safety and importance of vaccines at www.ImmunizeForGood.com and www.colorado.gov/cdphe/immunization-education.
- If you need help finding a health care provider, or finding free or low-cost vaccines, contact your LPHA, or call the state health department's Family Health Line at 1-303-692-2229 or 1-800-688-7777. You can find your LPHA at www.colorado.gov/pacific/cdphe/find-your-local-public-health-agency.
- Please share Page 2 of this letter with your student's health care provider as it provides helpful information about vaccines required for school entry per Colorado law.

Sincerely,

Colorado Immunization Branch | Colorado Department of Public Health & Environment
303-692-2700 | cdphe.dcdimmunization@state.co.us

COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

Dear Colorado healthcare provider:

Colorado School Entry Immunization Law (25-4-901 et seq, C.R.S) and Colorado Board of Health rule (6 CCR 1009-2) require students who attend a public, private or parochial K - 12 school, licensed child care, preschool or Head Start program to be vaccinated against many of the diseases vaccines can prevent. Students must be vaccinated against:

- diphtheria, tetanus and pertussis (DTaP, DT, DTP, Tdap),
- polio (IPV),
- measles, mumps, rubella (MMR),
- hepatitis B (HepB),
- haemophilus influenzae type b (Hib),
- pneumococcal (PCV13), and
- varicella (chickenpox).

The number, timing and spacing of the required vaccine doses is set by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP). To be considered valid, a dose of vaccine must meet both the **minimum age and minimum intervals** as defined by ACIP. You can view the current ACIP vaccine schedule for persons 0 - 18 yrs of age at www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf. Vaccines are recommended for rotavirus, hepatitis A, influenza, meningococcal disease and human papillomavirus, but are not required.

Colorado schools are required to review immunization records for school entry and can only accept valid doses of vaccine. Your patients may receive notification of noncompliance if a dose of vaccine does not meet the minimum age or minimum interval requirements per the ACIP schedule. There are three ways a school/student can meet the compliance requirements established by Colorado law:

- A student is considered fully immunized if he or she has received all doses of school-required vaccines according to the current ACIP schedule. Note: students are required to receive their final doses of DTaP, IPV, MMR and Varicella by kindergarten entry and their Tdap by 6th grade entry, even if the student is 10 years of age.
- A student is in the process of getting up-to-date on required vaccines and has a written plan from a parent/guardian on file with the school.
- The student (emancipated or 18 years of age or older) or student's parent/guardian has submitted a signed official *Immunization Non-Medical Exemption Form (Religious or Personal Belief)* or the healthcare provider (medical doctor, doctor of osteopathic medicine, advanced practice nurse or delegated physician's assistance) has signed an official *Immunization Medical Exemption Form* because of a condition that precludes a patient from receiving vaccine(s).

If students do not meet at least one of the compliance criteria, they are not permitted to attend school. If you have questions about the student's school immunization requirement, please communicate with the student's school nurse or school representative.

If you have questions about the ACIP immunization schedule, vaccines marked as invalid in your patient's immunization record, or about Colorado School Immunization Law, please contact us from 8:30 a.m. to 5 p.m., Monday - Friday at 303-692-2700 or cdphe.dcdimmunization@state.co.us. If you have questions about the Colorado Immunization Information System (CIIS), please contact us 8:30 a.m. to 5 p.m., Monday - Friday at 303-692-2437 (press 2), 1-888-611-9918 (press 1) or cdphe.ciis@state.co.us.

Other reliable clinical resources include:

- CDC Vaccines & Immunizations
  http://www.cdc.gov/vaccines/default.htm
- CDC's 13th edition (2015) of the Epidemiology & Prevention of Vaccine-Preventable Diseases
  http://www.cdc.gov/vaccines/pubs/pinkbook/index.html
- The Immunization Action Coalition: Ask the Experts
  http://www.immunize.org/askexperts/
- CDC Experts at the National Immunization Program
  nipinfo@cdc.gov or 1-800-CDC-Info (1-800-232-4636)

Sincerely,

Colorado Immunization Branch | Colorado Department of Public Health & Environment
303-692-2700 | cdphe.dcdimmunization@state.co.us

City of Thornton

MEDICAL RELEASE FORM

Only fill out this and the following medical pages if your youth has allergies, asthma, or medical needs.

Please fill out:

1. This Medical Release Form

OR

1. Medication Administration in School or Youth Care (filled out by your youth's physician)
2. Colorado School Asthma Care Plan/Allergy and Ananphylaxis Action Plan and Medication Orders (filled out by your youth's physician)

My youth _____, DOB_____,

has various allergies and/or asthma. They consist of _____

_____

They do not require use of an EpiPen, inhaler or any other form of medication while at school. Therefore, I will not be providing the school with any medications.

Please watch for the symptoms listed below. Please contact me at the number below if my youth has been exposed to any of the above allergens. I agree to keep my youth home if they have any symptoms of these allergies and/or asthma.

_____

_____

_____

_____

_____

Names of people and numbers to call (in order):

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

Parent Signature: _____ _____ Date: _____

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, and 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!

City of Thornton

COLORADO SCHOOL ASTHMA CARE PLAN

Every line must be filled in!

Please ask the pharmacist for a separate medicine bottle to keep at summer camp. Thank you!

Name	Birthdate
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 _____

GREEN ZONE: Pretreatment Steps for Exercise (Health provider please complete section)

☐ Give 2 puffs of rescue med *(name)* _____ 15 minutes before activity.
(Circle indication: 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 medication)

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 ☐ 2 puffs ☐ Via spacer ☐ Other _____ • If no improvement in 10-15 minutes, repeat use of rescue med. ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other _____ • 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

RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for rescue medication)

IF YOU SEE THIS:	DO THIS:
• Coughs constantly • Struggles or gasps for breath • Trouble talking (can speak only 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 ☐ Via spacer ☐ Other _____ • If no improvement in 10-15 minutes, repeat use of rescue med. ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other _____ • Call 911 Inform attendant the reason for the 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(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently

☐ Student is to notify his/her designated school health officials after using inhaler

☐ Student needs supervision or assistance to use his/her inhaler.

If not self carry, the inhaler is located _____

☐ Student has life threatening allergy, the epipen is loca\ed _____

_____ _____
Signature of Health Care Provider 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.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____ ☐ 504 Plan or IEP
Signature of School Nurse Date

Allergy and Anaphylaxis Action Plan and Medication Orders

Place child's photo here

Student's Name: _____ D.O.B. _____ Grade: _____
School: _____ Teacher: _____
ALLERGY TO: _____
_____
History: _____
_____
Asthma: ☐ YES (Higher risk for severe reaction) ☐ NO

To be completed by healthcare provider

◊ STEP 1: TREATMENT

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or **combination** of symptoms from different body areas:
- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - Antihistamine
   - Inhaler (bronchodilator) if asthma

*Antihistamine & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

→

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

DOSAGE

Epinephrine: inject intramuscularly using autoinjector (check one): ☐ **0.3 mg** ☐ **0.15 mg**
☐ Administer 2nd dose if symptoms do not improve in _____ minutes
Antihistamine: (brand and dose) _____
If Asthmatic: (brand and dose) _____

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

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. 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 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 with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

TRAINED STAFF MEMBERS

1. _____ Room_____
2. _____ Room_____
3. _____ Room_____
4. _____ Room_____
5. _____ Room_____

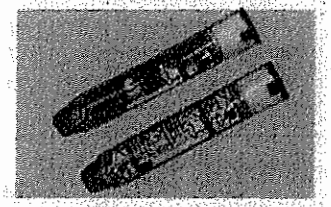
Self-carry contract on file. ☐Yes ☐No Medication located in: _____

Additional information:_____

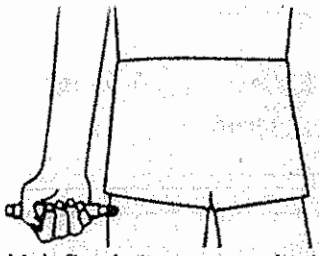
EpiPen® and EpiPen® Jr. Directions

Expiration date: _____

- Pull off blue activation cap.



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

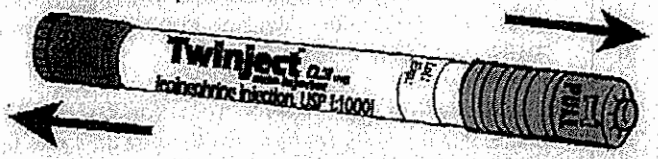


- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit and massage the injection area for 10 seconds.

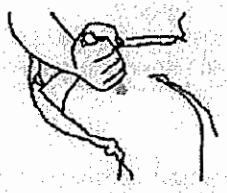
Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Expiration date: _____

- Remove caps labeled "1" and "2."

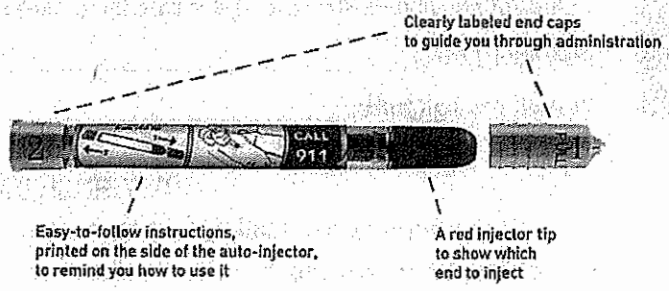


- Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



Adrenaclick 0.3 mg. and Adrenaclick 0.15 mg. Directions

Expiration date: _____



Once epinephrine is used, call 911. Student should remain lying down or in a comfortable position.

City of Thornton

PRESCHOOL AND KID CAMP PARENT CONTRACT AND PERMISSIONS FORM

- I will abide by the rules set by the City of Thornton Licensed Programs in order to ensure the safety and well being of all participants and their families.

  INITIAL: _____

- I understand the process followed should disciplinary measures be necessary.

  INITIAL: _____

- I authorize my youth to participate in supervised walking field trips with the City of Thornton Licensed Programs.

  INITIAL: _____

- I authorize my youth to view a video selected and /or developed by the staff. Parent will be notified before video is shown.

  INITIAL: _____

- I have read and understand the policies and procedures outlined in the parent information packet.

  INITIAL: _____

- I agree to apply sunscreen with a minimum SPF of 15 according to manufacturer instructions not more than 15 minutes prior to the arrival of my youth to the facility. I understand that youth may go outside each day and will apply sunscreen every day the youth is attending class. I understand that the center does not provide sunscreen nor have any on site for youth's use.

  INITIAL: _____

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Youth's Name

City of Thornton

PRESCHOOL TUITION CONTRACT

TUITION PAYMENT

- Payment can be made in full or on a monthly basis for the entire school year, September – April.
- The $45 registration fee is due by June 1 or, if registering during the school year, at the time of registration. If paying monthly, May's payment is due August 1 or, if registering during the school year, at the time of registration. All remaining payments will be due on or before the fifth of each month. For example: October payment is due on or before October 5. You have the option to participate in the automatic credit card process or pay in person.
- The May tuition deposit is used to hold a participant's spot in a program. It is due by August 1, or if registering during the school year, is charged at the time of registration and is considered part of the cost of the program per participant, per program session (i.e. the entire school year). May's tuition is due August 1. If your youth remains registered through the end of the school-year (May), your deposit will be applied to May's tuition. If you cancel out of the program at any time after paying, your deposit becomes non-refundable.
- **A $15 LATE FEE WILL BE ASSESSED FOR ANY PAYMENT RECEIVED AFTER THE FIFTH OF THE MONTH. IF PAYMENTS ARE TWO WEEKS PAST DUE AND/OR HABITUALLY LATE, YOU WILL FORFEIT YOUR YOUTH'S SPACE FOR THE REMAINDER OF THE SCHOOL YEAR.**
- If you forfeit your youth's space, you may then meet with the director to discuss the option of putting your youth's name on a wait list or trying to get him/her into one of our other classes.

YOUTH WHO ARRIVE OR ARE PICKED UP LATE

Youth who arrive late should enter the classroom quietly and join in the ongoing activities. Please be prompt when picking up your youth from his/her class. Staff members have 15 minutes to clean and prepare the classroom before the arrival of the next class. If the youth is not picked up 5 minutes after the class has ended, the preschool staff will start making necessary phone calls from your information form.

- **You will be charged $1 per minute that you are late.**
- Payment must be made at the front desk before your youth can be picked up.
- A receipt will be given to you for your payment.
- A youth will never be left alone in the classroom.
- If the parents or emergency contacts can not be reached 30 minutes after class has elapsed, the Recreation or Community Center will then turn the youth over to the City of Thornton Police Department and Adams County Social Services. Every reasonable effort will be made to contact the parent/guardians or authorized contact person before this time.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Print Youth's Name

City of Thornton

EMERGENCY INFORMATION CARD

Youth's Name _____

Parent's Name _____

Address _____

Home Phone _____ Age:_____ Eye Color _____ Hair Color _____

Allergies _____

_____

_____

Special Needs or Health Notes and Special Instructions _____

_____

_____

Name of Preferred Hospital _____

IN CASE OF EMERGENCY CALL:

First: _____
Name Relationship Home Phone Work Phone

Second: _____
Name Relationship Home Phone Work Phone

Third: _____
Name Relationship Home Phone Work Phone

PICK-UP LIST:

_____
Name Relationship Home Phone Work Phone

_____
Name Relationship Home Phone Work Phone

_____
Name Relationship Home Phone Work Phone

City of Thornton

Licensed Programs MEDIA WAIVER/PHOTOGRAPH PUBLISHING POLICY

At times, different media groups (newspapers, television, public relations, etc.) will cover activities at the City of Thornton Preschool with articles, video or still photography that may be published. In addition, the Licensed Programs may want to include photographs in various artwork to be displayed in the preschool hallway.

If parents DO NOT want their youth to be photographed or videotaped for news media or preschool purposes, please complete an "opt-out media form" that may be obtained from the preschool director. Simply complete the form and return it to the preschool director so the preschool has a record of your request that your youth is NOT to be photographed or videotaped during class. **This opt out does not apply to other public programs, events or facilities.**

The City of Thornton preschool staff will make every reasonable effort to identify the primary subjects in photographs and to not publish preschool-related photos containing students on the opt-out list.

This form is effective for the current school year your youth is registered for.