When completing your child's enrollment paperwork, please be sure to provide the office with the following forms. This follows the American Academy of Pediatrics guidelines. ****Due to Colorado state health regulations, we will be unable to allow any child to attend school without each of the below forms having been signed and filled out completely.**

(1) A current copy of your child's *immunization record*

- **Parent Toddler Families** – *****All PT students must have proof of their 15, 18 and 24 month well visits and any immunizations administered at those visits updated in their files as they occur throughout the year.***
- This form must have a live signature from both a healthcare provider and a parent/guardian.
- We will also need a copy of this form if your child has a medical/religious/personal exemption from any or all immunizations.

(2) A current copy of your child's *general health appraisal*

- This document is proof of your child's most recent well-visit exam, and also outlines any significant health concerns such as allergies, required medications or special dietary needs. This is very important!
- **Parent Toddler Families** – *****We must have health appraisals for all parent toddler students that reflect their 15, 18 and 24 month well visits and any immunizations administered at those visits updated in their files as they occur throughout the year.***
- This form must also have a live signature from both a healthcare provider and a parent/guardian.

This information is kept on file and tracked by your child's birth date, expiring annually based on your child's birth date. If your child has a birthday during the school year, you will be asked to submit an updated set to the school. Please plan to take the paperwork to your doctor during your child's annual exam.

DCP will send out reminders throughout the school year to families via email as health form expiration dates approach so that student files can stay current.

(3) A completed copy of the DCP *"Topical Preparations Permission Form"*

- This form covers a variety of *preventative* topical preparations (sunscreen, lotion & diaper cream) that may only be applied to a child's skin by DCP staff with parent/guardian permission.
- This form is required for each child's file so that we know what your preferences are for your child regarding the use of any or all of these topical preparations.

For any questions regarding student allergies or the extra documentation (care plan etc.) needed in these cases, please contact Janee at the number or email address listed below.

All completed health forms can be faxed, emailed or hand delivered to DCP attention:

Janee McConnell
480 Marion St
303-777-1252
janee@dcpplay.org.

General Health Appraisal Form

Parent: *Please complete*

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

Allergies: ❑ None ❑ Describe: _____

Type of Reaction: _____

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

❑ Special Diet: _____

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

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

I, _____ give consent for my child's health provider, school or camp personnel to discuss my child's health concerns. My child's health provider may fax this form (and applicable attachments) to my child's childcare provider, school, or camp. FAX Number: _____

_____ Date: _____

Parent or Legal Guardian Signature — Authorization expires 365 days after this date

Health Care Provider: *Please complete after parent section has been completed*

Date of Last Exam: _____ **Recent Weight:** _____ ****HCT:** _____ **** B/P:** _____ ****Lead Level:** _____

Physical Exam: ❑ Normal ❑ Abnormal *(see explanation of significant health concerns:)*

Significant Health Concerns: ❑ None ❑ Reactive Airways Disease ❑ Seizures ❑ Diabetes ❑ Developmental Delays

❑ Vision ❑ Hearing ❑ Hospitalizations ❑ Severe Allergies ❑ Other *(dental, nutrition, behavior, etc.)* _____

Explain above concerns (if necessary, include instructions to childcare providers): _____

_____

Current Medications/Special Diet: ❑ None ❑ Describe: _____

_____

(Separate medication authorization form required for medications given in Child Care)

Fever reducer or pain reliever ***(mark only one product: max. 3 consecutive days without additional medical authorization)***

❑ Acetaminophen (Tylenol®) may be given for pain or fever over 102° every 4 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

OR

❑ Ibuprofen (Motrin®, Advil®) may be given for pain or fever over 102° every 6 hours as needed:
Dose _____ ❑ See attached Dosage Schedule from our office

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

_____

Signature:

Next Well Visit: ❑ Per AAP Guidelines* or ❑ Age: _____

This child is healthy and may participate in all routine activities, sports, camps, and child care. 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 Number*

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

* 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.

** Required by Head Start programs only per state EPSDT schedule

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

DCP - TOPICAL PREPARATIONS (PREVENTIVE) PERMISSION FORM

This form covers a variety of preventive topical preparations that may be applied to the skin with parent/guardian permission

Child's Name _____ Parent/Guardian's Name: _____

SUNSCREEN

I give my permission for the staff at DCP to assist with applying or apply sunscreen to my child's exposed skin including the face, tops of ears and bare shoulders, arms, legs and feet 30 minutes before outdoor activities. 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 the parent/guardian.

- ☐ The school may apply **Rocky Mountain Sunscreen SPF 30** to my child. I understand that it is my responsibility to check the ingredients of this product to ensure my child is not allergic to it.
- ☐ My child may NOT use any sunscreen other than the one that he/she brings. It is my responsibility to provide sunscreen with a minimum SPF of 15. I understand I must provide the sunscreen in its original container labeled with my child's name and within the noted expiration date.

Special instructions: _____

Parent/Guardian Signature: _____ Date: _____

MOISTURIZING LOTION/CREAM/BALM

I give my permission for the staff at DCP to assist with applying or apply skin lotion/cream to my child. Skin lotion/cream/balm 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 the parent/guardian.

- ☐ The school may apply **Eucerin – Original Cream** to my child. I understand that it is my responsibility to check the ingredients of this product to ensure my child is not allergic to it.
- ☐ My child may NOT use any other skin lotion/cream/balm than the one he or she brings. I understand I must provide the lotion/cream/balm in the original over the counter container labeled with my child's name. It is my responsibility to check the ingredients of this product to ensure my child is not allergic to it

Special instructions: _____

Parent/Guardian Signature: _____ Date: _____

DIAPER OINTMENT/CREAM

I give my permission for the staff at DCP to apply over the counter diaper rash ointment/cream to my child. Ointment/cream 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 the parent/guardian.

- ☐ The school may apply **Balmex Cream 11.3% Zinc Oxide** to my child. I understand that it is my responsibility to check the ingredients of this product to ensure my child is not allergic to it.
- ☐ My child may NOT use any other diaper ointment/cream than the one he or she brings*. I understand that I may only provide diaper ointment or cream, free of antibiotic, antifungal or anti-inflammatory components without a written prescription from my doctor.* I understand I must provide the ointment/cream in the original over the counter container labeled with my child's name.

Special instructions: _____

Parent/Guardian Signature: _____ Date: _____