CASTLE KIDS

Forms

(Please return these on or before the first day of school)

Castle Kids Early Learning Center

General Permission Form

I hereby grant permission for my picture and/or my child's picture to be used in promotional materials related to Castle Kids Early Learning Center.

☐ Agree ☐ Disagree

I hereby grant permission for my child to leave the classroom site under the supervision of staff and in an authorized vehicle to participate in scheduled field trips.

☐ Agree ☐ Disagree

______________________________ ______________________

Parent/Guardian Signature Date

General Acknowledgements

The program assumes responsibility for the child during the scheduled hours as set by the parent handbook. Any student who arrives prior to the program hours or is not immediately picked up at the scheduled time becomes the responsibility of the parents or the guardian.

I agree to hold harmless Castle Kids Early Learning Center, Beth Eden Baptist Church & School, and its employees from any claim or judgment that may arise by virtue of my child's activities or presence in the program.

I hereby certify that this information is true. If any part is false, my participation in this agency's program may be terminated and may be subject to legal action. I understand that the information in this application will be held in strict confidence with the agency and accessible to me during normal business hours.

______________________________ ______________________

Parent/Guardian Signature Date

______________________________ ______________________

Verifying Staff Member's Signature Date

Castle Kids Early Learning Center

Immunization/Health Record

Must be completed by a doctor ~ Child may not attend until this record is complete

The child care facility must obtain for every child who enrolls in child care programs a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled child care program. This report is to be filled out by a licensed physician or other health care professional who has seen the child in the last twelve months.

Name of Facility ____________________________ **Type of Facility** ________________________________

Child's Name ______________________________Gender____ Birth Date ______________

Address ____

Past Illnesses

Please check the following illnesses that the above named child has experienced and give the approximate dates.

☐ Chicken Pox	_______	☐ Rubella	_______	☐ Measles	_______
☐ Rheumatic Fever	_______	☐ Asthma	_______	☐ Hay Fever	_______
☐ Diabetes	_______	☐ Mumps	_______	☐ Epilepsy	_______
☐ Whooping Cough	_______	☐ Poliomyelitis	_______	☐ Other	_______

This child ☐ is / ☐ is not physically and emotionally able to participate in the preschool named.

Surgeries, Accidents, Illnesses, Chronic Conditions, or Other Problems ______________________

____

Describe any physical condition requiring special attention by staff ________________________

____

Medication prescribed ____

Allergies we should be aware of ____

Prescribed routine ____

If tuberculin test given Date ________________ Result ______________________________

If chest X-ray taken Date ________________ Result ______________________________

Vision __________________________________ Hearing______________________________

Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization and attach to this form.

Date of the doctor's most recent examination of the child: ______________________________

____ ______________________

Signature of licensed physician or licensed nurse practitioner Date

Please print: ____

Name of Physician/Health Care Professional

____

Address

____

City State Zip Phone

Castle Kids Early Learning Center

Emergency Form

Home Information

Child's Name ______________________________ Age ____ DOB ____________

Address ____

Home Phone __________________________ Enrollment Date _______________

☐ Lives with both parents ☐ Lives with father only

☐ Lives with mother only ☐ Other ______________________________

Parent/Guardian Information

Name ___________________ Home Phone ____________ Cell Phone _____________

Address ____

Employer ___________________________ __ Work Phone _____________________

Employer Address ____

Name ___________________ Home Phone ____________ Cell Phone _____________

Address ____

Employer ___________________________ __ Work Phone _____________________

Employer Address ____

Pick Up Authorization

Unless notified, only the parents/guardians listed above & the individuals listed below may pick up the child.

Name __________________________ Address _____________________________

Home Phone ______________________ Work Phone __________________________

Name __________________________ Address _____________________________

Home Phone ______________________ Work Phone __________________________

Emergency Contacts

If parents are not available, these relatives or friends may be contacted in case of emergency.

Name __________________________ Address _____________________________

Home Phone ______________________ Work Phone __________________________

Name __________________________ Address _____________________________

Home Phone ______________________ Work Phone __________________________

Medical Information

Is your child taking any medications? ☐ Yes ☐ No If yes, please indicate. ______________________________

____

Is your child restricted from normal physical activity in any way? ☐ Yes ☐ No If yes, please explain:______

____

Known allergies or dietary needs ____

Birthmarks or blemishes ____

Other special attentions/behaviors (i.e., seizures, ADD, ADHD, asthma) ___________________________

Primary language spoken by family __________________________ Secondary ______________________________

Is your child on a behavior management program? ☐ Yes ☐ No If yes, please explain.________________

____

Doctor/Physician Information

Name ____ Phone ____________________________

Address ____

Dentist Information

Name ____ Phone ____________________________

Address ____

Preferred Hospital

Name ____ Phone ____________________________

Address ____

I hereby authorize Castle Kids Early Learning Center to take my child to the above named physician or facility for medical treatment in the event of an emergency in which neither parent or guardian can be reached and do authorize the employees and agents to act for me (and/or my child) according to their best judgment and ability in case of an emergency. I hereby authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above named physician cannot respond.

______________________________________ ______________________________

Parent/Guardian Signature Date Signed

2600 Wadsworth Blvd., Wheat Ridge, CO 80033
Phone: 303-232-2313 ~ Fax: 303-233-3027

Castle Kids Early Learning Center

Emergency Medical Form

I grant permission for the program supervisor or staff members to take whatever steps may be necessary to obtain emergency care if warranted. These steps may include, but are not limited to, the following:

- Taking the child to an emergency clinic in the company of a staff member or having the appropriate rescue personnel respond to the incident.
- Attempting to contact mother, father, or guardian.
- Attempting to contact parents/guardian through any of the persons listed on the emergency contact form.
- Attempting to contact the child's physician.
- Any expenses incurred above will be the responsibility of the child's family. When appropriate, a conscientious effort will be made to contact a parent before any action is taken.
- The program will not be responsible for anything that occurs as a result of false information given at the time of enrollment.

The emergency form details any medications, including over-the-counter medicines, which are being given to the child.

I hereby agree to the above authorization.

____ ______________________________

Parent/Guardian Signature Date