FORM

Child Information Form

Child's Name: _____ Primary Language: _____

Child's Address: _____
Street City/Town Zip Code

Place of Birth: _____ Date of Birth: _____/_____/_____

Child's Schedule: MON _____ TUE _____ WED _____ THU _____ FRI _____

Parent/Guardian Information

Name:_____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Home E-mail Address: _____ Home E-mail Address: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Home Phone: _____

Others in Family Relationship: _____

Parent/Guardian Business Information

Company Name: _____ Company Name: _____

Address: _____ Address: _____

_____ _____

Business Phone: _____ Business Phone: _____

E-mail Address: _____ E-mail Address: _____

Medical Information

Eye Color: _____ Hair Color: _____ Height: _____ Weight: _____ Race: _____ Gender ☐M ☐F

Identified Allergies: _____

Identifying Marks: _____

Health Insurance Provider: _____

Physician/Dentist Information

Name of Physician/Clinic: _____ Phone: _____

Physician Address: _____
Street City/Town Zip Code

Date of Child's Last Physical **(WA State Only)**: _____

Name of Dentist: _____ Phone: _____

Dentist Address: _____
Street City/Town Zip Code

Parent/Guardian Signature: _____ Date: _____

FOR CENTER USE: Center: _____ Date of Admission_____ Age of Admission: _____

Date Registration Fee Rec'd:_____ __ Discharge Date: _____ Director's Initials: _____

Authorization to Give Medication at School From Provider & Parents

Name of Center _____
Today's Date _____
Child's Name _____ DOB _____
Name of Medication _____
Dose _____ Route _____ Time _____
Start Date _____ End Date _____
Purpose of Medication _____
Adverse or Side Effects _____
Special Instructions _____
Provider's Printed Name _____
Provider's Signature _____
Provider's Phone # _____

Parent/Guardian Authorization to Give Medication

_____ Childcare Center has my permission to administer
(Name of center)
_____ to my child
(Name of medication)
_____ starting on _____
(Child's name) (Date)

and ending on _____ as prescribed by the provider.
(Date)

_____ _____
(Signature of parent) (Date)

All medication must be in the original pharmacy labeled container including the following information : Name of child, medicine, provider, and date, dose, time, route.

DATE	TIME	MEDS/DOSE	GIVEN BY	REASON,IF NOT GIVEN

Starting Medication Count_____ # of Pills_____ Date _____

Date	Count	Init.	Date	Count	Init.	Date	Count	Init.	Date	Count	Init.

When medication administration is completed, return this form to office for child's permanent file.

Yampa Valley Kids **Informed Consent**

Child's Name: _____

Access

I will have access to the center without notice when my child is present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

Child Release

For a child's safety, Yampa Valley Kids will release a child only to parent(s)/legal guardian(s) or to the third parties I authorized below. Parents/guardians are required to provide a current copy of any relevant Custody Order. Third party pick-up is subject to the following rules:

- At least two people other than the parents/guardians must be listed and designated as emergency contacts by checking the corresponding box below. Emergency contacts will be contacted if parents/guardians cannot be reached.
- If the person picking up is listed below, but does not pick up the child regularly, I will notify the center **verbally, in advance**. Verbal authorization is not permitted for any person not listed on this form.
- If the person picking up is **NOT** listed below, I must notify the center/school **in writing, in advance**. (Note: In RI, parents/guardians must also provide notice in person and in writing.)
- Photo identification will be required if the third party does not pick up the child regularly or is unknown to the staff member releasing the child.

THE FOLLOWING PEOPLE (WHO ARE NOT PARENTS/GUARDIANS) ARE AUTHORIZED TO PICK UP MY CHILD.

_____
NAME

_____
ADDRESS

_____
CITY/TOWN/STATE/ZIP CODE

_____
RELATIONSHIP TO CHILD

_____ _____
DAYTIME PHONE CELL PHONE

_____
E-MAIL

CONTACT IN THE EVENT OF AN EMERGENCY? ☐ YES ☐ NO

_____
NAME

_____
ADDRESS

_____
CITY/TOWN/STATE/ZIP CODE

_____
RELATIONSHIP TO CHILD

_____ _____
DAYTIME PHONE CELL PHONE

_____
E-MAIL

CONTACT IN THE EVENT OF AN EMERGENCY? ☐ YES ☐ NO

Yampa Valley Kids will not release a child to anyone who appears impaired. If an impaired person attempts to pick up your child, pick-up will be refused and we will attempt to contact the other parent/guardian or authorized persons. If alternative arrangements cannot be made, the local child protective services agency and/or the local police will be called, as required by state licensing.

Walk Permission

Weather permitting, children may go on walks supervised by staff in the surrounding area. Infants and young toddlers are transported in a buggy or stroller. Children may be taken to the areas listed below, which are not part of our licensed premises.

_____

_____

☐ I give permission for my child to participate in walks.

Preschool and school-age children may take field trips. A separate **Field Trip Permission Slip**, describing the activity, will be sent home for signature.

Photography & Video Permission

Yampa Valley Kids takes care that any use, display, or dissemination of photographs or videos of children is accomplished in a thoughtful and safe manner. Bright Horizons regularly takes photographs and videos of children enrolled. They may be shared with you and other families in a variety of ways: on the Yampa Valley Kids website, via email, through HiMama,, on a posting in the center, or in a parent newsletter. They may also be used to better communicate with families, to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. Additionally, they may be used for other center, general business, and marketing purposes, including online. Yampa Valley Kids retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment.

☐ I give permission for Yampa Valley Kids to take photographs and videos of my child and use these materials as described above.

☐ I give permission for Yampa Valley Kids to take photos and videos of my child and to only use those pictures for curriculum purposes, documenting my child's progress (HiMama and communication with me and other families.|

Child Illness

If my child becomes ill, I will be called. I may be required to to pick up my child as soon as possible (within 90 minutes at most). A child must remain out of the center until he/she is symptom free for 24 hours, unless a doctor's note is provided which states that the child is 1) not contagious; and 2) can participate in group care. The Family Guide contains Yampa Valley Kids' full Child Illness Policy, including protocols for contagious illnesses.

Children's Injuries

If my child sustains a minor injury during care, I will receive an Incident Report through the HiMama App. I will be contacted immediately if the injury produces any swelling, is on the face or head, or requires medical attention.

Emergency Medical Care

If emergency medical attention is needed for my child,

_____ , the center will attempt to contact me or the emergency contacts listed (if I cannot be reached). I authorize YVK to call an ambulance to transport my child for medical treatment to the closest hospital or medical facility, or to _____my preferred facility, if possible.

Staff is trained in pediatric first aid and CPR and I authorize staff to administer the same. My child's health information may be viewed by staff, on a need to know basis, and state licensors for compliance.

_____

CHILD'S HEALTH INSURANCE PROVIDER

_____

NAME OF INSURED

_____

POLICY NUMBER

Family Guide Acknowledgement

By signing below, I acknowledge and agree that: 1) in addition to this Informed Consent, I received the Yampa Valley Kids or client equivalent, as well as any center-specific information and relevant state policies; 2) it is my responsibility to read and familiarize myself with all these materials and address any questions with center management; and 3) I will abide by these materials.

I HAVE READ, UNDERSTAND, AND ACCEPT THE CONDITIONS NOTED ABOVE.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Annual parent/guardian review and signature is required by Yampa Valley Kids. If any changes are necessary, a new form will be completed.

_____ _____

PARENT/GUARDIAN SIGNATURE REVIEW DATE

_____ _____

PARENT/GUARDIAN SIGNATURE REVIEW DATE

_____ _____

PARENT/GUARDIAN SIGNATURE REVIEW DATE

FORM

Sunscreen and Insect Repellent - Permission

Sunscreen and insect repellent should be applied to a child at least once at home to test for any allergic reaction. Aerosols, sprays and combined sunscreen/insect repellents are prohibited.

Sunscreen must provide UVB and UVA protection with an **SPF of 15 or higher**.
Sunscreen **may not** be used on infants under **6 months** of age, unless parent permission below is granted.

Insect repellent may only be used if recommended by public health authorities or requested by a parent/guardian. The repellent must contain a concentration of **30% DEET or less.** Insect repellant **may not** be used on infants under **2 months** of age. Oil of lemon eucalyptus and para-methane products may not be used on children under the age of three.

All sunscreen and insect repellent provided by a parent/guardian must be:

- provided in the original container;
- clearly labeled with the child's full name;
- within the expiration date;
- appropriate for the age of the child; and
- free of nut ingredients.

Complete one of the following:

I **give** Yampa Valley Kids permission to apply (*name of sunscreen*) _____
and/or (*name of insect repellant*) _____
when outdoor conditions warrant and consistent with package instructions (subject to any special instructions below) to my child, _____
from _____/_____/_____ to _____/_____/_____ (not to exceed one year).

I **do not** give Yampa Valley Kids permission to apply ☐ sunscreen and/or ☐ insect repellant to my child _____. I do not hold Yampa Valley Kids responsible for my decision and understand that my child may be sunburned/bitten as a result.

I understand that **I should provide protective clothing including a hat, lightweight long sleeve shirt and pants** instead**,** to protect my child from sun exposure and insects during outdoor activities.

Special Instructions

Sunscreen: _____

_____

Insect Repellent: _____

_____

_____ _____
(Parent/Guardian Signature) (Date)

FORM

Food Preference Form - Cultural/Religious/Vegan/Vegetarian Reasons

This form is required for any child who should not be served particular foods due to cultural/religious/vegan or vegetarian reasons, but **excluding medical causes** (i.e. allergies) or **personal preferences** (i.e. dislike of certain foods).

When possible, Yampa Valley Kids offers food substitutions. The choices available will vary by location. As permitted by licensing, families may bring their own food from home, so long as it is "nut safe." Milk alternatives that are "nut safe" are permitted, but will be provided by the family if not offered at the location.

In order to manage any permitted food preferences, a child's photograph with the limitations must be posted in the classrooms and kitchen on a Food Preference Chart for staff to follow. I understand that Bright Horizons cannot guarantee that my child will not be exposed to a particular food, and that any changes to the preferences stated below must be made by me in writing.

Child's Name: _____

Due to cultural/religious/vegan or vegetarian reasons, I request that my child is not served the following foods

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____
Parent/Guardian Signature Date

To eliminate a food preference(s) and to permit a food to be served to your child, please complete the following.

I _____, acknowledge that my child is now able to eat

_____ _____

and may be served this item(s) while at Yampa Valley Kids.

_____ _____
(Signature of the Parent/Guardian) (Date)

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** – positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: _____ Date: _____

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

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

Informed Consent and Acknowledgment - COVID-19

A child care center is a community. During this public health emergency EACH member of our community needs to help keep COVID-19 out of our child care centers. Exposures in your center can lead to the closure of the entire center and impact all the families we are serving. We appreciate your partnership and commitment in this collective effort.

_____

1. Partnership

I understand that I play a crucial role in keeping everyone in our child care community safe and reducing the risk of exposure by following the policies and practices outlined in this Informed Consent and Acknowledgment. I acknowledge that my family may be denied access to the Center or disenrolled from the Center for my failure or refusal to act in accordance with these provisions at all times, in a respectful and appropriate way.

2. COVID-19 Exclusion Policy and Health Check and Illness Policy

I have reviewed and am familiar with **Yampa Valley Kids's COVID-19 Policy** and **Yampa Valley Kids's Health Check and Illness Policy.** I agree to comply with these policies, as they may be updated or amended from time to time.

3. Exposure to COVID-19

I understand that to enter the center my ENTIRE household must be free from any known *or suspected* exposure to COVID-19. If my household has any known or suspected exposure to COVID-19, I understand all members of my household will be required to remain out of the center for *at least* 14 days, until all criteria to return are successfully met. I acknowledge that known/suspected exposures include (but are not limited to):

- A member of my household having a confirmed case of COVID-19
- A member of my household traveling to a restricted area
- A member of my household being directed to quarantine or self-isolate
- A member of my household having "close contact" with persons with known or suspected exposure to COVID-19

4. Negative Tests after Exposure

I understand that in the case of any known/suspected exposure, a subsequent negative test result will NOT reduce the time my household is required to remain out of the center because the negative test result does not ensure the individual will not subsequently become positive during the balance of the 14 day incubation period.

5. COVID-19 Symptoms

I understand to enter the center my ENTIRE household must be free from the COVID-19 symptoms listed below. If COVID-19 symptoms are present in my household, I understand all members of my household will be required to remain out of the center for 14 days. I understand this list of COVID-19 symptoms may be updated.

- Cough
- Sore throat
- *Fever of 100.4° or higher
  **Threshold may differ in certain localities*
- Muscle aches
- Difficulty breathing
- New loss of taste or smell

6. Medical Clearance for Symptoms

If my household has been excluded from the center due to the presence of COVID-19 symptoms, I understand, under limited circumstances, I may be able to return to the center if I can provide acceptable medical clearance from a medical provider (M.D., O.D., N.P., and P.A.). To be acceptable, the medical clearance must demonstrate

that (i) the presenting symptoms have been determined to be associated with a known, non-COVID illness or condition, and (ii) the presenting symptoms are unrelated to COVID-19. Any return to the center would remain subject to the requirements of the center's standard illness policy and compliance with the daily health screen requirements.

7. Daily Health Screen

I understand health screens will be conducted daily upon arrival. I will answer all questions truthfully for myself, my child and for every other person in my household. I understand that a temperature check may be taken of each person dropping off.

8. Drop-off and Pick-up

For the safety of all those present in the center and to limit risk of exposure, I understand that I will not be permitted to enter the center beyond the designated drop-off and pick-up area. I understand that all adults are required to wear a face covering while at the center and are expected to respect social distancing requirements.

9. Acknowledgment

I understand that my child will be in contact with children, families and staff who may also be at risk for community exposure. I understand that no restrictions, guidelines or practices will remove all risk of exposure to COVID-19 as the virus can be transmitted by persons who are asymptomatic and before some people show signs of infection. I agree to use my judgment about what is best for my family and household, including undertaking additional precautions to protect the health of those in my household that may be at increased risk for severe illness from COVID-19.

I HAVE READ, UNDERSTOOD AND AGREE ON BEHALF OF ALL MEMBERS OF MY HOUSEHOLD AND ALL INDIVIDUALS AUTHORIZED TO PICK-UP MY CHILD TO THE CONDITIONS NOTED ABOVE.

Child(ren) Name(s):	
Parent Name:	
Signature:	
Date:	

FORM

Topical Applications Administration-Permission

Child's Name_____

I understand that **topical applications**, such as **ointment, lotion, lip balm, diaper cream/spray***, **or cornstarch/cornstarch powders** can be applied only as a preventive measure. Where required by licensing, application to open, oozing sores or continued use on a persistent diaper rash requires a Medication Authorization Form signed by me and my child's physician.

*Aerosol sprays are not allowed.

I understand that the topical ointment provided by me must:

- be appropriate for use on a child;
- be applied according to instructions on the label
- be labeled with the child's full name; and
- be handed to a staff member and not left in a diaper bag or cubby.

I give my permission for the staff at Yampa Valley Kids to apply:

- _____
- _____
- _____

as needed from: _____/_____/_____ to: _____/_____/_____ (not to exceed one year).

_____ _____

(Parent/Guardian Signature) (Date)

Notice to Families

Colorado Division of Child Care Services

Procedure for filing a complaint with the Department of Human Services, Division of Child Care:

To fila a complaint regarding possible child abuse by a caregiver, call your local police department at Department of Social Services.

Call the Division of child Care Services at 1.800.799.5876 or 303.866.5958 for help with the following:

- To complain about the care your child has received
- To report someone who is providing illegal, unlicensed care
- To find out if anyone has filed a previous complaint against an in-home or center-based child care

You will need to call ahead (at least 72 hours) to see those records and then go in-person to the Denver office to read the files: information cannot be given over the phone.

Colorado Division of Child Care/Colorado Department of Human Services

1575 Sherman Street

Denver, Co. 80203-1714

Main office: 303.866.5958

Children's Immunizations

This center *does* enroll and provide services to children that may not be fully immunized due to medical, religious, or personal reasons. Immunization rates are available upon request.