LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER
ENROLLMENT PACKET

CHECK LIST FOR FILE
(office use only)

START DATE:_____

____ENROLLMENT RECORD
____CURRENT IMMUNIZATION RECORDS
____AUTHORIZATION FORM
____POLICIES FORM
____HEALTH FORM
____LAKE DILLON PRESCHOOL PARENT CONTRACT

____EMERGENCY CONTACT PEOPLE
____HOME AND WORK NUMBERS
____ADDRESS
____ALLERGIES
____TOP TEN
____ ELVA RELEASE
____ ELVA BILLING
____CITY MARKET

ENROLLMENT RECORD START DATE:_____

_____

CHILD'S FULL NAME NAME CHILD GOES BY D.O.B.

PARENT'S NAME OTHER PARENT'S NAME

DRIVER'S LICENSE S.S. # DRIVER'S LICENSE S.S.#

PHYSICAL STREET ADDRESS PHYSICAL STREET ADDRESS

_____

MAILING ADDRESS MAILING ADDRESS

CITY STATE ZIP CITY STATE ZIP

PLACE OF EMPLOYMENT PLACE OF EMPLOYMENT

WORK PHONE CELL WORK PHONE CELL

_____

HOME PHONE HOME PHONE

_____

E-MAIL ADDRESS E-MAIL ADDRESS

SPECIAL INSTRUCTIONS FOR CONTACTING PARENTS_____

EMERGENCY CONTACT (other than Mother & Father, can be anywhere in the U.S.)
(MUST HAVE PHONE NUMBERS)

PERSONS AUTHORIZED TO PICK UP CHILD (other than Mother & Father, MUST be within 30 min):
(MUST HAVE PHONE NUMBERS)

PERSONS NOT AUTHORIZED TO PICK UP CHILD:_____

CHILD'S DOCTOR:_____PHONE:_____

CHILD'S DENTIST:_____PHONE:_____

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)

[redacted]

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

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PERSONAL HISTORY

HAS CHILD HAD PREVIOUS GROUP OR PRESCHOOL EXPERIENCE? ____YES ____NO
IF YES, WHEN AND WHERE?_____

DOES CHILD HAVE ANY ALLERGIES?…….___YES ___NO,WHAT?_____

ARE THERE ANY MEDICAL PROBLEMS?……...___YES ___NO, WHAT?_____

DOES CHILD HAVE ANY BOWEL OR BLADDER IRREGULARITIES? ____YES ___NO,
WHAT?_____

ARE THERE ANY SPECIAL FOOD OR EATING INSTRUCTIONS? ___YES ___NO,
WHAT?_____

ARE THERE ANY SLEEPING OR NAPPING INSTRUCTIONS? ___YES ___NO,
WHAT?_____

ANY ADDITIONAL INFORMATION SUCH AS DISCIPLINE, COMMUNICATION, COMFORTING, ETC.?_____

_____

_____

_____

_____

_____

_____

_____

AUTHORIZATION FORM

I/WE _____ , HEREBY GIVE MY/OUR PERMISSION TO LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER TO SEEK MEDICAL CARE FOR MY/OUR CHILD _____ SHOULD AN EMERGENCY ARISE. IT IS UNDERSTOOD THAT EVERY EFFORT WILL BE MADE TO CONTACT ME/US BEFORE EMERGENCY ACTION IS TAKEN, BUT IF IT IS NOT POSSIBLE TO CONTACT ME/US, THE EXPENSE OF EMERGENCY MEDICAL TREATMENT OR CARE WILL BE ACCEPTED BY ME/US.

I/WE UNDERSTAND THAT IF MY/OUR CHILD REQUIRES TRANSPORTATION TO ANY MEDICAL FACILITY LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER HAS PERMISSION TO CALL 911 AND SEND MY/OUR CHILD BY AMBULANCE OR FLIGHT FOR LIFE AND I/WE WILL COVER THE COST OF THIS EXPENSE.

LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER SHALL HAVE NO LIABILITY WHAT-SO-EVER FOR ANY ACTS OR OMISSIONS RESULTING IN INJURY TO MY/OUR CHILD WHILE BEING TRANSPORTED OR WHILE ON ANY FIELD TRIP EXCURSIONS.

AS PARENTS, I/WE ACKNOWLEDGE CERTAIN RISKS IN ANY PROPERLY SUPERVISED CARE. BEING FULLY AWARE OF THIS, I/WE AND MY/OUR CHILD SHALL PARTICIPATE AT HIS/HER OWN RISK AND SHALL HOLD LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER. EMPLOYEES AND OWNERS HARMLESS FROM ANY AND ALL LOSS, CLAIM, INJURY, DAMAGE, OR COST OF LIABILITY RESULTING FROM SUCH CARE. I/WE FURTHER UNDERSTAND THAT LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER CANNOT BE HELD RESPONSIBLE FOR MY/OUR CHILD'S PERSONAL BELONGINGS BROUGHT FROM HOME.

I/WE ALSO UNDERSTAND THAT LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER WILL NOT ASSUME RESPONSIBILITY FOR MY/OUR CHILD IF THEY HAVE NOT BEEN SIGNED IN WHEY THEY ARRIVE. I/WE FURTHER UNDERSTAND THAT ONCE MY/OUR CHILD HAS BEEN SIGNED OUT THEY ARE NO LONGER LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER RESPONSIBILITY.

PERMISSION IS GIVEN TO USE MY CHILD'S PICTURE FOR PUBLICITY PURPOSED, FOR PROMOTION, FEATURE NEWSPAPER ARTICLES, OR TELEVISION SPOTS.

_____ _____

PARENT SIGNATURE DATE

_____

PARENT SIGNATURE

STATEMENT OF MEDICAL AUTHORIZATION
2012

I/WE _____ , HEREBY GIVE MY/OUR PERMISSIONTO LAKE DILLON PRESCHOOL AND EARLY LEARNING CENTER TO CALL A DOCTOR FOR MEDICAL OR SURGICAL CARE FOR MY CHILD_____ SHOULD AN EMERGENCY ARISE. IT IS UNDERSTOOD THAT CONSCIENTIOUS EFFORT WILL BE MADE TO LOCATE US. WE WILL ACCEPT THE EXPENSE FOR AN EMERGENCY.

_____
PARENT SIGNATURE

_____ _____
PARENT SIGNATURE DATE

CHILD'S NAME_____

POLICIES FORM

Child's Name: _____

DISCIPLINE/DISRUPTIVE BEHAVIOR

We will make every effort to work with the parents of children having behavioral difficulties in our care. We are here to serve and protect all of our children. Children displaying chronic disruptive behavior which have been determined to be upsetting to the physical or emotional well-being of another child or staff member will be required to go through the following actions.

*Initial Consultation-The Teacher and Director will require the parent(s) of any child who attends Lake Dillon Preschool and Early Learning Center to meet for a conference (by phone if parents are not available in person). The problem will be defined on paper. Goals will be established and the parent will be involved in working out approaches to solve the problem.

*Second Consultation-If the initial plan for helping the child fails, the parent will again be required to meet with the Teacher and the Director. Another attempt will be made to identify the problem using an outside source/professional opinion, the group will discuss new approaches to the problem, and determine consequences if progress is not made.

*Suspension-When the previous attempts have been followed by teachers and parents and still no progress has been made towards solving the problem, the child will be suspended from the program indefinitely. Suspension decisions will be made jointly with the Teacher(s), Directors, and The Board of Directors.

*Immediate Suspension-We reserve the right of the Director, Assistant Director to immediately suspend a child at any time if he/she exhibits a behavior which is harmful to him/herself or others. A parent may be called from work or home at anytime the child exhibits uncontrollable behavior that cannot be modified by the staff. The parent may be asked to take the child home immediately.

Put a check on the line if your child has permission to do the following, WHEN S/HE IS OLD ENOUGH IF S/HE IS STILL IN OUR PROGRAM

My child has permission to be walked around Dillon OR be pushed in a stroller/ wagon provided by Lake Dillon Preschool and Early Learning Center _____

My child can wear any kind of sunscreen_____ (AFTER S/HE IS 6 MONTHS OLD)

My child has permission to sleep on a mat at naptime_____(AFTER S/HE IS 12 MONTHS OLD)

My child has permission to play at the parks in Dillon- Lake Park and Dillon Park_____ (AFTER S/HE IS 2 YEARS OLD)

My child has permission to ride the Summit Stage/public transportation to go to activities around the county-i.e. Keystone, Rainbow Park in Silverthorne, Silverthorne Library, The Silverthorne Recreation Center, etc_____ (AFTER S/HE IS 3 YEARS OLD)

*For big day trips, Lake Dillon Preschool will provide special permission slips and advanced notice.

Signature:_____ Date: _____

LDP TOP TEN

1. Every family has a purple family file at the front desk that supplies important fundraising and billing information as well as other correspondence and needs to be checked weekly if not daily.

2. Every LDP family is required to volunteer 1 hour per month (3 hours per quarter) per child. This can be accomplished by chaperoning a field trip, joining the board, helping with fundraising, or performing necessary maintenance jobs around the school.

3. If a family has more money than time, there is the option to purchase a gift card at City Market, Safeway, Wal-Mart, Target or Office Max for $40 per hour (please make sure you provide a receipt along with your gift card).

4. Any family who does not meet their required volunteer hours per quarter will be charged $50 for each hour not completed.

5. Tuition is due on the first of the month prior to service. On the sixth of the month a $50 fine will be charged to any overdue account.

6. Twice a year the LDP has large event fundraisers, usually in the Fall and Spring. Each family will be RESPONSIBLE for selling admission tickets.

7. According to Summit County Healthy Child guidelines a child should be sent home if he/she has a fever of 100 under the arm, 3 or more watery stools, vomits for any reason, or is inconsolable and requires one-on-one adult attention.

8. If your child gets SENT home for a fever, diarrhea, or vomiting he/she cannot return to childcare until he/she is symptom free for at least 24 hours WITHOUT medication.

9. Medication (including over the counter medicines, cough drops, diaper rash cream, fever reducer, etc…) must come in the original container, with the proper permission slip signed by both a doctor and parents, with proper dispensing instructions and details.

10. We are so glad you have chosen our facility for your child's early care. Please let us know if you have any questions.

Please realize that these policies help us insure the success of our non-profit organization at the lowest possible cost to parents, while allowing us to provide a safe, quality, caring, educational environment for your child.

_____

(parent signature and date)

In order for Lake Dillon Preschool and Early Learning Center to legally give medication to your child, one of these forms must be completely filled out by the physician and by you. One of these forms needs to be filled out for each medication given. Please feel free to make copies of this form or get new copies from the directors.

Physician's Authorization

Name of Child _____ DOB _____

Medication _____ Dosage _____ Route _____

Time to be given _____ Purpose _____

Special instructions/ parameters

_____

_____

Possible side effects _____

Date _____ _____

Signature of Person with Prescriptive Authority

* *

I hereby give my permission for _____ to take the above prescription or over-the-counter medication in the childcare setting. I understand that it is my responsibility to furnish this medication.

Date _____ _____

Signature of Parent or Guardian

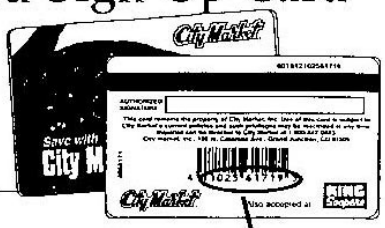
*Note…The prescription medication is to be brought to the childcare setting in its original pharmacy container labeled by the pharmacy or person with prescriptive authority along with a copy of the medication authorization order.
**Note…Over-the-counter medication must be in the original labeled bottle or container.

CITY MARKET CARES FUNDRAISING PROGRAM

BY COMPLETING THE FOLLOWING CITY MARKET SHEET YOU WILL BE ENROLLING IN OUR FUNDRAISING EFFORTS. THREE PERCENT OF EVERYTHING YOU SPEND AT CITY MARKET WILL BE DONATED TO LAKE DILLON PRESCHOOL. THIS PROGRAM WILL NOT AFFECT YOU IN ANY WAY, YOU WILL CONTIUNE TO RECEIVE ALL YOUR SAVINGS AND BENEFITS. THANKS FOR YOUR SUPPORT!

City Market Cares
ELECTRONIC FUNDRAISING PROGRAM

Value Card Sign-Up Card



Organization Name_____

Date____/____/____

Record these 10 digits in the Value Card column

Name	Value Card Number

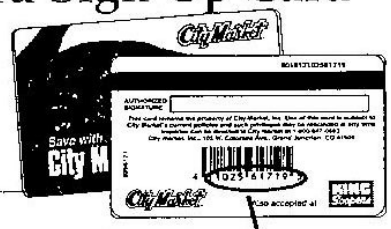
Address_____ Telephone (____)_____

Authorized Signature_____

By signing, I am indicating that I do wish to receive special offers by mail.

City Market Cares
ELECTRONIC FUNDRAISING PROGRAM

Value Card Sign-Up Card



Organization Name_____

Date____/____/____

Record these 10 digits in the Value Card column

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