On or before your child's first day of attendance we will need:

___Current records of immunization

___Completed emergency contact information form

___Enrollment Application

___Financial Agreement and Payment Policy
Form (signed by both parents if applicable)

___General Health Appraisal Form signed by physican

___Signed Permission Forms

___USDA Income Eligibility Form

___Allergy, Asthma, and Special Health Conditions

___Family Handbook Agreement

___Health Care Plan, if required

Your $50.00 registration fee and tuition for the first month/remainder of the month, paid by credit card (preferred method) on the website: https://commerce.cashnet.com/rrcccdcpay;
check made to "The Children's Center" and dropped in the locked payment box outside the Center office or Cash must be taken directly to RRCC cashier department and a payment confirmation slip returned to Center payment box.

Children's Center @ Red Rocks Community College 303-914-6328

**APPLICATION FOR ENROLLMENT**

Date of Enrollment _____ Date of termination _____

Child's Name_____Nickname_____

Birth Date_____Place of Birth_____Gender_____
Phone_____Child lives with_____
Relationship to child_____
Address_____City_____State_____Zip_____
Does your child have medical insurance?_____ Documented vision screening?_____ Documented hearing screening? _____ Documented dental screening? _____ Do you need resources on how to obtain medical insurance?_____
Name and phone of child's primary care provider _____

Family Member #1_____Relationship to child_____
___Parent___Step Parent____Legal Guardian____Temporary Guardian_____Other_____Joint Custody_____Not Joint Custody
Address_____City_____State_____Zip_____
Home Phone_____Work_____Cellular_____
email _____
Social Security #_____Driver's license #_____
Employer_____Occupation_____
Address _____

If we cannot immediately contact you at work, who could find you:
Name_____Phone #_____
Employer Address_____City_____State_____Zip_____

Family Member #2_____Relationship to Child_____
___Parent___Step Parent____Legal Guardian____Temporary Guardian____Other_____Joint Custody_____Not Joint Custody
Address_____City_____State____Zip_____
Home Phone_____Work_____Cell_____
email_____
Social Security #_____Drivers License #_____
Employer_____Occupation_____
Address _____

If we cannot immediately contact you at work, who could find you:
Name_____Phone #_____
Employer Address_____City_____State____Zip_____

Are there legal restrictions on who can have contact with your child? ___No __Yes
If yes, please list and submit legal papers.
Persons Name_____Relationship to child_____
Photo on file? ____No ____Yes

Other's living in home:
First & Last Names_____Age___Relationship to child_____

First & Last Names_____Age___Relationship to child_____
First & Last Names_____Age___Relationship to child_____
First & Last Names_____Age___Relationship to child_____
Ethnic Information for use in writing grant proposals:

What language is spoken in the home?_____

Check one: ____Alaskan Native/American Indian____Asian/Pacific Islander___Black, not Hispanic____Hispanic____White

People who may be called in an emergency and who are authorized to take your child from our Center. We cannot release your child to anyone NOT on the list, other than parents/guardians. Please indicate who to call first in an emergency.

Name #1_____Relationship to Child_____
Address _____ Phone # _____

Name #2_____Relationship to Child_____
Address _____Phone # _____

Name # 3 _____ Relationship to child _____
Address _____ _____Phone # _____

Health Care Practitioner Name _____Phone _____

Dentist's Name _____Phone _____

Preferred hospital _____

Address _____ Phone_____

We understand it is our responsibility to inform the Children's Center @ Red Rocks Community College any time the above information changes. We also understand that the center will attempt to reach one of the people on this form, trying to reach us as parents/guardians first, if there is an emergency, before any action is taken. In the event that we cannot be reached, the staff has our permission to use discretion in securing medical aid. We give permission for emergency medical or hospital personnel to perform the necessary care needed for our child during an emergency. We further understand that the Children's Center @ RRCC, the staff at the Children's Center @RRCC, Red Rocks Community College, the staff at Red Rocks Community College and/or any person responsible for obtaining medical aid for our child will not be responsible for any expense incurred by our family due to medical aid being given to our child.

Parent/Guardian #1 Signature_____
Date_____
Parent/Guardian #2 Signature_____
Date_____

**A $50.00 non-refundable registration fee is due with this application.**

# CHILDREN'S CENTER @RED ROCKS --EMERGENCY INFORMATION

Child's Name: _____ Birthdate: _____

Legal Guardian # 1 Name: _____
Telephone Numbers: Home _____ Work _____

Legal Guardian #2 Name: _____
Telephone Number Home: _____ Work _____

**Emergency Contacts** (to whom child may be released if legal guardian is unavailable)
Name # 1 _____
Address: _____
Telephone Numbers: Home _____ Work _____
Name # 2 _____
Address: _____
Telephone Numbers: Home _____ Work _____

**Child's Usual Source of Medical Care**

Name _____
Address: _____
Telephone Number _____

**Child's Usual Source of Dental Care**

Name: _____
Address: _____
Telephone Number _____

**Child's Health Insurance**
Name of Insurance Plan: _____ ID # _____
Subscriber's Name (on insurance card): _____

**Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations**
_____
_____

**Transport Arrangements in an Emergency Situation**

Ambulance service _____ Child will be taken to: _____
(Parents/guardians are responsible for all emergency transportation charges)

**Parents/Legal Guardian Consent and Agreement for Emergencies**

As parent/legal guardian, I give consent to have my child receive first aid by facility staff, and if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed to **act on my behalf** until I am available I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: _____ Parent/Legal Guardian's Signature # 1 _____

Date: _____ Parent/Legal Guardian's Signature #2 _____

# 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 if Appropriate**

****ONLY REQUIRED BY EARLY HEAD START AND HEAD START PROGRAMS PER STATE EPSDT SCHEDULE****

**** Height @ Exam** _____ **** B/P** _____ ****Head Circumference (up to 12 months)** _____ ******

**** HCT/HGB** _____ **** Lead Level ❑Not at risk or Level** _____

****TB ❑Not at risk or Test Results** ❑ Normal ❑ Abnormal

****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.

Copyright 2007 Colorado Chapter of the American Academy of Pediatrics

COLORADO LAW REQUIRES THIS FORM BE COMPLETE AND PROVIDED TO THE SCHOOL

**Name**_____ **Date of Birth**_____

**Parent/Guardian** _____

## COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

| Vaccine | | Enter complete date each immunization was given | | | | | |
|---|---|---|---|---|---|---|---|
| **Hep B** | Hepatitis B | | | | | | |
| **DTaP/Tdap** | Diphtheria, Tetanus, Pertussis | | | | | | |
| **DT/Td** | Tetanus, Diphtheria | | | | | | |
| **Hib** | *Haemophilus influenzae* type b | | | | | | |
| **IPV/OPV** | Polio | | | | | | |
| **PCV7** | 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 are optional. | | | | | | | |
| **HPV** | Human Papillomavirus | | | | | | |
| **Rota** | Rotavirus | | | | | | |
| **MCV4/MPSV4** | Meningococcal | | | | | | |
| **Hep A** | Hepatitis A | | | | | | |
| **TIV/LAIV** | Influenza | | | | | | |
| **Other** | | | | | | | |

To the best of my knowledge, the person named above has received the above immunizations.

Signed_____ Title_____ Date _____

(Physician, nurse, or school health authority)

## Table 1. MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION

| Vaccine[a] | Level of School/Age of Student | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Child Care 2 to 3 mos | Child Care 4 to 5 mos | Child Care 6 to 7 mos | Child Care 8 to 11 mos | Child Care 12 to 14 mos | Child Care 15 to 17 mos | Child Care 18 to 23 mos | Preschool 2 to 4 yrs | K Entry 4 to 6 yrs | Grades K to 5 5 to 10 yrs | Grades 6 to 12 11 to 18 yrs | College |
| Pertussis/Tetanus/ Diphtheria | 1 | 2 | 3 | 3 | 3 | 4 | 4 | 4 | 5/4[b] | 5/4[b,c] | 6[c,d] | |
| Polio[e] | 1 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 4/3[f] | 4/3[f] | 4/3[f] | |
| Measles/Mumps/ Rubella[g] | | | | | 1 | 1 | 1 | 1 | 2[h] | 2[h] | 2[h] | 2[h,i] |
| *Haemophilus influenzae* type b (Hib)[j] | 1 | 2 | 2 | 3/2 | 3/2 | 3/2/1 | 3/2/1 | 3/2/1 | | | | |
| Pneumococcal Conjugate[k] | 1 | 2 | 3/2 | 3/2 | 4/3/2 | 4/3/2 | 4/3/2 | | | | | |
| Hepatitis B[l] | 1 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | |
| Varicella[m] | | | | | 1 | 1 | 1 | 1 | 2[n] | 2[n] | 2[n,o] | |
| Meningococcal | | | | | | | | | | | | [p] |

**a:** Vaccine doses administered ≤ 4 days before the minimum interval or age are to be counted as valid.

**b:** Five doses of pertussis, tetanus, and diphtheria vaccines are required at school entry in Colorado unless the 4th dose was given at ≥ 48 months (i.e., on or after the 4th birthday) in which case only 4 doses are required.

**c:** For students ≥ 7 years who have not had the required number of pertussis doses, no new or additional doses are required. Any student ≥ 7 years at school entry in Colorado who has not completed a primary series of 3 appropriately spaced doses of tetanus and diphtheria vaccine may be certified after the 3rd dose of tetanus and diphtheria vaccine (or tetanus, diphtheria, and pertussis vaccine if 10 or 11 years) if it is given > 6 months after the 2nd dose.

**d:** The student must meet the minimum prior requirement for the 4th or 5th doses of diphtheria, tetanus, and pertussis vaccine and have 1 tetanus, diphtheria, and pertussis vaccine dose.

**e:** For polio, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

**f:** Four doses of polio vaccine are required at school entry in Colorado unless the 3rd dose was given ≥ 48 months (i.e., on or after the 4th birthday) in which case only 3 doses are required. Four valid doses are a complete series regardless of age at completion.

**g:** For measles, mumps, and rubella, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable for the specific disease tested. The 1st dose of measles, mumps, and rubella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

**h:** The 2nd dose of measles vaccine or measles, mumps, and rubella vaccine must have been administered at least 28 calendar days after the 1st dose.

**i:** Measles, mumps, and rubella vaccine is not required for college students born before January 1, 1957.

**j:** The number of Hib vaccine doses required depends on the student's current age and the age when the vaccine was administered. If any dose was given ≥ 15 months, the Hib vaccine requirement is met. For students who began the series < 12 months, 3 doses are required of which at least 1 dose must have been administered at ≥ 12 months (i.e., on or after the 1st birthday). If the 1st dose was given at 12 to 14 months, 2 doses are required. If the current age is ≥ 5 years, no new or additional doses are required.

**k:** The number of pneumococcal conjugate vaccine doses depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered at: (i) ≤ 6 months, 3 doses are required at 6 to 14 months and 4 doses are required at 15 to 23 months with 1 dose administered on or after the 1st birthday; (ii) 7 to 11 months, 2 doses are required at 6 to 14 months and 3 doses are required at 15 to 23 months with 1 dose on or after the 1st birthday; (iii) 12 to 23 months, 2 doses are required. If the current age is ≥ 2 years, no new or additional doses are required.

**l:** For hepatitis B, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

**m:** For varicella, written evidence of a laboratory test showing immunity or a documented disease history from a health care provider is acceptable. The 1st dose of varicella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

**n:** The second dose of varicella vaccine must have been administered at least 28 calendar days after the 1st dose. See Table 2 for the year of implementation for the second dose of varicella; for school year 2007–2008, the second dose of varicella is only required for kindergarten entry.

**o:** If the 1st dose of varicella vaccine was administered at ≥ 13 years, 2 doses are required, separated by a minimum of 4 to 8 weeks.

**p:** Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new student or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed.

Name_____ Date of Birth _____

**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)

_____

**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)

_____

**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)

_____ CDPHE IMM CI RCRev. 8/07

## Table 2. TIMETABLE FOR IMPLEMENTATION OF REQUIREMENTS FOR SELECTED IMMUNIZATIONS FOR GRADES K TO 12

Refer to Table 1 for the minimum number of doses required for a particular grade level. Table 2 shows the year of implementation for a requirement from Table 1 and is restricted to varicella vaccine dose 1 (Var1) and dose 2 (Var2) and tetanus, diphtheria, and pertussis vaccine (Tdap). Requirements and effective dates for other vaccines are listed in Table 1. In this table, after a vaccine is required for grades K to 12, it is no longer shown, but the requirements listed in Table 1 continue to apply.

| School Year | Grade Level | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | K | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 2007–08 | Var2 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 Tdap | Var1 | | | Tdap | | |
| 2008–09 | Var2 | Var2 | Var1 | Var1 | Var1 | Var1 | Var1 Tdap | Var1 Tdap | Var1 | | Tdap | Tdap | |
| 2009–10 | Var2 | Var2 | Var2 | Var1 | Var1 | Var1 | Var1 Tdap | Var1 Tdap | Var1 Tdap | Var1 | Tdap | Tdap | Tdap |
| 2010–11 (Tdap required for grades 6 to 12) | Var2 | Var2 | Var2 | Var2 | Var1 | Var1 | Var1 Tdap | Var1 Tdap | Var1 Tdap | Var1 Tdap | Var1 Tdap | Tdap | Tdap |
| 2011–12 | Var2 | Var2 | Var2 | Var2 | Var2 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 | |
| 2012–13 (Var1 required for grades K to 12) | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 | Var1 |
| 2013–14 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | | | | |
| 2014–15 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | | | |
| 2015–16 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | | |
| 2016–17 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | | |
| 2017–18 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | | |
| 2018–19 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | |
| 2019–20 (Var2 required for grades K to 12) | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 | Var2 |

ATTENTION PARENTS/GUARDIANS

This letter is to ensure that your child has his/her proper medical forms which will support our program in providing a healthy and safe environment for your child.

- Children needing any medication during program hours require **medication authorization(s)** that are signed by your health care provider.
- Children with **severe allergies** requiring medication are required to have a completed health care plan that is signed by your health care provider.
- Children with **asthma** that regularly require asthma medication during program hours are required to have a completed asthma health care plan that is signed by your health care provider.
- Children with **special health conditions** are required to have a completed health care plan signed by your health care provider. This plan will be individually designed for your child; as delegated by the program's nurse consultant, the program staff and the child's guardian(s).

---

**To Be Completed and Returned By Parent/Guardian**

- Does your child have any food exclusions due to an allergic reaction to the food? YES NO
  if yes, please list food and your child's reaction to exposure:

| Food | Reaction | Medication |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

- Does your child have any other allergies requiring medications or special attention?
  YES NO
- Does your child have a special health condition (such as seizures, diabetes, feeding tube, oxygen, etc.) that requires special attention by center staff?
  YES NO

If yes to any of the above, please circle the appropriate response below:

- I will provide a Health Care Plan signed by my child's health care provider.
- I understand that the nurse consultant will review the health care plan and is available to assist in this process.
- I do not want a HCP for my child at this time.
- Please do not serve these foods to my child at this time.

Child's Name_____ Birthdate_____

Parent's Signature_____ Date_____

# The Children's Center @ RRCC Permission Requests

## Topical Preparations (Preventive)

Please check all of the permissions that you agree to. If you do not wish to grant permission for any of the permissions below, please indicate NO and discuss with the director.

**Child's Name**_____

**Sunscreen:** I give permission for the staff of The Children's Center @ RRCC to apply sunscreen to my child's exposed skin. I understand that it is my responsibility to apply sunscreen to my child in the morning prior to or upon arrival. The staff will reapply sunscreen in the afternoon.

_____ I will provide sunscreen for my child, labeled with first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

_____ I authorize the use of Rocky Mountain, hypoallergenic SPF factor 30 on my child.

**Lotion/Lip Balm**

_____ I will provide a fragrance-free lotion and/or lip balm, labeled with my child's first and last name on the container, as well as the noted expiration date and I will replace prior to expiration.

_____ I authorize the staff to use fragrance-free moisturizing lotion on my child.

**Diaper Ointment/Cream**

_____ I authorize the staff of The Children's Center @ RRCC to apply diaper rash ointment/cream to my child, in the original container, labeled with my child's full name and with the noted expiration date and I will replace prior to expiration. I understand that I may only provide diaper rash ointment/cream, free of antibiotic, antifungal or anti-inflammatory components **without a written prescription from my doctor.**

I agree to the use of the products mentioned above and understand that I must check the ingredients of all products to ensure that my child is not allergic to them. I understand that skin lotion/cream/balm will not be applied to broken skin or if a skin reaction has been observed. Parent will be informed of skin reaction promptly.

_____ _____

Parent Signature Date

# The Children's Center @ RRCC Permission Requests

**Child's Name** _____

**College students working with children** The Children's Center is a lab site for students. Students may do observations and activities with children in The Children's Center for educational/training purposes. These students have completed background checks and are always supervised by staff.

_____ I give permission for my child to be observed and participate in activities with the Early Childhood Education students at the college.

**Photo/Video Use Photos**/videos taken of children in the classroom are often appropriate for staff and training in Early Childhood Education classes, as well as other classes such as Psychology. Videos and photos will never be used for commercial purposes.

_____ I give permission for my child's picture to be used for the above purposes.

**Walks on college campus** Children may take walks with the staff on the college campus, both indoors and out. If children were to cross streets, the walk would be considered a field trip and a special permission form would be requested, prior to the walk.

_____ I give permission for my child to take walks with the staff on college campus indoors and outdoors.

**Media Use On** rare occasions, a teacher may select a video to enhance topics that the children are investigating.

_____ I give permission for the staff to use video to enhance a topic the children are learning about.

**Use of Cots for Rest Permission** must be granted for children under the age of two to rest on a cot.

_____ I give permission for my child to lay on a cot during rest time.

_____ _____

Parent Signature Date

Center

# SPECIAL DIET STATEMENT

**(Colorado Department of Public Health and Environment, Child and Adult Care Food Program)**

Nutrition is an important part of good health and a good childcare program. Children need well-balanced meals to meet their daily energy needs and help build strong bodies and minds. Through the Child and Adult Care Food Program (CACFP), you can be assured that your child is getting balanced nutritious meals. All of the meals claimed must follow patterns set by the U.S. Department of Agriculture. As participants in the CACFP, your child care center can claim a maximum of one meal and two snacks or two meals and one snack daily per child unless they are approved to claim a fourth meal. Your childcare center receives a reimbursement for claiming these meals as well as information on nutritious meals for children.

If your child is unable to consume the foods that are required in the meal pattern, then substitutions may be made if authorized by a recognized medical authority. See reverse side of this page.

| Below are the minimum Child and Adult Care Food Program meal requirements for children 1 through 12 years old: | |
|---|---|
| **BREAKFAST** | **EXAMPLE** |
| 1) Fluid milk<br>2) Fruit, vegetable or juice<br>3) Bread/bread alternate | • Milk<br>• Sliced apples<br>• Corn flakes |
| **LUNCH/SUPPER** | **EXAMPLE** |
| 1) Fluid milk<br>2) Meat/meat alternate<br>3a) Fruit, vegetable or juice<br>3b) Fruit or vegetable<br>4) Bread/bread alternate | • Milk<br>• Chicken<br>• Green beans<br>• Sliced peaches<br>• Dinner roll |
| **SNACK** - Serve 2 of the following 4 foods: | **EXAMPLE** |
| 1) Fluid milk<br>2) Meat/meat alternate<br>3) Fruit, vegetable or juice<br>4) Bread/bread alternate | • Pineapple juice<br>• Wheat Crackers |

USDA forbids discrimination because of race, color, national origin, age, sex, or disability. Any person who believes he or she has been discriminated against in any USDA-related activity should write immediately to the Secretary of Agriculture, Washington, D.C. 20250.

# SPECIAL DIET STATEMENT

The child listed below participates in the USDA Child and Adult Care Food Program. Through this program, licensed childcare centers serve meals that meet the USDA meal pattern requirements (see reverse side of this form). Substitutions in the regular meal pattern may be made based on the authorization of a recognized medical authority, i.e., Physician, Physician's Assistant, Nurse/Practitioner, Child Health Associate or Registered Dietitian.

Child's Name: _____ Age: _____ Date*: _____

Child Care Center: _____ Substitution Effective Through*: _____

Reason for Substitution: _____

| **Substitutions are needed for the following food group (Please Check All That Apply)** | **Specific Foods to Avoid** | **Specific Food Substitutions** | **Key Nutrients that need to be Provided by Substitution** |
|---|---|---|---|
| Iron Fortified Infant Formula | | | Iron, Calcium, Zinc, Protein, Calories |
| Fluid Milk | | | Calcium, Protein |
| Meat/Cheese/Eggs | | | Protein, Iron, $B_{12}$ |
| Fruits | | | Vitamin A, C, Fiber |
| Vegetables | | | Vitamin A, C, Fiber |
| Bread/Grains | | | B-complex, Fiber |
| Others - please specify<br>_____<br>_____<br>_____ | | | |
| | | | |
| | | | |

Signature of Medical Authority: _____

Please Print or Type Name: _____

Address: _____

Phone: _____

Parent's Signature: _____

Please Print or Type Name: _____

Address: _____

Phone: _____

**This form must be updated every 6 months.**

## Follow Up Letter if Special Diet Statement Needs Clarification

Dear Medical Authority:

We have recently received a Special Diet Statement for _____.

The Diet Statement indicates _____

should be substituted for _____.

This substitution may not provide the child with sufficient _____

_____.

Unless you let me know of a change in the Special Diet Statement, I will assume that you are monitoring the child's nutritional status and making the necessary dietary additions.

Sincerely,

cc: _____
Parent

COLORADO
Department of Public Health & Environment

# Child and Adult Care Food Program
# Income Eligibility Form (IEF) 2017- 2018

**Part 1 - List name and age of each child enrolled.** Indicate each child's race and ethnicity. If this information is left blank, the institution representative may complete it based on visual identification. This information is for statistical reporting requirements and does not affect eligibility. **Note:** **A** =Asian; **AI/AN**=American Indian or Alaskan Native; **B/AA**=Black or African American; **H/PI**=Native Hawaiian or other Pacific Islander; **W**=White.

| First Name | Last Name | Age | Ethnicity (select one) and Race (select one or more) |
|---|---|---|---|
| | | | **Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino<br>**Race:** ❑ A ❑ AI/AN ❑ B/AA ❑ H/PI ❑ W |
| | | | **Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino<br>**Race:** ❑ A ❑ AI/AN ❑ B/AA ❑ H/PI ❑ W |
| | | | **Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino<br>**Race:** ❑ A ❑ AI/AN ❑ B/AA ❑ H/PI ❑ W |

**Participation in some programs allows automatic eligibility for free meals in the CACFP with required documentation.** If applicable, please check one of these boxes if one or more children listed above is:

❑ A **foster child** who is the responsibility of the State or was placed by the court. ❑ An **Early Head Start (EHS)**, or **Head Start child or pregnant mother (enrolled in EHS)** or an **Even Start** enrolled child. ❑ A **homeless, migrant, or runaway child.**

Refer to the back of this page for required eligibility documentation.

**Please note: If you marked one of the boxes listed above and it applies to ALL children listed above, *SKIP TO PART 5 - Signature*.**

**Part 2 - Assistance Programs:** Does anyone in your household receive benefits from any of the programs listed below? **If no**, go to **Part 3**. **If yes**, please mark which assistance program (only one is required), write the case number, and ***SKIP TO PART 5 - Signature***.

☐ Supplemental Nutrition Assistance Program (SNAP)
☐ Temporary Assistance for Needy Families (TANF)
☐ Food Distribution Program on Indian Reservations (FDPIR)

**CASE NUMBER**_____
(Quest Card or Social Security numbers are not acceptable)

**Part 3 - Income to report:** List the names of all household members who are not listed in Part 1, regardless of age. Write the amount of income received by each household member for the current month, projected income for the first month of this application, or the month prior to this application. Indicate if income is weekly (W), monthly (M), or annually (A). If you enter '0' or leave any fields blank, you are stating there is no income to report. **Refer to the back of this page for definitions of income.**

| First and Last Name | Gross Income/ Salary/Wages | Other Income | TOTALS Center Use Only |
|---|---|---|---|
| | $ W M A | $ W M A | $ W M A |
| | $ W M A | $ W M A | $ W M A |
| | $ W M A | $ W M A | $ W M A |
| | $ W M A | $ W M A | $ W M A |
| **Total number in Household** | **Note:** If necessary, convert multiple income schedules to annual income. Multiply weekly income by 52, bi-weekly by 26, monthly by 12. | **Total Income:** | $ W M A |

**Part 4 - Social Security Number (SSN):** If the adult household member completing this form does not provide a TANF, SNAP, or FDPIR number in Part 2, the person completing this form must provide the last four digits of his/her Social Security Number (SSN).

| X | X | X | - | X | X | - | | | | |
|---|---|---|---|---|---|---|---|---|---|---|

☐ **Check if no SSN**

**Part 5 - Signature:** I certify that all of the information on this form is true and correct and is given in connection with the receipt of Federal Funds. Information may be verified. Deliberate misrepresentation may subject me to prosecution under applicable State and Federal criminal statutes. Note: If the child is a foster child, an official of a court or other agency with responsibility for the child may sign this form.

Signature of Adult Household Member _____ Street Address _____

Printed Name _____ City _____ State _____ Zip Code _____

Date _____ Home Telephone _____ Work Phone _____

**Gross Income/Salary/Wages includes, but is not limited to:**

- Gross earned income or cash income before deductions.
- Monetary compensation for services, including wages, salary, tips, strike benefits, commissions, fees, withdrawals from savings, investments, trust accounts, and other accounts.
- Net income from self-owned businesses and farms.
- Social Security, public assistance or Welfare payments (e.g. TANF, General Assistance/General Relief), alimony, child support payments, and unemployment and worker's compensation.
- Private pensions or annuities, retirement benefits, disability benefits, veteran's benefits, dividends or interest, income from estates, trusts or investments, net rental income, cash withdrawals from savings, and net royalties.
- Student financial assistance (grants or scholarships) not used to meet education expenses.
- Regular contributions from persons not living in the household or any other money that may be available to pay for child (ren)'s meals.
- Child's income: The current earnings of a child or student grade 12 or below, regardless of age, who is a full-time or regular part-time employee, or who receives income from other sources, such as SSI or social security. Infrequent earnings, such as income from occasional baby-sitting or mowing lawns, are not counted as income and should not be listed on the application.

**The following documentation is required for automatic eligibility:**

- Documentation from the placement agency verifying the child is a foster child.
- One of the following documents from the Head Start program: 1) An approved Head Start or Even Start application; 2) A statement of Head Start or Even Start enrollment; 3) A list of participants from the Even Start or Head Start official; 4) Documentation from the Even Start official that confirms the child has not entered Kindergarten.
- Documentation verifying the status of a homeless, migrant or runaway child from the director of the homeless shelter, Migrant Education Program Coordinator or an official of the Runaway and Homeless Youth program.

**FOR CENTER STAFF USE ONLY**

**Income Category (check one):** ☐ **Free** ☐ **Reduced** ☐ **Paid** (Ineligible for Free or Reduced Priced meals)

This form expires 12 months after the month in which the institution makes the determination. Example: If the determination is **July 2017, the form is valid from July 1, 2017 through July 31, 2018.** The institution may use the date the parent/guardian signs the Income Eligibility Form, **OR** the date the institution's official makes the determination and signs the Income Eligibility Form. **The same approval method selected must be used for all forms approved by the institution.**

**Signature of Center's Eligibility Official**

**Determination Date:** **Month** **Year**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

The Children's Center @
Red Rocks Community College

## IMPORTANT INFORMATION REGARDING HANDBOOK

**Please bring this form to your family interview to be reviewed with the Director.**

College Training Site, pg. 3: Children are **never** left alone with practicum students at any time. Background checks are completed on all work study students and staff. ECE students come to us with a completed background check.

Drop off/pick up, pg. 4: We ask that all children be here from 8:45am-3:15pm. Chronic late arrival (after 9:30) will be discussed with family.

Cell Phone: So that you can give your children the attention they deserve, cell phone use in not permitted in our Center.

Attendance Days: Preference is given to typical attendance patterns: Full time, MWF, TTH. We cannot offer substitute days if your child is not able to attend on their enrolled day. If we have space, you may **add** a day at the full rate.

Admission & Registration, pg. 6: Record of immunization and health status form must be completed and delivered at drop off on the first day of attendance, and resubmitted annually. New Families-Registration is due when offered spot, and first month payment on child's first day of attendance. All tuition payments are due at the beginning of month of care. There is a $35.00 returned check fee.
Extended absences are billed as follows: 2 consecutive weeks at full tuition, additional consecutive days at 50%. Slots are not held through summer without payment for care.

Parent/Guardian agrees to notify director prior to enrollment if child has special needs, ILP, IEP or other support.

Curriculum:
We integrate elements of High Scope, Reggio Emilia and Montessori philosophies into our child-directed learning curriculum.

Celebrations: Because we respect all cultures and all family practices & beliefs and because we do not believe some celebrations are developmentally appropriate for young children, our celebrations always emerge from our curriculum. Please read handbook carefully.

I have discussed the above information with Center staff and understand and agree to it.

_____ _____ _____

Parent/Guardian Signatures Date

## FAMILY HANDBOOK AGREEMENT

I HAVE READ AND UNDERSTAND THAT OUR FAMILY WILL FOLLOW THE PRACTICES AND POLICIES SET FORTH IN THE MOST CURRENT FAMILY HANDBOOK FOR THE CHILDREN'S CENTER AT RED ROCKS COMMUNITY COLLEGE. I KNOW IF I HAVE QUESTIONS THAT I AM TO CONTACT THE DIRECTOR OF THE CENTER FOR ANSWERS TO MY QUESTIONS.

Parent/Guardian #1 _____Date _____

Parent/Guardian #2 _____Date _____

## FINANCIAL AGREEMENT AND PAYMENT POLICIES

- **Payment is due for the month of care of the first of each month. A late fee of $25.00 will be assessed on the 10th of the month if tuition has not been paid.**
- **Check:** Make checks payable to The Children's Center.
- **Credit Card:** All credit card payments (preferred method) are made on line at https://commerce.cashnet.com/rrcccdcpay. Responsible party must log in **the first attendance day of each month to make payment.**
- **Cash:** Cash payment must be made at college cashiers dept. Please pick up a Miscellaneous Deposit Form to take with your payment.
- Tuition is based on contracted days, not on actual days of attendance.
- **Payment is due for enrolled days whether child attends or not. We cannot substitute attendance days if your child does not attend on his/her scheduled days of attendance.**
- There is a non-refundable $50.00 registration fee per child due at time of registration and each August. A portion of this fee pays for the on line assessment program used to track each child's development. Families who enroll after May 31 will not be charged the annual fee until the following year.
- Holidays and in-service days are fee days. Families are not charged for 1 week of closure in Aug. and 1week of closure in Dec. Tuition is calculated multiplying weekly rate x 50 weeks /12 months and rate is consistent each month.
- Childcare may be denied for any child for whom tuition is more than 2 weeks late.
- Accounts are subject to a $25.00 processing fee for returned check or denied card.
- Late pick up fee is $1.00 per minute after 6pm. Consideration is made for weather conditions and circumstances.
- Vacations-full payment is due for 2 consecutive weeks of vacation, and 50% for additional consecutive weeks, if written notice of vacation is provided.
- Parent fees for families receiving CCCAP assistance must be paid in full on the first attendance day of each month.

I understand the monthly fee for my child is _____and I have read and agree to the financial policies outlined in the Family Handbook and above.

Signature_____ Date_____

Signature_____ Date_____