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 ❑Hospitallzations ❑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.

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: _____

Last Reviewed: December 2017

Immunization

Non-Medical Exemption Form (Religious and Personal Belief)

Vaccines are one of the greatest public health achievements of the past century and save an estimated 3 million children's lives every year. The Colorado Department of Public Health and Environment strongly supports vaccination as one of the easiest and most effective tools in preventing diseases that can cause serious illness and even death. For nearly all children, the benefits of preventing disease with a vaccine far outweigh the risks. Declining to follow the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) immunization schedule for number, space and timing of doses, may endanger an unvaccinated child's health and others who come into contact with him/her. Some vaccine-preventable diseases are common in other countries and unvaccinated children could easily get one of these diseases while traveling or from a traveler.

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities, and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and Head Start programs. Prior to kindergarten, a non-medical exemption must be filed each time a student is due for vaccines according to the schedule developed by the ACIP.[1,2] From kindergarten through 12th grade, a non-medical exemption must be filed every year during the student's school enrollment/registration process.[1] Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of the disease and the circumstances of the outbreak.

Please complete all required fields below; incomplete forms will not be accepted. *All fields are required unless noted optional.*

Type of Non-Medical Exemption Claimed: □ Personal Belief □ Religious

Student Information:

Last Name:	First Name:	(optional) Middle Name:
Gender: □ Female □ Male	Date of Birth:	
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box:	
City:	State:	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

Parent/Guardian Completing This Form: □ Check if an emancipated student or student over 18 years old

Last Name:	First Name:	(optional) Middle Name:
Relationship to student: □ Mother □ Father □ Guardian		
Street #:	Street Name:	Street Type (e.g. Ave.):
Unit #:	P.O. Box:	
City:	State:	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		□ Check if Not Applicable
Address:		
City:	State:	Zip Code:
Phone Number:		Grade of Student:

[1] Colorado Board of Health rule 6 CCR 1009-2: https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7698&fileName=6%20CCR%201009-2.

[2] 2018 Recommended Immunizations from Birth through 6 Years Old: www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf. Based on this schedule, a non-medical exemption would be submitted at 2 months, 4 months, 6 months, 12 months and 18 months of age.

Vaccine Preventable Disease Information

The information provided below is to ensure parents/guardians/students are informed about the risks of not vaccinating.

Diphtheria, tetanus, pertussis (DTaP, Tdap) - Unvaccinated children may be at increased risk of developing diphtheria, tetanus and/or pertussis if exposed to these diseases. Serious symptoms and effects of diphtheria include heart failure, paralysis, breathing problems, coma, and death. Serious symptoms and effects of tetanus include "locking" of the jaw, difficulty swallowing and breathing, seizures, painful tightening of muscles in the head and neck, and death. Serious symptoms and effects of pertussis (whooping cough) include severe coughing fits that can cause vomiting and exhaustion, pneumonia, seizures, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/dtap.pdf and http://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.pdf
Haemophilus influenzae type b (Hib) - Unvaccinated children may be at increased risk of developing invasive Hib disease if exposed to this disease. Serious symptoms and effects include bacterial meningitis, pneumonia, severe swelling in the throat, brain damage, deafness, infections of the blood, joints, bones, and covering of the heart, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hib.pdf
Hepatitis B - Unvaccinated children may be at increased risk of developing hepatitis B if exposed to this disease. Serious symptoms and effects include jaundice, life-long liver problems such as liver damage, scarring, liver cancer, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf
Inactivated poliovirus (IPV) - Unvaccinated children may be at increased risk of developing polio if exposed to this disease. Serious symptoms and effects include paralysis of muscles that control breathing, meningitis, permanent disability, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ipv.pdf
Measles, mumps, rubella (MMR) - Unvaccinated children may be at increased risk of developing measles, mumps, and/or rubella if exposed to these diseases. Serious symptoms and effects of measles include pneumonia, seizures, brain damage, and death. Serious symptoms and effects of mumps include meningitis, painful swelling of the testicles or ovaries, sterility, deafness, and death. Serious symptoms and effects of rubella include rash, arthritis, and muscle or joint pain. If a pregnant woman gets rubella, she could have a miscarriage or her baby could be born with serious birth defects such as deafness, heart problems, and mental retardation. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmr.pdf
Pneumococcal conjugate (PCV13) - Unvaccinated children may be at increased risk of developing pneumococcal disease if exposed to this disease. Serious symptoms and effects include pneumonia, lung infections, blood infections, meningitis and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/pcv13.pdf.
Varicella (chickenpox) - Unvaccinated children may be at increased risk of developing varicella if exposed to this disease. Serious symptoms and effects include severe skin infections, pneumonia, brain damage, and death. For more information: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.pdf

Required Vaccines for School Entry - Place an "X" next to each vaccine you are declining.

	Diphtheria, tetanus, pertussis (DTaP)		Inactivated poliovirus (IPV)
	Tetanus, diptheria, pertussis (Tdap)		Measles, mumps, rubella (MMR)
	Haemophilus influenzae type b (Hib)		Pneumococcal conjugate (PCV13)
	Hepatitis B		Varicella (chickenpox)

Statement of Exemption

I am the parent/guardian of the above-named student or am the student himself/herself (emancipated or over 18 years of age) and am declining the vaccine(s) indicated above due to a religious or personal belief that is opposed to vaccines. The information I have provided on this form is complete and accurate.

- I may change my mind at any time and accept vaccination(s) for my child/myself in the future.
- I can review evidence-based vaccine information at www.colorado.gov/cdphe/immunization-education, or www.ImmunizeforGood.com for additional information on the benefits and risks of vaccines and the diseases they prevent.
- I can contact the Colorado Immunization Information System (CIIS) at www.ColoradoIIS.com or my health care provider to locate my child's/my immunization record.[3]

I acknowledge that I have read this document in its entirety.

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

[3] Under Colorado law, you have the option to exclude your child's/your information from CIIS at any time. To opt out of CIIS, go to www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

Immunization
Medical Exemption Form

Colorado law C.R.S. § 25-4-902 requires all students attending any school in the state of Colorado to be vaccinated against certain vaccine-preventable diseases as established by Colorado Board of Health rule 6 CCR 1009-2, unless an exemption is filed. This law applies to students attending public, private and parochial kindergarten, elementary and secondary schools through 12th grade, colleges or universities and child care facilities licensed by the Colorado Department of Human Services including child care centers, school-age child care centers, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, Head Start programs. Students with a recorded immunization exemption may be kept out of a child care facility or school during a disease outbreak; the length of time will vary depending on the type of disease and the circumstances of the outbreak.

Please complete all required fields below. Incomplete forms will not be accepted.

Student Information:

Last Name:	First Name:	(optional) Middle Name:
Gender: □ Female □ Male	Date of Birth:	
Address:		
City:	State:	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

Parent/Guardian Completing This Form: □ Check if an emancipated student or student over 18 years old

Last Name:	First Name:	(optional) Middle Name:
Relationship to student: □ Mother □ Father □ Guardian		
Address:		
City:	State:	Zip Code:
Email Address:		County:
Phone Number:		□ Home □ Cell

School/Licensed Child Care Facility Information:

School Name/Licensed Child Care Facility:		
School District:		□ Check if Not Applicable
Address:		
City:	State:	Zip Code:
Phone Number:		Grade of Student:

Required Vaccines for Entering School: (Check each vaccine declined)		**List medical contraindication(s) for each vaccine declined**
□	Hepatitis B	
□	Diphtheria, tetanus, pertussis (DTaP, Tdap)	
□	Haemophilus influenzae type b (Hib)	
□	Inactivated poliovirus (IPV)	
□	Pneumococcal conjugate (PCV13)	
□	Measles-mumps-rubella (MMR)	
□	Varicella (chickenpox)	

The physical condition of the above named student is such that vaccination would endanger his/her life or health or is medically contraindicated due to other medical conditions.

Signature: _____ Date: _____

Physician (MD, DO), Advanced Practice Nurse (APN), or delegated Physician Assistant (PA)

Under Colorado law, you have the option to exclude your child's/your information from CIIS. To opt out of CIIS, go to: www.colorado.gov/cdphe/ciis-opt-out-procedures. Please be advised that you will be responsible for maintaining your child's/your immunization records to ensure school compliance.

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

COLORADO
Department of Public Health & Environment

Child and Adult Care Food Program
Special Diet Statement/Special Accommodation Form
(Food preferences are not an appropriate use of this form)

1. Name of Participant (Last, First)	2. Age or Date of Birth
3. Name of Parent or Guardian	4. Telephone Number
5. Institution/Child Care Provider Name	6. Telephone Number

7. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation (Refer to instructions below). Child care providers and school food authorities participating in federal nutrition programs **must comply with requests for special meals and any adaptive equipment. A licensed physician, advance practice nurse, dentist, or physician assistant must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Child care providers and school food authorities participating in federal nutrition programs are encouraged to accommodate reasonable requests. In order to serve a reimbursable meal or snack, sites are required to purchase and provide the recommended substitute food(s) indicated by the medical authority. If the recommended substitute is difficult to obtain or presents a financial hardship, an institution representative may contact the CDPHE-CACFP office to request approval to claim the child's meals although the parent/guardian provide the food item. **A licensed physician, dentist, physician's assistant, registered dietitian, or advance practice nurse must sign this form.**

8. Disability* or medical condition requiring a special meal or accommodation:
Describe the medical condition that requires a special meal or accommodation. For example: "Juvenile diabetes, allergy to peanuts, etc.

9. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:
Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."

10. Diet prescription and/or accommodation: Please describe in detail to ensure proper implementation. Use extra pages as needed.
Describe a specific diet or accommodation prescribed by a physician, advance practice nurse, dentist, or physician assistant; or describe diet modification requested for a non-disabling condition.

11. Foods to be omitted and substitutions:
List specific foods to be omitted and suggested substitutions. An additional sheet may be attached with additional information as needed. List specific foods that must be omitted. For example: "Exclude fluid milk and soy milk or soy products."

A. Foods To Be Omitted	B. Suggested Substitutions

12. If texture accommodations are needed, indicate texture needed by checking one of the boxes below:
Chopped ☐ Ground ☐ Pureed ☐ Liquid ☐

13. Adaptive Equipment:
Describe specific equipment required to assist the participant with dining. Examples may include a sippy cup, a large handled spoon, wheel chair accessible furniture, etc.

14. Signature of Parent/Guardian **Date Signed**

15. Signature of Medical Authority**	16. Printed Name of Medical Authority	17. Telephone Number	18. Date

19. Medical Office Name and Address

***Refer to the CDPHE-CACFP Manual for the federal definition of disability.**

****Physician, advance practice nurse, dentist, or physician assistant signature is required for participants with a disability. For participants without a disability, a licensed physician, dentist, physician assistant, registered dietitian, or advance practice nurse must sign the form.**

This form must be updated annually. If the participant is an infant, this form must be updated every six month.

The American with Disabilities Act Amendment Act defines a disability, in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008.
Locate information regarding the ADAAA, which expanded the definition of disability, at:
https://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf

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In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, 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 all 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 the 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
(3) Email: Program.Intake@usda.gov.

This institution is an equal opportunity provider.

COLORADO
Department of Public Health & Environment

Household Income Eligibility Guidelines Effective July 1, 2019- June 30, 2020

Household Size	Free				Reduced			
	Yearly	Monthly	Biweekly*	Weekly	Yearly	Monthly	Biweekly*	Weekly
1	$ 16,237	1,354	625	313	23,107	1,926	889	445
2	$ 21,983	1,832	846	423	31,284	2,607	1,204	602
3	$ 27,729	2,311	1,067	534	39,461	3,289	1,518	759
4	$ 33,475	2,790	1,288	644	47,638	3,970	1,833	917
5	$ 39,221	3,269	1,509	755	55,815	4,652	2,147	1,074
6	$ 44,967	3,748	1,730	865	63,992	5,333	2,462	1,231
7	$ 50,713	4,227	1,951	976	72,169	6,015	2,776	1,388
8	$ 56,459	4,705	2,172	1,086	80,346	6,696	3,091	1,546
For each additional family member add:	$ +5,746	+479	+221	+111	+8,177	+682	+315	+158

*Determine biweekly income by dividing the yearly income by 26, and by rounding up to the next whole number if it is more than .5 and rounding down if it is less than .5

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Department of Public Health & Environment

2019-2020 Income Eligibility Form (IEF) for Child Care

STEP 1: List ALL children in day care

Children in Foster care or Head Start and children who meet the definition of Homeless, Migrant or Runaway are eligible for free meals. Addition documentation is required to verify their eligibility status. Review the Dear Parent Letter for more details. If more than three children, please complete an additional form.

			Check all that apply				
Child's First Name	Child's Last Name	Age	Foster Child	Migrant	Runaway	Homeless	Head Start

STEP 2: Do any household members (including you) currently participate in one or more of the following assistance programs: SNAP, TANF or FDPIR?

IF YES → Write the case number here & proceed to STEP 4 (Do not complete STEP 3) **CASE NUMBER:** _____ (Write only one case number in this space.)
IF NO → Go to STEP 3

STEP 3: Report Income for ALL Household Members (Skip this step if you answered 'Yes' to Step 2) ☐ I do not wish to disclose income.

Flip the page for information on sources of income for child income and Household Members.

A. **Child Income**
Sometimes children in the household earn or receive income.
Please include the TOTAL income received by any children listed in STEP 1.

B. **All other Household Members (including yourself)**
List other household members not listed in STEP 1 (including yourself) even if they do not receive income. For each household member listed, if they do not receive income, report total gross income (before taxes) for each source in whole dollars (no cents). If they do not receive income from any source, write '0'. If you enter '0', you are certifying that there is no income to report.

Child Income:		Circle one: Yearly Monthly Bi-weekly Weekly

Name of other Household Members (First and Last Names)	Earnings from Work	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)	Welfare/ Child Support/ Alimony	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)	Pensions/ Retirement/ Social Security/SSI/VA Benefits	How Often? Yearly (Y) Monthly (M) Bi-Weekly (B) Weekly (W)
	$		$		$	
	$		$		$	
	$		$		$	
Total household Members (Children and Adults)		Last Four Digits of Social Security Number (SSN) of primary wage earner or other adult household member.			XXX-XX-	Check if no SSN ☐

STEP 4: Contact Information and Adult Signature

"I certify that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds and that CACFP officials may verify that information. I am aware that is I purposely give false information, the participant/center may lose meal benefits and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Address | City, State, Zip | Phone/Email

COLORADO
Department of Public Health & Environment

2019-2020 Income Eligibility Form (IEF) for Child Care

Source of Income for Children	
Sources of Child Income	Examples
Earnings from work	A child has a regular full or part-time job where they earn a salary or wages.
Social Security • Disability Payments • Survivors Benefits	A child is blind or disabled and receives Social Security benefits. A parent is disabled, retired or deceased, and their child receives Social Security benefits.
Income from person outside of household	A friend or extended family member regularly gives a child spending money.
Income from any other source	A child receives regular income from a private pension fund, annuity or trust.

Source of Income for Adults		
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**
Salary, wages or cash bonuses Net income from self-employment (farm or business) If you are in the U.S. Military Basic pay and cash bonuses (DO NOT include combat pay, FSSA or privatized housing allowances) Allowances for off-base housing, food and clothing	Unemployment benefits Workers compensation Supplemental Security Income (SSI) Cash assistance from State or local government Alimony payments Child support payments Veterans benefits Strike benefits	Social Security (including railroad retirement and black lung benefits) Private Pensions or disability benefits Income from trusts or estates Annuities Investment income Earned interest Rental income Regular cash payments from outside household

STEP 5: Children's Ethnic and Racial Identities

We are required to ask for information about your children's race and ethnicity. Responding to this section is optional and does not affect your children's eligibility for receiving meals during care. Check all boxes that apply to the child(ren) in your care. If this information is left blank, the institution MUST complete it based on visual identification.

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White (Includes Hispanic and Latino) ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native

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DO NOT FILL OUT: For center staff use only

Annual Income Conversion: Weekly x 52, Biweekly x 26, Monthly x 12

Total Income	$	How Often? (Circle One)	Yearly Monthly Bi-Weekly Weekly	Household size:		Eligibility	Free	Reduced	Paid

Determining Official's Signature Month/Year Expiration Date* (Month/Year) Today's Date

*This form expires 12 months after the month in which the institution makes the determination

Example: If the determination is **July 2019, the form is valid from July 1, 2019 through July 31, 2020.** The institution may use the date the participant/guardian signs the Income Eligibility Form **OR** the date the institution's official make the determination and signs the Income Eligibility Form.

The institution may use the date the parent/guardian signs the IEF OR the date the institution's official makes the determination and signs the IEF. **The same approval method selected must be used for all forms approved by the institution.**

Revised 07/2019

Jefferson Center
— With you in mind —

Dear Parent(s)/Guardian(s),

In order to provide the best possible care for your child,The Children's Center at Red Rocks Community College is partnering with a consultant from Jefferson Center. The consultation program provides early childhood information and support regarding social-emotional development to child care providers in Jefferson, Clear Creek, and Gilpin Counties.
Our goals are to promote children's social-emotional development, to support quality child care, and to enhance relationships among children, parents, and early care staff. The early childhood consultant provides support to Advantage Learning Center staff, students and parents. In addition, direct services with Jefferson Center can be requested by families.

Anything discussed between you, your child, the consultant, and The Children's Center is confidential, as protected by law. State and Federal laws indicate the following **exceptions** to the confidentiality policy: suspected child abuse and neglect, harm to self, or imminent harm to others.

This letter is to inform you that a consultant may be observing and interacting with your child in his/her classroom. The consultant and provider may exchange information about your child in their efforts to understand and address the specific needs of your child as well as the needs of the entire classroom. Your child may also be entered into the State of Colorado Office of Early Childhood's information systems for administrative and grant purposes only. All information is strictly confidential and will not be used for any other purposes. If you have any questions or concerns or wish to opt out, please feel free to speak with the director of The Children's Center, or contact Carla Sciarrino or Jennifer Bergin with the Jefferson Center.

We look forward to working with you!

Carla Sciarrino, LCSW, IMH-E ®
Early Childhood Mental Health Specialist
303-524-5448
CarlaS@jcmh.org

Jennifer Bergin, LPC, MFT, NCC
Bilingual Early Childhood Mental Health Specialist
720-618-8798
JenniferBe@jcmh.org

I have read the above letter and understand and consent to the consultation program:

_____ _____
Name of Child Child's Date of Birth

_____ _____
Parent/Guardian Printed Name Parent/Guardian Signature

_____ _____
Parent/Guardian Phone Number Today's Date

Parent/Guardian Email: _____

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/rrcecdcpay. 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_____