e11 Creative Workshop for Children

Registration Form

All sections of this packets must be completed and returned before your child's first day of attendance. A current physical must be provided within 30 days of enrollment and immunization records are due with registration papers.

Child's Full Name		**Birth Date**		**Age**	
Nickname		**Gender**			
Home Address					
City, State & Zip					
Home Phone					
Parent #1 Name		**Relationship**			
Driving License #		**State**			
Place of Employment		**Work Phone**			
Email		**Cell Phone**			
Parent #2 Name		**Relationship**			
Driving License #		**State**			
Place of Employment		**Work Phone**			
Email		**Cell Phone**			

Alternative Contacts *(You MUST provide at least 1)*					
Name		**Driving License #**		**State**	
Relationship to Child		**Phone Number**			
Address					
Choose One	**Authorized Pick-Up**	**Emergency Contact**			
Alternative Contacts *(You MUST provide at least 1)*					
Name		**Driving License #**		**State**	
Relationship to Child		**Phone Number**			
Address					
Choose One:	**Authorized Pick-Up**	**Emergency Contact**			

Enrollment Date	

Child's Profile

Child's Name		Birth Date	

Has or does your child have any known health problems?	YES NO		
If YES please have a medical provider with prescriptive authority fill out and sign the permission form(s) authorizing staff members of E11 Creative Workshop to administer medications if needed. NO medication can be administered without proper written authority.			
Does your child have any known or suspected allergies *If YES list allergies or explain concerns below:*	YES NO		
Food Allergies - Allergy & Reaction Severity (*circle*)			
	mild	moderate	severe
	mild	moderate	severe
	mild	moderate	severe
Medication or other Allergies - Allergy & Reaction Severity (*circle*)			
	mild	moderate	severe
	mild	moderate	severe
	mild	moderate	severe
A care plan may need to be developed by your child's pediatrician for allergic reactions and provided to the center before the first day of attendance. Medication cannot be kept on site or administered without current doctor's orders			
Is your child prone to (*circle all those that apply*) Stomachaches Colds Headaches Sore throats Earaches Other			
Are there any indications of vision or hearing problems	YES NO		
If YES, a care plan may need to be developed by your child's pediatrician or other licensed medical provider and provided to the center before the first day of attendance			
Do you have a back up plan in place if your child is ill and cannot attend	YES NO		

Parent/Guardian Signature

Date

Medical Release

I, _____, authorize E11 Creative Workshop (E11, Inc.) and its employees to seek emergency medical and or dental services for my child, _____, at any time while he/she is under the care of E11 Creative Workshop and its staff. I authorize my child to be transported by car or an ambulance/emergency medical vehicle to an emergency medical facility for treatment. I understand that E11 Creative Workshop and its staff will access emergency medical services as the staff deems necessary and I agree to pay for any medical services and transportation provided for my child.

Parent/Guardian #1 Signature		**Date**	
Parent/Guardian #2 Signature		**Date**	
Full Name of Minor			
Date of Birth		**Blood Type**	
Allergies to Medication(s)			
Special Health Problems			
Regular Medication			
Date of last physical exam			
The licensee shall not be responsible for providing or paying for the child's health care, dentistry or emergency transport. I/We agree that neither I/We nor my/our child will bring any claims of any kind against E11 Creative Workshop (E11, Inc.) or its staff as a result of any injuries, expenses or damages that I or my child may suffer in any way related to the use of our facilities, toys, other children, whether such claims are known or unknown or arise in the future.			
Parent/Guardian #1 Signature		**Date**	
Parent/Guardian #2 Signature		**Date**	
Hospital of Choice		**Phone**	
Hospital Address			
Primary Medical Insurance Information *Complete pediatrician & dentist information MUST be provided upon enrollment per state regulations*			
Provider		**Plan #**	
Pediatrician Name		**Phone**	
Pediatrician Street Address		**City, State, Zip**	
Primary Dental Insurance Information *Complete pediatrician & dentist information MUST be provided upon enrollment per state regulations*			
Provider		**Plan #**	
Dentist Name		**Phone**	
Dentist Street Address		**City, State, Zip**	

Primary Contact		**Secondary Contact**	
Name		**Name**	
Phone		**Phone**	
Street Address		**Street Address**	
City, State, Zip		**City, State, Zip**	

Sunscreen Permission Form

Child's Full Name		Birth Date	

Children must come to school with sunscreen applied on hot, sunny days. By signing my child in each morning, I/We acknowledge that I/We have applied sunscreen to all exposed areas of my/our child's skin.

Any child at E11 Creative Workshop going outside for more than 1 hour will have sunscreen re-applied to exposed skin. Sunscreen may be applied by a child over 4 years of age with direct supervision of a staff member (7.702.52D5).

Sunscreen may not be applied if there are open wounds or broken skin unless there is a written order by a prescribing practitioner. A medical provider's note is required if sunscreen will not be used, and alternate protection from the sun will be required (i.e. hat, gloves, long sleeves etc)

Sunscreen will be applied according to the manufacturer's instructions. Please provide sunscreen in an original container.

I give permission for the staff to apply sunscreen to my child according to the center's policy.

Parent/Guardian Signature

Date

General Permission Form

Full Name of Child		Birth Date	

E11 Creative Workshop and its staff have permission to:

Take my/our child/children on a field trip around Manitou Springs each day, including, but not limited to Memorial Park	YES	NO
Assist my/our child/children in the bathroom (Preschoolers)	YES	NO

As part of our documentation process E1 Creative Workshop regularly uses photography to document ongoing projects and activities of the children at the center.

Please be aware that E11 Creative Workshop may also use the photos on facebook, Instagram, in promotional materials and in on an online portfolio called Seesaw, as a way to share events, learning and experiences at E11.

Please make your center Director aware of any reasons why you do not wish to have your child's photograph used outside of the school. Thank you.

Parent/Guardian Signature

Date

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

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

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

Parent/guardian: _____

Required vaccines

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

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

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

Recommended vaccines

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

Health care provider signature or stamp: _____ Date: _____

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

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: _____ Date: _____

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

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

GENERAL HEALTH APPRAISAL FORM

PARENT please complete 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 @ Last 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

OR Dose_____or see the attached age-appropriate dosage schedule from our office

☐ 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 expectations are identified on this form.

_____ Date: _____

Signature of Health Care provider (certify form was reviewed)

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.