All Preschool~Pre-Kindergarten~Before and After Care registered students requirements

Per the State of Colorado each student will need to obtain a Health Appraisal form that must be completed and signed by your child's health care provider along with a current immunization record that is printed on a State of Colorado form (see attached examples). **Both forms must be signed and dated within 30 days of the start of the new school year and must be submitted to Sts. Peter and Paul School on or before the first day your child is in our care. If we DO NOT have these forms your child will not be allowed to attend our Preschool/Pre-Kindergaren Program or attend the Before and After Care Program until these forms are turned in.**

Welcome to Saints Peter and Paul Before and After School Care Program. Attached you will find a contract for our program as well as ALL state required forms for students enrolled in our program. At Saints Peter and Paul we hold a Large Center Daycare License that is regulated by the State of Colorado and is subjected to random inspections. We are required to keep a file with this paper work in the daycare room for each student at all times.

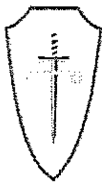
Beginning with the 2019-2020 school year we will be required to have all this paperwork in place to uphold our license. One major change will be that your child will need to have a General Health Statement and current immunizations on a state approved form. This General Health Statement will be good for 3 years in your child's file. Immunizations should be updated when any new immunizations are given. This General Health Statement and immunizations must be dated no earlier than 30 days prior to the first day of school. Your child will not be allowed to attend our Before or After Care program until these forms are turned in.

Please feel free to contact me with any questions or concerns via Fast Direct or at 303-424-0402.

Thank you for your continued support of Saints Peter and Paul Catholic School .

Melanie Gosage

Before and After Care Director



CHILD CARE PROGRAM CONTRACT

SAINTS PETER AND PAUL SCHOOL
3920 Pierce St., Wheat Ridge, CO 80033
Phone (303) 424-0402
Fax (303) 456-1888

Saints Peter and Paul Child Care program is open from 6:45 A.M. to 6:00 P.M. each school day. We serve working families who desire both parochial school education and supplementary child care in a Catholic environment for children enrolled at Saints Peter and Paul School in Preschool through 8th grade.

Our Child Care program is entirely financed by its fees. Regular and prompt payment assures the continuation of personnel and the provision of ample supplies, equipment and snacks. Billing is done weekly for the previous week's services. Payment is due on Friday of the week bill is received.

CHILD CARE RATES & FEES FOR 2019-2020 SCHOOL YEAR

Registration fee: $50.00 per child Non-Refundable (Maximum $75.00 per family)

Program fee: Saints Peter and Paul Child Care offers four options. A two week notice must be given for any change in enrollment. Christmas vacation and Spring Break will not be charged.
* Fees below are based on 1st and 2nd child in the same family. The 3rd child's fees are 50% off and additional children receive full scholarships. Discount fees do not apply to carpools.

Option A	Option B	Option C	Option D
6:45 AM to 7:30 AM		**6:45 AM to 7:30 AM**	**Drop in as needed**
3:00 PM to 6:00 PM	**3:00 PM to 5:00 PM**		
$75.00 per week	**$50.00 per week** *After 5:00 PM there will be a $5.00 an hour charge per child per day*	**$25.00 per week**	**$6.00 per hour**

Delinquency Policy for late payment of Child Care charges

Invoices are due and payable in full upon receipt. Statements are picked up at the Child Care Center desk on Tuesday of each week. Payment is due every Friday.

PLEASE NOTE:

- According to state guidelines, your child/children will be signed in by our staff and must be signed out by the parent or legal guardian.
- It is the parents' responsibility to pick up statements which will be available on the first Tuesday of each month.
- Saints Peter and Paul Child Care must register a minimum number of children in the program in order to cover expenses. If sufficient registration is not obtained, this program may be terminated.
- A $25.00 NSF fee will be charged for any returned checks.
- If your account is delinquent for the previous month, your account will change to pay-in-advance status for the remainder of the year.

____ ____________________
Parent/Guardian Signature Date

____ ____________________
Printed Name Social Security Number

Child(ren) Name ______________________________ Grade(s) _______________

Address ______________________________ Zip __________ Phone _______________

CHILD CARE PARENT POLICY AND ACKNOWLEDGEMENTS

I agree that I will not bring my child for any Child Care if I reasonable believe that he/she is ill and may be contagious. I understand and acknowledge that any child who appears to be ill upon arrival shall not be admitted to Child Care. Nevertheless, I assume full responsibility for the risk to my child that other children who are present in Child Care may be ill and transmit contagious disease.

I understand and acknowledge that no medical professionals are on duty at Saints Peter and Paul Child Care, except as may be required under Colorado law.

I have authorized my child's physician to receive calls from Saints Peter and Paul Child Care workers while my child is in Child Care.

I authorize Saints Peter and Paul Child Care workers to authorize and consent to any medical care for my child that he or she considers reasonable or necessary, including, but not limited to, hospitalization or surgery. I agree to pay my expenses related to such medical care. I understand and acknowledge that Saints Peter and Paul Child Care workers will attempt to obtain my permission by telephone before authorizing or consenting to any medical care for my child if time and conditions permit.

I understand and acknowledge that any medical expenses related to illness or injury to my child while in Saints Peter and Paul Child Care are NOT covered by any insurance program maintained by the Archdiocese of Denver, and that I am primarily responsible for paying such expenses.

I UNDERSTAND AND ACKNOWLEDGE THAT BY BRINGING MY CHILD INTO SAINTS PETER AND PAUL CHILD CARE I AM ASSUMING FULL RESPONSIBILITY FOR THE RISK OF ILLNESS AND INJURY THAT MY CHILD MAY INCUR. I RELEASE THE ARCHDIOCESE OF DENVER, SAINTS PETER AND PAUL PARISH AND SCHOOL, AND ANY CHILD CARE WORKER FROM LIABILITY FOR ANY ILLNESS OR INJURY THAT MY CHILD MAY INCUR WHILE IN CHILD CARE, WHETHER CAUSED WITH OR WITHOUT FAULT BY THE ARCHDIOCESE OF DENVER, THE PARISH, SCHOOL, OR BY ANY OF THEIR AGENTS, SERVANTS AND EMPLOYEES, INCLUDING ANY CHILD CARE WORKERS.

I have carefully read this Child Care Agreement, and I understand and agree to each of the covenants and conditions set forth above. This Child Care Agreement is effective for one year from the day stated below, unless earlier revoked.

______________________________ ____________________

Parent/Guardian Signature | Date

______________________________ ____________________

Printed Name | Child Care Director

CHILD CARE PROGRAM
SAINTS PETER AND PAUL SCHOOL

Enrollment Date ______________________________

Child's Name ______________________________ Date of Birth __________

Child's Name ______________________________ Date of Birth __________

Please check from following options: (Billing is done weekly for the previous week's services.Payment is due on Friday of the week bill is received.)

* Fees below are based on 1st and 2nd child in the same family. The 3rd child's fees are 50% off and additional children receive full scholarships. Discount fees do not apply to carpools.

☐ **Option A** ☐ **Option B** ☐ **Option C** ☐ **Option D**

Option A	Option B	Option C	Option D
6:45 AM to 7:30 AM		6:45 AM to 7:30 AM	Drop in as needed
3:00 PM to 6:00 PM*	3:00 PM to 5:00 PM		
$75.00 per week	$50.00 per week *After 5:00 PM there will be a $5.00 an hour charge per child per day*	$25.00 per week	$6.00 per hour

Name by which child is most often called ______________________________

Name of parents(s) ______________________________

Home Address ______________________________

____

Home phone number ______________________________

Father or Guardian's name ______________________________

Place of employment ______________________________

Business address ______________________________

Business phone number ______________ Hours of Employment __________

Home address (if different from child's) ______________________________

Home phone number (if different from child's) ______________________________

Mother or Guardian's name ______________________________

Place of employment ______________________________

Business address ______________________________

Business phone number ______________ Hours of Employment __________

Home address (if different from child's) ______________________________

____

Home phone number (if different from child's) ______________________________

ADDITIONAL PEOPLE TO CALL IF PARENTS CANNOT BE REACHED

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

Other people in the family:

NAME	AGE	RELATIONSHIP

Person(s) authorized to pick up child:

NAME	ADDRESS	PHONE

Persons(s) **PROHIBITED** from picking up child:

NAME	ADDRESS	PHONE

CHILD CARE WORKERS WILL NOT ADMINISTER MEDICATION UNLESS AUTHORIZED TO DO SO ON A SEPARATE AUTHORIZATION FORM.

Child's Doctor:

Name Address Phone

Child's Dentist:

Name Address Phone

Child's Accident/Health Insurance Carrier and Policy Number ______________________________

Child's special needs regarding dietary supplements or restrictions, medications, or avoidance of allergies ______________________________

Child's limitations on normal physical activities ______________________________

Additional information that may help the Child Care Workers in caring for child ______________________________

Hospital Preference ______________________________

Emergency Contact ______________________________

Saints Peter & Paul Catholic School
Before and After Care Enrollment

Date of Enrollment ________________

Child's Name ______________________________ **Nickname** ____________________________

Home Address ____

Home Phone __________________ **Sex M F Age** ________ **Date of Birth** ________________

Family Members: ____

Mother or Guardian's Name ____

Address if different from child's ____

Zip ___________ **Home Phone** __________ **Cell Phone** ______________ **Email** ______________

Name of employment (mother/guardian) ____

Address of employment (mother/guardian) __________________________ **Work Phone** _________

Father or Guardian's Name ____

Address if different from child's ____

Zip ___________ **Home Phone** __________ **Cell Phone** ______________ **Email** ______________

Name of employment (father/guardian) ____

Address of employment (father/guardian) ____________________________ **Work Phone** _________

Special instructions for reaching parent or guardian _______________________________________

EMERGENCY CONTACTS

1. **Name** ____________________________________ **Home Phone** _________________________

Address ____

Work Phone ____________________________ **Relationship to child** _________________________

2. **Name** ____________________________________ **Home Phone** _________________________

Address ____

Work Phone ____________________________ **Relationship to child** _________________________

CHILD PICK UP INFORMATION

Persons authorized to pick up your child
(Must show photo ID)

Name____

Home Phone ______________________________**Work Phone**_____________________________

Name____

Home Phone ______________________________**Work Phone**_____________________________

Name____

Home Phone ______________________________**Work Phone**_____________________________

Name, address and phone number of child's doctor _____________________________________
____

Name, address and phone of child's dentist ____
____

Hospital of Preference (Please check one)

The Children's Hospital
13123 East 16th Avenue
Aurora, CO 80045
720-777-1234

Lutheran Medical Center
8300 West 38th Avenue
Wheat Ridge, CO 80033
303-425-4500

St. Anthony's Hospital
11600 Weat 2nd Place
Lakewood, CO 80228
720-321-0000

St. Joseph's Hospital
1375 East 19th Ave.
Denver, CO 80218
303-812-2000

Other Hospital ____

Chronic Medial conditions ____

Does your child have a health care plan ? _________ **If yes, the health care plan must be provided on or before the first day the child is in care.**

Is your child fully immunized ? _______ **Completed immunization records must be provided on or before the first day the child is in care.**

Food Allergies ____

HEALTH HISTORY
(Chronic or recurring)
Ear Infections ____________
Diabetes________________
Heart disease/defect_______
Convulsion/seizures_______
Asthma ________________
Nosebleeds______________
Measles_________________
Mumps__________________
Chicken Pox _____________
Flu or Flu shot ___________

ALLERGIES
(Nature of Reaction)
Hay Fever__________
Plant Poisoning______
Insect stings_________
Penicillin____________
Other drugs_________
Animals_____________
Food_______________
Other______________

Operations or serious injuries (dates)____

Is the child on any medications? (Explain)____

If yes, please describe____

Physical limitations____________________Describe if yes____________________________

Dietary limitations_____________________Describe if yes___________________________

Vision _____________________________Hearing__________________________________

Additional information or comments____

____

Authorization for Emergency Medical Care

I hereby give my permission to __________ to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for my child, ____________________________________.

It is understood that the child care provider will make a conscientious effort to locate the parent/guardians and emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate emergency contacts listed treatment will not be delayed. I/we will accept the expense of emergency transportation, medical or surgical treatment.

Parent/Guardian signatures

____Date ___________________

____Date___________________

Child's Name____Phone #_____________________

Please red, initioal, sign and date. Return as soon as possible to your child's teacher.

MEDIA USE

The teachers sometimes carefully pick a video to enhance topics that the children have been discussing.

_____I give permission for the staff to use the above form of media to enhance a topic the children are learning about.

PERMISSION FOR WALKS

From time to time, classes will take walks with members of the childcare staff on the church grounds. If children were to cross streets, it would be considered a field trip anda special permission form would be sent home with families prior to the field trip.

_____I give permission for my child to take walks with childcare staff on church premises.

SUNSCREEN AUTHORIZATION

Please have my child use sunscreen in the following way:

_____His/Her own provided and labeled with first and last name on the bottle or tube.

_____I authorize the staff to use sunscreen provided by Sts. Peter and Paul School, Hypoallergenic SPF30 on my child.

HAND LOTION AUTHORIZATION

Please have my child use hand lotion after hand washing in the following way:

_____His/Her own fragrance free moisturizing hand lotion provided and labeled with first and last name on the bottle or tube.

_____I authorize tha staff to use fragrance free moisturizing hand lotion provided by Sts. Peter and Paul School on my child.

COLLEGE STUDENT WORKING WITH CHILDREN

We would like to give permission for college students to do observations and activities with your child in our center for training purposes.

_____I give permission for my child to be observed and participate in activities with Colorado 2 year/4 year college or university Early Childhood Education students.

I____________________________ understand and have initialed the above permission requests.

______________________________	______________________________
Parent/Guardian Signature	**Date**
______________________________	______________________________
Child's Name	**Phone #**

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

CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official immunization record for every student enrolled.

Name: ______________________ **Date of birth:** ______________

Parent/guardian: ______________________

Required vaccines

Each immunization date MM/DD/YY — **Titer date**

Vaccine							Titer date
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
DT Diphtheria, Tetanus (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	

Recommended vaccines

Each immunization date MM/DD/YY

Vaccine					
HPV Human Papillomavirus					
Rota Rotavirus					
MCV4/MPSV4 Meningococcal					
Men B Meningococcal					
Hep A Hepatitis A					
Flu Influenza					
Other					

Optional review signature by the school health authority or health care provider

I have reviewed this immunization record

Signature: ______________________ Date: ______________

(Optional) TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT

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

Signature: ______________________ Date: ______________