

Welcome, Parents!



Dear Parents,

We look forward to meeting you and "learning through play" with your child at our new Steele Street Preschool. As our staff enthusiastically prepares for your child's first day we need pertinent details about you and your child in order to place _____ on our roster. Enrollment Date _____

Your child's full name and "nickname" _____

Home Address _____

Home Phone _____ Sex M F Age _____ Date of Birth _____

Family Members: _____

Mother or guardian's Name _____

Address (if different from your child's) _____

Zip _____ Home Phone _____ Cell Phone _____ Email _____

Employer's name _____

Employer's address _____ work phone _____

Father or Guardian's Name _____

Address (if different from your child) _____

Zip _____ Home Phone _____ Cell Phone _____ Email _____

Employer's name _____

Employer's address _____ 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 _____

Dear Parents,

We need the following information in order to protect your child. First, please provide us with the names of adults authorized to pick up your child from school. We will request to see their photo ID at the time your child is picked up. Second, we need hospital preferences along with medical information in case of an unexpected emergency. Thank you!

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 number of child's dentist _____

- Hospital Preference (Please check one)
- The Children's Hospital
13123 East 16th Ave.
Aurora, CO 80045
 - Swedish Medical Center
(Kaiser Permanente Affiliate)
501 East Hampden Ave.
Englewood, CO 80110
 - Swedish Medical Center
(Emergency Department)
501 East Hampden Ave.
Englewood, CO 80110 303-788-5000
 - Other

Chronic Medical conditions _____

Does your child have a health care plan? _____ If yes, please provide our staff with your child's complete health care plan on or before the first day.

Is your child fully immunized? _____ Please provide our preschool with completed immunization records before your child's first day.

Food Allergies _____

Dear Parents,

We need the following information in order to provide your child with excellent care. Thank you!

YOUR CHILD'S 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 your child on any medications? (Explain) _____

If yes, please describe. _____

Authorization for Emergency Medical Care

I hereby give my permission to the staff person in charge at Steele Street Preschool to call a doctor or emergency medical service and for the doctor, hospital or medical service I named to then provide emergency medical or surgical care for my child, _____

It is understood that Steele Street Preschool will make a conscientious effort to locate the parent/guardian 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 accept the expense of emergency transportation, medical, or surgical treatment.

Parent/Guardian signatures:

_____ Date _____

_____ Date _____

EMERGENCY INFORMATION & AUTHORIZATION & TRANSPORTATION

Child's Name _____ Nickname _____ Date of Birth _____
Last First

Home Address _____ Home Phone _____
Street City/State Zip

Parent/Guardian Name _____ Cell Phone/Pager _____
Last First

Employer/School _____

Employer/School Address _____ Phone _____
Street City/State Zip

Parent/Guardian Name _____ Cell Phone/Pager _____
Last First

Employer/School _____

Employer/School Address _____ Phone _____
Street City/State Zip

Alternate Emergency Contacts:

(1) _____
Name Relationship Phone Number Cell Phone Pager
Address _____

(2) _____
Name Relationship Phone Number Cell Phone Pager
Address _____

Additional Persons Authorized to Pick up Child:

(1) _____
Name Relationship Phone Number Cell Phone Pager
Address _____

(2) _____
Name Relationship Phone Number Cell Phone Pager
Address _____

Health Care Facility _____
Name Address (if known) Phone Number Pager

Allergies/Reactions _____

Chronic Illnesses/Special Needs _____

Medications _____

Insurance Information _____

Authorization for emergency medical care and transportation:

In the event of an emergency I hereby give my permission for the Steele Street Preschool staff to access emergency medical services for my child, including transport to the nearest health care facility, to receive emergency medical care and treatment. It is understood that a conscientious effort will be made to locate me, and I accept the expense of care and transport.

Parent/Guardian Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

Steele Street Preschool, 1201 South Steele St., Denver, CO 80209 www.steelstreetschool.com

TOPICAL PREPARATIONS (PREVENTIVE) PERMISSION FORM

This form covers a variety of preventive topical preparations that may be applied to the skin with parent/guardian permission

Child's Name _____ Parent/Guardian's Name: _____

SUNSCREEN

I give my permission for the staff at _____ to assist with applying or apply sunscreen to my child's exposed skin including the face, tops of ears and bare shoulders, arms, legs and feet 30 minutes before outdoor activities. It is my responsibility to provide sunscreen with a minimum SPF of 15. I understand I must provide the sunscreen in its original container labeled with my child's name and within the noted expiration date. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

- In the event that my child does not have sunscreen with them, the school may apply _____ to my child. It is my responsibility to check the ingredients of this product to ensure my child is not allergic to it.
- My child may NOT use any sunscreen other than the one that he/she brings.

Parent/Guardian Signature: _____ Date: _____

MOISTURIZING LOTION/CREAM/BALM

I give my permission for the staff at _____ to assist with applying or apply skin lotion/cream to my child. I understand I must provide the lotion/cream/balm in the original over the counter container labeled with my child's name. It is my responsibility to check the ingredients of this product to ensure my child is not allergic to it. Skin lotion/cream/balm will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

- Name of product: _____
Special instructions: _____
- My child may NOT use any other skin lotion/cream/balm than the one he or she brings

Parent/Guardian Signature: _____ Date: _____

DIAPER OINTMENT/CREAM

I give my permission for the staff at _____ to apply over the counter diaper rash ointment/cream to my child. I understand that I may only provide diaper ointment or cream, free of antibiotic, antifungal or anti-inflammatory components without a written prescription from my doctor. I understand I must provide the ointment/cream in the original over the counter container labeled with my child's name. Ointment/cream will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

- Name of product: _____
Special instructions: _____
- My child may NOT use any other diaper ointment/cream than the one he or she brings

Parent/Guardian Signature: _____ Date: _____

SAMPLE

MEDIA USE PERMISSION FORM*

Child's Name: _____ Age: _____

I do/do not give permission for my child to use or view the following:

	YES	NO
Television Viewing	_____	_____
Video Viewing	_____	_____
Music	_____	_____
Video Games	_____	_____
Computer Use	_____	_____
Other: _____	_____	_____

My child may engage in the approved activities for up to _____ total hours per day.

- * Regulations for facilities caring for children require that media use is permitted only with the written approval of a child's parent or guardian, including appropriate time limits.

These activities must not contain violence, profanity, nudity, sexual, or inappropriate content.

All children must be provided with an alternative activity once the child/children lose interest in the media activity.

Signature of Parent or Guardian: _____ Date: _____



1201 South Steele Street, Denver, CO 80210
(720) 459-8590

2013-2014 Tuition
(per month)

Half Day

3 days per week	\$475.00
4 days per week	\$579.00

Full Day

3 days per week	\$ 660.00
4 days per week	\$ 800.00

Yearly Registration Fee

\$150.00

Additional Hours

Current students of Steele Street Preschool may attend additional hours, depending on availability and must be prearranged with Steele Street Staff. There is a flat fee for morning and afternoon times.

Morning (8:30am-12:30pm)	\$40.00
Afternoon (12:30pm-3:30pm)	\$30.00

Tuition is due on the 1st of each month. A late fee of \$50.00 will be assessed for payments received after the 5th of each month. Advance payments for pre-paid tuition is accepted. Any additional hours attended each month will be totaled and charged on the following month's statement.

ILLNESS POLICY WHEN TO KEEP YOUR CHILD AT HOME

Young children frequently become mildly ill. Infants, toddlers and preschoolers experience a yearly average of six respiratory infections (colds) and can develop one to two gastrointestinal infections (vomiting and/or diarrhea) each year.

Deciding when children can go to child care or school can be difficult. Parents and caregivers should discuss the child's symptoms and decide what to do.

Parents should contact the child care program or school when their child is sick and describe the symptoms. If a specific diagnosis, (such as strep throat or "pink eye") is made by a doctor (health care provider), let program staff know so other families can be alerted.

Sometimes it is necessary for a child to remain at home.

There are three reasons to keep (exclude) sick children out of child care or school:

1. The child is not able to participate in usual activities. Child may be very tired, irritable or cry a lot.
2. The child needs more individual care than program staff can provide.
3. The illness or symptoms are on the exclusion list.

Look at the symptoms and/or illness list below to help you decide if your child should be kept home from child care or school:

ILLNESS OR SYMPTOM	EXCLUSION IS NECESSARY
CHICKEN POX	Yes - until blisters have dried and crusted (Usually 6 days). If blisters occur after vaccination, refer to Colorado Health Department guidelines
CONJUNCTIVITIS (pink eye) (pink color of eye and thick yellow/green discharge)	Yes - until 24 hours after treatment (if indicated) If your health provider decides not to treat your child, a note is needed authorizing return to group care
COUGHING (severe, uncontrolled coughing or wheezing, rapid or difficulty in breathing)	Yes - medical attention is necessary. <i>Note: Children with asthma may be cared for with a written health care plan and authorization for medication/treatment</i>
COXSACKIE VIRUS (Hand, foot and mouth disease)	No - may attend if able to participate in usual activities, unless the child has mouth sores and is drooling
CROUP (see COUGHING)	Seek medical advice <i>Note: May not need to be excluded unless child is not well enough to participate in usual activities</i>
DIARRHEA (frequent, loose or watery stools compared to child's normal pattern; not caused by diet or medication)	Yes - if child looks or acts ill; diarrhea with fever and behavior change; diarrhea with vomiting; diarrhea that is not contained in the toilet, (infants/children in diapers should be excluded)
EARACHE	No - unless unable to participate in usual activities or fever with behavior changes (see FEVER)
FEVER with behavior changes or illness (an elevation of body temperature above normal) <i>Note: An unexplained temperature of 100°F or above is significant in infants 4 months of age or younger and requires immediate medical attention</i>	Yes - when fever is accompanied by behavior changes or other symptoms of illness, such as rash, sore throat, vomiting, etc. <i>Note: Fever alone is not a reason to exclude from care</i>

Illness Policy Page 2	
ILLNESS OR SYMPTOM	EXCLUSION IS NECESSARY
FIFTH'S DISEASE	No - child is no longer contagious once rash illness appears
HEADLICE OR SCABIES	May return after treatment starts
HEPATITIS A	Yes – until 1 week after onset of illness or jaundice and when able to participate in usual activities
HERPES	No – unless child has mouth sores and blisters and does not have control of drooling
IMPETIGO	Yes – until 24 hours after treatment starts
BODY RASH <u>with</u> fever	Yes - seek medical advice. Any rash that spreads quickly, has open, weeping wounds and/or is not healing should be evaluated <i>Note: Body rash without fever or behavior changes usually does not require exclusion from the program; seek medical advice</i>
RESPIRATORY OR COLD SYMPTOMS (stuffy nose with clear drainage, sneezing, mild cough)	No – may attend if able to participate in usual activities
RINGWORM	May return after treatment starts Keep area covered for the first 48 hrs of treatment
ROSEOLA	No – unless child cannot participate in usual activities and has fever with behavior changes.
RSV (Respiratory Syncytial Virus)	Seek medical advice. Once a child has been infected, spread is rapid. <i>Note: A child does not always need to be excluded unless child is not able to participate in usual activities</i>
STREP THROAT	Yes - until 24 hours after treatment and the child is able to participate in usual activities
VACCINE PREVENTABLE DISEASES Measles, Mumps, Rubella (German Measles), Pertussis (Whooping Cough).	Yes – until judged not infectious by the health care provider
VOMITING (2 or more episodes of vomiting in the past 24 hrs; vomiting with fever; recent head injury)	Yes – until vomiting resolves or a health care provider approves return to program.
YEAST INFECTIONS (thrush or candida diaper rash)	No Follow good hand washing and hygiene practices

Handout developed by The Children's Hospital School Health Program, Denver, CO (303)-281-2790, 1995, revised 1999, 2001, 2003, 2005

References

- American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care, *Caring for Our Children: National Health and Safety Performance Standards*, Second Edition, Elk Grove Village, IL 2002
- American Academy of Pediatrics, *Managing Infectious Diseases in Child Care and Schools*, Elk Grove Village, IL 2005
- Colorado Department of Public Health and Environment, Communicable Disease Epidemiology Program, *Infectious Disease in Child Care Settings: Guidelines for Child Care Providers*, Denver, CO., December 2002
- Kendrick AS, Kaufman R., Messenger KP, Eds. *Healthy Young Children: A Manual for Programs*. Washington, D.C. National Association for the Education of Young Children; 2002