FORT LUPTON
RECREATION CENTER
PARKS & RECREATION DEPARTMENT

Enrollment Date: _____

2021 - 2022
PRESCHOOL ENROLLMENT PACKET

Child's Full Name: _____ Age: _____ Gender: ____

Address: _____ City: _____ Zip: _____

Mother's Name: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Email: _____

Employer: _____ Work Phone: _____

Father's Name: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Email: _____

Employer: _____ Work Phone: _____

INDIVIDUALS OTHER THAN PARENT/GUARDIAN AUTHORIZATION

Child's Full Name: _____

ONLY these individuals have my authorization to care for my child in the event of an emergency and/or for drop-off and pick-up.

Parent/Guardian Initials_____

Please advise these individuals that they are authorized and will need to present identification to staff.

Full Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Email: _____

Full Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Email: _____

Full Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Email: _____

MEDICAL HISTORY
AND INFORMATION FORM

Child's Full Name: _____ Gender: _____ Birthdate: _____

Please check illnesses that your child has had:

Chicken Pox _____ Measles _____ Rubella _____ Hay Fever _____

Rheumatic Fever _____ Asthma _____ Epilepsy _____ Mumps _____

Poliomyelitis _____ Whooping Cough _____ Diabetes _____

Surgery/Accidents/Illnesses/Chronic Health Problems: _____

_____

Describe any physical condition requiring special attention by center staff: _____

_____

Check those allergies staff should be aware of and give the prescribed routine below.

Food (type) _____ Insect bites/stings _____

Penicillin _____ Other Drugs _____

Other _____

Date of most recent examination of this child: _____

Physician: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____

Medical Insurance: _____ Group #: _____

Dentist Name: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____

Dental Insurance: _____ Group #: _____

Hospital of Choice: _____

Address: _____ Phone: _____

CHILD'S SOCIAL HISTORY

A description of your child's behavior and reaction to various incidents is desired. This information is confidential and will be reviewed by the Recreation Manager and the Preschool Director as a key to working with your child as an individual member of our program.

Child's Name: _____

Interaction with males: _____

Interaction with females: _____

Fears and dislikes: _____

Types of discipline used at home: _____

Reward system used at home: _____

Positive/negative school / camp experiences: _____

_____

Child's favorite activity: _____

Does your child currently have any emotional or behavioral problems and /or conditions such as Attention Deficit Disorder? YES NO
If so, what steps have you taken to control this condition? _____

_____

What works best at home for you and your child? _____

Does your child prefer to play alone? YES NO

Additional comments on child's social history: _____

_____

PLEASE FEEL FREE TO DISCUSS ANY SOCIAL CONCERNS YOU MAY HAVE WITH THE RECREATION MANAGER AND / OR THE PRESCHOOL DIRECTOR.

We have forms for Generalized meds, Allergies and Asthma. Please see me if your child requires medication on site.

Thank You!
Julie Holm

This health record and information is correct as far as I know and the person herein described has permission to engage in all prescribed activities, unless otherwise stated.

Signature of Parent / Guardian

Date

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby give my permission to The Fort Lupton Recreation Center staff 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 _____ should an emergency arise. It is understood that the Fort Lupton Recreation Center summer day camp staff will make a conscientious effort to locate the parent/guardian or the emergency contact listed on the registration document before any action will be taken. If it is not possible to locate the emergency contact listed, I will accept the expense of emergency medical or surgical treatment.

Signature of Parent / Guardian

Date

PARENT MANUAL
RELEASE/STATEMENT OF UNDERSTANDING

I have read and understand the Fort Lupton Recreation Center's Summer Day Camp Handbook and understand the policies contained within.

Signature of Parent / Guardian

Date

SUNSCREEN PERMISSION FORM

Children will apply sunscreen to themselves under the direct supervision of a preschool staff member 15-30 minutes before outdoor activities. 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 parent/ guardian. The preschool program will be using Rocky Mountain Sunscreen, with a minimum SPF of 30.

Signature of Parent / Guardian

Date

GENERAL HEALTH APPRAISAL FORM

PARENT

Please complete, date, and SIGN.

Child's Name: _____ Birthdate: _____

Allergies: ☐ None OR ☐ List food/medication: _____

Diet: ☐ Breastfed ☐ Age appropriate ☐ Special-Describe: _____

Skin Care: ☐ Sunscreen/creams may be applied as requested in writing by parent unless skin is broken or bleeding.

Sleep: Your healthcare provider recommends that all infants less than 1 year of age be placed on their back for sleep.

I, _____, give permission for my child's healthcare provider to share this form and applicable attachments with my child's school, childcare, or camp. Contact information for the person to receive this form:

Name:_____ Fax:_____ Email:_____ _____

Parent/Guardian Signature:_____Date:_____

HEALTH CARE PROVIDER

Please complete after parent section has been completed.

Date of most recent health appraisal: _____ Age:_____ Weight: _____

Physical Exam: ☐ Normal ☐ Abnormal-describe: _____

Allergies: ☐ None OR ☐ List food/medication: _____ Type of Reaction _____

Current Medications: ☐ None OR ☐ List:_____

A separate medication authorization form (link) is required for medications given in school, childcare, or camp.

Current Diet: ☐ Breastfed ☐ Age appropriate ☐ Special-describe: _____

A separate diet statement (link) is required for food provided at school, childcare, or camp.

Health Concerns: ☐ Severe Allergies ☐ Asthma ☐ Seizures ☐ Diabetes ☐ Hospitalizations ☐ Behavior Concerns ☐ Developmental Delays ☐ Vision ☐ Hearing ☐ Oral Health ☐ Under/Overweight ☐ Other: _____

Explain above concerns (if necessary, include instructions to care providers): _____

Immunizations: ☐ See attached immunization record or official exemption form ☐ Next vaccine due date: _____

HEALTH CARE PROVIDER

Please complete if appropriate. This information is required by Early Head Start and Head Start Programs per the State EPSDT Schedule.

Height: _____ B/P: _____ Head Circumference (up to 12 months): _____ HCT/HGB:_____

Lead Level: ☐ Not at risk OR ☐ Lead level: _____ TB: ☐ Not at risk OR Test Result: ☐ Normal ☐ Abnormal

Screens Performed: ☐ Vision: ☐ Normal ☐ Abnormal ☐ Hearing: ☐ Normal ☐ Abnormal ☐ Oral Health: ☐ Normal ☐ Abnormal Developmental Screen: ☐ ASQ ☐ PEDS ☐ Other: _____

Developmental Concerns: _____ 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, childcare, or camp. Any concerns or exceptions are identified on this form.

_____

Signature of Healthcare Provider (certifying form reviewed)

_____

Date

*The AAP recommends Well Child Visits at 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, and annually after 3 years.

OFFICE STAMP

Or write Name, Address, Phone Number, Email

The form was created by the American Academy of Pediatrics, Colorado Chapter and Healthy Child Care Colorado to satisfy childcare and Head Start requirements in Colorado. While accepted by most schools, childcare programs and camps, this is not an official government form. Updated 01/2021.

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: _____

CITY OF
Fort Lupton
EST 1836

Recreation Department

130 S. McKinley Avenue
Fort Lupton, CO 80621
Phone: 303.857.6694
Fax: 303.857.0351
www.fortluptonco.gov

RECREATION CENTER COVID-19 ACKNOWLEDGEMENT

The Fort Lupton Recreation Department has taken steps to implement and adhere to public health protocols and policies recommended by the federal, state and local governments to attempt to slow the transmission or the spread of the Covid-19 virus.

With full knowledge of the potential health risks associated with the Covid-19 virus, the undersigned voluntarily acknowledges, accepts, and assumes the inherent Covid-19 health risks, both known and unknown, associated with use of the Fort Lupton Recreation Center and or participation in related activities, events, gatherings and services provided at the Fort Lupton Recreation Center and releases the City from any liability therefrom.

PRINTED PARTICIPANTS NAME: _____

SIGNATURE OF PARTICIPANT: _____
(Parent signature if participant is under 18 years old)

DATE SIGNED: _____

City of Fort Lupton Recreation Center

203 South Harrison Avenue
Fort Lupton, Colorado 80621
Phone (303) 857-4200 Fax (303) 857-6421
www.fortluptonco.gov
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FORT LUPTON RECREATION CENTER
PARKS & RECREATION DEPARTMENT

PARTICIPATION WAIVER AND RELEASE

I represent that I am the party registering for an activity with the Ft. Lupton Recreation Department or the parent or legal guardian of the child being registered herein and I am legally authorized to execute this Waiver and Release on behalf of my child and my family.

I hereby voluntarily allow my child to participate in activities and programs sponsored or run by the Ft. Lupton Recreation Department or that are otherwise sponsored by the City of Ft. Lupton and or the Ft. Lupton Recreation Center. I knowingly assume all risks of participation and waive any and all possible claims for personal injury or property damage against the City of Ft. Lupton, the Ft. Lupton Recreation Department, its employees, independent contractors, volunteers, management and staff that could possibly be incurred as a result of my participation or my child's participation in activities organized, run, or sponsored by the Ft. Lupton Recreation Department.

I hereby acknowledge that participation in physical activities and recreational programs of the Ft. Lupton Recreation Department may involve strenuous physical exercise that may include physical contact. I represent that neither I nor my child has any physical limitations that would prevent me or my child from participating fully in all activities organized, run, or sponsored by the Ft. Lupton Recreation Department.

As with any athletic or physical activity, I understand the inherent risks of injury associated with my participation and or my child's participation and I fully assume said risks. I am aware the risk of injury to my child or myself from the activities involved in these programs is significant, including the potential for permanent disability and death, and while particular rules, equipment, and personal discipline may reduce this risk, the risk of serious injury does exist. I have knowingly executed and acknowledged this waiver of liability form with the full knowledge of the risks associated with participation in recreational activities at the Ft. Lupton Recreation Center or activities sponsored by the Ft. Lupton Recreation Department.

I represent that if I am injured or if my child is injured while participating in activities organized, run, or sponsored by the Ft. Lupton Recreation Department, I shall be financially responsible for any and all medical treatment that may be deemed necessary and I hereby release the City of Ft. Lupton, the Ft. Lupton Recreation Department, its employees, independent contractors, volunteers, management and staff from any liability associated with any injury that may be suffered by me or my child.

PARTICIPANT'S NAME: _____

PARTICIPANT'S SIGNATURE: (If over 18 years) _____

PARENT/GUARDIAN PRINTED NAME: (If participant is under 18 years) _____

PARENT/GUARDIAN SIGNATURE: (If participant is under 18 years) _____

DATE SIGNED: _____