FirstArt Christian Academy

Today's Date_____ Starting date_____
Class_____ Attend FT (all day) or PT(8:45-11:45) _____ Attend which Days? M T W TH F

T-Shirt Size: Youth XS S M L XL Adult S M L XL

Family ID (everyone has same first 4 numbers) which 4 #'s would you like your code to be?_____

Basic family information:
Child's name_____ Birth Date _____

Father/Guardian name_____ (Code #XXXX1)
Street Address_____ city_____ Zip_____
Cell #_____ home #_____
Employers name _____ Phone #_____
Email address_____

Mother/Guardian name_____ (Code #XXXX2)
Street Address_____ city_____ Zip_____
Cell #_____ home #_____
Employers name _____ Phone #_____
Email address_____

Siblings _____ age _____ Siblings _____ age _____
Siblings _____ age _____

Emergency Contacts:
Additional people allowed to pick up your child and emergency contacts:
Please only list people we can call in an emergency and people who are able to pick up your child when you are unable.

Emergency contact name_____ (Code XXXX3)
Street Address_____ city_____ Zip_____
Cell #_____ home #_____
Employers name _____ Phone #_____

Emergency contact name_____ (Code XXXX4)
Street Address_____ city_____ Zip_____
Cell #_____ home #_____
Employers name _____ Phone #_____

Emergency contact name_____ (Code XXXX5)
Street Address_____ city_____ Zip_____
Cell #_____ home #_____
Employers name _____ Phone #_____

Child's Full Name _____ Birth Date_____

Acknowledgment

I have received and understood the policies listed in the parent handbook, including but not limited to: lunch and food policies, behavior management policies, communication, health, and the tuition policy. I understand that tuition must be pre-paid and any unpaid balance is subjected to late fees and un-enrollment. Any account taken to a collection agency for payment will be charged for any fees accrued by such collection agency in addition to any late fees as stated by our parent handbook.

Parents Signature _____ Date_____

Sunscreen Permission

I,_____ give FirstArt Christian Academy permission to use _____ (type) of sunscreen on my child to help prevent sunburns. Sunscreen will be put on the child 10 minutes before going outside.

Parents Signature_____ Date_____

Emergency Permission Form

I,_____ (parents full name) place my child in the care of FirstArt Christian Academy at 801 S. 5th Street Brighton, Co 80601, whose phone number is 303.659.3008 and 625 S. 8th Avenue whose number is 303.659.1202. I understand that in the event of an emergency every attempt will be made to contact me. Should an emergency arise and I am unable to be reached immediately, I hereby give permission for FirstArt Christian Academy to seek immediate medical attention for my child in the manner as they deem necessary. This may include transportation by ambulance or by personal staff transportation to Platte Valley Hospital with whomever the on-call doctor might be.

Parents Signature_____ Date_____

Insurance company_____

Subscriber Name _____

Policy#_____ Group #_____

Please provide a copy of your insurance card.....front and back.

Parents Emergency information

Name _____

Work #_____

Cell #_____

Home #_____

Parents emergency information

Name_____

Work #_____

Cell #_____

Home #_____

Child's full name_____

Medical Information:
Dentist_____ Address_____
Phone #_____
Hospital _____ Address_____
Phone #_____

Please write Frequent (F), Occasional (O), or Not Applicable (N/A)
High Fever _____ Stomach aches_____ Ear infections_____
Allergies_____ Respiratory infections _____Asthma_____
Headaches_____

Allergies/reactions/treatments_____
Major illnesses/accidents_____
Dietary restrictions_____
Speech or Motor development_____
Vision or hearing problems_____
Identifying birthmarks_____
Eating habits_____
Sleeping habits_____

Health exam
Date of last exam_____
Physician's name_____
Physician's address_____ Phone #_____

Are this child's immunizations current?_____ Please return a current immunization card
Foods/Dietary restrictions
_____
_____

Are child's vision, hearing and dental screenings up to date? Vision Y/N Hearing Y/N Dental Y/N

Is this child currently taking any medication?_____ (If FirstArt Christian Academy is to give any medication, a medication form must be filled out by the doctor and signed before medication can be given)
Allergies_____
Child's allergic reaction(s)_____
Treatment for allergic reaction_____
If a child requires medication or an epi-pen to control allergies, the physician must fill out an allergy medication plan.
Physical conditions or limitations_____
_____

Physician signature_____ Date_____
For Physician: When is this child's next health exam due? Date_____
Parent's signature_____ Date_____

Tell us about your child

What do you consider your child's strengths to be?_____

_____

Tell us about your child's personality_____

_____

What are your child's favorite things, foods, etc...._____

_____

Tell us about discipline techniques used at home_____

Previous school experience

Tell us about any past experience you and your child have had. Tell us what you liked and what you would have liked to change._____

_____

_____

Your wishes

What goals do you have for your child in the upcoming year?

Socially_____

_____

Academically_____

_____

Physically_____

_____

Spiritually_____

_____

Commitment to learning

As a parent of FirstArt, I agree to participate in my child's learning by partnering with my child's teachers and by communicating with them regarding my child's progress and well-being. I understand that the staff at FirstArt Preschool do continuous evaluations of every child to monitor each child's progress and to more efficiently plan for classroom instruction. I understand that If I ever have any concerns, I am welcome to bring those concerns to the teacher or director immediately and will do so to discuss and resolve the situation. I also understand that appropriate behavior is expected at school and I will support the teachers when it comes to behavior as it is not acceptable for my child to curse, hit, spit, kick, throw continuous temper tantrums or any such behaviors that harm any individual or disrupt classroom routines.

_____ _____

Parent Signature Date

Tuition Will be Paid:

(Circle One)

Weekly

Bi-weekly

Monthly

Payments are to be made before care is given.

Weekly billing statements are sent out every Friday. Payments can be made directly from a link provided in the statement. You can also sign up for auto payments by filling out an authorization form. We do accept checks and money orders. Those can be placed in the payment drop box outside the office door. We also accept cash, but request that it is given directly to an office staff member and it is the parents responsibility to receive a cash receipt.

I understand that no matter my pay cycle, if my payment falls a week behind, I will be charged a 10% late fee of the past due amount.

If any account is 3 weeks past due, the family will be unenrolled, late fees will be applied and their account will be sent to collections.

A **2-week written notice is required** for all families who want to withdrawal their child(ren) from our center. If a 2-week written notice is not given, tuition will be charged for 2 weeks after the child's last day of attendance. All accounts must be paid in full before the child's last day. If a balance is left on an account without an agreement of when it will get paid, late fees will be applied, and the account will be sent to collections.

Parents Signature _____ Date _____

Staff Use Only

Date Received:

Transport Consent Form

This form records consent for a child/student to travel in private/school vehicles. Where private transport is to be utilized, the school will ensure that any person who provides that transport is the holder of a current driver's license and that the vehicle they drive is registered. Drivers will include teachers or volunteers from the program/school.

Activity risks and insurance

Please note that FirstArt does not have personal accident insurance coverage for children/students. If your child is injured as a result of an accident or incident while participating in the activity, all costs associated with the injury, including medical costs, are the responsibility of the parent/guardian. If you have private health insurance, some costs may also be covered by your provider. Any other costs must be covered by parents/guardians. It is up to all parents/guardians to decide what types and what level of private insurance they wish to arrange to cover their child. Please take this into consideration in deciding whether or not to allow your child to participate in this activity.

Behavior

I understand that my child will be expected to behave properly while on school/staff vehicles. I will encourage good behavior and quiet voices in order to promote safety while the vehicle is in route.

Consent

I hereby give permission for my child_____ to travel by private/school transport with staff or program volunteers to and from before and after school care, the library, rec. center, parks and other field trips or activities as planned by the school

_____ _____ _____

Parent/Guardian name Parent/Guardian signature Date

Photo Release Form

FirstArt Christian Academy
625 S. 8th Ave.
Brighton, Co 80601

Permission to Use Photographs

Student: _____

I grant to FirstArt Christian Academy, its representatives and employees the right to take photographs of my child, their artwork and/or projects in connection with our school. I authorize FirstArt Christian Academy, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that FirstArt Christian Academy may use such photographs of my child with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature _____

Printed name _____

Address _____

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: FirstArt Preschool Fax: N/A Email: FirstArtPreschool@yahoo.com _____

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 LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name _____ Date of Birth _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
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	Measles						
Mumps	Mumps						
Rubella	Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date		Lab Verification Date	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ Title _____ Date _____
(Physician, nurse, or school health authority)

Name_____ Date of Birth _____

Parent/Guardian _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.

SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

***Medical exemption** to the following vaccine(s):*

***La exención por razones médicas** aplica a la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Physician (Médico)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

***Religious exemption** to the following vaccine(s):*

***Exención por motivos religiosos** de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

***Personal exemption** to the following vaccine(s):*

***Exención por creencias personales** de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

Colorado Department of Public Health and Environment