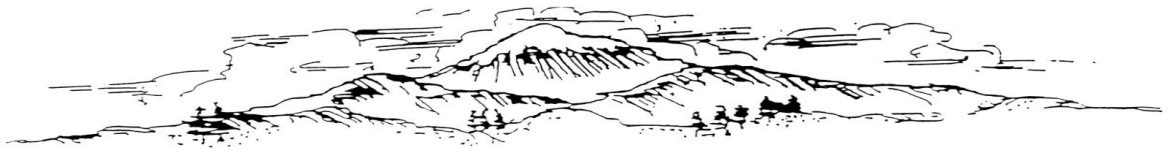

Children's House of Durango

Montessori Education

1689 West Third Avenue
Durango, CO 81301
970-259-1089

Date: _____

AUTHORIZATION FORM

Authorization for emergency medical care must be obtained from the parent of each student. I/We ___ _____ hereby given my/our permission to Children's House Staff to call a doctor for medical or surgical care for my/our child, _____ should an emergency arise. It is understood that a conscientious effort will be made to locate me/us before emergency action will be taken, but if this is not possible, the expenses of emergency treatment or care will be accepted by me/us.

_____
Parent/Guardian

_____
Parent/Guardian

Emergency Phone Numbers:

Parent/Guardian Name: _____

_____ (Home) _____(Cell) _____(Work)

Parent/Guardian Name: _____

_____ (Home) _____(Cell) _____(Work)

Backup Name: _____

_____ (Home) _____(Cell) _____(Work)

Name and number of child's physician: _____

Name and number of child's dentist: _____

Children's House of Durango

Montessori Education

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970-259-1089

AUTHORIZED PICK-UP LIST

I hereby authorize the following people to pick up my child:

1. Name: _____

_____(Home)_____(Cell) _____(Work)

2. Name: _____

_____(Home)_____(Cell) _____(Work)

3. Name: _____

_____(Home)_____(Cell) _____(Work)

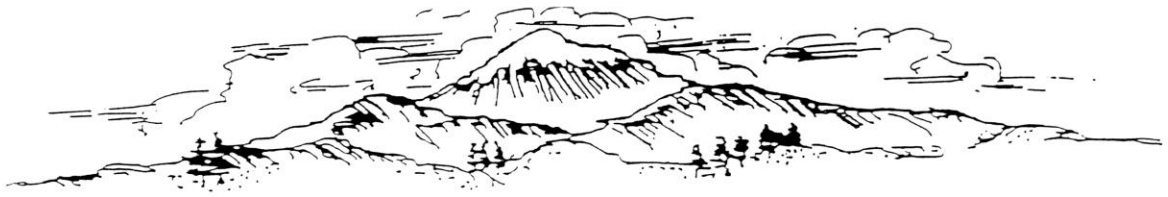
4. Name: _____

_____(Home)_____(Cell) _____(Work)

I understand that my child _____ will be released only to the persons on this list. The school must be contacted in writing to make any changes or additions to the authorized pick-up list.

_____ _____

Signature Date



Children's House of Durango

Montessori Education

1689 West Third Avenue
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970-259-1089

Date: _____

GENERAL INFORMATION

Child's name: _____ Male _____ Female _____

Age: _____ Birth date: _____

Mother's name: _____

Address: _____

Home phone: _____ Work phone: _____

Occupation: _____

Father's name: _____

Address: _____

Home phone: _____ Work phone: _____

Occupation: _____

Are there any special concerns in the areas of vision, hearing, speech, motor abilities, etc., that we should be aware of to best serve your child?

Is your child receiving any services through San Juan BOCS or does he/she require an aide in the classroom? If so, please attach a copy of your child's evaluation.

To give us a better working knowledge of your child as an individual, we ask that you share with us the following "out of school" information.

Socializing:

Has your child attended other preschools? _____ Where? _____

Does your child participate in children's groups or other extracurricular activities?

_____

What are the ages of your child's regular playmates? _____

What are the names and ages of all brothers and sisters?

_____

_____

Will your child be dependent on school for most of his socializing? _____

Does your child enjoy playing alone? _____

Eating Habits:

Does your child have a large or small appetite? _____

Is she/he used to frequent snacking? _____

Does your child readily accept breakfast in the morning?

usually _____ always _____ never _____ seldom _____

Does your child try or willingly accept new foods? _____

Responsibilities:

Does your child dress him/herself?

not at all _____ partially _____ completely _____

Does your child have regular duties at home such as picking up toys, making the bed or feeding pets? _____

_____

CONFIDENTIAL HEALTH RECORD

Has your child had any type of surgery? _____ If yes, please explain:

Is your child on any regular medication? _____ If yes, please explain:

Has your child had chicken pox? _____ (Yes) _____ (No)

If yes, what year? _____

Does your child have any allergies to food? _____ (Yes) _____ (No)

If yes, please list what food(s): _____

Please give a detailed description of your child's reaction to the food(s) listed above:

Is your child allergic to any medication? _____ (Yes) _____ (No)

If so, please list: _____

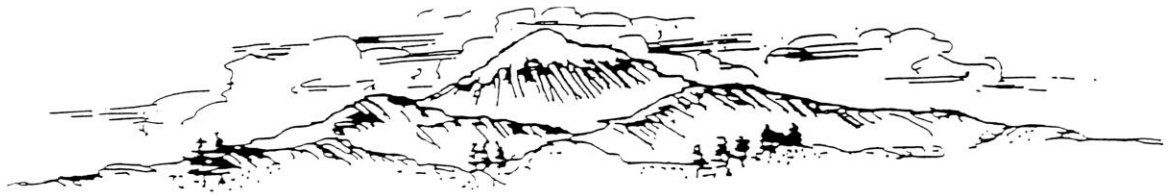
Does your child have any other allergies or illnesses that may arise at school such as asthma? _____ If so, please explain:

To help us better serve your child please describe any childhood illnesses or condition that may effect their behavior or you feel is pertinent:

Has your child ever had a vision or hearing exam? _____ Date? _____

Results? _____

Please remove the "Child's Medical Statement" from this packet and submit it to your to your child's primary care provider to complete and sign. You can return the form directly to the school or have the doctor's office fax it to Children's House at 970-259-1089 along with a copy of your child's immunization record.



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Montessori Education

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970-259-1089

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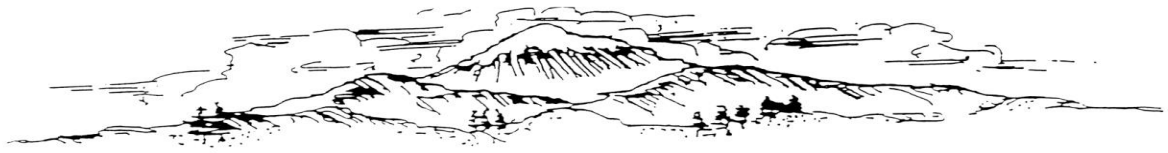

Children's House of Durango

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SUNSCREEN

Children's House staff members will be applying sunscreen to children 30 minutes prior to outdoor activities. We also recommend a sun hat as another way of providing protection and it can be kept in your child's bin. Please label the hat with your child's name if you choose to keep one here are school.

Please sign under ***one of the following options*:

School Will Provide

A Children's House staff member has my permission to assist with applying or to apply a minimum of **SPF 30** sunscreen to my child's exposed skin 30 minutes before outdoor activities.

_____ _____
Signature Date

Parent Will Provide

I choose to supply Children's House with a designated sunscreen for my child and a Children's House staff member has my permission to assist with applying or to apply this sunscreen to my child's exposed skin 30 minutes before outdoor activities. I understand that the sunscreen container must include my child's first and last name and will be kept at school in his/her bin. Children's House will notify me when the sunscreen is low so that I may provide a replacement.

_____ _____
Signature Date

Children's House of Durango

Montessori Education

1689 West Third Avenue
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970-259-1089

POLICIES AND PROCEDURES

I/We have read and agree to the policies and procedures of Children's House, as explained in the Parent Handbook.

_____ _____
Signature Date

_____ _____
Signature Date

PERMISSION TO SHARE PHONE NUMBER, EMAIL AND/OR ADDRESS

I give____ I do not give____ Children's House permission to release my child's name, my name, my address and phone number to other Children's House families on an address list, which will be located on the parent bulletin board. This information will not be released to any other individuals not associated with Children's House. (This is so parents can send out birthday invitations or make play dates etc.)

_____ _____
Signature Date

PERMISSION TO GO ON FIELD TRIPS AND WALKS AT CHILDREN'S HOUSE

My child _____ has permission to leave Children's House for scheduled activities including field trips and walks. I understand that I will be notified in advance of any field trips. My child's car seat or booster (in accordance with Colorado State Law) will be used when traveling in cars. Emergency information and supplies will be brought with Children's House Staff

_____ _____

Children's House of Durango

Montessori Education

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MATERIAL USE

I, _____, understand that as part of the Montessori curriculum, small educational materials and breakable items such as glass and ceramics are accessible to children in the classroom environment. I give permission for my child, _____, to receive lessons in the use of these materials and to use these materials independently while attending Children's House of Durango.

_____ _____
Signature Date

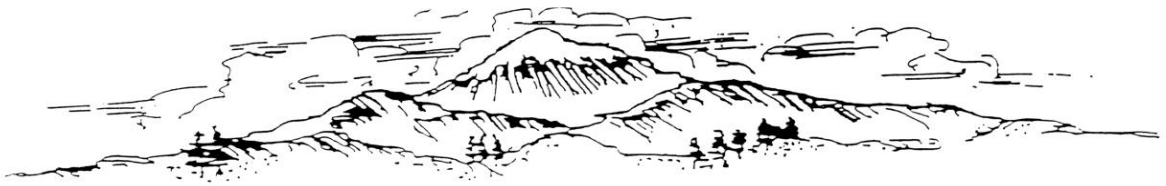
PHOTO PERMISSION

From time to time we take pictures during school activities. We would like your permission to use these pictures on our website, our school's Facebook page, in newsletters, and/or on our bulletin boards. We will never reference your child by name or provide any specific information regarding your child. Please take a moment to let us know your preferences regarding our use of photos of your children:

_____YES. I grant permission to use photos of my child, _____, on the Children's House website & Facebook page (pictures only, no names), newspaper, bulletin boards, and /or newsletters.

_____ NO. Please do NOT take or use any photos of my child, _____.

_____ _____
Signature Date



Children's House of Durango

Montessori Education

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NAP & QUIET TIME POLICY

Please sign under **one** of the following options:

Nap

I would like for my child _____ to take a nap at school after lunch. I understand that I need to provide a blanket clearly labeled with my child's name to be kept at school. I also understand that I will be responsible for taking the blanket home to wash every other week.

_____ _____
Signature Date

Quiet Time

I do not wish my child _____ to take a nap at school. I understand that by signing below my child will have quiet time with stories and music from 1:00-1:45 p.m.

_____ _____
Signature Date

Children's House of Durango

Montessori Education

1689 West Third Avenue Durango, CO 81301
970-259-1089 (telephone & fax number)

CHILD'S MEDICAL STATEMENT

(To be completed by a licensed health care practitioner)

Child's name: _____ Sex: _____

Child's age: _____ Child's birth date: _____

Mother's name: _____ Father's name: _____

Address: _____ Phone number: _____

Surgery: _____

_____

Accidents: _____

Illnesses: _____

_____

Chronic Health Problems: _____

Describe any physical condition requiring the facility's special attention:

_____

_____

Allergies: _____
Vision exam results: _____
Hearing exam results: _____

Physical findings: _____

_____

Comments and recommendations to child care personnel: _____
_____

***Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization and attach to this form.**

Date: _____ Provider's Signature: _____

Provider's Phone: _____

Permission for Medication Administration

Children's House of Durango, LLC * 1689 West Third Avenue* Durango, CO 81301* 970-259-1089 (Phone & Fax)

Name of Child: _____ DOB: _____

Parent Contact Name and Phone Number: _____

Primary Health Care Provider: _____Phone: _____

Medication: _____

Dosage: _____ Route: _____

Time(s) of day medication is to be given: _____

Possible side effects: _____

Purpose of medication: _____

Anticipated number of days it needs to be given at Children's House: _____

Medication stored in the refrigerator? _____ or at room temperature?_____

Date: _____ _____

Signature of Person with Prescriptive Authority

Parent/Guardian

I hereby give my permission for _____

to take the above prescription or over-the-counter medication at Children's House, as ordered by a provider with prescriptive authority. I understand that it is my responsibility to furnish the medication and any medication administration devices.

Date: _____ _____

Signature of Parent or Guardian

Note: The medication is to be brought to the childcare facility in its original pharmacy container appropriately labeled by the pharmacy or person with prescriptive authority along with the above permission form completed. A staff member, who has completed the Medication Administration Curriculum Training, given by a registered nurse, will administer medication to your child.