BEFORE AND AFTER CARE BEGINS ON MONDAY, AUGUST 19TH

Please FIRST register online for Before and After School Care at www.elizabethpr.com. Thank You.

Hello and welcome to the 24/25 Kids Club Before and After Care Program! The Elizabeth Park and Recreation District is very excited to be taking over the Kids Club program this school year.

Before School Care: Please feel free to bring a nut free breakfast to enjoy in the morning.

After School Care: Please pack nut free snacks in your child's school backpack. One nut free snack will be provided.

Please carefully review and complete the following pages. *All forms must be current, completed and returned (addresses below) for each child before the first day of care. In accordance with State of Colorado child care licensing regulations, children cannot attend without the following:

- ☐ Before and After Care Program Application (page 1)
- ☐ Emergency Information (page 2)
- ☐ Pick Up Authorization (page 3)
- ☐ Permission Signatures (pages 4 and 5)
- ☐ Off-Campus/Field Trip Consent (page 6)
- ☐ General Health Appraisal Form (page 7)
- ☐ Certificate of Immunization* (page 8)
- ☐ Asthma Care Plan (if necessary) (page 9)
- ☐ Allergy and Anaphylaxis Plan (if necessary) (pages 10 and 11)

*This is the standard form provided by the State of Colorado. Your physician can use this form or a differently formatted, certified immunization form.

Please contact me with questions.

With Joy,

Tina Brisnehan, MEd

Email: tina@elizabethpr.com (scans accepted here)
Mail or Drop Off: Elizabeth Park and Recreation District, PO Box 434, 34201 County Road 17, Elizabeth, 80107

Kids Club

Before and After Care :: Program Application

Application Date: _____

Child's Name:_____

Last First Birthdate Age

_____

Home Address City Zip

_____

Mailing Address (if different than above)

_____

Name of Parent/Legal Guardian 1 Email Relationship to Child

_____

Cell Phone Home Phone Work Phone

_____

Employer Name Employer Address

_____

Name of Parent/Legal Guardian 2 Email Relationship to Child

_____

Cell Phone Home Phone Work Phone

_____

Employer Name Employer Address

Child Lives With:

{ } Both Parents
{ } Father Only
{ } Legal Guardian(s)
{ } Mother Only
{ } Foster Parents
{ } Other

_____

Child's School Name City Zip

_____

Names and Ages of Siblings Also Attending EPR Kids Club

Any applicant who knowingly or willfully makes a false statement of any material fact of thing in this application is guilty of perjury in the second degree as defined in Section 18-8-503, C.R.S., and, upon conviction thereof, shall be punished accordingly.

Emergency Information

Child First Name Last Name

Contacts

In addition to the parents/legal guardians, the child will not be released to anyone who is not specified below in the event of illness or injury. Emergency Contacts must be prepared to show valid picture identification and be over the age of 16.

Emergency Contact #1 First Name	Last Name	Relationship to Child
Home Address	City	Zip
Cell Phone	Home Phone	Work Phone
Employer Name	Employer Address	
Emergency Contact #2 First Name	Last Name	Relationship to Child
Home Address	City	Zip
Cell Phone	Home Phone	Work Phone
Employer Name	Employer Address	

Physician and Dentist Information

Child's Physician First Name	Last Name	Phone
Address	City	Zip
Child's Dentist First Name	Last Name	Phone
Address	City	Zip

Emergency Information (cont.) _____

Child First Name Last Name

Preferred Hospital (circle or write in)

Parker Adventist Sky Ridge Medical Center Other: _____

I, the undersigned, do hereby authorize EPR Kids Club employees and staff to contact, directly or indirectly, the persons named above, and to render such treatment as may be deemed necessary in an emergency for the health and safety of the child. In the event the parents or other persons named on this form cannot be contacted, school officials are hereby authorized to take whatever actions are deemed necessary in their judgment for the health and safety of the child.

_____

Parent/Legal Guardian Printed First Name Printed Last Name Signature

Pick Up Authorization

In addition to the parents/legal guardians, the child will not be released to anyone who is not specified below. Contacts listed below must be prepared to show valid picture identification and be over the age of 18. In an emergency case where someone not on this list must pick up the child, the parent/legal guardian must email the Childcare Programs Coordinator or call the Elizabeth Park and Recreation office at (303) 646-3599 with an explanation and the full name and phone number of the temporary authorized pick up person.

_____may be picked up from the EPR Kids Club program
Child's First Name Last Name
by the following:

First Name	Last Name	Relationship to Child
Home Address	City	Zip
Cell Phone	Home Phone	Work Phone
First Name	Last Name	Relationship to Child
Home Address	City	Zip
Cell Phone	Home Phone	Work Phone
First Name	Last Name	Relationship to Child
Home Address	City	Zip
Cell Phone	Home Phone	Work Phone
First Name	Last Name	Relationship to Child
Home Address	City	Zip
Cell Phone	Home Phone	Work Phone

Permission Signatures

Child's First Name Last Name

Sunscreen, Lip Balm, Lotion

I give my permission for my child to apply sunscreen, lip balm and/or lotion under staff supervision and with assistance, if needed. I understand that all sunscreen, lip balm and/or lotion brought from home must be labeled with my child's name and given to a staff member. I understand that staff will provide Rocky Mountain Sunscreen SPF 30 to be applied when appropriate, if one from home is not provided.

Parent/Legal Guardian Printed First Name Printed Last Name Signature

Photography

I give my permission for my child to be photographed, including digital, video and/or motion methods, either individually or in a group for internal/program use.

Parent/Legal Guardian Printed First Name Printed Last Name Signature

I give my permission for my child to be photographed, including digital, video and/or motion methods, either individually or in a group for print or digital marketing purposes, including Facebook and/or Instagram.

Parent/Legal Guardian Printed First Name Printed Last Name Signature

Child Protection

I understand that all staff are required by law to report any suspected child abuse or neglect to the Department of Human Services.

Parent/Legal Guardian Printed First Name Printed Last Name Signature

Movie Permission

I give my permission for my child to view G and pre-screened PG rated videos.

Parent/Legal Guardian Printed First Name Printed Last Name Signature

Permission Signatures (continued)

Exclusion Policy Based on Needs

If it is determined that my child's needs exceed the service capacity of the program, the child may be denied acceptance into the program.

Parent/Legal Guardian Printed First Name	Printed Last Name	Signature

Termination of Services

I understand that my child may be terminated from the program for the following:

Unsafe or unhealthful behavior towards self, other children or adults.
Missing or incomplete paperwork including immunization record.
Failure to pay tuition.
Failure to follow program policies.

Parent/Legal Guardian Printed First Name	Printed Last Name	Signature

Indemnification

I agree to indemnify and hold harmless Elizabeth Park and Recreation District (EPR) for any and all claims, demands, costs, expenses, including reasonable attorney's fees that EPR may suffer as a result of any claim, action, demand or judgment against it arising from the attendance of Before and After School Care by this applicant. Provided, however, that the above and foregoing shall not be construed to indemnify EPR from any act of negligence or fault on the part of EPR, its officers, agents or employees.

Parent/Legal Guardian Printed First Name	Printed Last Name	Signature

Consent Form For Off-Campus Activity/Field Trips

I _____ give permission for _____ to attend off site field trips for the Kids Club Program. My signature on the field trip sign up sheet will serve as permission for each time we leave the campus.

All children attending Kids Club programming on field trip days will be required to be part of the trip. No extra staff will be available to stay behind.

1. The parent or legal guardian acknowledges that there are potential and unknown risks beyond the expected risks associated with normal activities on the Singing Hills Elementary School property. These may include, but are not limited to, risk of personal injury, sickness, death, and loss or damage to personal property. 2. The parent or legal guardian whose signature appears below, exempts Elizabeth Park and Recreation District, its employees, and authorized volunteers, from all claims arising from the student's participation in the activity/trip, unless caused by actions for which Elizabeth Park and Recreation District would otherwise be liable under Colorado State Law. 3. The student must use the provided transportation. This may include transportation by common carriers as well as any authorized driver of private vehicles.

All children who attend off site activities are expected to behave in a safe, responsible manner at all times. Children who do not behave appropriately on trips will not be able to continue participation in off site activities.

Please describe any allergies, medications, or other medical problems your child may have:

_____

Pediatrician Name:_____ Phone: _____

Health Insurance Information

Provider:_____ Subscriber Name: _____

Policy Number:_____ DOB of Insured: _____

Contact Information

Primary Contact Person:_____ Cell Phone #: _____

Emergency Contact:_____ Cell Phone #: _____

I, the undersigned, do hereby authorize EPR Kids Club employees and staff to contact, directly or indirectly, the persons named above, and to render such treatment as may be deemed necessary in an emergency for the health and safety of the child. In the event the parents or other persons named on this form cannot be contacted, school officials are hereby authorized to take whatever actions are deemed necessary in their judgment for the health and safety of the child.

_____

Parent/Legal Guardian Printed First Name Printed Last Name Signature

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

cdphe.colorado.gov/immunization

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 Advisory Committee on Immunization Practices (ACIP) schedule. If the student provides an immunization record in any other format apart from this Certificate or an Approved Alternate Certificate (details found at cdphe.colorado.gov/immunization/forms), the school health authority must transcribe the record onto this form. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at sixth grade entry.

Student Name: . . . . . **Date of birth:** . . . . .

Parent/guardian:(if student is under 18 years of age and not emancipated) . . . . .

Required Vaccines

	Immunization date(s) MM/DD/YY						Titer Date* MM/DD/YY
HepB 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	

*The shaded area under "Titer Date" indicates that a titer is not acceptable proof of immunity for this vaccine.

In several instances, laboratory confirmation of positive titers are an acceptable alternative to written documentation of vaccination. A positive laboratory titer report must be provided to the school to document immunity. More information on titers can be found within the Colorado Board of Health rule 6 CCR 1009-2.
† For DTaP and Tdap, both the diphtheria and tetanus titers must be positive. A titer is never acceptable to demonstrate immunity to pertussis.
‡ Laboratory confirmation of positive titers are an acceptable alternative to the MMR vaccine only when titers for all three components (measles, mumps, and rubella) are positive.

Recommended Vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
RV Rotavirus							
MCV4 Meningococcal							
MenB Meningococcal							
HepA Hepatitis A							
Flu Influenza							
COVID-19							
Other							

Health care provider printed name/signature: _____ / _____ Date: _____

Student is current on required immunizations for age (circle one): OR Yes No
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: _____

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS*

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

I approve this care plan and give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), and to comply with board policies, if applicable. I am aware ***911 may be called if a quick relief inhaler is not at school*** and my child/youth is experiencing symptoms.

Parent/Guardian Signature _____ **Date** _____

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ **Albuterol** ☐ **Other**: _____

Common side effects: ↑ heart rate, tremor ☐ **Use spacer with inhaler (MDI)**

Controller medication used at home: _____

TRIGGERS: ☐ **Weather** ☐ **Illness** ☐ **Exercise** ☐ **Smoke** ☐ **Dust** ☐ **Pollen** ☐ **Poor Air Quality** ☐ **Other:** _____

☐ **Life threatening allergy specify:** _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.

☐ Student understands proper use of asthma medications, and in my opinion, can **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely Give **QUICK RELIEF MED** 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray/blue	1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs ***Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

Health Care Provider Signature _____ **Print Provider Name** _____ **Date** _____

Good for 12 months unless specified otherwise in district policy.

Fax _____ **Phone** _____ **Email** _____

School Nurse/CCHC Signature _____ **Date** _____

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

Colorado Allergy and Anaphylaxis Emergency Care Plan and Medication Orders

To be completed by healthcare provider

Student's Name: _____ D.O.B. _____ Grade: _____

School: _____ Teacher: _____

ALLERGY TO: _____

HISTORY: _____

_____

Place child's photo here

Asthma: ☐ YES (higher risk for severe reaction) – refer to their asthma care plan
☐ NO

◊ STEP 1: TREATMENT

SEVERE SYMPTOMS: Any of the following:
- LUNG: Short of breath, wheeze, repetitive cough
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Swelling of the tongue and/or lips
- HEART: Pale, blue, faint, weak pulse, dizzy
- SKIN: Many hives over body, widespread redness
- GUT: Vomiting or diarrhea (if severe or combined with other symptoms
- OTHER: Feeling something bad is about to happen, Confusion, agitation

→

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
   - Ask for ambulance with epinephrine
   - Tell EMS when epinephrine was given
3. Stay with child and
   - Call parent/guardian and school nurse
   - If symptoms don't improve or worsen give second dose of epi if available as instructed below
   - Monitor student; keep them lying down. If vomiting or difficulty breathing, put student on side

Give other medicine, if prescribed. (see below for orders) Do not use other medicine in place of epinphrine. **USE EPINEPHRINE**

MILD SYMPTOMS ONLY:
- NOSE: Itchy, runny nose, sneezing
- SKIN: A few hives, mild itch
- GUT: Mild nausea/discomfort

→

1. Stay with child and
   - Alert parent and school nurse
   - Give antihistamine (if prescribed)
2. If two or more mild symptoms present or symptoms progress **GIVE EPINEPHRINE** and follow directions in above box

DOSAGE: **Epinephrine**: inject intramuscularly using auto injector (check one): ☐ **0.3 mg** ☐ **0.15 mg**

☐ If symptoms do not improve ____ minutes or more, or symptoms return, 2nd dose of epinephrine should be given if available

Antihistamine: (brand and dose)_____

Asthma Rescue Inhaler (brand and dose)_____

Student has been instructed and is capable of carrying and self-administering own medication. ☐Yes ☐No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____ Date: _____

◊ STEP 2: EMERGENCY CALLS ◊

1. If epinephrine given, **call 911**. State that an anaphylactic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.
2. Parent: _____ Phone Number: _____
3. Emergency contacts: Name/Relationship Phone Number(s)
   a. _____ 1) _____ 2) _____
   b. _____ 1) _____ 2) _____

DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Parent/Guardian's Signature: _____ Date: _____

School Nurse: _____ Date: _____

Student Name: _____ **DOB:** _____

Staff trained and delegated to administer emergency medications in this plan:

1._____ Room _____

2._____ Room _____

3._____ Room _____

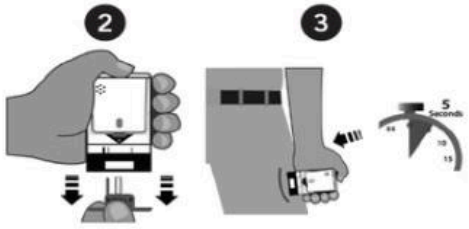
Self-carry contract on file: ☐Yes ☐No

Expiration date of epinephrine auto injector: _____

Keep the child lying on their back. If the child vomits or has trouble breathing, place child on his/her side.

AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.

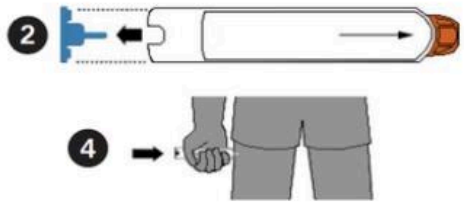


ADRENACLICK® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle enters thigh.
5. Hold in place for 10 seconds. Remove from thigh.

EPIPEN® AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the clear carrier tube.
2. Remove the blue safety release by pulling straight up without bending or twisting it.
3. Swing and firmly push orange tip against mid-outer thigh until it 'clicks'.
4. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove auto-injector from the thigh and massage the injection area for 10 seconds.



If this conditions warrents meal accomodations from food service, please complete the form for dietary disabilitiy if required by district policy.

Additional information:_____

_____

_____

_____

Adopted from the Allergy and Anaphylaxis Emergency Plan provided by the American Academy of Pediatrics, 2017